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Combating Life Care Plans

"You've got to know the rules before you can break'em. Otherwise, it's no fun." –Sonny Crockett (Miami Vice)

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Combating Life Care Plans

Life care plans are no longer confined to catastrophic loss claims and are being seen in increasing frequency, as an easy way for plaintiffs' counsels to substantially increase claimed economic damages with minimal proportional investment. Knowing the 'rules' is the key to combating these plans. Methodology matters, and life care planners have some common methods for creating opinions, which could substantially increase the exposure value of even minor claims. Learning the common methodology can become a powerful tool for understanding the industry of life care planning and its use to inflate future economic damages. Join us in a panel and group discussion over life care planning methodology, its application in the world of expert admissibility, and contribute to a discussion on tips and tricks for combatting life care plans.

Testimony from Treating Physicians

Typically, opinions as to the costs of future care depend fundamentally on there being admissible recommendations for future medical care. Although we do encounter life care experts attempting to create their own recommendations for future care[i], the future care recommendations are typically coming from medical providers, whereas the costs of those services are provided by the life care planner. Foundationally, this means too that you should first be asking whether the testimonial opinions of the treating physician are admissible?

Under Florida law, for instance, treating physicians are considered 'hybrid' expert, in that they are non-retained experts able to provide testimony as to their past performance of care and opinions that arose in diagnosis and treatment of the patient. However, the admissibility line begins to blur when a non-retained medical provider is asked to provide opinions concerning possible future medical care over long periods of time intended solely for litigation purposes.[ii] In other states, like California, the plaintiff is not required to make an expert declaration for the opinions of a treating physician but must disclose them when intending to use the treating physicians in an expert role.[iii] In New York, a treating physician *may* testify to treating observations but *may* also give expert opinions, *without prior notice*.[iv] Thus, depending on your jurisdiction, it can be a constant struggle to identify future care opinions in pre-trial discovery and prevent prejudice by surprise at trial.

Generally, ordinary treating physicians are not planning care for decades. Where a treating physician steps beyond their normal function, the future care opinions further raise a fair question as to whether the treating medical provider exceeds their expert qualifications by offering future care opinions at all. As mentioned above, where those opinions can be concealed or are not subject to expert disclosure or pre-trial discovery, this too potentially raises further issues of fundamental due process. Bringing this issue to the surface can be done through careful planning. Consider the following inquiries in your pre-trial strategy, particularly in written discovery and depositions:

- Is the patient already a candidate for the future care modality?
- Are there conditions or factors (*i.e.,* prerequisites) to be met for their candidacy for a certain care modality?
- Is there an accepted method (*i.e.,* a standard of care) and/or factors to be considered before candidacy for a particular care option?
- Are there reasonable alternative methods for care not being proposed?
- When can the care modality be scheduled?
- Are these future care modalities something that are contingent or depended upon future presentation?
- What are the clinical guidelines for the specific care modality? Is the recommending physician following those guidelines?
- When recommending modalities in a periodic series (*i.e.,* injections, ablations, etc.) what is the accepted

standard of care for the repeatability of the procedure and what are the side effects of repetitive prolonged care (*i.e.*, for instance, the efficacy loss of narcotics over time or the adverse effects of prolonged steroid administration, etc.).

- What methodology, facts, and data (*i.e., Daubert*) is the medical provider using to opine to the likelihood of future medical care options, particularly where care modalities are considered contingent on patient responses and/or may occur over a long period of time?

The goal should be to challenge by motion practice and/or *voir dire* and then impeach at trial the future care opinions at their source—the treating physician—such to foundationally undermine the source of the life care planner's testimony.

What is your legal standard for admissibility of future loss?

Where treating physicians and the retained life care planner are offering expert opinions, the threshold question is whether those opinions are admissible '*expert*' opinions for your jurisdiction? Most states have—either in full or in part—adapted the *Daubert* standard for admissibility of expert testimony.[v] Generally, *Daubert* requires that the expert be (1) qualified to offer specialized knowledge based on their knowledge, skill, experience, training, or education and (2) must form the opinion based upon sufficient facts or data, which is the product of reliable principles and methods, and properly apply the principles and methods reliability to the facts of the case. However, where the expert testimony involves non-scientific, alternative methodology, or subjective determinations this can create potential issues for a material challenge. The evidentiary shift from *Fry*[vi] to *Daubert* was supposed to have been intentional, more limiting the nature of expert testimony and increasing the reliability of the admissible evidence. As cited across the County, the U.S. Supreme Court provided factors, such as whether the expert's conclusion can be tested, subjected to peer review, can an error rate be determined, *etc*. This more rigid standard *should* be more difficult to meet in the context of future medical care particularly where (1) the certainty of future medical care is often fundamentally debatable, wherein it inherently involves a degree of speculation, and (2) the 'methodology' for establishing the present costs of future medical care is difficult to standardize, even according to professionals within the industry.

