

RESEARCH ARTICLES

Chapter 1: Foundation for Cost Research in Life Care Planning

Dana Penilton, Laura Woodard

<https://doi.org/10.70385/001c.155162>

Journal of Life Care PlanningVol. 24, Issue 1, 2026

The purpose of this chapter is to explore guiding principles for the practice of life care plan cost research. Documents which elucidate principles, beliefs, or doctrines generally acknowledged by a profession, practice, or field are reviewed. They outline decision-making guidelines, define practice expectations, describe a foundation for a system of behaviors, and provide a framework for practice implementation and decision-making. The documents selected for review in this chapter have been instrumental in the evolution of the process of life care plan costing. These types of documents have articulated and shaped the direction of the field and have been helpful in the development of a Costing Framework to guide life care planners in doing cost research. Chapter 3 will also provide insight into publications and presentations relevant to life care plan costing.

The history of life care planning can be traced to the mid-1970s through the work of rehabilitation specialist Paul Deutsch and economist Dr. Fredrick Raffa (Weed & Rutherford-Owen, 2024). The basic tenets of life care planning were first published in 1985 in the book *A Guide to Rehabilitation* (Weed, 2019). Life care planning standards of practice (SOP) were first published in 2000 (International Academy of Life Care Planners, 2000), and the first consensus and majority statements were also developed in 2000 (Weed & Berens, 2001) following the first life care planning summit. Both the standards of practice and the consensus and majority statements continue to be updated to reflect advancements in the field. The first life care planning survey was published in 2001 (Neulicht et al., 2002), and the first role and function study of life care planners was published in 2010 (Pomeranz et al., 2010). These foundational documents guide practitioners while acknowledging the role of individual judgment in this evolving specialty practice.

This chapter focuses on foundational documents that show the overarching principles of life care plan costing and addresses the standards set out in Rule 702 of the Federal Rules of Evidence. It describes the need for a costing framework that life care planners can use to make informed decisions about which costing techniques to use and how to develop a costing methodology that adheres to practice guidelines. To gain an understanding of the foundation of cost research practices among professionals in the field, the following documents were reviewed:

- International Academy of Life Care Planners (IALCP) Standards of Practice for Life Care Planners (2000, 2006, 2015, and 2022)
- American Association of Nurse Life Care Planners (AANLCP) Nurse Life Care Planning Scope and Standards of Practice (2015)
- American Academy of Physician Life Care Planners (AAPLCP) Standards of Practice (2025)
- Consensus and majority statements by life care planners developed during the 11 life care planning summits held from 2000 to 2022
- Tenets of Life Care Planning (Deutsch et al., 2005 p. 5–13 to 5-19)
- Life care planning surveys (2001, 2009, and 2022)
- Role and function studies of life care planners (2010, 2014, 2020 and 2025)

[Table 1](#) appearing later in this chapter, presents the costing research methodology elements addressed in these foundational documents. The standards of practice published by three life care planning professional organizations, the life care planning consensus and majority statements, and the tenets of life care planning require that assessment and data collection be consistent, valid, and reliable. The International Association of Rehabilitation Professionals (IARP) /IALCP standards of practice and the consensus and majority statements additionally require a consistent, valid, and reliable approach to be used in the life care planner's approach to cost research. Life care planning standards of practice (International Academy of Life Care Planners, 2022), the consensus and majority statements (Johnson et al., 2018, 2025), and the tenets of life care planning (Deutsch et al., 2005) indicate costs should be relevant to an evaluatee's geographical area. The IARP/IALCP standards of practice, AAPLCP standards of practice (2025), consensus and majority statements, and tenets of life care planning note costing resources used in cost research should be reliable. In addition, standards of practice published by IARP/IALCP, AANLCP, and AAPLCP consensus and majority statements and the tenets of life care planning require identification of non-discounted costs.

Standards of Practice

The life care planning standards of practice published by IARP/IALCP, AANLCP, and AAPLCP have defined the process life care planners should follow in addition to practice competencies. Consensus and majority statement number 29 indicates the standards of practice shall assert the role

and accountability of life care planners (Johnson et al., 2018, p. 16, 2025, p. 76). The following section presents information about costing quoted from each organization's standards of practice.

