How Obamacare May Limit Projected Expenses in Personal Injury Life Care Plans

Plaintiffs in personal injury litigation often rely on life care plans to increase the value of their damages claim. A life care plan is a personalized projection of a plaintiff’s future medical expenses arising from the defendant’s alleged negligence. The plan comes in the form of a report, and is usually prepared by a medical doctor or certified life care planner, with a supplemental report by an economist. A life care plan has the potential to significantly maximize (or inflate, depending on which side you speak to) a damages award, as future medical expenses are one of the largest categories of damages claimed by an injured person.

Defense attorneys primarily attack life care plans by arguing that the plan anticipates medical needs that have no basis in the evidence, or that the projected costs for those needs are purely speculative. The jury is free to consider the life care plan as it considers any other evidence, by assigning as much or as little weight as it sees fit.

However, one attack that the jury is forbidden from considering is whether the plan factors the plaintiff’s health insurance coverage into its projection of future expenses. Because health insurance is off-limits to the jury, life care plans rarely, if ever, take the plaintiff’s health insurance into consideration. Therefore, life care plans often assume that 100% of future medical expenses are to be paid out-of-pocket by the plaintiff. That result usually does not comport with reality, as many projected expenses are in fact covered by the plaintiff’s health insurance.

The Affordable Care Act may change this calculus.

When the law is fully implemented, the Patient Protection and Affordable Care Act (the “ACA”), better known as Obamacare, will result in almost all Americans being covered by some minimum level of quality health insurance, without regard to preexisting conditions. The
question that will be litigated in the coming months and years is whether it remains fair to continue to force the fiction upon the jury that future medical expenses projected by a plaintiff’s life care plan will be paid 100% out-of-pocket, when in the post-ACA world, that will be the case for almost no one.

The Present Common Law and Statutory Landscape

The rule against considering health insurance finds its roots in the common law. At common law, the jury is forbidden from considering evidence that a plaintiff’s health insurance will cover any amount of future medical costs. As such, defendants in states that apply the common law rule are precluded from attacking a life care plan on the basis that most, if not all, of the projected future medical costs will be covered by the plaintiff’s health insurance. Because the jury is prevented from hearing such evidence, there is the potential under the common law rule for a plaintiff to obtain a double-recovery for medical expenses; one from a jury’s damages award, and one from the plaintiff’s health insurance.

Many states, including New York, responded to the double-recovery issue by adopting so-called collateral source statutes. New York’s collateral source statute is codified in section 4545 of the Civil Practice Law and Rules (“CPLR”). CPLR § 4545 does not displace the common law rule, instead, it provides a compromise. Evidence of health insurance coverage is still generally inadmissible before the jury. However, the judge may consider such evidence in a separate “collateral source hearing,” held after the jury has rendered a damages verdict. At the collateral source hearing, the defendant is permitted to present evidence before the judge of the

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1 See, e.g., Inchaustegui v. 666 5th Ave. Ltd. P’ship, 268 A.D.2d 121 (1st Dept. 2001).
3 Id.
4 See CPLR § 4545; see also Wooten v State of New York, 302 AD2d 70 (4th Dept. 2002) lv denied 1 NY3d 501 (NY 2003); Teichman v Community Hosp. of W. Suffolk, 205 AD2d 16 (2 Dept., 1994), mod on other grounds, 87 NY2d 514 (NY 1996).
plaintiff’s health insurance coverage, and if the judge determines that the evidence establishes a "reasonable certainty" that whatever future medical expenses identified by the defendant will be covered by the plaintiff’s health insurance, conditioned only upon the plaintiff’s continued payment of premiums, then the plaintiff’s damages award is reduced accordingly.\(^5\)

Therefore, under current New York law, as with the common law, defendants in New York courts may not attack a plaintiff’s life care plan in front of the jury with evidence of the plaintiff’s health insurance coverage. Instead, determinations regarding health insurance are made by the judge, post-verdict, at the collateral source hearing.

**The Affordable Care Act Undermines the Policy Behind CPLR § 4545**

The implementation of the ACA presents a challenge to the present evidentiary and procedural scheme. Defendants in the near-future will undoubtedly argue that if the ACA will result in near-universal health care coverage, then there is no reason for the jury continue to be forbidden from considering a plaintiff’s health care coverage when evaluating a life care plan’s prediction of future medical expenses. The question on the horizon is whether implementation of the ACA should cause the courts or legislature to finally allow direct presentation of the plaintiff’s health insurance coverage to the jury, instead of the collateral source hearing work-around that CPLR § 4545 provides.

The policy considerations behind the common law rule and collateral source statutes like CPLR § 4545 are rooted in nineteenth century understandings of health insurance.\(^6\) At that time, most individuals were not covered by health insurance.\(^7\) It was rare for employers to pay any

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\(^5\) The CPLR § 4545(a) formula provides that the court shall reduce the award by the amount of collateral source payments “minus an amount equal to the premiums paid by the plaintiff for such benefits for the two-year period immediately preceding the accrual of such action and minus an amount equal to the projected future cost to the plaintiff of maintaining such benefits.”


\(^7\) *Id.*
portion of health insurance premiums, so the few individuals who were insured did so on their own initiative, by paying all premiums out-of-pocket.\textsuperscript{8} Seeing the economic utility in health insurance, courts sought to incentivize and protect the individual decision to purchase insurance by prohibiting the jury from considering evidence of it when determining the medical expense portion of damages.\textsuperscript{9} Hence, the common law rule was born.