Even where there are qualified expert opinions, there is often still a question of whether those future care recommendations are sufficiently competent to meet the evidentiary threshold of your jurisdiction. What is the evidentiary threshold for admissible evidence of future loss? In Florida, for instance, "the proponent of expert testimony must, when properly challenged, establish the basis for its admissibility by a *preponderance of the evidence.*"[vii] However, the threshold standard for recovery of future loss, including future medical care, is 'reasonable certainty.'[viii] Alabama[ix], Arizona[x], New York[xi], and Connecticut[xii] are states that seem to require some degree of 'certainty' to prove future medical expenses. However, in other states such as Alaska[xiii] and Texas[xiv] appear to follow a more relaxed burden of proof for future medical damages. In practice, where future medical case recommendations and costs seem far from certain, the defending party should be prepared to focus on the speculative nature of long-term care. When examining a life care planner, who is relying upon the recommendations of treating physicians, it can be very important to inquire about what standard the life care planner utilized when considering whether the future care was merely speculative, probable, or reasonably certain to occur in the future, as this inquiry could create a significant basis for challenging the admissibility of the care.

Finally, you need to determine whether your jurisdiction requires an economist to serve as a secondary expert to adjust future costs to present value. With the growth of the life care planning industry, few are also uniquely qualified to economically adjust the future costs of care to present value. Notably, where the expert is utilizing source materials to provide cost opinions, the source material itself is often reliant on even older price data and is

not itself adjusted for inflation or other economic drivers. The cost of care in 2025 is not the same as the cost of care in 2035, 2045, or 2055. If your jurisdiction requires that the jury be presented with evidence to determine the *present value of future costs*, overlooking the value provided by an economist expert may be a key weakness to the admissibility of a life care plan. On the other hand, keep in mind that inflation historically increases the costs of services, so it may be imprudent to raise this issue where it will ultimately result in an overall increase to a cost projection at trial.

Life Expectancy Tables

Where future medical care damages are predicated on the remaining life expectancy of the plaintiff, life care planners often rely upon life expectancy tables. Rules of evidence modeled after Federal Rule 705 essentially provide that an expert may rely upon inadmissible data or fact when forming their opinions but, when challenged, the expert may be compelled to disclose the underlying facts or data. Florida takes it perhaps one step further by providing that "If the [challenger] establishes prima facie evidence that the expert does not have a sufficient basis for the opinion, the opinions and inferences of the expert are inadmissible unless the party offering the testimony establishes the underlying facts or data."[xv] This can be a powerful tool in challenging an life care planner's reliance on life expectancy tables and cost sources, where the expert may or may not be able to establish the reliability of the underlying data.

It is further notable that not all life expectancy tables are the same. For instance, life care planners regularly utilize (among other common tables) life expectancy tables from the Center for Disease Control, the most recent version being of 2022.[xvi] CDC's methodology is generally cited in its report, which includes a blend of 2020 census data and beneficiary data from Medicare and Medicaid.[xvii] This methodology also includes a nation-wide approach. Even CDC's methodology notes that the data is subject to error, particularly in smaller states and involving younger people. Typically, a life care planning expert intends to rely upon a life expectancy table to provide a multiplier (i.e., number of years for future life expectancy) for annual and/or repeated care but otherwise has limited knowledge of the reliability of the life expectancy figure. This creates a potential opportunity for further inquiry including the following areas:

- What, if any, analysis did the expert perform in attempting to most accurately apply the national life expectancy to the individual plaintiff?
- Does the plaintiff have co-morbidities (*i.e.*, obesity, diabetes, family history, cancer, etc.) that affect life expectancy and, if so, how is the expert compensating for those?
- Did the expert attempt to utilize a state-specific life expectancy table?
- Has the expert accounted for race or gender, and not just age of the plaintiff?
- Has the expect accounted for social (*i.e.,* smoking, alcohol), economic (*i.e.* vocation, education, income), or psychological (*i.e.,* depression, anxiety) factors?
- Did the expert compare, contrast, or analyze any other life expectancy sources?

In 2014, the National Institute of Health published a study on the reliability of life expectancy estimates for life care planning after spinal injury and found need for more refined models for economic factors.[xviii] This article, although primarily focused on spinal injury and economic factors, raises notable points of inquiry for challenging a life care planner's overreliance on life expectancy data, without consideration of material factors that can have a substantial affect on the reliability of life expectancy determination. According to its authors, certain economic factors had notably statistical deviations between 60 and 80 percent impacting total life expectancy, which is huge. Thus, this type of inquiry could have substantial value for both challenging and/or impeaching the basis of a life care plan.

