
# Dealing with the *Cuevas* decision

## Regarding future medical costs, the appellate court overlooked the uncertainty of health insurance in the future

**By Eustace de Saint Phalle and Andrew Clay**

By now, many plaintiffs' attorneys in medical malpractice cases have been confronted by defendants citing *Cuevas v. Contra Costa County* (2017) 11 Cal.App.5th 163. This First District decision holds that future medical damages may be based on the discounted rates that insurers pay for medical services, as evidence of the "market rates" for the reasonable value of medical services in a medical malpractice case. (*Id.* at 178) Further, *Cuevas* holds that future insurance benefits under the Affordable Care Act are admissible evidence as to the cost of future medical expenses in malpractice cases. (*Ibid.*)

As one of the attorneys who tried the *Cuevas* case, I want to let my fellow plaintiff attorneys know about the critical limitations of the First District's opinion and what the Court ignored to justify its ultimate holdings. In fact, there were a number of legal issues and important evidence that the trial court's decisions were based upon that were not discussed by the Court of Appeal. In addition, there are elements of the *Cuevas* decision that are useful for plaintiffs and points left unresolved that plaintiff's attorneys should continue to press in order to reverse some of the unjust aspects of the decision.

Defendants will likely cite *Cuevas* in medical malpractice cases as authority for including evidence of (1) ACA-mandated private health insurance plans that will (allegedly) cover your plaintiff's future care, in order to offset defendant's obligation to pay damages; and/or, (2) the discounted prices for items of medical care under various ACA plans.

Defendants will try to use this evidence to drastically reduce plaintiff's claims for future medical damages by using heavily discounted medical prices for future care that would not otherwise be available or are likely to change in the future. These assertions are speculative and should be opposed with opinion testimony and factual evidence.

### *Cuevas* and non-medical-malpractice cases

Defendants may even attempt to apply aspects of the *Cuevas* decision to non-medical-malpractice cases. The *Cuevas* Court held that the collateral source rule in a medical malpractice case is not violated by introducing evidence of discounted future medical prices. Defendants may argue that this part of the Court's ruling was "independent of section 3333.1 [MICRA]" (*Cuevas, supra,* 11 Cal.App.5th 163 at 179). Thus, the defense may cite *Cuevas* in non-med-mal cases for the proposition that heavily


discounted insurance rates for medical services, allegedly reflecting "market value," should be used to compute plaintiff's future medical costs.

A ruling of this kind at trial would contradict the central purposes of the tort system: To compensate the injured plaintiff for their losses and make them whole, allocating payment of damages to the party responsible rather than forcing reliance on the state. (See, *Brown v. Stewart* (1982) 129 Cal.App.3d 331, 341 [purpose of MICRA is not to "bail out doctors and other health providers by the use of public funds."].)

The *Cuevas* Court's decision to admit defense opinion on future ACA-mandated health insurance was particularly disappointing, as it ignored significant evidence and opinion testimony presented at the original trial. In the underlying case, the trial court held that defense expert testimony on *future ACA benefits lacked foundation*, because the defense opinion testimony on the availability of future insurance coverage, pricing, and discounts were too unreliable as a basis for a future damage award.

Expert opinion before the trial court – including defense opinion testimony – showed that future health insurance benefits were unreliable, due both to the unpredictable nature of future medical insurance and its prices and benefits, and to the uncertainty regarding the ACA program itself. The trial court excluded future insurance as speculative, because the defense did not meet its burden of proof on these issues.

In contrast, the Court of Appeal's discussion on future damages ignored the trial court's concern with the very real problems of the defense experts' testimony on future insurance benefits (policies, coverage, prices, and discounts) in the highly volatile medical insurance industry. The Court of Appeal sidestepped the main basis for the trial court's decisions to exclude this evidence, i.e., because future health insurance is unstable and the benefits are speculative. Further, the Court took an unreasonably rosy view of the longevity and reliability of benefits under the Affordable Care Act, especially given recent political attacks on the program.

We will explore several issues raised by the *Cuevas* decision and how they will affect your practice. This article, the first of a series, will explore the background of the decision itself and describe some gaps in the logic of the decision. We will give you tools to address the *Cuevas* decision and also hope to open a discussion in the legal community about the reasons *Cuevas* was wrongly decided and should be overturned or limited.