International Association of Rehabilitation Professionals-International Academy of Life Care Planners Standards of Practice for Life Care Planners, 4th Edition (2022)

Assessment and evaluation of an evaluatee

This step refers to the activities performed in gathering the information necessary for preparation of a life care plan.

9. STANDARD: The life care planner performs comprehensive assessment through the process of data collection involving multiple elements and sources.

PRACTICE COMPETENCIES:

- a. Uses a consistent, valid, and reliable approach to data collection.
- b. Collects data in a systematic, comprehensive, and accurate manner.
- d. Obtains information from records, evaluatee/family (when available or appropriate), and relevant treating or consulting health care professionals and others (International Academy of Life Care Planners, 2022, p. 12).

Analysis and synthesis to identify functioning, disability, and health

This step refers to organizing collected data into an empirically derived and conceptually coherent format that incorporates case-salient factors.

10. STANDARD: The life care planner analyzes data using a consistent, valid, and reliable process.

PRACTICE COMPETENCIES:

- b. Follows a consistent method for organizing and interpreting data (International Academy of Life Care Planners, 2022, p. 12).

Delineating costs

This step includes methodology for determining the costs of future care recommendations.

14. STANDARD: The life care planner uses a consistent, valid, and reliable approach to costs.

PRACTICE COMPETENCIES:

- a. Uses a consistent method to determine costs for various categories of available/needed services
- b. Uses geographically relevant and representative costs
- c. Identifies services and products from reliable sources
- d. Follows a consistent method for organizing and interpreting data for projecting costs
- e. Explains the life care planning process to involved parties to obtain needed information
- f. Cites verifiable cost data (International Academy of Life Care Planners, 2022, p. 14).

15. STANDARD: The life care planner communicates their opinions.

PRACTICE COMPETENCIES:

c. Considers classification systems (e.g., International Classification of Diseases [ICD],

Current Procedural Terminology [CPT], Healthcare Common Procedure Coding

System [HCPCS], International Classification of Functioning, Disability, and Health

[ICF]) to provide clarity regarding care recommendations and costs (International Academy of Life Care Planners, 2022, p. 14).

American Association of Nurse Life Care Planners Nurse Life Care Planning Scope and Standards of Practice

Standards of Practice

Standard 1. Assessment: The nurse life care planner performs comprehensive data collection pertinent to the healthcare consumer's health and unique situation (Howland, 2015, p. 54).

Standard 3. Outcomes Identification: The nurse life care planner identifies expected outcomes for a life care plan individualized to the healthcare consumer or situation.

Competencies:

- Considers associated risks, benefits, costs, current scientific evidence, expected trajectory for condition, and clinical expertise (Howland, 2015, p. 55).

Standard 4. Planning: the nurse life care planner develops a plan that prescribes strategies, interventions, and alternatives to attain projected outcomes

Competencies:

- Includes an analysis of the economic effect on the healthcare consumer, family, caregivers, or other affected parties
- Provides alternatives, associated costs and benefits (Howland, 2015, p. 56).

American Academy of Physician Life Care Planners (AAPLCP) Standards of Practice (2025)

Standard 4: Quantification

Quantification describes the quantification of future medical requirements in a life care plan. When quantifying future medical requirements:

A. Physician life care planners reference/exhibit all variables used to perform their calculations.

B. Physician life care planners describe the methodology used to perform all calculations, so as to make their cost analyses independently replicable/disprovable.

C. Physician life care planners quantify the total cost of future medical requirements in their life care plans.

D. Unless a physician life care planner is qualified as an expert to formulate present value analyses, Certified Physician Life Care Planners formulate the total cost of the subjects' *[sic]* future medical requirements in nominal value, without accounting for inflation, discounts, or any other time value of money considerations.

E. Physician life care planners, whenever possible/practicable cite and/or references *[sic]* all data sources from which they obtained cost data.

