

# Life Care Planning and Acquired Brain Injury: Determining Needs and Costs at the Dawn of the Patient Protection Affordable Care Act

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## Introduction

Life care plans involve synthesis of diverse and sometimes divergent information into a documented plan representing dynamically integrated needs and associated costs. From early roots in the 1970's with origins in the experimental analysis of behavior, developmental psychology and case management, life care planning has evolved into a well-established field that is both clinically and forensically recognized (Weed, 2010, Weed and Berens, 2012). The philosophies, foundations and methodologies of life care planning have been well reviewed in a broad array of publications (Deutsch, Allison and Reid, 2003; Riddick-Grisham and Deming 2011; Weed and Berens, 2010). Key elements include: 1) a consistent methodology to effectively analyze evaluatee needs; 2) needs driven recommendations that are articulated to the specific individual and have a basis in the known medical and rehabilitation outcome research literature; and 3) strong medical, rehabilitation, case management and psychological foundations (Deutsch 1995; 2013).

## Needs and Costs

Needs driven recommendations are crucial to each life care plan. It is essential to understand that needs and costs are different. Needs reflect the treatment, services, equipment and other supports required to remove or moderate handicapping conditions associated with an index event for an individual. This may involve a catastrophic injury, chronic medical condition or other complex episode that resulted in the individual's loss of functional capacity compared to pre-morbid abilities. Costs involve the resources required to implement the necessary interventions and supports.

It is important for a life care plan to assess all relevant needs of the evaluatee without bias to costs. Evaluating a case within a pre-defined cost parameter, say a given sum of money, likely deflects from identifying all salient needs. For example, an evaluation that stops once a dollar threshold is crossed has no assurance that the most salient or profound needs have been identified. Additionally, an emphasis on costs over needs can obscure non-dollar resources that may be available. After the life care plan is complete, if needs subsequently exceed resources, available resources can then be appropriated to prioritized needs.

## Valuation

Costs are obviously important and as appropriate, life

care plans involve monetization of identified remedies. A key consideration is what "costs" entail. Best practices for identifying costs in the field of life care planning include verifiable data from appropriately referenced and reliable sources, identified costs that are geographically specific when appropriate and available, non-discounted/market rate prices, and more than one cost estimate when appropriate (Preston and Johnson, 2012). These practices are congruent with International Academy of Life Care Planners (IALCP) Standards of Practice requiring transparency in the life care planning process, consistent methods to determine available costs, and accurate and timely cost information that can be easily utilized by the evaluatee (IALCP, 2009).

Life care plans historically represent locally sourced usual and customary charges, sometimes referred to as non-discounted prices. Contractual or other discount rates, when they occur, vary widely across providers and over time. They are not considered a predictable source for determining future costs. For example, a negotiated discount available to one group, such as a large insurance company with millions of subscribers may not be available to a small subscriber pool, or an individual. Moreover, because of the proprietary nature of such information, they are also not readily accessible or verifiable by independent parties, further adding to the speculative nature of such data (Leung v. Verdugo Hills Hospital, 2013).

Two relatively recent cases in California have opened discussion on the concept of market pricing. In *Howell v. Hamilton Meats & Provisions, Inc.* (2011), the court ruled that the plaintiff could not recover damages for past medical bills greater than the amount the medical providers had accepted as payment in full, even if usual and customary charges were higher. The California court noted that this "does not violate the collateral source doctrine; rather it embodies the well-established principle that a plaintiff is entitled to recover an amount that would make her whole, but not over compensate her..." It is important to note that collateral source rules vary by state. This ruling also does not directly affect life care plans, which are based on prospective rather than retrospective needs and services.

Subsequently, *Corenbaum v. Lampkin* (2013) moved into the province of determining future costs, noting, "... we conclude that any expert who testifies on remand with respect to the reasonable value of the future medical services that Corenbaum and Carter are reasonably likely to require may not rely on the full amounts billed for plaintiffs' past

medical expenses.” What constitutes the reasonable value of future medical services has become a key controversy in California courts.

Different California courts and jurisdictions have provided widely different rules and qualifications, not only on the sourcing of such costs, but whether or not the sources can be revealed to juries. This can affect a jury’s deliberations when trying to determine equitable compensation in the face of divergent pricing. Additionally, it is not clear that what a provider has accepted in one case or at one point in time as payment in full represents what he or she customarily accepts as full payment. This is often the case in MediCal, Medicaid and even Medicare reimbursements. Here a provider may accept a limited number of such patients into their practice at a loss, balancing them with others who are at least able to pay for the actual costs of services. Other providers may opt out of any insurance reimbursement or only provide “concierge” service at substantially higher out of pocket expenses. The complexity of a patient’s case and needs may also have to be considered; i.e., more specialized cases that require more attention and professional training/knowledge can cost more per visit to treat and incur greater reimbursement demands. Reasonable access may be another consideration. The ultimate determination of “reasonableness” in California may require a state supreme court ruling (Holakiewicz, 2014).

### **The Patient Protection Affordable Care Act**

Implementation of the Patient Protection Affordable Care Act (PPACA) has also raised questions pertaining to future settlements in personal injury and other medical-legal cases. Congdon-Hohman and Matheson (2013) have posited that a number of currently identified expenditures in life care plans would be covered by “the ‘guarantee issue’ and individual mandate ‘requirements’” of the PPACA. They postulated that this could potentially cap many health expenditures at a personal maximum of \$6,250 per year and transform the role of a life care planner into determining what expenses are covered by PPACA and what expenses are beyond its coverage.

