

Determining the Value of Past Lost Insurance

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Abstract: *In personal injury tort and employment discrimination actions, damages can be claimed for lost medical, dental, vision and life insurance. Provision of insurance by an employer can be an important part of fringe benefits provided to employees in addition to money earnings lost because of an injury. Future lost insurance, either as a part of lost earning capacity or part of “front pay” can be replaced and are not the subject of this paper. Past lost insurance, however, cannot be replaced because the time during which the insurance would have had value has passed, raising the question of methods for valuing a benefit that no longer is needed. Courts have wrestled with the question of how to value past lost insurance. Courts have arrived at three possible answers: (1) determining the out-of-pocket costs borne by a personally injured plaintiff because the plaintiff did not have the lost insurance; (2) determining what would have been the market cost for replacing the past lost insurance; or (3) determining the cost to the employer of providing the insurance that was not provided because of the injury or termination. Defendants have generally preferred the first method, while plaintiffs have generally preferred one of the second or third methods. The purpose of this paper is to elaborate on the three methods and to provide a sampling of what the courts have said about this issue. The primary emphasis of this paper will be on medical insurance, but one important court decision involving life insurance will also be discussed.*

I. Introduction

In personal injury and wrongful termination actions, one of the elements of damage that a plaintiff can claim is loss of job-related fringe benefits. Job-related fringe benefits can include vacation pay, sick pay, overtime pay and other premium pay arrangements, which are not considered in this paper because they lead directly to payment of money income. Job-related fringe benefits can also include access to parking, access to company recreational facilities, an automobile,

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clothing allowance, food allowance, gasoline allowance and so forth. Benefits of those types will also not be considered in this paper. The focus of this paper will be on job-related fringe benefits that directly or effectively represent insurance of various types, including medical insurance, dental insurance, life insurance, disability insurance and retirement benefits. Retirement benefits are not typically thought of as insurance, but some types of retirement benefits are paid on a life-contingent basis and have important insurance qualities. Retirement benefits directly serve in lieu of disability benefits if a worker has already qualified to receive retirement benefits at the time of an injury. In such cases, a person is forced into retirement by the injury or termination of employment and retirement benefits serve in lieu of disability benefits. Any life-contingent financial instrument is effectively a type of insurance, though, as with "whole life" life insurance policies, can also serve other financial purposes. This paper considers past lost insurance of all types, but primarily focuses on medical insurance because medical insurance has been the primary focus of most of the decisions that will be described in the appendix. However, one of those decisions, *Fariss v. Lynchburg Foundation* (1985), focuses on life insurance in a way that will be discussed at some length; see Appendix for full citation.

The important difference between past lost insurance and future lost insurance is that future lost insurance can be both replaced and compensated, while past lost insurance can be compensated but not replaced. If an individual has lost future insurance, replacement insurance is available in the commercial marketplace. However, one cannot go back into the past and purchase insurance for past periods that have now expired. The distinction between "compensation" and "replacement" is an important consideration when methods for valuing past lost insurance are considered. There are also issues with respect to how replacement cost for the future is to be determined, but the general standard under the "make whole" principle is that an award for future lost insurance should be sufficient to allow replacement so that no future loss associated with the lack of insurance occurs. An award winner may not choose to use the award to replace lost future insurance, but it is at least possible for replacement to occur. If lost future insurance is replaced, there will be no future harm from lack of insurance. The lack of past insurance causes harm through anxiety about what might happen, even if the insurance was not needed. The harm suffered in the form of anxiety because of the lack of insurance can be compensated, but the harm has already occurred and cannot be undone. It can be compensated for, but it cannot be prevented.