## Changing case law: past and future medical expenses

Over the last several decades, California courts have struggled to define the measure of plaintiffs' medical damages. Plaintiffs are entitled to claim the "reasonable cost of reasonably necessary medical care." (CACI 3903A) There are several potential measures for medical costs including, most importantly, the full medical bill charged by the provider and the reduced amount typically paid by the medical insurer. Historically, the lower paid billings were excluded from evidence because these were evidence of collateral source benefits from insurance. (*Helfend v. Southern Cal. Rapid Transit Dist*. (1970) 2 Cal.3d 1, 6.)

As the full medical billings and the discounted paid amounts diverged, courts questioned the use of the full-price medical bill as the measure of damages. In *Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635, the Court of Appeal held that an injured plaintiff in a tort action cannot recover more than the amount of medical expenses actually paid or incurred. (*Id*. at 641.) After *Hanif*, plaintiffs would typically introduce the plaintiff's full past medical bills into evidence, and then make a post-trial motion to reduce the jury's award to the amount actually paid. This fulfilled the collateral source rule, as the jury did not see evidence of the insurer's contractual discounts. (See, e.g., *Greer v. Buzgheia* (2006) 141 Cal.App.4th 1150, 1157.)

In *Howell v. Hamilton Meats & Provisions Inc*. (2011) 52 Cal.4th 541, the California Supreme Court held that the full amounts of past medical damages were not admissible evidence of the reasonable value of those damages. The Court held that the full bills were often too inflated to be meaningful (*Id*. at 562.) and did not reflect actual expenses incurred by the plaintiff. (*Id*. at 567.) However, the *Howell* decision left open the possibility that the full medical bills could be relevant on some issues, such as "noneconomic damages or future medical expenses." (*Ibid*.)

In *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308, *Howell*'s logic was extended to future medical damages. *Corenbaum* reviewed and rejected various reasons for including the full amount billed for past medical services, and held that the full past bills are not relevant to a determination of the reasonable value of future medical services, and cannot be used for expert opinions on future medical prices. (*Id*. at 1326.)

*Corenbaum*'s language appeared to preclude any use of the full medical billings as a foundation for the actual cost of the medical service. Nevertheless, post-*Corenbaum,* courts permitted "full billed amounts" for trial evidence to establish the cost of future medical expenses, as long as the final award reflected a reduced percentage of the full billed amount. (See, *Markow v. Rosner* (2016) 3 Cal.App.5th 1027, 1050-1051 [affirming jury verdict awarding future medical damages at 65 percent of the projected full-billed value stated by plaintiff's life care planning expert].) Further, where plaintiffs remain fully liable for the amount of the medical provider's charges, courts will accept evidence of the full medical bills. (*Moore v. Mercer* (2016) 4 Cal.App.5th 424, 439 [full bill accepted as proper value of past medical damages; discounted rate paid by a bill collector was not admissible evidence].) Finally, while *Corenbaum* precluded the use of the plaintiff's full *past* medical bills, it had no opinion on whether plaintiff's expert could opine on *future* medical pricing by


using (for example) a national database of medical prices that included some "full" charges.

### Future medical expenses in medical malpractice cases

In medical malpractice cases, the medical pricing issue is interpreted in light of MICRA's partial abrogation of the collateral source rule. (This fact alone should limit the *Cuevas* decision to medical malpractice cases, and prevent its application to other civil cases.) Civil Code section 3333.1 allows a defendant to introduce evidence of plaintiff's medical insurance for past medical expenses. This includes evidence of price reductions, and also evidence that an insurer had paid the medical bills. The law envisioned, not an absolute rule discounting the plaintiff's medical damages because of future insurance, but merely giving the jury the information and letting them decide: "Although section 3333.1 . . . does not specify how the jury should use such evidence [of collateral source benefits], the Legislature apparently assumed that in most cases the jury would set plaintiff's damages at a lower level because of its awareness of plaintiff's 'net' collateral source benefits." (*Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, 164-165.)

Civil Code section 3333.1 has limited application. The collateral source rule still applies for past Medi-Cal benefits. (See, *Brown v. Stewart* (1982) 129 Cal.App.3d 331, 336-338.) Plaintiffs usually argued that the collateral source rule applied for similar public sources of benefits like Regional Centers, which provide support for developmentally disabled persons.

Section 3333.1 clearly applied to past medical bills in MICRA cases. However, prior to *Cuevas,* it was unclear how the collateral source rule would be applied to future medical benefits. On its face, Civil Code Section 3333.1(a) is limited to "any amount *payable*" – a past-tense usage. If MICRA doesn't apply to future benefits, then the collateral source rule remained in effect to preclude future medical insurance benefits.