Consensus and Majority Statements

The consensus and majority statements provide further guidance regarding life care plan costing. These have been developed since the first life care planning summit in 2000. By the 2015 summit, there were 102 consensus and majority statements. At the 2017 summit, there was a consensus to systematically review the existing statements to determine if they were still appropriate and relevant. After the Delphi study was completed, 96 statements remained, and of these renumbered statements the following address costing specifically (Johnson et al., 2018, pp. 15–18, 2025, pp. 72–76 and Johnson, 2015, pp. 35–38):

50. Revised: Life Care Planners shall utilize research (including identifying relevant literature to provide a foundation for recommendations, costing for equipment and services, etc.) in Life Care Plan that is reasonable, relevant, and appropriate. (This was statement 55 in the 2015 statements.) This statement was agreed to by consensus at the 2008 summit (Preston et al., 2008).

54. Life Care Planners shall research condition, resources, services and costs (Johnson et al., 2018, p. 16). (This was statement 59 in the 2015 statements.) This statement was agreed to by consensus at the 2000 summit (Weed & Berens, 2001).

62. Revised: Life Care Planners shall utilize standardized procedures and tools for gathering and reporting information and feature standardized forms and formats. (Statement 67 in the list of 2015 statements was rolled into this revised statement.) This statement was agreed to by consensus at the 2000 summit (Weed & Berens, 2001).

69. Life Care Planners shall utilize protocols for cost research. (This was statement seven in the 2015 statements.) This statement was agreed to by consensus at the 2002 summit (Riddick-Grisham, 2003).

70. Life Care Planners shall gather geographically relevant & representative prices. (This was statement 77 in the 2015 statements.) This statement was agreed to by consensus at the 2000 summit (Weed & Berens, 2001).

76. Revised: Life Care Planners as a whole/or part of the specialty practice of life care planning through ethical practice will contribute to the reliability, validity and accuracy of life care plans. (This was statement 86 in the 2015 statements, reaffirmed in 2017.) This statement was agreed to by consensus at the 2004 summit (Deutsch & Allison, 2004).

82. The cost of private hire home care includes care giver compensation and associated expenses. (This was statement 95 in the 2015 statements.) This statement was agreed to by consensus at the 2010 summit (Johnson et al., 2010).

85. Best practices for identifying costs in life care plans include:

- A. Verifiable data from appropriately referenced sources
- B. Costs identified are geographically specific when appropriate and available
- C. Non-discounted/market rate prices
- D. More than one cost estimate, when appropriate (Johnson et al., 2018, p. 17).

(This was statement 98 in the 2015 statements, reaffirmed in 2017.) This statement was agreed to by consensus at the 2012 summit (Johnson, 2012).

Additional consensus statements address the need for validity, reliability, and consistency in life care planning practice, including the collection, analysis, and synthesis of data, without explicitly mentioning costs/prices. These include the following:

5. Life Care Planners shall understand the definition of reliability and consistently practice in such a manner (Johnson et al., 2018, p. 15). (This was statement 5 in the 2015 statements.) This statement was agreed to by consensus at the 2000 summit (Weed & Berens, 2001).

52. Life Care Planning shall depend on data collection, analysis and synthesis. (This was statement 57 in the 2015 statements.) This statement was agreed to by consensus at the 2000 summit (Weed & Berens, 2001).

59. Life Care Planners shall utilize a reliable, consistent method for reaching conclusions (Johnson et al., 2018, p. 16). (This was statement 64 in the 2015 statements.) This statement was agreed to by consensus at the 2000 summit (Weed & Berens, 2001).

71. Life Care Planners shall utilize protocols for using local versus national resources. (This was statement 78 in the 2015 statements.) This statement was agreed to by consensus at the 2002 summit (Riddick-Grisham, 2003).

72. Life Care Planners shall follow generally accepted methodology. (This was statement 79 in the 2015 statements, reaffirmed in 2017.) This statement was agreed to by consensus at the 2008 summit (Preston et al., 2008).

74. Life Care Planning databases, templates and software shall have appropriate foundation. (This was statement 81 in the 2015 statements.) This statement was agreed to by consensus at the 2008 summit (Preston et al., 2008).

75. Life Care Planning products and processes shall be transparent and consistent. (This was statement 82 in the 2015 statements, reaffirmed in 2017.) This statement was agreed to by consensus at the 2008 summit (Preston et al., 2008).

89. Life Care Planners shall identify the sources of their recommendations (Johnson et al., 2018, p. 17). (This was statement 102 in the 2015 statements.) This statement was agreed to by consensus at the 2015 summit (Albee et al., 2017).

