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Deflating Those Life Care Plans to Sink the Nuclear Verdict!

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this article, we briefly discuss 5 strategies that can be employed to help manage medical expenses in personal injury and product liability cases. The five strategies cover (1) determination of attributable expenses, (2) assessing reasonable & fair market value, (3) examining medical necessity, (4) re-visiting life expectancy, and (5) dealing with medical funding, liens, & letters of protection.

1. Determination of attributable expenses

It may seem obvious, but the first step in managing medical expenses in personal injury and product liability is perhaps the most important one, and that is determining whether, or what proportion, of an alleged harm is *attributable* to the incident, versus some other factor. Or, in the case product liability, whether or to what proportion an alleged harm can be attributable to a product defect or product use, versus some other factor.

In the case of acute injuries that are alleged to be associated with a particular incident, such as a motor vehicle accident (MVA), the attribution of injuries and conditions to the incident may in some cases be straightforward—for example, an individual was involved in an MVA and claims to have suffered a head injury and had no head injuries or history of head trauma prior to the accident. To the extent a head injury can be shown to have occurred (e.g., evident in an MRI), the temporal sequence of events may point to the MVA as a potential cause. In this example, it would be critical to know whether there is any relevant past history, whether the MVA could have caused the head jury, and whether there could possibly have been any intervening and unrelated incidents that resulted in the head injury. It is also necessary to evaluate the medical bills to determine whether any clearly non-attributable expenses are finding their way into the claim. For example, if a claimant had routinely visited a physical therapist prior to the incident, an argument could be made that ongoing visits to the same physical therapist would have occurred regardless of the incident in question. Similarly, if the claimant has a chronic condition, such as diabetes, it's clear that post-incident diabetes drugs and doctor visits are not attributable to the incident. These types of "attribution checks" are useful for past medical and future medical.

Attribution can be more complicated in product liability matters, especially in cases that involve chronic conditions alleged to have been caused or exacerbated by some type of exposure to a product. In these cases, the role of biostatistics is critical, because biostatistics (and statistical analysis more generally) can help quantify the extent to which a condition could be attributable to the exposure versus attributable to other potential causal factors. For example, there are very few cancers that are attributable to a single causal factor. Even lung cancer, which is normally associated with smoking, is caused by things other than smoking in 10-20% of cases. Comprehensive reviews of the medical literature, including rigorous meta-analyses, are often very useful in determining attribution and causation. The most important approach to attribution and causation, however, is to treat it like a testable hypothesis; don't simply assume that the causal relationship is simply the popularly reported one. More often than not, the causal pathway is much more complex and muddled than the conventional wisdom.

2. Assessing reasonable & fair market value

The second in our "5 strategies" is to never assume that a medical expense is reflective of fair market value or reasonable value. Most jurisdictions allow injured parties to claim medical expenses as damages, but also state in some form or another that defendants are allowed to challenge the reasonableness of those charges. Simply put, in most jurisdictions a plaintiff can say they paid $1 million dollars for a simple

lab test, but defendants are allowed in return to challenge whether the charge was reflective of fair market value, reasonable value, or relative market value.

There's a good reason this type of language exists in statute. It turns out that challenging medical bills is very important, because medical bills, unlike prices and charges in other industries, generally do not reflect reasonable value or fair market value. The reasons are twofold. First, decades ago the U.S. health industry was virtually 100% non-profit. In order for health care institutions to maintain their non-profit status, they were required to show a substantial "community benefit." This was usually in the form of charity care but would also include bad debt. Consequently, health care organizations had incentives to set prices as high as possible, so that if they received less those prices as payment in full, they could assign the difference to either charity care or bad debt. The second reason for the disconnect between medical prices and fair market value came later, in the 1990s, with the advent of "managed care organizations" (MCOs). MCOs typically focused on tightly managing care, but also negotiated with providers on reimbursement amounts. This provided strong incentives on the part of providers to set prices unusually high, so that even after negotiations with MCOs, providers would still receive favorable rates. Accordingly, MCOs gave providers ongoing reasons to set rates arbitrarily high.

