


# *Audish*: the new Medicare dilemma for jurors valuing future medical costs

## California appellate court misapplied existing case law and ignored the existence of the federal statute on Medicare

By Mike Kelly and Noah Epstein



California law allows a personal injury plaintiff to recover an amount no greater than the "reasonable value" of the medical services received for their injury. (*Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635, 640.) The reasonable value of past medical services is the dollar amount that providers accept as payment, regardless of whether the payments were made by the plaintiff or on their behalf. (*Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635, 641.)

Defining the reasonable value of future medical expenses is unique when the plaintiff is a Medicare beneficiary. Medicare cannot pay for a plaintiff's medical care when another primary plan must pay. (42 U.S.C. § 1395y(b)(2)(A).) The relevant statute "plainly includes tortfeasors and their insurance carriers within its definition of 'primary plan.'" (*Karpinski v. Smitty's Bar, Inc.* (2016) 246 Cal.App.4th 456, 463 [quoting *Taransky v. Sec'y of U.S. Dept. of Health and Hum. Servs.* (2014) 760 F.3d 307, 314].) Consequently, after a plaintiff has received a damages award, Medicare regularly ceases coverage for medical expenses stemming from the injury that produced the lawsuit and the verdict. (*Ibid.*) Where Medicare has paid past charges, it will have established a lien on the lawsuit proceeds, which it can enforce against the client, counsel, or insurers.

As all counsel know, Medicare reimburses healthcare providers at significantly lower rates than private insurers. Meanwhile, the rates providers charge uninsured patients – alternately referred to as "provider rates" or "chargemaster rates" – are much higher than those providers accept from private insurers. These "provider rates" reflect the actual cost that an otherwise Medicare-eligible plaintiff must pay for future care if Medicare elects to stop paying for benefits after a verdict or settlement. The fact that Medicare does not cover accident-related charges post-verdict is apparently not understood by California trial or appellate courts.

If a jury is not instructed that Medicare has no obligation to make any payments for accident-related care post-verdict, it will mistakenly believe that Medicare will cover a plaintiff's future medical expenses. The jury is thus likely to premise its calculations of future medical expenses on inapplicable, pre-verdict reimbursement rates. In this circumstance, a jury's award of damages for future medical expenses will necessarily undercompensate the injured party.

### *Audish* [2024] puts seniors at disadvantage

In *Audish v. Macias* (2024) 102 Cal.App.5th 740, the trial court admitted the following flawed testimony of the plaintiff's life-care planner: (1) that she "assumed" the plaintiff would qualify for Medicare at 65; (2) that her estimates of the plaintiff's future medical costs had not accounted for whether he was owed Medicare reimbursements; and (3) that insurers often settle bills for less than providers' charges. (*Id.* at 640.)

(*See the second article in this issue on* Audish, *written by the attorney who tried the case to verdict. – Editor.*)

In permitting the defendant to introduce Medicare rates as evidence of reasonable future medical costs, the Court of Appeal misapplied existing case law and ignored the existence of the federal statute precluding Medicare from providing benefits to a plaintiff for injuries stemming from his or her suit. The court's

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holding undermines the ability of plaintiffs over 65 to recover full compensation for their anticipated future medical costs.

The collateral source rule prevents deducting any compensation a plaintiff has received from independent sources from the damages the plaintiff would otherwise collect from the tortfeasor. (*Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, 548.) Because health insurers have a lien against a plaintiff's recovery, the collateral source rule does not lead to a double recovery. In *Howell* the court ruled that a plaintiff's recovery for past medical services is limited to the actual amount their provider accepted as payment, noting that "the rule does not address losses or liabilities the plaintiff did not incur and would not otherwise be entitled to recover." (*Id.* at 564.) The court held that the plaintiff's economic damages should be calculated based on the real amount paid by the insurance provider, not the inflated chargemaster prices that hospitals typically list. (*Ibid.*) This approach limits the recoverable damages to the real cost paid by the insurance provider.

The *Audish* court attempted to apply the reasoning from *Howell* to damages awards for future costs for a Medicare recipient, but the court was either unaware of, or ignored, Medicare's statutory obligation to stop paying for all future care related to the compensable injury once a verdict is returned.

