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"Reports of my death have been greatly exaggerated"

Despite efforts to redefine the reasonable value of medical care, plaintiff still has a right to full and fair compensation for future medical damages

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"[A] person injured by another's tortious conduct is entitled to recover the reasonable value of medical care and services reasonably required and attributable to the tort." (*Hanif v. Housing Authority of Yolo County* (1988) 200 Cal.App.3d 635, 640.) To recover damages for future medical expenses, a plaintiff must prove the reasonable cost of reasonably necessary medical care that the plaintiff is reasonably certain to need in the future. (See CACI 3903A and Civ. Code, § 3283)

After *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308 [an expert cannot base his or her opinion as to the reasonable value of future medical services on the past billed amount for the same medical services] we have seen an increasing number of motions in limine regarding how to calculate the reasonable cost of future medical damages. There has been no change to the foundational requirements for establishing future medical care costs. This is true whether the claim of future care relates to the Affordable Care Act (PPACA), private insurance, Medicare or Medi-Cal. The following arguments and legal authorities may help you craft your own motions in limine, or otherwise preserve the record for appeal.

PPACA

The Patient Protection and Affordable Care Act ("PPACA") mandates that individuals sign up for medical insurance plans. In the typical case, the defense experts offer testimony at deposition about the availability and estimated cost of



individual categories of particular items of medical care under certain PPACA plans as evidence of the cost of items of plaintiff's future medical care. This testimony at trial is speculative. It also violates the collateral source rule.

Evidence of damages that is speculative, remote, imaginary, contingent or merely possible cannot serve as a legal basis for recovery. (*Piscitelli v. Freidenberg* (2001) 87 Cal.App.4th 953, 989.) Evidence of future collateral source payments is all of the above. It must be excluded.

In *Cox v. Superior Court*, (2002) 98 Cal.App.4th 670, the plaintiff was an ophthalmologist who was rendered permanently disabled as a result of shoulder surgery performed by the defendant. In that case, the plaintiff had paid premiums for a disability policy with after-tax dollars resulting in his receipt of tax-free disability income from that policy. (*Id.* at 672.) The trial court denied plaintiff's motion in limine to exclude evidence of the tax-free status of his income. The Court of Appeal reversed the trial court's decision and in its opinion, cited to *Rodriguez v. McDonnell Douglas Corp.* (1978) 87 Cal.App.3d 626, as follows:

> It is our view that adoption of the rule which would permit the introduction of evidence of future tax consequences to affect the amount of an award in personal injury and wrongful death actions would open the door to intense speculation about the future on the part of the jury. The ramifications of such a rule of law could be immense. The less speculation that is involved in the jury's fact-finding process, the more likely will jury awards conform to the standard of fairness and justice between litigating parties.

(*Rodriguez*, 87 Cal.App.3d at 667-668 cited at *Cox*, 98 Cal.App.4th at 674-675.)

The prohibition against jury speculation addressed in *Rodriguez* and *Cox* is well-established. Indeed, the "Introduction to Damages" jury instruction cautions juries: "However, you must not speculate or guess in awarding damages." (CACI 3900.)

Speculative testimony by any witness is not admissible and should be

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excluded under Evidence Code section 352. This is particularly so for matters supporting expert opinion. Evidence Code section 801(b) notes that expert opinion must be based upon matters "of a type that reasonably may be relied upon by an expert in forming an opinion upon the subject to which his testimony relates." An expert's opinion which is based on assumptions of fact without evidentiary support or on speculative or conjectural factors has no evidentiary value and should be excluded.