The Basic Tenets of Life Care Planning

The Basic Tenets of Life Care Planning include the following:

- Tenet 5 indicates that life care plans should specify provisions throughout life expectancy, not depend on any one service or supplier, use at least three sources for major cost items, and not seek or use negotiated or discounted rates, as it is not possible to guarantee that the cost will remain constant. Costs should reflect the real value of goods and services found within the patient's local market, and outliers should

be eliminated from the market analysis to prevent the representation of an unrealistically low or high cost of an item (Deutsch, n.d., and Deutsch et al., 2005, pp. 5–15).

- Tenet 6 states that regional factors and geographical location should be considered (Deutsch, n.d., and Deutsch et al., 2005, pp. 5–15).
- Tenet 11 indicates that life care planners should consider the entire cost of each recommendation by considering all cost factors associated with a given service option or piece of equipment (Deutsch, n.d., and Deutsch et al., 2005, pp. 5–17).
- Tenet 12 notes that the costs provided in a life care plan do not include potential complications or future technology (Deutsch, n.d., and Deutsch et al., 2005, pp. 5–18).

As life care planning evolved into a subspecialty, it was recognized that “needs, rather than funding sources, drive the planning process. At no time during the plan development process should budgetary concerns influence care and rehabilitation recommendations.” (Deutsch et al., 2005, pp. 5–6). See [Table 1](#) for a comparison of the costing principles elucidated in the sections above. The consistency of approaches and methods published by different associations in multiple documents strengthens the use of these as a foundation for costing research. For the historical evolution of summit statements, see the narrative above.

Life Care Planning Decennial Surveys

Since 2001, surveys of life care planners have been conducted to ascertain their methodologies; the most recent surveys were made in 2009 and 2022, respectively. The survey results provide longitudinal data over a period of 20 years regarding the process, methods, and protocols of life care planning. The 2022 survey (Neulicht et al., 2022) addressed the definitions of “charge” and “cost.”

In the 2022 survey, respondents were asked to define “charge” and “cost” in their own words. Among the participants who responded to this question, there was no consensus about the definition of either term. However, the analysis of the responses revealed themes related to the terms “cost” and “charge.” Neulicht et al. (2022) found that

Themes for the definition of charge included associated cost for an item, bill for services/goods, and cost without discount. Themes for the definition of cost included the amount of money needed to purchase a service or item and charge fee for the service or item.

Table 1. Comparison of Current Costing Methodology Described in Life Care Planning Standards of Practice, Consensus and Majority Statements, and Tenets

Costing Methodology	IALCP/ IARP SOP 4 th Edition (2022)	AANLCP Scope of Practice and SOP (2015)	AAPLCP SOP (2025)	LCP Consensus and Majority Statements (2018)	Tenets of Life Care Planning (Deutsch, n.d.)
Assessment– data collection: consistent, valid, reliable, reasonable	Standards 9a, 9b & 9d	Standards 1 & 9	Standard 2A	Statements 5, 50, 52, 59, 69 & 76	Tenet 2
Use consistent, valid, and reliable methodology	Standards 10b, 14a, 14d & 14f			Statements 5, 50, 54, & 72	
Use geographically relevant costs	Standard 14b			Statements 70, 71 & 85b	Tenet 6
Identify verifiable, reliable sources	Standard 14c & 14f		Standard 4E	Statements 5, 85a & 89	Tenet 5
Identify expected outcomes		Standard 3. Competencies: consider risks, benefits, costs, expected trajectory of condition, etc.			
Provide annual costs		Standard 4. Essential Function (annual cost of each item)			
Provide total costs			Standard 4C & D		Tenet 11 references cumulative cost considerations
Reference variables used to perform calculations			Standard 4A		
Describe methodology used to perform calculations			Standard 4B		
Cite or reference data sources for cost data			Standard 4E	Statements 75, 85a & 89	
Consider entire cost of recommendation				Statements 50 & 82	Tenet 11
Use non-discounted costs	Standard 14f		Standard 4D	Statement 85c	Tenet 5
Costs do not include potential complications or future technology					Tenet 12

A majority of respondents indicated:

- More than one quote on items or services is routinely obtained (69.42%).
- The number of cost quotes varies depending on the availability of items or services in the evaluatee's geographic area (82.64%), availability of current vendor appropriate cost (74.79%), item or service availability (73.14%), the nature of the item or service itself (65.7%), and availability of national database(s) (50.83%).
- Current vendors or providers are used to obtain costs (64.61%, 76-100% of the time).
- Local vendors and providers are used (64.23%, 76-100% of the time).