A Medicare beneficiary will be responsible for the full billed amount of their future medical services because there is no longer an insuring agreement that has negotiated a lower rate. (42 U.S.C. § 1395y(b)(2)(A).) Consequentially, the plaintiff is left effectively uninsured and saddled with paying higher provider rates for care arising from the injuries sued upon. Where an uninsured plaintiff is liable for, or has paid, the provider rates their recovery in trial is not limited to the amount paid on their behalf. (*Moore v. Mercer* (2016) 4 Cal.App.5th 424, 438-39 [Uninsured plaintiff's recovery not limited to discounted amount paid by medical finance company to plaintiff's health care providers to purchase their bills, since plaintiff was still fully liable for amount of providers' charges].)

## *Audish* effectively leaves seniors uninsured for future meds

In a case like *Audish*, it makes no sense to consider the rate paid by Medicare as the measure of recovery, as Medicare will no longer pay any amount for that care. The *Audish* court should have extended *Moore*, but they instead misapplied *Howell*. Compounding this error, the *Audish* court held that even if Medicare does not cover the plaintiff's future care costs (leaving the plaintiff liable to pay the full provider billed amount from settlement proceeds) evidence of Medicare rates could serve as "background information" for the jury when evaluating the reasonable value of future services (*Audish*, 321 Cal.Rptr.3d at 643.) But this rationale has no justification and can only operate to deny the plaintiff a full recovery. Irrelevant "background information" should not be admissible under the Evidence Code.

Older plaintiffs covered by Medicare will never have their future medicals covered by Medicare and must always pay them from lawsuit proceeds. The *Audish* court failed to provide any explanation as to why the law should not entitle the plaintiff to recover his or her full projected future billed amounts.

California case law, which empowers plaintiffs to fully recover their incurred costs, see *Moore*, *supra*, 4 Cal.App.5th at 438-39, supports the principle that the reasonable value of future care in *Audish* is the amount that the plaintiff will be liable for – the provider rates paid by the uninsured. The provider rate that an uninsured plaintiff must pay represents reasonable value, even if other insured patients pay less. (See *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288, 1296-98.)

Suggesting any figure between the billed rate and the Medicare rate is appropriate without proof misleads the jury into awarding the plaintiff less than they will have to pay. (*Ibid.*) A fundamental principle of tort law is that damages should "restore an injured person as nearly as possible to the position he or she would have been in had the wrong not been done." (*Turpin v. Sortini* (1982) 31 Cal.3d 220, 232; Rest.2d Torts, § 901.) How could any value be more reasonable than the cost incurred on the open market?

Following a verdict or settlement, the plaintiff in *Audish* will only qualify for Medicare reimbursements related to medical expenses incurred for injuries or illnesses *other than those for his injury*. Failing to advise the jury that Medicare does not pay for post-verdict accident-related treatment is unfair. Allowing a jury to consider Medicare rates as "background information" for calculating a plaintiff's damages for future medical expenses has no conceivable benefit.

## Conclusion

Plaintiffs' attorneys should move in limine to exclude evidence of Medicare rates when calculating future damages for Medicare-eligible clients under Evidence Code section 352. There is no probative value to this evidence, and its inclusion will mislead the jury. The expert testimony admitted by the trial court in *Audish* invites jury confusion. Since Medicare is not liable for the plaintiff's future medical expenses, any evidence of the plaintiff's Medicare coverage is irrelevant, and informing the jury that the plaintiff has Medicare coverage makes no sense.

Under Evidence Code section 801, "Irrelevant or speculative matters are not a proper basis for an expert's opinion." (*Roscoe Moss Co. v. Jenkins* (1942) 55 Cal.App.2d 369 [expert may not base opinion upon a

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comparison if the matters compared are not reasonably comparable...."].) Medicare reimbursement rates have little correlation to the amount that a non-Medicare eligible plaintiff will have to pay to providers when Medicare decides post-verdict to cease coverage for accident-related treatment. Billed rates, which an injured and uninsured plaintiff is personally obligated to pay, are the only rates that serve as a sound basis for an expert opinion on the reasonable value of those services.


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