When an individual has endured a loss of past insurance courts have considered three possible alternatives. The three general methods considered by the courts have been:

- (1) *The out-of-pocket approach.* The out-of-pocket approach allows plaintiffs to recover for their own out-of-pocket costs for replacement insurance and/or amounts paid by plaintiffs that would have been covered by lost past insurance;
- (2) *The employer cost approach.* The employer cost approach allows plaintiffs to recover an amount equal to what employers would have paid for medical insurance if the injury, death or termination had not occurred;
- (3) *The market-replacement cost approach.* The market-replacement cost approach allows plaintiffs to recover an amount equal to what it would have cost plaintiffs to purchase replacement insurance (even if they did not do so) equivalent to the insurance that employers would have provided if the injury, death or termination had not occurred.

The first alternative has generally been favored by defendants. The second and third alternatives are generally favored by plaintiffs and are often confused with each other. This paper will consider what the courts have said about and the practical implications of those three methods.

II. The Out-of-Pocket Approach

If, as a result of injury, death, or termination, a plaintiff is left without medical insurance but has not had to pay for medical expenses other than perhaps the costs of the injury itself, the lack of medical insurance has not caused a financial loss to the plaintiff. Insurance, which would have paid for losses had they occurred, has not been needed and the loss to the plaintiff has been an anxiety loss consisting of fear that insurance was not available if needed. As a result, there is no "out of pocket" financial loss and the "out of pocket" method implies no award to the plaintiff for past loss of insurance. Since that result is fairly common, most plaintiffs favor employer cost or market-replacement cost approaches while most defendants favor the out-of-pocket approach.

However, use of employer cost or market cost methods is a double-edged sword, as is indicated in *Fariss v. Lynchburg Foundation* (1985). That decision related to life insurance rather than medical insurance, but the underlying principle is similar. In that case, a plaintiff brought an age-discrimination claim against his

employer after being terminated. While the case was still being prosecuted two years later, the plaintiff died and his widow filed suit for her damages resulting from her husband's discriminatory termination. Her husband's death cut off lost earnings damages at two years, given that the court reasonably concluded that he could not have had lost earnings after his death. Similarly, his death would have cut off any medical insurance he would have had if he had not been terminated, so his widow had no claim for lost medical insurance after her husband's death. At issue, however, was the fact that one of the decedent husband's job-related fringe benefits was life insurance. When employed, the decedent husband was provided with life insurance as a benefit with a face value of \$42,000. The widow's claim was that she had lost the \$42,000 that would have been paid to her if her husband had not been terminated at the time of his death. In this case, the 4th Circuit held that the wife was only entitled to recover the cost to the employer for providing the life insurance and not the lost \$42,000 that resulted from the lack of that insurance being in effect because of the decedent's termination. This decision was clearly beneficial to the defendant even though it rejected the "out-of-pocket" loss approach that is usually favored by defendants.

Under the logic of the out-of-pocket approach, the wife would have been able to recover the \$42,000 face value of the life insurance. A corresponding example might be the medical expenses of a child in a worker's family following a termination. Assume that the child's medical expenses were \$300,000 and that the employer's medical insurance plan would have paid for \$270,000 of the \$300,000. This would be a loss to the worker of \$270,000. Assume further that the employer's cost per worker for medical insurance was \$8,000 per year and that the period since the termination has been two years. Under an employer cost measure, the loss to the worker would be \$16,000, compared with the actual loss of \$270,000 from the "out-of-pocket" loss standard. Without the child's medical expenses, the discriminated-against worker would have recovered \$16,000 more under the employer cost standard, but with the \$300,000 in medical expenses, the discriminated-against worker lost \$270,000 based on the "out-of-pocket loss" standard. In most cases, either the employer cost approach or the market-replacement cost approach would be beneficial to the defendant in that it would provide substantial recovery. In a few cases either of those methods would be greatly inferior from the worker's standpoint to the "out-of-pocket loss" standard.