- National databases with geographic adjustment are used (58.65%, 76-100% of the time). A clear majority of respondents do not use national databases if geographic adjustment is not available (66.51%).
- If a cost is difficult to quantify, an annual allowance/allocation for goods and services is included (68.03%).
- Geographic location is the primary factor that affects decision making in determining which resources to use to secure cost information (92.21%).
- Other important factors when choosing cost resources include the life care planner's experience with the item or service (78.28%), experience with the vendor/provider (68.03%) and family and evaluatee preferences (57.79%).
- Billing codes are used greater than 50% of the time when requesting cost quotes (61.8%).
- Cost research includes use of cash prices (67.8%), established fee schedules (65.68%) and billed charges (64.83%).
- Nearly all survey respondents documented pre-existing conditions (95.26%) but most (77.02%) did not include related costs.
- Private/direct-hire costs are included in home care cost research options (57.45%).
- A majority of respondents (50.21%) never identify collateral sources as a mechanism for funding a life care plan, but 31.06% do if required by statute or case law, and 28.94% do when requested by a referral source.
- Cost research excludes negotiated or discounted costs (91.95%).

Other factors identified by less than a majority of respondents or from respondent write-in answers identified other considerations in life care plan cost research:

- Personal contacts (calls, e-mails, etc.) are used by nearly a majority of respondents 76-100% of the time to obtain costs for home care (48.93%), facility projected evaluations (35.04%), medication(s) (34.19%), future medical care routine (32.33%), health/strength maintenance (31.91%), facility care (45.3%), and projected therapeutic modalities (36.71%).

- Ancillary costs such as shipping, assembly, membership and maintenance costs are included by 43.5% of respondents.
- Examples of collateral sources included or identified by some life care planners are drug plans, Individualized Education Plan/504 Plan items, and universal health care if it is a long-term established collateral funding program that is standard across the country.
- Life care planners utilize published databases for costs of medical/surgical intervention (46.38%), routine medical care (45.38%), therapeutic modalities (44.26%), evaluations (42.62%), acute medical interventions (44.02%), medications (43.46%), and diagnostic/educational testing (34.04%) of the time.
- For home modification costs, respondents use an architect estimate/quote 26.42%, a contractor estimate/quote 29.69% of the time, an independent home accessibility evaluator/specialist 27.19%, literature 27.27%, a rehabilitation engineer 63.18%, and the Veterans Administration [sic] home modification benefit 34.85% of the time.

Life Care Planning Role and Function Studies

Role and function studies assess prevalent practice patterns and protocols, define job tasks and competencies specific to a profession or practice, establish certification requirements, and ensure that certification tests evolve with the profession or practice. One such study of life care planners was done by Pomeranz et al. (2010) independent of any certification organization, another one was done to support the mission of the Certified Nurse Life Care Planner (CNLCP®) Certification Board (2014), one was done by the International Commission on Health Care Certification (2020), which offers the Certified Life Care Planner (CLCP)® credential, and one was undertaken by the Universal Life Care Planning Certification Board (ULCPCB™) to improve the quality of the CNLCP® credentialing program (2025).

Role and Function Study of Life Care Planners

The Role and Function Study of Life Care Planners (Pomeranz et al., 2010) identified the roles and functions of life care planners by importance and frequency and grouped items into 21 themes. Specifying costs was a role and function found across multiple themes, including accessing independent living needs, health promotion, equipment needs/assistive technology, evidence-based practice, health care management, insurance benefits/health care services, and vocational information. Theme 10, evidence-based practice, represents a systematic approach using scientific or empirical evidence that

includes Item 37, reviews current catalogs and websites to determine the costs of needs and services, and Item 29, provides fair and representative costs relevant to the geographic area or region.