Methodology Matters

According to the International Academy of Life Care Planners ("IALCP"), a life care plan is "a dynamic document based upon published standards of practice, comprehensive assessment, data analysis, and research, which provides an organized, concise plan for current and future needs with associated costs for individuals who have experienced catastrophic injury or have chronic health care needs." [xix] However, in a litigation setting, it can be difficult to see the comprehensive nature of the planning, where the retained expert is provided curated or incomplete materials. As has become common, life care plans are not necessarily confined to catastrophic injuries and are often used as a relatively inexpensive investment to substantially increase the potential claim value. However, while value may be added on the face of the claim, there are telltale signs that the growth of the life care planning industry has created intellectual laziness in the profession, where 'experts' are utilizing limited materials, ignoring patient histories, and serving solely as a conduit for hearsay evidence, without performing substantive analysis.

Commonly, even including catastrophic injury cases, a life care planner's methodology can be surprisingly simple, involving little more than an interview with the plaintiff (now, often via teleconference), limited review of available medical records (often lacking historical records), conferences with treating physicians (wherein undocumented future care plans are solicited for the first time), and the use of several different source materials (which are misused from their intended purpose). Depending upon the expert, this methodology may include use of sources such as the Physician Fee Reference ®, Medical Fee Directory, FAIR Health, and Context 4 Healthcare. Notably, each of these sources, amongst others, provide some predicate for their methodology and/or terms of use that can be helpful for use against the life care planner. First, it is important to note that all of these source materials generate income from their use and often maintain proprietary methods for collecting their data. This means too that life care planning experts are not generally able to fully articulate, validate, or support the veracity of the cost figures they are utilizing from other platforms, often without any independent analysis performed separately by the expert.

By way of example, Medical Fees Directory provides in its introduction that the purpose of its publication is "Setting fees requires a knowledge of how health insurance plans and third-party payers process and pay health insurance claims […]." However, in a legal setting, it is critical to understand that the data provided therein represents amounts that medical providers should charge to third-party payors and *not* the actual cost or reimbursement cost for the future services. Stated differently, plaintiffs seek to offer to the jury the inflated cost charged by the provider to maximize recovery costs from an insurer and not what the patient would *actually* be charged for the service. Physicians' Fee Reference ® unequivocally states in the first line of its publication that it is "designed as a management and marking tool to assist users [medical providers] in analyzing medical fees and is for reference only." Neither source represents itself as being intended for use in predicting the future cost of medical procedures in a litigation context, but this is exactly what a life care planner is utilizing the source for.

Other online subscription-based sources now also often include terms and conditions, for those willing to locate them. For instance, Context 4 Healthcare publishes its End User License Agreement Terms and Conditions, which provides, in part, that (1) the expert should not copy, distribute, or create derivative work without prior written consent, (2) Context 4 Healthcare does not guarantee the reliability of its information, (3) the expert should independently evaluate the data recommendations provided, and (4) that the product is only intended for internal business purposes.[xx] Where the threshold for admissibility is always about reliability, these terms of service create avenues to raise doubt over the reliability of the underlying costs being offered by the expert. The nature, purpose, and scope of these sources provide substantive avenues for meaningful impeachment where the expert is being used solely as a conduit for inputting care modalities into proprietary software rather than actually performing

expert analysis.

Understanding the source material underlying cost estimates is crucial for challenging and impeaching the basis of a life care plan. As noted above, in conjunction with a rebuttal expert, defense counsel often has at their disposal key information from the underlying publishers to draw from when challenging the expert's methodology, particularly where the life care planner wholly relies upon (and misuses) data from independent sources. When challenging the expert's methodology, it is helpful to consider the following:

- Is the expert utilizing source materials for cost estimates or creating their own?
- Where that source material is proprietary, is the expert able to articulate some basis for verifying, testing, or analyzing the source materials of another or are they simply a conduit for inadmissible evidence?
- Is the source material being used within its intended purpose or, otherwise, does the expert have a methodology for adjusting from the estimates provided by others?
- While the source material often utilizes a geographical modifier, is the expert utilizing it and/or utilizing it correctly?
- Where there is actual billing from the treating provider, is the expert considering it, relying upon it, or rejecting it?

In many instances, it is the burden of the offering party to support the qualification and methodology of the expert witness, and the court's burden to serve as a 'gatekeeper' for reliable and admissible evidence. With this foundation, the plaintiff's case-in-chief can be contested long before trial with careful planning, prudent examination, and effective challenging of a life care planning expert.