The PPACA is presently viewed by most parties as too new and too vulnerable to be considered a stable source of funding (Auerbach, Heaton and Brantley, 2014; *Halsne v. Avera Health*, 2014; *Vasquez-Sierra v. Hennepin Faculty Assocs.*, 2012). The base of subscribers is still expanding, rules and regulations are still developing and strong political divisions remain regarding the future scope, viability and even the existence of this program. Should the PPACA remain in its present format and be fully deployed by 2016, Auerbach et al. (2014) estimates a relatively small impact on costs.

Of additional consideration, PPACA mandated services and levels of medical treatment cover only a portion of assistance that many people who experience disability following acquired brain injury (ABI) require. As needed,

services such as extended allied health therapies (e.g., occupational therapy, physical therapy, speech/language pathology, psychology), case management, residential treatment, home care, community support staff and especially, “prosthetic brain” services (Voogt, 2006) are not included, only partially covered, or require frequent reviews that can affect service continuity. The by now familiar catastrophic, bronze, silver, gold and platinum policy levels cap costs of PPACA plans, but do not assure the consistency of provided services. Thus, the dichotomous decision making postulated by Congdon-Hohman and Matheson (2013) may not be so simple. Unlike Medicare, which is centrally administered, each insurance company within local markets is individually directed within general PPACA guidelines.

Hence, different insurance companies’ formularies may cover different medications or have different criteria for generic vs. brand medications. Treatment panels vary, are reportedly more limited than most non-PPACA coverage (Pear, 2013) and may change in composition, thus requiring more frequent shifts in providers with associated impairments in continuity of care. Providers on panels may or may not have specific experience serving individuals with ABI; out of over 8,000 physiatrists in the United States, only a small percentage specialize in ABI. Specialists and special services such as surgeries may be difficult to access, in some cases requiring jumping through administrative hoops. This may not only delay or deny the specific treatment, but may impair overall treatment if other services are waiting on a specific resolution from this intervention. Coordination between services providers, as required for treatment efficacy, may be difficult to assure. Individuals switching between insurance policies across years, whether by choice or exigency as insurance companies come and go in the market place may also affect treatment continuity and efficacy. One could compare all insurance plans within a given policy level in a specific geographical market for available services, formulary/panel relevance to the evaluatee’s needs, treatment path approval processes and costs. Still, findings would only represent a current year’s costs and not the “predictive future.” Relevance, continuity and accessibility of identified services may be equally important to “cost.”

The ultimate trajectory of the PPACA is also likely to affect collateral source rules and determination of compensation, though this is typically beyond the role of a life care plan. These rules state that a tortfeasor-defendant cannot mitigate the damages he owes to a plaintiff by introducing evidence of collateral source payments from third parties, such as insurance coverage. Rationales for this rule have included that the defendant should not benefit from an injured party’s foresight to arrange for insurance, as a means of deterring others from injuring future plaintiffs, to assure restoration of the injured party, and to encourage the purchase of health insurance, especially at a time when having health insurance was considered rare (Levin, 2013).

Collateral source rules vary widely across states relative to differences in recoverable compensation compared to actual medical payments. It is postulated that additional changes could occur if almost all people in the United States ultimately have health insurance coverage (Levin, 2013; Levinson, 2011). However, the ultimate path of such changes currently remains speculative. For example, how will package of health care benefits and services evolve over time and what is the likelihood of coverage and cost stability and predictability? How effectively will proposed Medical Reimbursement Data Centers reflect market rates for medical services, articulate geographic differences for those rates, and incorporate measures for qualitative analysis and specialty services? Will these data centers also accurately represent market rates for medical services not covered by insurance, or by providers/services/supplies outside of insurance reimbursement? What rights to judicial relief become available to willfully uninsured individuals? Do future injury associated health care needs become automatically covered by health insurance policies given the repudiation of pre-existing clauses, thus distributing the costs to all subscribers in the overall insurance pool, or remain the liability of the tortfeasor to make the plaintiff whole? What rights to subrogation will insurance companies and other “first response funders” retain? These may be new considerations for lawyers involved in acquired brain injury cases.

### Summary and Recommendations

The life care plan’s strength is based on its medical, rehabilitation, case management and psychological foundations. Its integrity is dependent on the consistency of its methodological approach and its durability rests on integrative components that represent a specific evaluatee’s overall needs and life quality. Health care services represent one component of a life care plan. Other equally important considerations include habitation; transportation; personal adaptive supports; productive activity patterns including but not limited to vocational, educational and leisure/recreational pursuits; community integration; social capital and personal validation.

Impending changes in health care service delivery and reimbursement may promulgate changes regarding future assessments of associated costs and valuation. However, at this early phase of implementation, coupled with a lack of clinical, legal and financial experience, there is uncertainty regarding the future direction and tenure of these changes. This yields greater speculation than certainty compared to existing financial models. It is important to keep abreast of these developments, per a life care plan’s responsibility to provide well-established, accurate, predictive and timely information.

Ultimately, it is most important to recognize that a life care plan is much more than an actuarial exercise or an accounting of health care needs. It involves comprehensive assessment by a qualified rehabilitation professional, thorough representation with support and foundation of an

evaluatee’s current and future needs relative to an index event, and a prospective process to ameliorate/moderate associated handicapping conditions.

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