AANLCP Role and Function Study

According to the AANLCP Role and Function Study, the registered nurse (RN) develops a dynamic document that outlines with reasonable certainty the future healthcare needs of an individual along with the associated costs and frequencies of goods and services necessary to promote quality of life and a safe environment (Manzetti et al., 2014). The study delineated tasks that were divided into six major categories: Patient assessment, collaboration with others, life care plan development, cost research, life care plan report construction, and professional activities.

The following cost research tasks were rated as frequently performed:

- obtaining costs for items and services in a life care plan using provider/vendor contacts
- determining costs based on geographic location
- obtaining costs for items and services in life care plan using internet sources

The following cost research tasks were rated as low in frequency of performance:

- obtaining costs for items and services in a life care plan using national databases (without geographic adjustment)
- using worker's compensation fee schedules
- using collateral resources
- using alternative payment sources such as cash pay, private insurance, and Medicaid
- other considerations used in determining life care plan costs include referral source requests and Medicare guidelines

Respondents rated these tasks high in importance for content performance:

- provider/vendor contact
- geographic location
- internet sources
- recent billing

International Commission on Health Care Certification (ICHCC) Role and Function Investigation

The ICHCC Role and Function Survey (May & Rekabdarkolae, 2020) asked life care planners to identify the tasks that they perform in the creation of life care plans. The job tasks were assigned to 16 knowledge domains and 23 associated subfactors. Subfactor three was cost analysis, indicating that life care planners determine and specify the costs of needed items and services. The life care planning functions grouped under this subfactor include the following:

- 36. If applicable, specifies cost for independent living and adaptive equipment needs for independent function/living
- 51. Determines costs of needed equipment for the injured person
- 67. Specifies cost for physical therapy services
- 68. Specifies the cost of speech therapy services
- 69. Specifies the cost of occupational services
- 70. Reviews current catalogs to determine the costs of assistive devices needed by the evaluatee
- 78. Specifies cost for and replacement of orthotics and prosthetics (e.g., braces, ankle/foot orthotics)
- 80. Specifies cost for projected evaluations (e.g., PT/OT, SLP, individual counseling, family counseling, group counseling, marital counseling, etc.)
- 81. Specifies cost for projected therapeutic modalities (e.g., PT, OT, SLP, individual counseling, family counseling, group counseling, marital counseling, etc.)
- 82. Specifies cost for case management services
- 83. Projects associated costs for non-medical diagnostic evaluations (e.g., recreational, nutritional) for the injured person
- 86. Specifies cost for architectural renovations for accessibility (e.g., widen doorways, ramp installations)
- 87. Specifies costs for evaluatee's home furnishing needs and accessories (e.g., specialty bed, portable ramps, patient lifts)
- 90. Specifies cost for health/strength maintenance (e.g., adaptive sports equipment and exercise/strength training)

- 93. Determines costs of needed social services for the evaluatee
- 108. Determines costs of needed medical services for the evaluatee
- 121. Research pricing of medical recommendations
- 124. Research services costs and frequencies
- 161. Reviews current catalogs and websites to determine the costs of needs and services
- 162. Provide fair and representative costs relevant to the geographic area or region

Nurse Life Care Planning Practice & Protocols: 2024

A job task analysis was undertaken by the ULCPCB™ and the results were published by Bate & Roughan (2025). The data analysis included a demographic summary, including answers to questions related to pricing of life care plans. National databases used to obtain pricing among the 88 respondents include Medical Fees in the U.S. (about 59%), VA Reasonable Charge Data/Find-A-Code (50%), Milliman (about 22%), American Hospital Directory (about 38%), Metadata (about 15%), FairHealth (about 32%), Context4Healthcare (about 31%), Physician's Fee Reference (about 29%), about 4% do not use databases, and 15% responded "other." In response to the question "What percentile do you use most often when obtaining pricing from a national database," out of 88 respondents, 10% use the 50th percentile, 33% use the 75th percentile, 43% use the 80th percentile, 2% use the 90th percentile, 6% do not use databases, and 6% responded "other." Regarding a question about how respondents determine a cost when using national databases, 36% use one database to determine cost and 26% use the median cost of three or more databases. Sixteen percent use the average cost of two or more databases. Cost research was one of five domains of tasks performed by life care planners. Coding and costing research was one of the knowledge areas of a life care planner.