III. The Employer Cost Approach

None of the methods for measuring loss of insurance described above is perfect. Each has its own limitations that will be discussed below. To explain why, it will be useful to consider why the true loss cannot be measured in a reliable way. Assume the following set of facts: John Jones was injured and had to quit work as of two years ago today. Medical bills from his injury have been paid for by the defendant and thus are not an issue in the current litigation. No family member has had any medical expense during that past two years that would have been covered by previously existing medical insurance. The employer of John Jones would have paid \$16,000 for medical insurance over the two-year period. John Jones could have purchased replacement insurance in the commercial marketplace for \$22,000, but did not do so. Under these circumstances, John Jones has suffered a loss, but not a financial loss because he had no out-of-pocket expenses that he would not have had if still employed. At the same time, however, John Jones probably suffered from anxiety about what would have happened if he had medical expenses that would previously have been covered. The problem is that there is no reliable way to measure the dollar value of the anxiety involved.

In the example, the dollar value to John Jones for having endured risk anxiety could not have been greater than \$22,000. If the loss was greater than \$22,000, John Jones would have purchased replacement insurance. This would have entitled John Jones, under the out-of-pocket approach, to recover \$22,000. The risk anxiety value would have been whatever John Jones would have been willing to pay to have the risk anxiety eliminated. It can be reasonably assumed that there is some amount that John Jones would have been willing to pay to maintain medical insurance over the past 24 months. It is possible that John Jones himself might not have known what that value was. Many people would be willing to pay some price to own a Ferrari automobile, but most people do not know what that amount is. It makes no sense to spend time thinking about what one would pay for something one already knows one could not afford, given existing market prices. If John Jones knew that the cost for maintaining medical insurance was significantly higher than what he was willing to pay, it is unlikely that he would have determined an amount he was actually willing to pay.

Furthermore, even if John Jones could have determined a maximum amount he was willing to pay to maintain medical insurance, there would still be a problem: he would still have nothing that would prove that amount was the correct amount. His personal

testimony would be regarded as self serving. Thus, under all circumstances there would be no known value that could be proven that was equal to the dollar-equivalent value for avoiding the anxiety stress suffered by John Jones because of the absence of past lost medical insurance.

IV. The Market-Replacement Approach

With no out-of-pocket losses, there may be a utility loss based on anxiety, but there would be no financial loss. If John Jones received an award of any amount for past lost insurance in a verdict and that John Jones was “made whole” in all other respects by the verdict, John Jones would have been made “more than whole” as of the date of the verdict. This is a point made in several of the cases described in the appendix. His loss of enjoyment of life was in the past. He can only be “made whole” with respect to the future. Looking forward into the future, he will have the opportunity to obtain replacement medical insurance. His lost earnings, his household services and any added life care costs will be included in the verdict. He can be compensated for having suffered a loss of enjoyment in the past, but that compensation will take the form of making him “more than whole” with respect to the future. As a result, he would have to spend the award on something other than medical insurance since he would also be given an award for future medical insurance. The concept must be that his expenditures on dinners, movies and so forth in the future will provide additional utility to compensate for utility lost in the past. But since all other losses have been replaced for the future, John Jones will be made more than whole with respect to the future.

If John Jones had purchased replacement insurance at a cost of \$22,000 for the two-year period the same problem would not arise. The \$22,000 would have been paid from existing financial assets. Including the \$22,000 for past replacement insurance as a damages element restores, but does not increase the net worth of John Jones compared to what it would have been prior to the injury. If the goal is to make the plaintiff whole as of the date of the verdict, restoring the \$22,000 spent for past lost insurance puts the plaintiff back into the net worth position the plaintiff was in before the injury. Arguments have been made that the same is true with respect to an award for past earnings. It is possible, but not necessarily true that the injured plaintiff cut back on various consumption items during the period between the injury and the trial, but an award for lost earnings is typically assumed by the courts to be earnings that could have been spent at any given time period. As viewed by the courts that have favored the out-of-pocket

concept, an award for past lost earnings simply restores the earnings that the injured person would have received during the past loss period. Whether the injured person would have saved those lost past earnings or used them for consumption would have been up to the injured person. One can make arguments based on assumptions about consumption and savings. Money that was not spent on consumption in the past because of financial exigency is arguably similar to expenditures on medical insurance in the past, but that is not how courts favoring the out-of-pocket approach have viewed such circumstances. Money income has been treated as fungible between time periods at the discretion of the person who has lost income because of an injury. Losses of money income in the past are considered to be replaced by an award for that past lost money income in the present. Not all treatment of money-income is fungible even if court decisions have suggested that it is.