Additionally, the existence of future medical insurance benefits for a given plaintiff is uncertain. The existence of any particular policy, the benefits provided by the policy, any price discounts provided by that policy, whether individual items would be covered – are all issues that cannot be guaranteed decades into the future. For that reason, plaintiffs were almost always successful in excluding future medical insurance as evidence of any reduction in price of future medical care.

### A new twist: The Affordable Care Act's coverage guarantee

Further complicating these issues, Congress enacted the Affordable Care Act (ACA), which sought to make health insurance more broadly available. Some defendants began to argue that the ACA removed any uncertainty relating to a plaintiff's future medical insurance and that ACA insurance prices should be admitted as evidence of future medical pricing since the benefits were now guaranteed.

In the unpublished Second District opinion in *Aidan Ming-Ho Leung v. Verdugo Hills Hospital* (2013 WL 221654) ("*Leung*"), the trial court excluded future medical insurance for two reasons: (1) the court felt that section 3333.1 applied to past benefits only, based on the "payable" language in the statute; and, (2) future medical insurance is uncertain and speculative. The Court of Appeal was sympathetic to the idea that section 3333.1 did not apply to future benefits (*Leung,* at 6), but ultimately declined to rule on this issue as it agreed with the trial court that future insurance benefits were speculative. (*Leung,* at 8.) The Court made this decision even though the ACA (which theoretically guaranteed future medical insurance) had just passed a Supreme Court test in *National Federation of Independent Business v. Sebelius* (2012) 567 U.S. 519. The *Leung* Court reasoned,

> To show the amount of future insurance coverage that is reasonably certain, the evidence would have to: (1) link particular coverage and coverage amounts to particular items of care and treatment in the life care plan, (2) present a reasonable basis on which to believe that this particular plaintiff is reasonably certain to have that coverage, and (3) provide a basis on which to calculate with reasonable certainty the time period such coverage will exist . . . . [T]he evidence in the record is that such a prediction is entirely speculative.

(*Leung, supra,* 2013 WL 221654 at 11.)

*Leung* is an unpublished case. Nevertheless, this case tracked the *Cuevas* trial court's reasoning on the standard of whether it was reasonably certain that insurance will provide benefits in the future. (Interestingly, the *Cuevas* defendants to some extent adopted *Leung* in their appellate briefing, as they argued that the defense experts had met the *Leung* standards – which they clearly had not.)

### The *Cuevas* trial: Plaintiff's evidence on future medical insurance

The *Cuevas* case was a birth injury medical malpractice action. The young plaintiff suffered loss of blood to his brain, causing permanent neurological damage and impairments. The case went to trial in the summer of 2014. Plaintiff's medical experts testified plaintiff would need significant life-long medical, therapeutic, and attendant care. Plaintiff's past medical care had been paid for largely through Medi-Cal.

The trial court considered several motions in limine relating to proper evidence of plaintiff's future medical expenses. Plaintiff moved, inter alia, to generally exclude all future collateral source benefits, and specifically to exclude future ACA-mandated medical insurance benefits as speculative.

Plaintiff's life care planner, Jan Roughan (who had also testified in the *Leung* case), offered a Life Care Plan that utilized Usual Customary and Reasonable (UCR) charges – prices charged by the same or similar providers for the same or


similar services in the same or comparable medical community. Roughan obtained these prices through a subscription database service and used the 80th percentile of these prices. Roughan offered a Declaration explaining her methods and noting that UCR yielded results similar to the average of prices used after insurance deductions.

Roughan's Declaration criticized the use of insurance-discounted prices as unreliable, since the discounts vary widely between different plans and even in the same plan for different years. Roughan also noted that insurance plans often provide inadequate heath care, by denying or delaying care, or using sub-optimal physicians or services. Roughan noted that the passage of the ACA would not change the inherent volatility of private insurance discounts, prices, and benefits.

Plaintiff also included a Declaration from health insurance expert Richard Lievense who stated that ACA rates and services were likely to have some volatility: (a) restricted access to services leading to lower quality, (b) inaccurate reflection of the payments to the physicians; and (c) constantly changing rates and services offered. Lievense also noted that the ACA may yet be voted out of existence given the current political environment.