Defense of Costing Methodology

Life care planning foundational documents provide a philosophical framework for defining associated costs in a life care plan. Although they do not define specific costing methodologies, each requires assessment and data collection to be completed using a consistent, valid, and reliable process. However, there is a lack of specificity regarding the performance of costing research using a valid and reliable approach. In addition, life care planning surveys and 2022 summit discussions confirm the need for education and guidance regarding conducting cost research. When life care planning was first developed, costing methodology consisted of obtaining information via telephone calls and review of catalogs. Costing items in a life care plan has become more complex and new data sources are now available, mainly

internet-based resources. Due to the development of new data sources, the complexity of costing research, and the lack of guidance regarding costing methodology, developing a costing framework is important to guide current and future life care planners in selecting and implementing generally accepted costing methodologies.

Another crucial aspect of costing research is life care planners' ability to identify reliable methods of costing and to defend the costing methodology utilized. Defensibility is especially important in the forensic setting, as rules regarding expert testimony require an opinion to be based on sufficient facts or data, and to be the product of reliable principles and methods reliably applied to the facts of the case (Rule 702: Testimony by Expert Witnesses [FRE 702], 2011, p. 1). The Costing Framework aims to provide life care planners with the information and resources needed to describe and defend their costing research methodology.

The *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923) decision set forth the general standard for expert admissibility. This standard of admissibility requires [expert witness](#) testimony have general acceptance with the scientific community. With the U.S. Supreme Court case *Daubert v. Merrell Dow Pharmaceuticals Inc.*, 509 U.S. 579 (1993) and the amendment to Rule 702 of the Federal Rules of Evidence in 2000, judges were required to scrutinize not only the expert's methodology but also the underlying scientific principles. The Daubert ruling identified four factors for courts to consider when assessing the reliability of scientific evidence: 1) whether the theory or technique can be tested; 2) whether it has been subjected to peer review and publication; 3) its known or potential error rate; and 4) its general acceptance in the relevant scientific community. The Daubert standard is used to determine the admissibility of an expert's testimony in all federal courts.

On December 1, 2023, an amendment to Federal Rules of Evidence 702 went into effect in the United States. The amendment clarifies that expert testimony can only be admitted if the proponent can show it is more likely than not the testimony meets the rule's admissibility requirements. The full text of the Rule 702 amendment states:

A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if the proponent demonstrates to the court that it is more likely than not:

- (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;
- (b) the testimony is based on sufficient facts or data;
- (c) the testimony is the product of reliable principles and methods; and

(d) the expert's opinion reflects a reliable application of the principles and methods to the facts of the case.

Life care planners also need to be aware of case law on a state-by-state or jurisdictional basis.

Summary

A review of foundational documents, in addition to the Federal Rules of Evidence and case law regarding expert testimony, indicates the costing research methodology used by life care planners needs to be reliable and generally accepted by the scientific (life care planning) community. A costing framework will give life care planners the ability to research and analyze costs in a scientific manner that is reliable, valid, and consistent. It will also help life care planners to defend their costing research methodology

Published: February 09, 2026 CST.



This is an open-access article distributed under the terms of the Creative Commons Attribution 4.0 International License (CCBY-NC-ND-4.0). View this license's legal deed at <https://creativecommons.org/licenses/by-nc-nd/4.0> and legal code at <https://creativecommons.org/licenses/by-nc-nd/4.0/legalcode> for more information.