V. Additional Comments

As discussed previously, loss of past insurance can be compensated even if it cannot be replaced. The loss consists of living with a lower level of financial security, with the plaintiff knowing that a medical expense could produce financial hardship because of the lack of insurance. The impact of financial insecurity differs widely by individuals. Thus, the same loss of past insurance would not affect any two individuals in the same way. Those who are more risk averse would lose more life enjoyment than those who are less risk averse. With respect to future lost insurance, the costs of replacement are the same for all individuals, regardless of risk preferences. Legal decisions seem to be uniform in accepting some form of replacement cost as the appropriate method for valuing lost future medical insurance. Legal decisions that support use of either the cost to employers of providing past lost insurance or the cost to workers of replacing lost past insurance with market equivalents acknowledge that such measures may make workers better off (“more than whole”), but focus on erring in favor of injured workers rather than erring in favor of defendants who are held liable for damages. All legal decisions appear to acknowledge that employer cost methods and market-replacement methods are likely to overstate losses by some unknown amount. However, decisions favoring employer cost and market-replacement methods appear to accept probable over-compensation of persons with lost past insurance at least in part because those methods typically favor victims rather than defendants.

The decisions provided in the Appendix appear to assume that there is no difference between employer cost and the market-replacement cost of lost past medical insurance. In reality, employer cost and market replacement cost were likely in the past to be significantly different dollar costs. This difference is because employer-provided insurance policies are group policies and private policies involve higher cost because they are subject to adverse selection. Under most circumstances, the costs of private replacement insurance would have been significantly larger than the per worker cost to employers of equivalent group policies. Under the Affordable Care Act, which precludes insurance companies from charging higher rates based on pre-existing medical conditions, the difference may narrow, but it is too early to reach that conclusion. Employer cost for providing insurance is much easier to determine and substantiate than private replacement cost because employers are likely to have that information. Individuals who did not privately purchase replacement insurance have often not sought to determine the premiums that would have been charged unless directed to do so by their attorneys. Further, because medical insurance policies are complex instruments with multiple formulas for co-payments and limits on coverage for particular types of medical expenses, it is very difficult to establish that apples are being compared with apples in the medical insurance market. Finding appropriate policies from which to determine market replacement costs is difficult and would probably require a medical insurance specialist to be done with complete accuracy. Thus, employer cost is often used because it is more easily accessible and avoids the difficulties of comparing different policies.

However, as pointed out in *Moore v. The Health Care Authority* (WA 2014), even the appropriate measure for employer cost is subject to some differences in itself; see Appendix for full citation. *Moore* was a class action lawsuit in which differences based on individual workers was not a central issue. The suit was filed on behalf of all part-time employees claiming that they should have received medical benefits. The Washington Supreme Court agreed. However, the decision that had to be made was the size of the portion of the award for all part-time employees, not amounts that should be paid in damages to individual part-time employees. As noted in the Appendix, attorneys representing the plaintiff class suggested three different methods for determining the amount of damages to be paid to the class based on one of three methods:

- (1) Treat the amount the State would have paid to provide health benefits as the loss;
- (2) Treat the amount the State unlawfully retained by failing to provide health benefits as the loss; and
- (3)

Treat the amount the State would have paid in health care costs for the group if they had been covered as the loss. (*The “State” refers to the State of Washington as the defendant. Italics added.*)

How the award would be divided among members of the class, as determined by any of these broad-based conceptual methods, was not discussed. All of these methods, however, were based on employer costs, not on the costs that part-time employees would have faced in obtaining replacement insurance in the commercial market.