For these reasons, few medical bills or charges are reflective of what economists would think of as being fair market value or reasonable value. This is because those same medical services are routinely available for much lower prices; that is, providers routinely accept amounts much lower than their prices every hour of the day, and routinely accept much lower amounts as payment in full. Fortunately, there are tools developed in the fields of economics, health economics and health services research that can be employed to determine the fair and reasonable market value of any medical service, including ancillary medical services such as prescription drugs and home care attendants. The most important approach to assessing medical expenses, however, is to treat it like a testable hypothesis; don't simply assume that charged and billed amounts reflect fair market value—most of the time they do not.

3. Examining medical necessity

In some personal injury and product liability matters, claimants put forth a "life care plan" (LCP) that details what they allege will be *medically necessary* in the future to mitigate harms alleged to have been caused by an incident, exposure, etc. The author of the LCP, or some other medical care provider, provides an opinion regarding medical necessity. This week's strategy #3 is very simple, and similar to the preceding strategies. And that is to never assume that the claimant's assessment of medical necessity accurately reflects some objective measure of medical necessity.

Any assertion of medical necessity can be challenged, even if it seems plausible at first glance. However, some types of medical services are highly variable in terms of utilization rates, and health economists generally regard high variation in treatment patterns as indicative of the presence of unnecessary and inappropriate care. Put differently, the medical profession is probably not as precise and consistent in its approach to diagnosis and treatment as the general public tends to believe. This means that an LCP could contain alleged future needs that would not be considered medically necessary or appropriate by other providers. This is where a two-pronged strategy of (1) a detailed review of the medical literature, and (2) expert testimony from a medical care provider *familiar with the literature* can be a critical part of a case medical losses. Having a medical care provider cite literature can help avoid the battle of medical experts possibly undermining the medical necessity discussion by reducing it to simply opposing opinions.

4. Re-visiting life expectancy

Life care plans (LCPs) are increasingly part of personal injury and product liability cases. In our previous three installments in this series, we have discussed how LCPs can benefit from a thorough assessment of causation, reasonable value, and medical necessity. What often gets overlooked is that LCPs can also benefit from an assessment of life expectancy (LE). There are two questions that sometimes arise when the topic of LE comes up: (1) Why not just use standard life tables? And (2) if there is some other way of calculating LE, what is the basis for it, and who can do it?

Starting with the first question, the short answer is that if anyone has documented comorbid pre-existing conditions, they are no longer on the "curve" represented in standard life tables. For example, if someone is a smoker, we know that their LE will be reduced by around 15%. Significant decrements also exist for obesity, diabetes, chronic obstructive pulmonary disease, cardiovascular disease, etc. In the field of biostatistics, if we don't know anything about an individual, we assign them the average (life table) LE. However, if we have information about an individual, we typically use that information to estimate life expectancy, not a generic population-based life table.

Health economists do this all the time as part of economic modelling, where it is necessary to calculate mortality or survival for various subpopulations or treatment groups and control groups. If someone is a known smoker or is known to be obese, there is no medical rationale for assigning them the same LE as a non-smoker or a non-obese individual. The medical literature, including the biostatistics literature, has relatively well-developed studies of how various pre-existing chronic conditions impact life expectancy, so a very robust basis can support an opinion that there will be a decrement in LE. These types of adjustments to LE are of course very important in LCPs, where estimated future medical expenses are a multiple of remaining years of life.

5. Dealing with medical funding, liens, & letters of protection

Personal injury cases and product liability cases increasingly rely on the use of third-party litigation financing, wherein a medical funding or medical financing company (referred to interchangeably hereafter as "MFCs") has undertaken responsibility to pay providers for services rendered (i.e., post-incident but not including alleged future care). Although the specific structure and form of MFC arrangements vary, in general these arrangements involve a third-party entity assuming responsibility for payment of medical services. These arrangements are most often observed in personal injury cases where the MFC receives a percentage of the damages amount resulting from a settlement (or post-trial verdict) or a compounding interest payment on amounts owed. MFCs have also been observed in mass tort product liability cases. Nominally, proponents submit that these arrangements improve access to care for those with injuries, care that they allegedly may not have otherwise been able to obtain in the absence of third-party funding. There has been considerable growth in the MFC industry, with reports of approximately 30% growth in the number of requests from 2017 to 2021. Though these arrangements have generally been considered legal, several serious concerns have been raised by observers and experts, and such concerns have led to numerous calls to further regulate MFCs, which currently operate with virtually no oversight. Specifically, there are four serious concerns with MFCs, each of which is discussed below.