References

- Albee, T., Gamez, J., & Johnson, C. (2017). 2017 Life Care Planning Summit Proceedings. *Journal of Life Care Planning*, 15(3), 19–29.
- American Academy of Physician Life Care Planners. (2025). *Standards of practice*. <https://aaplcp.org/About/PracticeStandarts.aspx>
- Bate, B., & Roughan, J. (2025). Nurse Life Care Planning Practice & Protocols: 2024. *AANLCP Journal of Nurse Life Care Planning*, XXV(2), 15–37.
- Deutsch, P. (n.d.). *The basic tenets of life care planning*. <http://www.paulmdeutsch.com/LCP-tenets-of-life-care-planning.htm>
- Deutsch, P., & Allison, L. (2004). Proceedings of the life care planning summit 2004. *Journal of Life Care Planning*, 3(3), 193–202.
- Deutsch, P., Allison, L., & Reed, C. (2005). An introduction to life care planning: History, tenets, methodologies & principles. In P. Deutsch & H. Sawyer (Eds.), *A guide to rehabilitation* (Vol. 1, p. 5.1-5.30). AHAB Press.
- Howland, W. (Ed.). (2015). *Nurse life care planning scope and standards of practice*. American Association of Nurse Life Care Planners.
- International Academy of Life Care Planners. (2000). *Standards of practice for life care planners*.
- International Academy of Life Care Planners. (2022). *Standards of practice for life care planners* (4th ed.). International Association of Rehabilitation Professionals. <https://rehabpro.org/page/ialcp-standards-of-practice>
- Johnson, C. (2012). The 2012 Life Care Planning Summit: Third Time is a Charm. *Journal of Life Care Planning*, 11(2), 3–8.
- Johnson, C. (2015). Consensus and majority statements derived from life care planning summits held in 2000, 2002, 2004, 2006, 2008, 2010, 2012 and 2015. *Journal of Life Care Planning*, 13(4), 35–38.
- Johnson, C., Berens, D., Pomeranz, J., & Preston, K. (2010). Life Care Planning Summit 2010 Proceedings. *Journal of Life Care Planning*, 9(2), 3–14. <https://doi.org/10.70385/001c.151374>
- Johnson, C., Pomeranz, J., & Stetten, N. (2018). Consensus and majority statements derived from life care planning summits held in 2000, 2002, 2004, 2006, 2008, 2010, 2012, 2015, and 2017 and updated via Delphi study in 2018. *Journal of Life Care Planning*, 16(4), 15–18.
- Johnson, C., Williams, C., Mackenzie, A., & Feerick, B. (2025). Consensus and majority statements since 2000: Updated at the 2025 life care planning summit. *Journal of Life Care Planning*, 23(2), 72–79. <https://doi.org/10.70385/001c.142260>
- Manzetti, C., Bate, B., & Pettengill, A. (2014). A survey of nurse life care planners: A role delineation study in the United States. *Journal of Nurse Life Care Planning*, 14(3), 694–707.
- May, V., & Rekabdarkolae, H. (2020). The International Commission on Health Care Certification life care planner role and function investigation. *Journal of Life Care Planning*, 18(2), 3–67.
- Neulicht, A., Riddick-Grisham, S., Barros-Bailey, M., Knott, M., Maxwell, A., Albee, T., Marcinko, D., Mitchell, N., & Robinson, R. (2022). Life care plan survey 2022: Process, methods and protocols- A 20-year perspective. *Journal of Life Care Planning*, 21(3), 5–113.
- Neulicht, A., Riddick-Grisham, S., Hinton, L., Costantini, P., Thomas, R., & Goodrich, B. (2002). Life care planning survey 2001: Process, methods, and protocols. *Journal of Life Care Planning*, 1(2), 97–148.

- Pomeranz, J., Yu, S., & Reid, C. (2010). Role and function study of life care planners. *Journal of Life Care Planning*, 9(3), 57–106.
- Preston, K., Pomeranz, J., & Walker, C. (2008). Life Care Planning Summit 2008 Proceedings. *Journal of Life Care Planning*, 7(2), 49–60.
- Riddick-Grisham, S. (2003). Life care planning summit 2002. *Journal of Life Care Planning*, 2(2), 73–101.
- Weed, R. O. (2019). A brief history of life care planning. *Journal of Life Care Planning*, 17(3), 5–14.
- Weed, R. O., & Berens, D. (2001). *Life care planning summit 2000 proceedings*. Elliott & Fitzpatrick.
- Weed, R. O., & Rutherford-Owen, T. (2024). Life Care Planning: Past, Present, and Future. In T. Rutherford-Owen, M. Barros-Bailey, & R. O. Weed (Eds.), *Life Care Planning and Case Management Across the Lifespan* (pp. 3–24). Routledge. <https://doi.org/10.4324/9781003388456>