SETTING THE RECORD STRAIGHT: *JONES V. METROHEALTH*, THE AFFORDABLE CARE ACT, AND LIMITATIONS ON DAMAGES FOR FUTURE MEDICAL EXPENSES

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While the state of Ohio has allowed political subdivisions to be sued, it has significantly reduced their liability by statute. R.C. 2744.05(C)(1) sets caps on non-economic damages and R.C. 2744.05(B)(1) provides for a reduction of economic damages when a plaintiff is entitled to have those damages paid by an insurance company (or any other source).

In *Jones v. MetroHealth Medical Center*, 2016-Ohio-4858, 2016 WL 3632469 (8th Dist.), the Eighth District Court of Appeals reduced a $14.5 million jury verdict against MetroHealth (a government-owned hospital) to just over $5.1 million based upon the provisions in the aforementioned statute regarding political subdivision liability.

Notably, the court upheld an offset for future medical expenses based upon the plaintiff being "entitled to" have future medical expenses paid by an Affordable Care Act insurance plan. A motion has been filed to have the case heard *en banc*, and OAJ and CATA filed a joint Amicus Brief in support of the Motion.[1]

Even though the offset in *Jones* was based upon a statute that only applied to political subdivisions, private defendants will cite *Jones* in post-trial motions (we have already seen it done) and argue that they are entitled to receive a similar offset for future benefits under an ACA plan. It is so important to remember that the *Jones* case has a very limited holding and that it only applies to cases brought against governmental tortfeasors. Additionally, there are still many, many reasons why a governmental tortfeasor in future cases would not be entitled to such an offset.

CASE FACTS

Alijah Jones was born at 25 weeks and suffers from cerebral palsy, developmental delays, and visual impairment. He will need 24-hour attendant care for the remainder of his life. The Becker Law Firm obtained a $14.5 million verdict against MetroHealth and Steven Weight, M.D., for the birth injury sustained by Alijah Jones.

THE VERDICT

The jury verdict against MetroHealth and Dr. Weight consisted of $5 million in non-economic damages for Alijah (reduced to $250,000 per statutory caps), $1 million for loss of consortium by Alijah's mother (reduced to $250,000 per statutory caps), and $500,000 in past economic damages (reduced to $0 per statutory collateral source offset). Those reductions were all upheld in their entirety by the appellate court.

The verdict also included an award of $8 million for future economic loss. The trial court held that the entire $8 million award corresponded to future medical

expenses, but that the maximum amount Alijah could recover for future medical expenses was $2,951,291 because any medical expenses in addition to that would be covered by a collateral source (an ACA plan or Medicare).

The Eighth District held that "the court erred because it could not have concluded to a reasonable degree of certainty that the $8 million award for future economic damages comprised only the life care plan. The court failed to consider the possibility that at least some part of the $8 million award consisted of lost future wages."[2]

The *Jones* court determined that at least $1.7 million of the verdict should have been attributed to future lost income, and that only $6.3 million represented compensation for the life care plan. The *Jones* court ultimately added $1.7 million back to the verdict, but agreed with the trial court that $2,951,291 was the maximum amount Alijah could recover for future medical expenses since any additional medical expenses would be covered by a collateral source (an ACA plan or Medicare).

Practice Tip: The burden of proving entitlement to an offset is on the political subdivision. The *Jones* court stated, "a political subdivision like MetroHealth that makes it known it intends to seek a post-trial offset for collateral benefits chooses to forego offering specific interrogatories at its own peril. MetroHealth as the party seeking an offset under R.C. 2744.05(B)(1), had the burden of showing its entitlement to offset."[3]

Thus, the Eighth District reduced the verdict to $5,151,291 (i.e., $250,000 + $250,000 + $2,951,291 + $1,700,000). See the chart for a breakdown of the verdict.

Category of Damages in Verdict	Amount of Verdict	Reduction by Trial Court	Review by Eighth District
Non-economic damages for Alijah	$5,000,000	Reduced to $250,000 per damages caps under R.C. 2744.05(C)(1)	Upheld
Loss of consortium for Alijah's mother	$1,000,000	Reduced to $250,000 per damages caps under R.C. 2744.05(C)(1)	Upheld
Past economic damages	$500,000	Reduced to $0 per statutory collateral source offset under R.C. 2744.05(B)(1)	Upheld
Future economic damages	$8,000,000	Reduced to $2,951,291 in future medical expenses per statutory collateral source offset under R.C. 2744.05(B)(1)	$1,700,000 added back to the verdict to represent future loss of earning capacity
TOTAL	**$14,500,000**	**$3,451,291**	**$5,151,291**