Moore v. The Health Authority (2014) also makes one other point in favor of the method of valuing lost past medical insurance as best measured by employer cost. The argument made by the trial court and approved by the Washington Supreme Court was that “deferred [health] care is often more expensive and less effective” than health care that is obtained immediately when needed. The *Moore* court also said that “[p]eople without health benefits are less likely to seek and obtain medical treatment, especially preventive care.” The court indicated that it was not in error for the trial court to have considered these long term consequences of potentially reduced health on the class of part-time employees who had not received medical benefits. It is logical to assume that the health of any given person might have been affected by not seeking preventive health care because of the absence of medical insurance. Proving such a result for an individual worker is more difficult because in most instances the costs of preventive care would have remained financially feasible for the plaintiff. Lack of medical insurance would be only one factor in a decision not to seek preventive care.

This argument probably has more strength in a class action that involves a number of plaintiffs than in an individual case of personal injury. The *Moore* decision was in a class action case involving a number of part-time workers who were not provided with medical insurance. The judges in *Moore* were impressed with statistics indicating that there were important health effects for the group of plaintiffs as a whole. However, such statistics would be less persuasive in the case of a given individual whose personal health consequences could be measured and determined. If there were no detectable effects, this argument would probably not be effective. Even if the plaintiff’s health had deteriorated to some extent, defendants could argue that factors other than a lack of insurance were primarily responsible for the health deterioration.

The Appendix to this paper contains descriptions of eleven decisions. All eleven decisions were in the context of discrimination or violations of rights of workers under various statutes. None of these decisions was in the context of a personal injury or directly in the

context of a wrongful death action. As such, it cannot be determined whether courts would react differently in personal injury contexts than in discrimination and violations of worker's rights statutes. All but one of the decisions was the decision of a federal court and all but one of the ten federal court decisions were decisions of federal circuit courts. The federal circuits were divided between a majority of circuits favoring the out-of-pocket approach, but with a significant minority relying on the employer cost method. None of the decisions favored the market-replacement method. When federal circuits are divided, it is often the case that the United States Supreme Court takes up a case to resolve the differences between the circuits. However, the existing differences are not new and go back to at least 1985, based on the decisions discussed in the Appendix. The reason may be that differences regarding the proper method for valuing past lost insurance are ordinarily not the central differences that divide the parties in most personal injury and discrimination/termination litigation.

VI. Conclusions

In most forensic economic valuations of earnings losses, some method must be chosen for valuing past lost insurance. This paper has discussed the three basic methods involved and court arguments in favor and in opposition to those methods. Based on the decisions described in the Appendix, this issue is unlikely to be completely resolved in favor of one method or the other in the near future. The best advice for an economic expert is the same advice that is usually applicable to different legal possibilities: Ask the attorney who retained you what should be done. However, being able to explain the issue itself to an attorney is useful for a forensic economic expert. It is hoped that this short paper has provided some of the background necessary to do so.

Appendix: Legal Decisions Regarding Value of Past Lost Insurance

EEOC v. Dial Corporation, 469 3d 735 (8th Cir. 2006). This was a sex discrimination action under Title VII of the Civil Rights Act of 1964 against the Dial Corporation on behalf of four women who were denied employment. With respect to damages for past lost medical insurance these women would have had, the court said:

Dial also challenges the award of lost medical premiums, arguing the claimants should have been required to prove they incurred

medical expenses. Our court has not decided whether out of pocket expenses are required before health care benefits can be awarded, *see Tolan v. Levi Strauss & Co.*, 867 F.2d 467, 470 (8th Cir. 1989), and other circuits are divided on the issue. In the view of the Fourth Circuit, Congress intended fringe benefits to be part of the monetary award compensating claimants for the discrimination they suffered. *See Fariss v. Lynchburg Foundry*, 769 F.2d 958, 965-66 (4th Cir. 1985) (awarding medical benefits to widow of age discrimination victim without requiring proof of out of pocket medical insurance costs); *see also Blackwell v. Sun Elec. Co.*, 696 F.2d 1176, 1185-86 (6th Cir. 1983) (granting the amount of health care premiums to claimant as part of recovery); *but see Galindo v. Stody Co.*, 793 F.2d 1502, 1517 (9th Cir. 1986) (reimbursing only out of pocket expenses incurred to obtain health care).

