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ACA Could Be Used To Cut Future Damages Down To Size

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In passing the Patient Protection and Affordable Care Act, Congress may have unintentionally passed significant federal tort reform legislation. As the application of several of the key parts of the ACA have become clearer, tort defendants have begun to argue, and some courts have recognized, that the ACA may provide a basis to substantially limit future damages. By providing for mandatory insurance coverage, including requirements for many "essential health benefits" and setting annual cost limits that an insured may pay for such coverage, the ACA could redefine not only the prospect of future coverage, but the calculation of what such coverage may cost to a plaintiff claiming future medical damages.

Plaintiffs rely on the collateral source rule — still the law in many states — as a basis to argue that evidence of prospective ACA coverage is inadmissible. The collateral source rule, in essence, prohibits the admission of evidence that the plaintiff or victim has received compensation from some source other than the damages sought against the defendant. The rule dates back, however, to a time where many individuals lacked health insurance and when the prospect of future insurance coverage was speculative at best. Despite the longstanding application of the rule in many states, it appears that defendants may be starting to make headway in convincing courts that evidence of ACA coverage and cost limits is admissible.

Two trial court rulings in Ohio are illustrative on this point. In Jones v. MetroHealth Medical Center, No. CV 11-75713 (Cuyahoga County Ohio Court of Common Pleas April 14, 2015), the court ruled, following a post-trial hearing, that an offset of damages was appropriate, in part on the availability of insurance coverage to the plaintiff under the ACA. The court observed as follows:

All of the experts testified that [plaintiff] will qualify for Medicare at age 20 and the plaintiffs' argument that it is possible Medicare will not be available lacks merit. As it exists now, the evidence before the

court shows Medicare covers 80 percent of customary and ordinary care. Therefore, the expenses allocated to age 20 for all categories in the Life Care Plan, except Transportation, Home Care and Housing should be set off in their entirety and the amount remaining should then be set off by 80 percent to account for what Medicare would cover, adding in the cost of care under the Affordable Care Act for the eight-year period until [plaintiff] becomes eligible for Medicare and then deducting the previous three years allocated to Transportation. Therefore, after all of the deductions, [plaintiff]'s award for future economic damages should be reduced to $2,951,291 [from $8,000,000].

Additionally, the court stated that, "[a]t most, [plaintiff]'s premium under the ACA would be $8,000 per year, with $6,500 for maximum out-of-pocket expenses. Multiplying those expenses by the amount of years he could at most be ineligible for Medicaid and/or Medicare, his annual maximum totals $116,000." (Currently, the out-of-pocket cost limit for any individual Marketplace plan is $6,600; an individual's premium varies based on age, location, tobacco use and type of plan chosen.) As such, the court rejected the plaintiff's argument that future damages were not limited because insurance was not guaranteed to be available and that any setoff would be speculative.

A later Ohio Court of Common Pleas ruling came to a similar conclusion. In Christy v. Humility of Mary Health Partners, No. 2013 CV 01598 (Trumball County Ohio Court of Common Pleas May 4, 2015), the court denied the plaintiff's pretrial motion to preclude the defendant from (1) introducing past medical bills as evidence of amounts previously accepted as payment by certain medical providers (as opposed to full billing rates) and (2) referencing the ACA or Medicaid. With regard to the plaintiff's second argument, the court declared that evidence of the ACA is admissible "as it is the law of the land." The court also found it improper for the plaintiff to introduce "full billed" future medical costs, suggesting that doing so would grossly overstate the plaintiff's damages.

Courts in other jurisdictions have also admitted ACA-related evidence, but some have not gone so far as to allow the evidence to include the effect on a plaintiff's out-of-pocket costs or the availability of coverage. See, e.g., Donaldson v. Advantage Health Physicians PC, No. 11-69181-NH (Kent County Circuit Court Mich. 2015) (ruling that defendants could discuss/argue "medical care and therapies" provided by insurance through the ACA, because such coverage was "reasonably likely to continue into the future"); First Banker's Trust Company v. Memorial Medical Center, No. 11L184 (7th Judicial Circuit Ill. April 2, 2015) ("Defendants may produce evidence of the [ACA] only as to its effect on the actual reasonable costs of medical services. Defendants may not refer in any manner to the act's effect on out of pocket costs payable by the plaintiff or on insurance coverage that may be available to plaintiff.")

All of these cases seem to undermine a key argument often raised by plaintiffs with regard to ACA evidence — that availability of future coverage is speculative. Despite current political debate as to whether the ACA will survive, the above-mentioned courts appear confident in the Supreme Court's decision upholding the individual mandate (which virtually guarantees the availability of medical coverage for the vast majority of Americans).

As evidenced by the court's ruling in Jones v. Metrohealth, evidence of coverage and out-of-pocket cost limits under the ACA may prove to be useful to defendants seeking to limit future damages, which is often the most substantial element of a plaintiff's damages award. In contesting plaintiff's life care planning estimates, defendants should seek to introduce evidence of the ACA's identified "essential health benefits" that must be covered by most health insurance plans. These include 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 (such as prosthetics and wheelchairs), as well as physical and occupational therapy.

Given the out-of-pocket costs limits under the ACA, and the broad categories of essential coverage, use of an expert to calculate damages in light of the ACA and/or use of effective cross-examination of a plaintiff's expert on this topic, may result in significantly decreased and more realistic damages awards if the court is willing to entertain such evidence. Accordingly, defense counsel should be aware of, and appropriately pursue, the admission of such evidence.

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