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[i] The admissibility of this evidence will depend on the state. For instance, in Louisiana, a life care planner may be permitted to overrule the recommendations of the treating physician. *See Lavigne v. Allied Shipyard, Inc.*, 2018-0066 (La. App. 4 Cir. 1/15/20), 289 So. 3d 1088 (holding that the plaintiff's life care planner was admissible and any error harmless even where the expert created her own opinions and rejected the care plan of the treating physicians), *but see*, *Anderson-Moody v. Wilson*, 357 So. 3d 1240, 1242 (Fla. 1st DCA 2023), reh'g denied (Mar. 20, 2023) (reversing a jury verdict and holding that a life care planner could not infuse his or her own opinions medical care).

[ii] *See Gutierrez v. Vargas*, 239 So. 3d 615, 622 (Fla. 2018) (holding, in part, treating physicians are limited to testimony as to "past facts based on personal knowledge"); see also, *Tillman v. Sweat*, 398 So. 3d 465, 469 (Fla. 5th DCA 2024) (holding that treating physician opinion as to 'causation and/or damages, including, but not limited to, ... impairment, permanency, disability ... and relationship of past and future medical care' "exceeds the scope of a fact witness treating physician whose testimony relates to diagnosis and treatment of injury or disease. [Emphasis added]"); *Richardson v. Tenery*, No. 6D2023-2853, 2025 WL 2958769, at *4 (Fla. 6th DCA Oct. 21, 2025) (finding reversible error occurred where plaintiff offered treating physician as an undisclosed expert, while shielding the 'treating' physician from expert discovery).

[iii] *See Kalaba v. Gray*, 95 Cal. App. 4th 1416, 1418, 116 Cal. Rptr. 2d 570, 572 (2002) (affirming the exclusion of improperly disclosed expert opinions from treating physicians in a medical malpractice case).

[iv] *Krinsky v. Rachleff*, 276 A.D.2d 748, 750, 715 N.Y.S.2d 712, 714 (2000) ("In addition to testifying to his or her own observations, a treating physician may give expert opinion testimony (*see, Perrone v. Grover,* 272 A.D.2d 312, 707 N.Y.S.2d 196) and may do so without prior notice pursuant to CPLR 3101(d)").

[v] *Daubert v. Merrell Dow Pharms., Inc*., 509 U.S. 579, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993)

[vi] *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923). *Frye* created a broader test for the admissibility of expert testimony where recognition for a methodology had been generally accepted. This relied less on scientific certainty, repeatable testing, or more concrete reliability and, instead, created a admissibility standard largely based on consensus.

[vii] *Baan v. Columbia Cnty*., 180 So. 3d 1127, 1131-32 (Fla. 1st DCA 2015).

[viii] *See Volusia Cnty. v. Joynt*, 179 So. 3d 448, 450 (Fla. 5th DCA 2015) ("[T]he appropriate test is to permit the recovery of future economic damages when such damages are established with reasonable certainty." Citing *Auto–Owners Ins. Co. v. Tompkins*,

651 So.2d 89, 91 (Fla.1995)).
[ix] *See, Owens-Corning Fiberglass Corp. v. James*, 646 So. 2d 669, 671 (Ala. 1994).
[x] *See, Griffen v. Stevenson*, 1 Ariz. App. 311, 312, 402 P.2d 432, 433 (1965).
[xi] *See, Adebiyi v. Yankee Fiber Control, Inc.*, 705 F. Supp. 2d 287, 297 (S.D.N.Y. 2010).
[xii] *See, Doe v. Thames Valley Council for Cmty. Action, Inc.*, 69 Conn. App. 850, 878, 797 A.2d 1146, 1164 (2002)
[xiii] *See, Alexander v. State, Dep't of Corr.*, 221 P.3d 321, 325 (Alaska 2009).
[xiv] *See, Berry Prop. Mgmt., Inc. v. Bliskey*, 850 S.W.2d 644, 664 (Tex. App. 1993), *writ granted* (Sept. 10, 1993), *writ dismissed by agreement* (Jan. 12, 1994), *writ withdrawn* (Jan. 12, 1994).
[xv] *Fla. Stat.* § 90.705(2).
[xvi] CDC's 2022 Life Tables, https://www.cdc.gov/nchs/data/nvsr/nvsr74/nvsr74-12.pdf, issued December 2025.
[xvii] Id.
[xviii]Krause JS, Saunders LL. Life Expectancy Estimates in the Life Care Plan: Accounting for Economic Factors. J Life Care Plan. 2010 Jun;9(2):15. PMID: 25285312; PMCID: PMC4181946, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC4181946/.
[xix] International Association of Rehabilitation Professionals, Standards of Practice for Life Care Planners, 4th ed., Standard No. 12-a, available at https://member.aanlcp.org/wp-content/uploads/2023/03/IALCP-Standards-of-Practice-2022-4th-ed.pdf
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