THE STATUTORY OFFSET

First, at a post-trial hearing, the trial court heard new evidence regarding the appropriate amount of the offset. Plaintiff argued that it was improper for the trial court to hear new evidence post-trial. The Eighth District held that "R.C. 2744.05(B) requires a post-trial hearing in which the trial judge is authorized to hear additional evidence" and that "the court, not the jury, decides the amount that must be offset from a damage award against a political subdivision."[4]

Practice Tip: You can cite to *Jones* to prevent a defendant from introducing evidence of an ACA insurance plan at trial. In support of its ruling that a post-trial offset hearing was necessary, the court stated: "R.C. 2744.05(B) does not 'abrogate that aspect of the collateral source rule which provides that the receipt of [collateral] benefits is not to be admitted in evidence, or otherwise disclosed to the jury.'"[5]

Second, the *Jones* court (adopting the trial court's findings) held that, per the statutory collateral source offset, the maximum amount of future medical expenses that Alijah could recover was $2,951,291. The court arrived at this conclusion by looking at the life care plan and determining (or speculating as to) which benefits would be covered by a collateral source.

Practice Tip: Offsets must "match" losses that are actually included in the verdict. The Ohio Supreme Court has stated: "[T]he one inexorable source of agreement seems to be that there shall be no constitutionality without a requirement that deductible benefits be matched to those losses actually awarded by the jury."[6]

Both parties agreed that neither Medicare nor an insurance plan under the ACA would cover expenses for transportation, home care, and housing,[7] so Alijah was permitted to recover those expenses.

Practice Tip: In future cases, it must be pointed out to the judge that even the trial court in *Jones* excluded from offset those items in the life care plan which would not be covered by Medicare or an ACA insurance plan (although the *Jones* court did not go far enough in this regard).

Alijah was 12-years old at the time of the verdict, and all the experts who testified at the post-trial hearing agreed that he would be eligible for Medicare when he turned 20 (due to his father's disability). The court found that for that 8-year period before he turned 20, an ACA insurance plan would cover Alijah's medical expenses and that "the maximum amount of the child's premium for health care would be $8,000 per year, with a maximum out-of-pocket expense of $6,500 per year" so that "the most the child would spend in the eight-year period for medical expenses would be $116,000."[8]

The court also found that Medicare would cover 80% of customary and ordinary care after Alijah turned 20 and so Alijah was permitted to recover 20% of the expenses

in the life care plan (excluding transportation, home care, and housing), after he turned 20.

So the amount of $2,951,291 constituted transportation, home care, housing, the price of an ACA plan for 8 years, and 20% of the other expenses in the life care plan after age 20.

THE *JONES* DECISION ONLY APPLIES TO CASES BROUGHT AGAINST GOVERNMENTAL TORTFEASORS

Chapter 2744 of the Revised Code is titled "Political Subdivision Tort Liability" and allows political subdivisions to be sued under certain circumstances. When suit is allowed to be brought against a political subdivision, R.C. 2744.05 limits the damages recoverable.

> Essentially, R.C. 2744.05(B) provides for two things when an action is brought against a political subdivision to recover for injury, death, or loss to persons or property. First, the collateral source rule is abrogated as to the political subdivision. The clear language of the statute requires the court to deduct the collateral benefits from the award recovered by the plaintiff. This conserves the fiscal resources of political subdivisions by providing the protection of sovereign immunity when a person injured by the negligence of the political subdivision is compensated by insurance or some other source of reimbursement. *Menefee v. Queen City Metro* (1990), 49 Ohio St.3d 27, 29, 550 N.E.2d 181, 182. The statute limits the recovery of injured parties to the amount of the award which has not been paid by other sources. Second, R.C. 2744.05(B) abolishes the insurer's right of subrogation against the political subdivision. Thus, a governmental tortfeasor is liable to pay the injured party only the amount not covered by insurance or some other source, and insurers are not permitted to recover the money paid to an insured by asserting subrogation rights against the governmental entity. *Grange Mut. Cas. Co. v. Columbus* (1989), 49 Ohio App.3d 50, 53, 550 N.E.2d 524, 527.[9]

Practice Tip: Explain to the judge that there is no similar statute that applies to private defendants, and more importantly, such a statute would be constitutionally impermissible; the only reason liability against a political subdivision can be limited in this way, and that subrogation interests can be extinguished by statute, is because the default setting for governmental liability is complete governmental *immunity*.

Practice Tip: R.C. 2323.41 permits a defendant to place into evidence certain collateral source benefits – but the statute excludes collateral benefits that have "a mandatory self-effectuating federal right of subrogation, a contractual right of subrogation, or a statutory right of subrogation." It is virtually certain that every single ACA-compliant insurance plan will provide the insurance companies with a right of subrogation, and therefore benefits under an ACA plan cannot be introduced into evidence, nor can

private defendants seek an offset for such benefits. See Affidavit of Jeffrey D. Zimon, Esq., which is attached as Exhibit A to Plaintiffs' Brief in Opposition to Defendants' Motion to Conduct Post-Trial Evidentiary Hearing on Setoff of Economic Damages Award, *Riedel v. Akron General Health System,* Cuyahoga County, No. 14-834147, filed July 22, 2016. This Brief and Affidavit are available to download from the Cuyahoga County Clerk's website, or just email me, and I will send you a copy. (Please note: this motion for setoff that cited *Jones* was filed by a private defendant.)