Health care benefits are an important element of an employee's overall employment package, and Dial does not contest that it would have awarded claimants health care benefits had they been hired. The district court only required Dial to compensate the claimants for the amount of health care premiums that would have been part of their employment package had they not suffered discrimination. No reimbursement for health care costs incurred by uninsured claimants was awarded. The court's limited award was reasonable, for "[t]his insurance coverage, not the proceeds, is the benefit for which the employer must be held liable." *Fariss*, 769 F.2d at 965.

EEOC v. Wilson Metal Casket Co., 24 F.3d 836 (6th Cir. 1994). The majority held in this decision that the winning plaintiff in a sex discrimination case was entitled to recover for medical expenses she claimed would have been covered if she had not been wrongfully terminated. A dissent claimed that no evidence had been provided indicating that her particular medical expenses (for chemical dependency) would have been covered by her employer provided insurance. No claim was made that she was entitled to recover for the employer cost of medical insurance.

Fariss v. Lynchburg Foundation, 769 F.2d 958, 965 (4th Cir. 1985). This was an appeal of a trial court decision in an Age Discrimination in Employment Act (ADEA) case. The ADEA plaintiff had subsequently died after his termination. On the issue of whether past lost insurance should be calculated on the basis of past out-of-pocket costs, market value of the insurance or the employer cost for providing the insurance, the 4th Circuit said:

Had Mr. Fariss not been terminated, he would have been covered by a life insurance policy with a \$42,000 face value for the two years before his death. This insurance coverage, not the proceeds, is the benefit for which the employer must be held liable. Here the employer would in no event have been liable to the employee for the \$42,000, but only for the continuing payment of premiums. The value of being insured for a given period is precisely the amount of the premiums paid. To require the employer to pay the face value of the policy would be to compel assumption of a risk not undertaken on behalf of any other employee.

Nor is it sufficient to respond that an employer who discriminates in violation of the ADEA deserves to bear such a sizable and unanticipated penalty, for in most instances, the employee can easily avoid the risk of being uninsured by purchasing an individual policy of comparable value. Where the employee elects to obtain substitute insurance, the “make whole” concept underlying ADEA damages . . . would permit full recovery of any additional premiums for the comparable individual policy beyond what the employer would have paid for group insurance.

The 4th Circuit also held that the defendant was entitled to an offset against back pay and front pay for a lump sum for pension benefits that Mr. Fariss received at the time of his termination. Since that lump sum was larger than his lost earnings because of his subsequent death, there was no net loss of financial support from his lost earnings to his surviving wife.

Galindo v. Stoddy Co., 793 F.2d 1502 (9th Cir. 1986). The 9th Circuit held that:

Where an employee’s fringe benefits include medical and life insurance, a plaintiff should be compensated for the loss of those benefits if the plaintiff has purchased substitute insurance coverage or has incurred, uninsured, out-of-pocket medical expenses for which he or she would have been reimbursed under the employer’s insurance plan.

A footnote to this passage included references to three supporting decisions and two decisions in opposition to the 9th Circuit’s decision that had held that a worker could or “might” recover for the employer cost of providing medical insurance. Those latter two decisions were *Fariss v. Lynchburg Foundation*, 769 F.2d 958, 965 (4th Cir. 1985) (indicating plaintiff in an ADEA case might recover the cost to employer of providing insurance even where no substitute insurance is purchased); and *Jacobson v. Pitman Moore, Inc.*, 582 F. Supp. 169, 179

(D. Minn. 1984) (award of lost insurance benefits in ADEA case not limited to actual expenses).