First, the use of MFCs is largely an attempt on the part of plaintiffs to circumvent the reasonable value of

medical expenses. Courts generally allow for the reasonable value of medical expenses to be recovered by plaintiffs in personal injury and product liability cases. In many cases, MFCs are used to obfuscate the reasonable value of incurred expenses and to otherwise circumvent courts' rules regarding reasonable value, and in some cases result in financed amounts that far exceed providers' UCR charges. In cases where MFCs have been engaged, medical losses should continue to be based on the reasonable value of services rendered, regardless of the specifics of the MFC arrangement. In fact, MFCs are often the source of claims for inflated future medical expenses because past medical expenses are themselves inflated.

Second, the nominal justification for MFCs that they help improve access to care for injured individuals, is without merit. Due to the Affordable Care Act ("ACA"), rates of insurance in the U.S. general population have risen to 90%, and 91% among working individuals. At the same time, the prevalence of serious injury in the U.S. population has declined significantly over the past decade, by as much as 20%. The combination of increasing insurance coverage and decreasing injury incidence suggests that any "gaps in access" to health care by injured individuals would have narrowed substantially over the years, the same period over which MFCs *increased* in number and caseload. This strongly suggests that MFCs are not merely responding to some sort of problem in access to treatment; if they were, their caseloads would be declining not increasing. Indeed, observers have argued that the motivation for MFCs is, instead, strictly the ability to earn windfall profits from plaintiffs and defendants in personal injury litigation, so much so that hedge funds seeking high returns on investment have become increasingly involved in litigation funding. In addition, there is no evidence that MFCs provide financing of treatment that is *not* part of litigation, which again further undermines the credibility of their alleged mission to increase access to care.

Third, related to the previous concern, plaintiff attorneys and MFCs argue that the service is the *only* means through which injured persons can obtain treatment. This is simply not true. The typical MFC contract requires individuals (and their providers) *not* to submit claims to any third-party payers. Even in the absence of coverage, it is widely known that individuals can negotiate with health care providers. Most providers will accept as payment in full amounts equal to or even lower than fair market or reasonable value and are likely to accept, as payment in full, amounts as low as their marginal costs (i.e., the lowest amount at which they can "cover" their costs).

Fourth, most MFCs empanel physicians (e.g., pain specialists and orthopedic surgeons) who agree to provide services initially at a discount in exchange for larger payments post-settlement or verdict, in some cases involving liens or letters of protection ("LOP"). Such arrangements provide powerful financial incentives for physicians to overtreat and turn away non-litigation patients in favor of litigation patients. Consider the following hypothetical example. An orthopedic surgeon might normally charge $100,000 for spine surgery and might normally accept $20,000 as payment in full for that surgery (i.e., the fair market RV of the service is $20,000). In a personal injury case with an MFC, the MFC might offer to pay $150,000 for the same service, initially paying the surgeon his regular $100,000 full charge (which he rarely, if ever, receives as payment in full in a normal transaction not involving an MFC), and then another $50,000 later in the event of a settlement or verdict in favor of the plaintiff. This enables the plaintiff to argue that she has already paid the full amount (via the MFC). The result is a net windfall gain to the surgeon of $130,000 more than what he would normally accept as payment in full. In other words, he will receive more than *six times* more than what he normally receives for the same procedure. There is ample evidence that physicians, when faced with these types of financial incentives, are more likely to perform services that they would not otherwise perform, which in turn leads to higher rates of medically inappropriate or unnecessary treatment. Indeed, there is evidence that litigation funding and MFCs result

in higher rates of unnecessary treatment.