OFFSETS MUST "MATCH" LOSSES ACTUALLY INCLUDED IN THE VERDICT AND MATCHING DETERMINATIONS MUST BE MADE WITH "REASONABLE CERTAINTY"

A political subdivision "is entitled to an offset for future collateral benefits only to the extent that they can be determined with a reasonable degree of certainty."[10] Reasonable certainty has been defined by the Sixth Circuit as a "high probability."[11]

> [I]t is the defendant's burden to prove the extent to which it is entitled to an offset under R.C. 2744.05(B). Otherwise, the statute could operate to arbitrarily reduce the damages that a jury awards a plaintiff by allowing deductions for collateral benefits that are not included in the jury's award, or that are not reasonably certain to be received.[12]

SIDE-STEPPING THE VIABILITY OF THE ACA (WHAT A MOVE!)

The *Jones* Court side-stepped the issue of whether the ACA is reasonably certain to exist in the future. It did so by addressing the viability of Medicare first, stating that the Plaintiff gave "no plausible basis for us to conclude that Medicare will cease to exist in the near future."[13] Then later in the decision, the Court lumped in the ACA with the previous arguments, stating Plaintiff "does argue that Medicaid, Medicare, and the Affordable Care Act are political targets subject to privatization, budget cuts, and even repeal, but those are the same arguments we earlier rejected and need not repeat." No other attention was given to the viability of the ACA or whether it may be repealed or amended.

"REASONABLE CERTAINTY"? "ENTITLED TO RECEIVE"? WHAT WILL AN ACA PLAN LOOK LIKE NEXT YEAR? IN 10 YEARS??

The ACA does not entitle plaintiffs to specific medical treatment in the future. Rather, it represents an obligation to purchase health insurance or face adverse tax consequences. The ACA sets some minimum requirements, but plans vary widely from state to state, and the "truth is that the essential benefits that the ACA requires health plans to cover are extremely vague and unstable."[14] The ACA uses general terms such as "hospitalization" and "pediatric services",[15] and "leaves it up to the states to fill in the details."[16] "Moreover, the essential benefits requirements do not apply to self-insured plans, employer plans in the large group market, or plans that already existed when the ACA was enacted."[17]

The fact of the matter is that "[i]ndividual health insurance plans continue to have wide leeway in deciding which services they will cover at any point in time."[18] And in addition to that, plans are only good for one year at a time, people switch insurance plans overtime, they change jobs, they move from state to state, and the insurance plans and coverage they purchase will depend upon their marital status, age, health, etc. "Furthermore, plans continue to be allowed to decide whether or not a certain type of care is 'medically necessary,' and therefore will or will not be covered."

How can a verdict be reduced based upon benefits the plaintiff is "entitled to receive," when coverage still depends upon the approval of an insurance company at some unascertained point in the future? Would an insurance company be legally required to approve all treatment contained within the plaintiff's life care plan 10 or 20 years down the road? Of course not. Likewise, there is the issue of certain care being "in network" or "out-of-network," which, as we all know, can substantially affect the price of medical care. As one commentator observed, "[t]here is no degree of certainty regarding the exact coverage a plaintiff will receive in the future or whether the law's requirements will stand the tests of time."[19]

The bottom line is that nobody knows what specific medical care a person will be entitled to receive under an ACA insurance plan 5, 10, or 20 years from now.

Practice Tip: The arguments above – and the sources cited in the footnotes – can be used in cases involving private defendants, but also, they can still be used in cases involving governmental tortfeasors. Before an offset can occur, the specific care to be offset must, first, be contained within the verdict, and second, must be matched to a benefit which the plaintiff is entitled to receive in the future. Rather than merely focusing on the viability of the ACA in general, focus on whether the plaintiff is (will be) entitled to receive the *specific medical care in the life care plan* in the future. The answer to that question depends upon the state in which the person resides at the time the medical care is required, the specific insurance plan the person bought, the insurance company that issued the plan, whether the essential benefits required under an ACA plan have changed, whether the insurance company will approve the treatment as "medically necessary" at the time the treatment is sought, and whether the chosen healthcare provider is "in-network" or "out-of-network". Furthermore, nobody knows what an ACA plan will cost in 5 or 10 years, so a court should not be permitted to limit a plaintiff's recovery to the amount it would cost to purchase a plan today.