In *Sargon Enterprises, Inc. v. University of Southern California* (2012) 55 Cal.4th 747, the California Supreme Court urged trial courts to act as a gatekeeper to exclude improper expert opinion. Courts should review the foundation and methodology of each expert's opinions. (*Id.* at pp. 771-772) The Court emphasized that each expert's conclusions must be supported by reliable foundational materials. (*Id.* at p 771, citing *General Electric Co. v. Joiner* (1997) 522 U.S. 136, 146; see also, *Pacific Gas & Electric Co. v. Zuckerman* (1987) 189 Cal.App.3d 1113, 1135 [no evidentiary value to expert opinion based upon factors that are speculative, remote, or conjectural]; *Kolta v. Regents of U.C.* (2004) 115 Cal.App.4th 283 [courts have obligation to require adequate foundation for expert opinion]; *Stephen v. Ford Motor Co.* (2005) 134 Cal.App.4th 1363 [insufficient foundational basis for expert witness opinion].)

Damages sought by a tort victim may not be speculative or contingent upon uncertain events. (*Eagle v. City of Oroville* (1965) 238 Cal.App.2d 266, 272.) The *Eagle* court explained that, "recovery…is still subject to the fundamental rule that damages which are speculative, remote, imaginary, contingent, or merely possible cannot serve as a legal basis for recovery." (*Ibid.*) The same principle applies when defendants attempt to deduct speculative amounts from damages. (See *Cox v. Superior Court* (*Shields*) (2002) 98 Cal.App.4th 670, 676.) In *Cox*, defendant contended that the tax consequences of a medical malpractice recovery should affect the amount of the verdict. (*Ibid.*) The court found such considerations speculative: "To permit evidence of potential future tax consequences to affect the amount of an award would improperly invite juror speculation," and would invite "intense speculation about the future on the part of the jury." (*Id.* at 675-76.)

To the extent that a defendant will attempt to introduce evidence about the PPACA or other collateral sources through an expert witness, it would likewise be improper. Irrelevant or speculative matters are not a proper basis for an expert's opinion. (See *Long v. Cal.-Western States Life Ins. Co.* (1955) 43 Cal.2d 871 (speculative or conjectural data); *Eisenmayer v. Leonardt* (1906) 148 Cal. 596 (speculative or conjectural data); Evid. Code, § 801, Law Revision Commission Comments.)

Moreover, the state of the PPACA, government funding, and the availability of physician services under the PPACA have been the subject of controversy since the PPACA's inception. Rates continually change. Currently there is no real basis to predict long-term access or rates. No one can predict with reasonable certainty how much insurance will cover; what it will cover; or what will be available in the future. Indeed, this legislation may change, particularly as this current administration comes to an end. All of these factors are contingent on these variables.

Projections using the amounts of PPACA-mandated insurance benefits are not reliable as estimates of the cost of future medical expenses because:

- Discounts for medical services vary considerably with different insurers and with different insurance contracts.
- Medical insurance contracts are in flux and are frequently revised.
- On revision, a medical insurance contract may drop certain medical services that are needed by the patient and may change or eliminate discounts.
- Entire medical plans may be dropped, forcing the patient to look for a new plan with new terms, price schemes and discounts.

Given the uncertainties with future medical insurance and discounts, the PPACA, or any other collateral source, it would be speculative and misleading to suggest to the jury that plaintiff will be able to obtain a particular kind of health insurance policy for a particular monthly premium that will provide him with coverage for all of the incident-related medical care he will require for the rest of his life. Therefore, the defense must be precluded from soliciting any evidence, reference, mention or argument about the PPACA, or any other collateral source.

Private insurance

The portion of a medical bill that a private insurance company pays does not reflect the reasonable value of future medical costs. As a matter of law, this evidence is impermissible because it implies evidence of a collateral source to the jury. As a matter of fact it does not necessarily represent the full value received by health-care providers from the insurance company.

> [F]or an expert to base an opinion as to the reasonable value of future medical services, in whole or in part, on the full amount billed for past medical services provided to a plaintiff would lead to the introduction of evidence concerning the circumstances by which a lower price was negotiated with that plaintiff's health insurer, thus violating the evidentiary aspect of the collateral source rule.

(*Corenbaum, supra*, 215 Cal.App.4th at 1332.)