### Defendant's expert opinion on future medical insurance

On the defense side, defendant's Life Care Planner Linda Olzack offered a Life Care Plan that incorporated prices based on Affordable Care Act health care plans in California. At deposition, Olzack admitted that ACA-mandated health insurance policies can change from year to year. Insurance companies can raise premiums and restrict the availability of items of care. Also, some types of care, including extended care, require an insurance pre-authorization, which can be denied. Olzack admitted that "no one knows" how the prices, benefits, or restrictions on ACA-based plans will change going into the future.

Defendant also provided a Declaration from health insurance expert Thomas J. Dawson. Dawson opined that the ACA would remain in force, and would mandate health insurance benefits for plaintiff. Dawson noted that California had ACA-based insurance plans that would be available for plaintiff. Dawson reached the general conclusion that plaintiff Cuevas would have similar access to continued coverage through a combination of public and private insurance.

However, neither Dawson nor any of the defense experts testified they were certain that any particular private insurance policy would continue to be available, provide certain benefits, or price items of care at particular rates, in a reliable manner going forward over the plaintiff's future life span (projected to be 74 years for this child). Plaintiff's counsel argued that these issues made future insurance benefits unreasonably uncertain as the basis for future medical damages. Further, as plaintiff was on Medi-Cal, he was not in fact eligible for private insurance.

### Trial court excluded future insurance benefits as speculative

After hearing these presentations, the trial judge decided not to admit evidence of future ACA-mandated insurance benefits. Notably, the trial judge did not make a blanket ruling that section 3333.1 did not apply to any future medical benefits; in fact, he implied that such benefits could possibly be admissible, if the proper foundation was laid. Rather, the trial court ruled that the defense testimony on future ACA benefits did not meet the standards of reasonable certainty for admissibility. The court held there were many reasons why ACA benefits may not be available into the future, including uncertainty as to particular plans and coverage, and uncertainty as to the ACA itself.

At trial, the jury found in favor of plaintiff and awarded $100 million for future medical expenses, reduced to $9,577,000 in present cash value.

### The *Cuevas* Court of Appeal's holdings on future meds

On appeal, the First District Court of Appeal made four major holdings: (1) Section 3333.1 allows the introduction of future as well as past collateral source medical benefits; (2) the collateral source rule did not require exclusion of evidence of discounted health care payments; (3) the trial court abused its discretion in excluding evidence of the effect of the ACA on patient's medical expenses based on its conclusion that it was speculative to assume the ACA would continue to exist; and (4) free Regional Center services were not admissible under MICRA's exception to the collateral source rule. (*Cuevas, supra*, 11 Cal.App.5th 163.)

Crucially, the Court of Appeal did not address the foundational issue of whether there was sufficient evidence that future insurance benefits were reasonably certain to continue. This was the chief reason the trial court had excluded evidence of future ACA-related insurance.

The Court of Appeal's decision included a lengthy discussion of the legislative history of section 3333.1. The Court concluded that section 3333.1 was intended to apply to future collateral sources of medical care, as well as past collateral sources. (*Cuevas, supra*, 11 Cal.App.5th at 173-178.) While this was an important legal issue, this was not the actual basis for the trial court's evidentiary rulings. As noted, the trial court *did not hold* that section 3333.1 only applied to past benefits as a matter of law. Rather, the trial court excluded future insurance benefits because there was insufficient foundational evidence these benefits would continue into the future, making defense opinion testimony on such benefits speculative and inadmissible.

The Court of Appeal also held that, "[T]he collateral source rule is not violated when a defendant is allowed to offer evidence of the market value of future medical benefits," i.e., evidence of


discounted prices paid by insurers in medical malpractice cases. (*Cuevas, supra*, 11 Cal.App.5th at 180, citing, *Markow v. Rosner* (2016) 3 Cal.App.5th 1027, 1050-1051.) In so holding, the Court extended the logic of the *Corenbaum* case, to hold that future medical insurance should be admissible as evidence of "market value."

Again, this holding did not directly address the trial court's decisions. The trial court did not rely primarily on the collateral source rule to exclude future insurance benefits, but simply held that defense opinion testimony on future insurance was speculative and not reasonably certain.

