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# ACA's Impact On 'Most Likely' Cost Of Future Care

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The Patient Protection and Affordable Care Act was championed by Former President Barack Obama to provide all persons in the United States with near-universal health care. The ACA is generally regarded as the most significant statutory reform of the United States health care system in decades. Addressing the implementation of the ACA, Obama declared: "In the United States of America, health care is not a privilege for the fortunate few — it is a right." White House Office of the Press Secretary, Remarks by the President on the Affordable Care Act at Prince George's Community College (Sept. 26, 2013).


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Since its adoption on March 23, 2010, the ACA has withstood a barrage of both legislative and constitutional challenges, see e.g., National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566 (2012); King v. Burwell, 135 S. Ct. 2480 (2015), and has largely remained intact and unscathed. Notwithstanding continued opposition, the ACA remains the governing law of the land. As a result, legislators, judges and attorneys must critically assess the ACA's effect upon Nevada law, and, more specifically, must determine whether evidence of the cost of coverage under the ACA should now be viewed as the "most likely" cost of future care.

**Essential Components of the ACA**

The ACA was designed to improve access to the health care and health insurance markets, reduce the escalating costs of health care and minimize cost-shifting. Two of the essential components of the ACA, which are highly critical to this analysis, are (1) the creation of state operated "health benefit exchanges" and (2) the "guaranteed issue requirement" (i.e., preventing the denial of coverage to individuals with pre-existing conditions). Each are briefly explained below.

**State Exchanges and Minimum Essential Benefits**

The ACA provides for the creation of state-operated "health benefit exchanges," which allow individuals and small business to leverage their collective buying power to obtain price-competitive health insurance. See 42 U.S.C. § 18031. These exchanges provide a place where the uninsured individuals, families and small employers can shop for and buy new products and are designed to make insurance more accessible and affordable. All "qualified plans" on the state exchanges are required to provide "minimum essential coverage," which covers expenses such as: (1) ambulatory patient services; (2) emergency room services; (3)

hospitalization; (4) mental health and substance abuse; (5) prescription drugs; (6) rehabilitative services and devices; (7) laboratory services; and (8) preventative and wellness services and chronic disease management.

**Guaranteed Issue Requirement**

The "guaranteed issue requirement" bars insurance companies from denying coverage to individuals with pre-existing conditions. See 42 U.S.C. §§ 300gg-19(a) to 300gg-39(a); 42 U.S.C. § 18001. It works in conjunction with the "community rating requirement," which prohibits insurance companies from charging higher rates to individuals based upon their medical history. Further, every health insurance issuer that offers health insurance coverage in the individual or group market in a state must accept every employer and individual in the state that applies for such coverage, insurance companies are prohibited from "dumping" individuals based on their health, and neither annual nor lifetime limits on dollar value of benefits for minimum essential benefit plans is permitted. This means that a person can obtain guaranteed coverage under the act, even after she is injured.

**ACA and the Probability that Future Costs Will be Incurred**

In order to recover future medical expenses, a plaintiff must show "a reasonable probability that such expenses will be incurred." Yamaha Motor Co. v. Arnoult, 114 Nev. 233, 249 (1998); see also Nev. J.I. 10.02 (providing that recoverable future medical expenses are those that a jury believes a plaintiff "is reasonably certain to incur"). With the enactment of the ACA, there is no longer a "reasonable probability" that a plaintiff will incur expenses in excess of the cost of premiums under the ACA. No reasonable plaintiff would voluntarily incur medical costs out of pocket if it would be less expensive to have those costs covered by insurance obtained through the ACA. In fact, recovery of medical costs at their reasonable market value would provide a windfall to plaintiffs who could purchase insurance through the exchange and put the rest of the money in their pockets.

**ACA and a Plaintiff's Duty to Mitigate Damages**

It is unquestioned that an injured person cannot recover for damages that could have been avoided by the exercise of reasonable care. Automatic Merchandisers Inc. v. Ward, 98 Nev. 282, 646 P.2d 553 (1982). A plaintiff is not entitled to recover damages for any harm that she could have avoided by the use of reasonable effort or expenditure after the commission of a tort. See e.g., Restatement (Second) of Torts § 918(1) (1979). If purchasing insurance through the ACA will reduce the cost of a plaintiff's future medical care, the plaintiff would have a duty to mitigate damages by purchasing available insurance options that would reduce the cost of future care. Indeed, that duty is consistent with the affirmative obligation under the ACA for all persons to be covered by insurance. See 26 U.S.C. § 5000A (the individual mandate requires every "applicable individual" to obtain "minimum essential coverage" or otherwise pay a penalty).

**Role of the Collateral Source Rule**

The most glaring obstacle to whether evidence of the cost of insurance should be admissible in personal injury litigation is the collateral source rule. The collateral source rule has been a staple in Nevada personal injury law for more than two decades. Adopted by the Nevada Supreme Court in Proctor v. Castelletti, 112 Nev. 88 (1996), the rule prohibits the admission of evidence that the plaintiff has received compensation from a source wholly independent of the defendant. The Nevada Supreme Court's recent holding in Khoury v. Seastrand, 132 Nev. Adv. Op. 52, 377 P.3d 81 (July 28, 2016) provides instruction as to whether the collateral source rule will bar the admission of evidence of insurance to mitigate future medical damages in personal injury litigation in light of the ACA.

In Khoury, the Nevada Supreme Court held that medical liens do not implicate the collateral source rule.

The court reached this conclusion because plaintiffs, not third parties, pay for medical treatment when obtained on liens. As a result, the collateral source rule is not implicated. As this reasoning applies to the present analysis, if a defendant is found liable, the defendant will provide the funds necessary for the plaintiff to purchase ACA insurance. The funds provided by the defendant would not only cover much of the plaintiff's future care, but would also enable the plaintiff to comply with her legal obligations under the ACA's individual mandate. Because the future insurance would be purchased with funds provided by the defendant, the insurance would not be "wholly independent" of the defendant. The collateral source rule should not bar the admission of such evidence.

**Pre-ACA Rationale is Inapplicable**

Many arguments have been made supporting the exclusion of evidence of insurance to mitigate future medical expenses in personal injury litigation, including that future coverage is uncertain because of an insurer's right to deny, or drop, coverage because of a pre-existing condition, or because the type of coverage is unknown or speculative, or because insurance is neither a right nor a guarantee. Such arguments have been eliminated as a result of the implementation of the ACA.

Individuals may no longer be denied, or dropped from, coverage as a result of a pre-existing condition. Individuals are also provided more certainty as to what future medical expenses will be covered in light of "minimum essential coverage" plans. Neither annual nor lifetime caps may be placed on individuals' benefits. Thus, the pre-ACA rationale for excluding insurance to mitigate future medical expenses in personal injury litigation is no longer applicable in our post-ACA society. While it could be argued that the ACA may be repealed or modified with the election of President Donald Trump, a court must base its legal analysis on the law as it exists — not on speculation as to how the law may change in the future.

**Conclusion**

Evidence of the cost of insurance under the ACA should be admissible to show the amount of expense an injured plaintiff is reasonably certain to incur in the future. Such evidence does not implicate the collateral source rule and plaintiffs have a duty to mitigate their damages, which includes purchasing insurance under the ACA. The pre-ACA rationale for continuing to exclude such evidence is no longer persuasive.

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