> The collateral source rule prevents a defendant from discounting its damages from collateral payments where the plaintiff has been compensated by an independent source, such as insurance, pension, continued wages or disability payment. (*Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 17-18.) Evidence of collateral source

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payments is generally not admissible. (*Hrnjak v. Graymar, Inc.* (1971) 4 Cal.3d 725, 728-29.) The rule applies both to insurance benefits paid for by the patient, and also to benefits gratuitously provided to the patient. (*Arambula v. Wells* (1999) 72 Cal.App.4th 1006, 1014.)

In the *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, the Supreme Court affirmed the collateral source rule. (*Id.* at 566) Thus, it is still improper to introduce any discussion of future medical insurance, including any discounted amounts for items of care under particular private insurance plans.

Private insurance is also inadmissible because it does not reflect the actual and reasonable value of the medical services. The actual amount a health-care provider is paid is not limited to the cash payments credited to patients' accounts as reflected on their bills. Health-care providers often receive an annual stipend from insurance companies, kickbacks based on write-offs, and other valuable consideration for being a "gate keeper." Amounts listed on a patient's bill as "write-offs" or "adjustments" appear to the layperson as if they go unpaid. These amounts, however, are often paid at a later date, often at the end of the contract or quarterly. These amounts do not show up on a patient's bill.

In addition to hidden supplemental cash payments, medical providers accept less than their full retail charges because they receive valuable non-cash consideration from insurance companies.

Examples include promised patient volumes, more rapid payment, and shortened audit periods (e.g., withdrawal of payments made in error won't be initiated more than 12 months after payment). These terms are negotiated between the provider and insurer when they enter into a contractual arrangement. At the end of the contract period the medical provider reviews the "contractual account" to determine if any particular contract generated a profit or loss, and uses that information in subsequent negotiations.

For these reasons, the actual (read: reasonable) value of services under private insurance plans is higher than what is shown on a patient's bill. Thus, evidence of private insurance cannot be used as a basis to limit the cost of future medical services.

Medicare and Medi-Cal

Using Medicare and Medi-Cal rates as the basis for an expert opinion is impermissible because it suggests the existence of a collateral source, and would require the expert to reveal that the plaintiff is receiving or will receive public benefits.

In addition, the amount paid by Medicare for a particular service does not necessarily capture the full amount a provider receives. Hospitals may receive an additional cash payment from Medicare if they can show that the cost of care for Medicare patients was greater than the Medicare reimbursement. That payment is often delayed, sometimes for years, while the bureaucratic process unfolds to produce the additional cash payment. These payments are not reflected in the amount paid by Medicare on a patient's bill. Because this evidence is incomplete, it is less probative than prejudicial (introducing evidence of public benefits) and should be excluded under Evidence Code section 352.

It is also speculative to assume that Medicare rates will remain unchanged. Changes in the Department of Health and Human Services' budget affect the availability of Medicare funds. The budget is dictated by the political process and subject to political change. Past or current Medicare payments are too speculative a basis for the cost of future medical care.

As for Medi-Cal, payment amounts on a patient's bill do not always convey the full value of payments received by the doctor or hospital. The Medi-Cal Disproportionate Share Hospital ("DSH") program makes additional payments to hospitals that can show they provide care to a "disproportionate share" of Medi-Cal patients. The DSH program makes quarterly payments posted to a special account ("Medi-Cal contractual clearing account"). These payments do not show up on an individual patient's bill. This process renders this evidence excludable under Evidence Code section 352 as well.

Conclusion

We must continue to defend our clients' rights to be fully and fairly compensated for all of their future medical damages. Fortunately, we have in our quivers the time-tested arrows of the collateral source rule, Evidence Code section 352, and common sense. Let's not hesitate to use them.


Leary

Elinor Leary is the team leader of the Leary Trial Team at The Veen Firm, *which handles complex cases that involve life-altering injuries or death. Ms. Leary has tried cases to verdict as well as reached large settlements in numerous other cases, including cases listed in The Recorder's "Top Settlements" publications. Elinor is rated "AV Preeminent" by Martindale-Hubbell, the highest rating possible for both legal and ethical standards. She has been selected by peers to the Northern California Super Lawyers List and to the Top Northern California Female Lawyers.*

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