### The Court of Appeal relied on the defense expert's rosy view of the ACA's future and ACA plans' reliability

Having decided that future medical insurance benefits were admissible, the Court of Appeal held that evidence of ACA-mandated medical insurance should have been admitted. Defendants' appellate briefing argued that the ACA was established law, and it was improper to speculate as to changes in the law (citing *Dist. of Columbia Court of Appeals v. Feldman* (1983) 460 U.S. 462, 477). Defendant noted that the ACA had survived several political and judicial challenges, including *King v. Burwell* (2015) 135 S.Ct. 2480, as well as the earlier *Sebelius* case in 2012. Defendant also argued that the defense experts had met the standards set forth in the unpublished *Leung* case, in that the defense had identified specific insurance plans and specific items in these plans which were reasonably certain to cover plaintiff.

The Court of Appeal held that evidence of ACA-mandated insurance should have been admitted at trial. The Court dismissed critiques of the ACA's viability, stating there was evidence of "the continued viability of the ACA, as well as its application to plaintiff's circumstances." (*Cuevas, supra*, 11 Cal.App.5th at 180.) This holding was based almost entirely on defense expert Dawson's Declaration. (*Ibid*.)

### Ruling ignored problematic foundation

The Court of Appeal largely ignored the problematic foundation for future insurance benefits, prices, and discounts. While the Court of Appeal focused on legal issues relating to section 3333.1, the *Corenbaum* case, and the ACA, the Court ignored the actual evidence presented at trial regarding the unreliability of future private medical insurance. Plaintiff's experts had testified that future private insurance was inherently unreliable, with or without the ACA. The trial judge considered whether any particular insurance policy would continue to be available, provide certain medical benefits, or price items of care at particular rates, in a reliable manner for years or decades into the future.

At deposition, defense expert Olzack had admitted that, even assuming the ACA remained in force, there was considerable instability regarding private insurance policies, benefits and rates, such that these could not be guaranteed over the course of the plaintiff's lifetime.

The *Cuevas* Court appears to have ignored plaintiff's evidence showing the problematic foundation for future insurance pricing. The Court did not analyze whether there was evidence these plans would continue to exist and provide necessary benefits, at the same discounted prices, over the plaintiff's lifetime. On this issue, the trial court had dryly noted that Dawson had merely used the "magic words . . . 'reasonable certainty' [of future insurance]," and was not convinced this testimony provided proper foundation. This seems to be a proper exercise of the court's gatekeeper role – to keep out speculative expert opinion and unwarranted leaps of logic. (See, *Sargon Enterprises, Inc. v. University of Southern Cal.* (2012) 55 Cal.4th 747, 774 [proper to exclude speculative expert opinion that company would have increased its profits 157,000 percent].)

Instead, the Court of Appeal simply accepted defense expert Dawson's Declaration about the ACA's viability and helpfulness for plaintiff, holding that Dawson had "identified specific California insurance plans that would be available to meet many of [plaintiff's] needs." (*Cuevas, supra*, 11 Cal.App.5th at 180.) (In fact, Dawson had made no analysis of Brian Cuevas's specific medical needs, or how any particular insurance plans would cover his needs.) Further, the defense's insurance plans were subject to change on an annual basis; thus, by definition these plans could not predict the future availability requirement. It is unfortunate that the Court of Appeal did not engage more critically with this issue, which was central to the trial court's decision to exclude ACA evidence.

### The Court dismissed attacks on the ACA

The Court's decision took place after the November 2016 presidential election, and after the new President of the United States stated his intent to seek repeal of the ACA. The Court opted to ignore these new political facts. (*Cuevas, supra*, 11 Cal.App.5th at 181 fn. 14.)

As it turned out, following the *Cuevas* decision in April 2017, there were further federal actions undermining the ACA program, some of which were potentially fatal for the ACA. Among these actions were: ending cost-sharing reduction (CSR) payments to insurers; repealing the individual mandate of the ACA; expanding the use of short-term health plans with lower standards than standard ACA plans; and the U.S. Justice Department's refusal to defend the ACA in court. (See, "Sabotage Watch: Tracking Efforts to Undermine the ACA," from the Center on Budget and Policy Priorities, at https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca)

These federal actions add more uncertainty to any future defense health care projection that relies on ACA benefits over your client's lifetime.


(This situation was predicted by plaintiff's experts, and directly contradicts the defense expert opinions and the Court of Appeal's conclusion.)

### Future articles on the *Cuevas* decision

Future articles in this series related to the *Cuevas* decision will address the viability of the ACA in light of current political developments, and ways to attack defendant's use of discounted insurance payments as measures of reasonable value of care.


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