CPLR § 4545 was enacted in the late twentieth century, recognizing the new reality that most people had some form of health insurance, and thereby providing for the collateral source hearing to eliminate the double-recovery issue. However, by keeping intact the common law rule’s prohibition against presenting evidence of health insurance directly to the jury, state collateral source statutes recognized that fundamentally, the decision to obtain health insurance coverage was a matter of individual choice, which should still be incentivized and protected by the courts as a matter of public policy.

The ACA’s individual mandate undermines the policy considerations at the foundation of both the common law rule and the state collateral source statutes. Under the ACA, purchasing health insurance is no longer a choice. The ACA provides that all citizens must obtain health insurance, with only a few exemptions. Therefore, it is no longer necessary to incentivize and protect what was historically an individual choice to purchase health insurance, because obtaining health insurance is now required by statute.

Given the twenty-first century realities of health insurance coverage, it will not be long before state and federal courts, as well as state legislatures, are confronted with arguments that statutes like CPLR § 4545 should no longer preclude the jury from directly considering evidence of a plaintiff’s health insurance.

\textsuperscript{8} Id.
\textsuperscript{9} Id.
The Effect on Life Care Plans

If defendants in an ACA world are permitted to dispense with the collateral source hearing and present evidence of health insurance coverage directly to the jury, such evidence should significantly curtail the persuasiveness that life care plans’ projections represent actual future medical expenses that are supposedly to be paid completely out-of-pocket by the plaintiff. While such projections were already suspect in the pre-ACA world, where most individuals had some form of health insurance coverage, such projections will be further compromised following the ACA’s implementation, where all individuals will be required to purchase quality health insurance, with the emphasis on quality.

Juries will have to be presented with the reality that that the expensive medical care that a plaintiff’s life care plan projects will be mostly covered by health insurance, and as such, the plaintiff will suffer mitigated economic injury to the extent that her future medical expenses are covered.

Some Limitations

Certain future expenses that are often staples of life care plans will never be covered by health insurance, no matter how quality the coverage. Expenses such as long term care, nursing care, and homecare, which are known in the insurance industry as “permanent confinement issues” are hardly ever covered by health insurance. Those expenses are often extremely pricey, and are paid either out-of-pocket, or by short and long term disability insurance, if the individual has obtained such insurance. The ACA is limited to health insurance, not disability insurance, so, the decision to purchase disability insurance remains an individual choice not mandated by statute. Therefore, the portions of a plaintiff’s life care plan pertaining to such expenses would
remain free from the new attacks occasioned by the ACA, and would still be worked out at the collateral source hearing required by CPLR § 4545.

Similarly, other expenses, such as continuous physical therapy and occupational therapy, are often capped by most health insurance plans at a certain number of visits. These are known as “frequency issues” by insurers. Life care plans often project extensive numbers of such visits, which often go beyond the frequency cap of even the highest quality health insurance policies. Therefore, to the extent that a plaintiff’s health insurance contains a frequency cap, those non-covered expenses projected by the life care plan will remain out-of-pocket.

A potent argument against allowing direct presentation of future health insurance coverage to the jury is that although the ACA’s individual mandate will result in near-universal coverage, it does not account for the innumerable variations in coverage levels that are available. As an individual goes through life, he or she will likely go through several different insurance policies, all with various levels of coverage. The argument goes that it is impossible to predict what level of coverage an individual will have at any given point in the future, and that the ACA merely assures that the individual will have some coverage. Therefore, it is claimed that life care plans should remain free from attack in front of the jury on account of failure to factor in future health insurance.

This argument has the potential to be extensively litigated in the future. Given the infancy of the ACA’s implementation, there is very little settled law on this matter as of yet. However, an unreported California state court case, Aidan Ming-Ho Leung v. Verdugo Hills Hospital, provides at least some insight. Leung involved a medical malpractice claim that resulted in a jury verdict that included a damages award for future medical expenses. The hospital defendant argued on appeal that it should have been permitted to introduce evidence of
the plaintiff’s health insurance to rebut the plaintiff’s alleged future medical expenses in part because due to the ACA, “the availability of such federally mandated available insurance options makes the prospect of future health insurance coverage for plaintiff anything but speculative.”

The court was not persuaded, holding “such evidence, standing alone, is irrelevant to prove reasonably certain insurance coverage…because it has no tendency in reason to prove that specific items of future care and treatment will be covered, the amount of that coverage, or the duration of that coverage.”

Obviously, personal injury defendants will claim the Leung court failed to take into account the ACA’s minimum coverage requirements. Under the ACA, all plans will be required to meet a certain minimum coverage standard. Therefore, while it is true that there will be future variations above and beyond that minimum standard, it is also true that notwithstanding any such variation, all plans policies will maintain a certain required baseline. As such, at the very least, defendants will argue that the jury should be permitted to consider an attack on a life care plan that fails to take into account the fact that no matter what health care coverage a plaintiff may obtain in the future, any such coverage must meet the ACA’s minimum requirements.

Conclusion

The intersection of the ACA and life care plans has only barely begun to materialize. The issue has received scant attention in the academic literature, and only one case, Leung, has dealt with the issue. However, as the ACA’s implementation progresses and the full effects of the law are digested by society, both academics and practitioners will have no choice but to

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10 Aidan Ming-Ho Leung v. Verdugo Hills Hospital, 2013 WL 221654 (CA Ct. App., 2013)
11 Id.
wrestle with the issue more thoroughly. In the interim, expect New York’s insurance defense bar to begin sharpening its spears, as the type of argument discussed above begins to make its way into New York’s courts.

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