Hance v. Norfolk Southern, 571 F.3d 511 (6th Cir. 2009). This decision involved a ruling that a worker who was fired because of National Guard obligations was wrongfully terminated. The worker was reinstated and awarded back pay, raising questions regarding how past lost medical insurance and payroll taxes/pension rights should be treated. The Court held that a terminated worker could be awarded out-of-pocket expenses for either medical expenses that would have been covered or cost of replacement insurance, but was not entitled to recover the market value of medical insurance the worker would have had if he had remained employed. The Court held that awarding the market value of past lost medical insurance would have made the worker “more than whole.” The Court also held that the Norfolk Southern would be required to pay Tier I and Tier II payroll taxes on back pay, but that the worker would receive credit for having worked during those time periods during which he had been dismissed so that he would not have lost any credit toward future pension. Thus, no amount would be owed in the form of back pay based on a claim of lost pension benefits.

Jacobson v. Pitman Moore, Inc., 582 F. Supp. 169, 179 (D. Minn. 1984). The Court allowed plaintiff in an Age Discrimination in Employment Act (ADEA) case to recover for the “cost of replacing past lost insurance benefits instead of actual out-of-pocket costs as claimed by the defendant in this case.” The Court said:

Defendants also object to including as damages \$7,882, which represents the cost of replacing insurance benefits defendants provided to plaintiff. Instead, defendants argue that plaintiff should be awarded actual expenditures made by plaintiff in obtaining replacement insurance coverage, and if an uninsured loss is incurred, the actual loss to the extent it would have been covered by the employer’s insurance programs. The Court does not accept the defendants’ proposed method of calculating plaintiff’s damages. . . . The insurance benefits plaintiff lost are not any less of a monetary benefit to her because she could not afford to replace her insurance benefits or because she did not become sick. . . . Accordingly, the Court finds that plaintiff is entitled to recover her lost insurance benefits.

Kossmann v. Calumet County, 800 F.2d 697 (7th Cir. 1986). This decision addressed the question of whether and how past lost medical insurance of ADEA age discrimination claimants should be determined, as follows:

The primary goal of the backpay award is to make a victim of age discrimination whole. (Omitting citation.) Including the cost of insurance coverage in a back pay award when the victim of discrimination fails to secure alternative coverage allows the victim to recover an unwarranted windfall unless he or she can demonstrate that they were unable to secure coverage and had a medical expense. As the preceding cases demonstrate, Kossman and Jodar must establish that in fact they incurred expenses in securing alternative insurance coverage or incurred medical expenses that would have been covered under the County's insurance program had they not been terminated in order that they might recover the cost of the insurance benefits or be reimbursed for any proper medical expenses incurred. Thus, the trial court should consider whether Kossman and Jodar after their retirement purchased insurance coverage the County would have purchased for them. The court should include those expenditures in the backpay award that Jodar and Kossman incurred if in fact they did purchase alternative coverage or in lieu thereof incurred medical expenses ordinarily covered under the County's policy.

The court also held that:

Common sense dictates that Kossman and Jodar certainly had no need for deputy sheriff's uniforms during the period they were not employed as deputy sheriffs. The inclusion of the clothing allowance in the backpay award, therefore, would not be in accord with the underlying policy of the ADEA, to make the victim of age discrimination whole.

Lubke v. City of Arlington, 455 F.3d 489 (5th Cir. 2006). The 5th Circuit reversed a trial court decision allowing plaintiff subject to age discrimination to recover for the "value" of past lost insurance, and said:

Because the remedies available under the ADEA (Age Discrimination in Employment) and the FMLA (Family Medical Leave Act) both track the FLSA, cases interpreting remedies under the statutes should be consistent. Consequently, we hold that the correct measure of damages for lost insurance benefits in FMLA cases is either *actual* replacement cost for the insurance, or expenses *actually* incurred that would have been covered under a former insurance plan. The lost "value" of benefits, absent actual costs to the plaintiff, is not recoverable. Here, because the jury awarded an undifferentiated sum for employee benefits without segregating insurance benefits, and the award was based on an

incorrect understanding of FMLA remedies, we must remand to the district court for redetermination of this damage element (*parentheses added*).