CONCLUSION – TEN TAKEAWAYS

1. *Jones* only applies to cases against governmental tortfeasors.
2. There is no statute that entitles private defendants to a similar offset to the one in *Jones*.
3. The burden of proving entitlement to an offset is on the defendant.

4. To be offset, collateral benefits must be "matched" to losses actually awarded by the jury.
5. To be offset, collateral benefits must be "reasonably certain" to be received in the future.
6. *Jones* reaffirms that the collateral source rule would prevent evidence of ACA benefits from being disclosed to the jury.
7. All ACA-compliant insurance plans will contain a right of subrogation and therefore private defendants cannot obtain an offset for benefits obtained through an ACA plan or introduce evidence of such benefits at trial.
8. There will be many items in a life care plan that will not be covered by Medicare or an ACA plan under any circumstances, and the holding in *Jones* requires that those items not be subject to an offset.
9. It is impossible to determine whether the specific medical treatment listed in a life care plan will be covered in the future by an insurance plan or whether the care the plaintiff seeks will be "in-network" or "out-of-network".
10. The costs of ACA-compliant insurance plans are ever-changing, and the trial court should not speculate as to what the maximum premiums or out-of-pocket expenses will be in 5 or 10 or 20 years down the road.

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[1] As of the date of this writing (October 27, 2016), no decision has been made as to whether the Eighth District will hear the case *en banc*.
[2] *Jones*, 2016-Ohio-4858, ¶ 37.
[3] *Jones*, 2016-Ohio-4858, ¶ 40 (citing *Buchman v. Bd. of Edn.*, 73 Ohio St. 3d 260 (1995)).
[4] *Jones*, 2016-Ohio-4858, ¶'s 19-20.
[5] *Jones*, 2016-Ohio-4858, ¶ 18 (quoting *Buchman v. Bd. of Edn.*, 73 Ohio St. 3d 260, 270 (1995)).
[6] *Buchman v. Bd. of Edn.*, 73 Ohio St. 3d 260, 269, 652 N.E. 2d 952, 960 (1995).
[7] The life care plan also had a second option for "facility care" which totaled $6,374,639. Both parties agreed that neither Medicare nor an ACA insurance plan would cover facility care. In the Motion for Reconsideration, Plaintiff argues that jury could have awarded this amount and thus there should be no offset whatsoever for future medical expenses.
[8] *Jones*, 2016-Ohio-4858, ¶ 55.
[9] *Lamb v. Quincy*, Ohio App.3d 592, 597, 636 N.E. 412, 415 (3rd Dist. 1993).
[10] *Buchman,* 73 Ohio St. 3d at 266.
[11] *Schilz v. City of Taylor, Mich.*, 825 F.2d 944, 946 (6th Cir. 1987).
[12] *Buchman*, 73 Ohio St. 3d at 270 (emphasis added) (citations omitted).
[13] *Jones,* 2016-Ohio-4858 at ¶ 50.
[14] See Maxwell J. Mehlman, Jay Angoff, Patrick A. Malone, Charles M Silver, and Peter H. Weinberger, *Compensating Persons Injured by Medical Malpractice and Other Tortious Behavior for Future Medical Expenses Under the Affordable Care Act*, Annals of Health Law, Volume 25, Issue 1, Winter 2016, p.35 (citing Nicholas Bagley & Helen Levy, Essential Health Benefits and the Affordable Care Act: Law and Process, 39 J. HEALTH POL., POLY, & L. 441, 448 (2014) (stating that the states have "no additional guidance or regulations on essential health benefits" leaving leaders to make decisions based on "vague guidance and guesswork").
[15] See 42 U.S.C.A. § 18022 (2015) ("[The ACA states: . . . T]he Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items

and services covered within the categories: (A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory services. (I) Preventive and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care.").

[16] See Mehlman at 38, citing Amanda Cassidy, Health Policy Brief: Essential Health Benefits, HEALTH AFF. 1 (May 2, 2013) ("Rather than establishing a national standard for these benefits, the Department of Health and Human Services (HHS) decided to allow each state to choose from a set of plans to serve as the benchmark plan in their state. Whatever benefits that plan covers in the 10 categories will be deemed the essential benefits for plans in the state.").

[17] See Mehlman at 39.

[18] See Mehlman at 39, citing Jennifer McCarthy, The Complete Guide to Health Insurance, THE SIMPLE DOLLAR, http://www.thesimpledollar.com/health-insurance-guide/ (last updated May 1, 2015) (referencing a comparison image that illustrates that 68% of Minnesota's health insurance plans do not cover labor and delivery, 60% do not cover mental health services, and 28% do not cover specialty drugs and only 45% of Massachusetts's plans cover hospitalization, hospital-based physician care and imaging).

[19] See Mehlman at 40, citing Seth L. Cardeli, Thwart the Assault on Future Medical Expenses, 50 TRIAL 14, 19 n.4 (2014).