McMillan v. Mass. Society for the Prevention of Cruelty to Animals, 140 F.3d 288 (1st Cir 1998). The plaintiff won an award based on being underpaid because of sexual discrimination. The trial court had added 21% to back pay to account for allegedly lost job-related fringe benefits. The 1st Circuit held that:

Lost benefits are recoverable only if the plaintiff has offered evidence of out-of-pocket expenses for the same benefits. *See Kossman v. Cahmet County*, 800 F.2d 697, 703-04 (7th Cir. 1986) (holding that, to recover damages representing benefits, a plaintiff must show that she actually incurred insurance or medical care expenses); *Taylor v. Central Pa. Drug & Alcohol Servs. Corp.*, 890 F. Supp. 360, 372 (M.D. Pa. 1995); *Berndt v. Kaiser Aluminum & Chem. Sales, Inc.*, 604 F. Supp. 962, 965 (E.D. Pa. 1985). In this case, even if the budgeted value of benefits corresponding to plaintiff's salary had been less than the budgeted value of benefits corresponding to the salaries of the other department heads, plaintiff presented no evidence that she incurred insurance expenses. In addition, she presented no evidence that any employer-contributed retirement benefits were tied to the amount of her salary. Further, that benefits may have amounted to twenty-one percent of her supervisees' salaries does not mean that benefits constituted an equal percentage of higher salaries. Indeed, it would be logical to expect that employer insurance contributions at all salary levels were substantially the same and that, therefore, benefits were a considerably lower percentage of higher salaries. Because there was no competent evidence from which a reasonable jury could conclude that Dr. McMillan suffered any loss in benefits as a result of her lower salary, Dr. McMillan's back pay award should be accordingly reduced by the amount of the lost benefits award.

Moore et al. v. The Health Care Authority et al., 181 Wn.2d 299; 2014 Wash. LEXIS 641 (WA 2014). This decision considered alternative methods proposed by employees and the State of Washington to value past medical insurance lost by part time employees as part of a class action lawsuit. The State argued that the only damages that it should pay were out-of-pocket costs paid by class members for medical expenses or for substitute health insurance that class members purchased during time when they were denied health benefits. This was to be established through an individual claims

process. Employees held that the State's method was inaccurate, contrary to the evidence, and would lead to a windfall to the wrong doer. Employees proposed three alternative methods for measuring damages resulting from the State's failure to provide medical insurance to part-time employees: (1) Treat the amount the State would have paid to provide health benefits as the loss; (2) Treat the amount the State unlawfully retained by failing to provide health benefits as the loss; and (3) Treat the amount the State would have paid in health care costs for the group if they had been covered as the loss. The trial court generally sided with the Employees, but had "refused to grant summary judgment to either side because additional information was needed on the likelihood that any members would have opted out of coverage" because of availability from another source (pp. 313-314). The trial court had also held that long term consequences of failures to seek medical attention because of lack of medical insurance should be considered. The Washington Supreme Court agreed with the trial court with respect to summary judgment and the need for more information, but emphasized that its ruling should not be treated as a "one size fits all" ruling for all future cases.

Tolan v. Levi Strauss & Co., 867 F.2d 467 (8th Cir. 1989). This decision in an age discrimination case provided a review of decisions prior to 1989 with respect to the question of whether a plaintiff could recover the market value of lost past medical and life insurance or medical expenses caused by the lack of insurance and/or costs of replacement insurance before ruling that the award for past lost insurance must be reduced to amounts actually paid by the plaintiff for replacement insurance. This decision was cited in *Hance v. Norfolk Southern*, 571 F.3d 511 (6th Cir. 2009) as providing a review of decisions before 1989.