Medical-malpractice damages after the *Cuevas* case

The new case defense counsel *will* use against you

By Bruce G. Fagel

The presentation and admissibility of future medical care costs is the most important part of the damages in any medical-malpractice case with catastrophic injuries requiring future care. Since the recovery of non-economic damages is limited to a maximum of $250,000 it is essential that any plaintiff with catastrophic injuries receive the full amount of compensatory damages for future medical care costs.

The recent 1st District Court of Appeal decision in *Cuevas v. Contra Costa County*, 2017 DJDAR 4018, will provide the defense with additional case law to use the Civil Code Section 3333.1 exemption of the collateral source rule to offset plaintiff's future care cost damages. The Court specifically held that it was reversible error for the trial court to not allow evidence about the ACA benefits to cover future medical care costs, and it also re-confirmed that the correct measure of medical care costs was the amount paid to a health care provider rather than the amount billed. (*Howell v. Hamilton* (2011) 52 Cal.4th 541)

The Court also re-confirmed that MediCal is not a collateral source offset, because MediCal payments do not go to the plaintiff, and MediCal has the right to a lien for repayment of any funds paid on behalf of the plaintiff. (*Brown v. Stewart* (1982) 129 Cal.App.3d 331). The Court also held that Regional Center benefits are also not a collateral source off-set against future medical care costs (Welf. & Inst. Code, § 4659.10, 4659.11, 4659.15). Although the plaintiff argued that Civil Code section 3333.1, which allows an exemption to the collateral source exclusion in medical-malpractice cases only applies to "past damages" as amounts paid, the Court rejected this argument and specifically held that future health insurance payments can be admitted into evidence for the jury to consider as an "offset" to such future damages.

Facts of the *Cuevas* case

The case involved hypoxic-ischemic brain injuries to a child at birth with the requirement for future medical care. The primary injuries were cognitive with a low verbal IQ and language disabilities. Although diagnosed with cerebral palsy and developmental delays, the child is able to handle the activities of daily living (feeding, dressing, bathing) without assistance. He is medically stable and the jury found a life expectancy of 74 additional years, and awarded future medical care costs in the amount of $100 million with a present cash value of $9,577,000.

The ratio of 10 to 1 between total damages and present cash value is consistent with a life expectancy of 74 years, where more than half of the future care cost damages would be incurred in the last 10 years of life expectancy. Because the plaintiff would be "dependent on others," for his personal care and safety for the rest of his life, the bulk of plaintiff's life-care plan was for a specialized supportive living environment, due to plaintiff's low IQ, after age 22.

Prior to trial, the plaintiff was able to exclude evidence of any Regional Center and MediCal benefits. The trial court also ruled the ACA was inadmissible because "there was no reasonable certainty that that benefit will be in place" and the trial court also ruled that Civil Code section 3333.1 only applies to past benefits and not to future benefits. Thus, plaintiff's expert was allowed to present evidence about future care costs without any consideration of offsets, and the defense expert was limited to present evidence on the expected private pay payment for future medical care costs, to show they were lower than the plaintiff's cost amounts.

Plaintiff vs. defense life-care plan methodology

The life-care plan methodology in catastrophic injury cases is remarkably similar between plaintiff and defense. Both present charts listing categories for all possible medical care services, supplies, lab, X-ray, therapies, hospitalizations, home/attendant care, etc. and give the base cost, frequency, and basis for each recommendation. The number of items on such a life-care plan can easily exceed 75-80 separate items, although the home/attendant care category generally will account for 85 to 90 percent of the total annual cost of the life-care plan.

The plaintiff life-care plan generally presents one option for most care costs with agency cost for attendant care in the home. The costs for medical care items like doctor visits, hospitalizations, therapies, lab, X-ray, etc. are usually based on information from surveys on such costs, which can vary widely, but all such past care costs have usually been paid by either MediCal or private health insurance, and the amounts actually paid for such care can be easily documented and are rarely subject of dispute between plaintiff and defense experts.

Instead, defense experts focus on the future care costs where they generally make two arguments. One argument is that actual medical care costs are usually significantly lower than the amount that is billed for such care, and the other argument is that there are collateral sources, allowable under Civil Code section 3333.1 that will provide or pay for future care needs, which will result in an offset for such claimed future care costs. To further confuse the issues for a jury, the defense life-care plan offers four "options" for future care —MediCal, Regional Center, ACA, and "private pay." The defense then attacks the plaintiff experts for not taking any other sources for payment into account.

The first defense argument is supported by the *Howell* decision which confirms that plaintiff is only entitled to recover the actual amount paid for past medical care costs rather than the amount billed. For future care costs, the *Corenbaum* decision provides the defense expert with a basis for claiming that only amounts that will be paid for care should be part of plaintiff's damages rather than what might be billed. However, if there is a health insurance policy for future care, the amount billed or paid for care becomes irrelevant, since insurance would presumably pay whatever amount is charged, whether at a reduced contracted rate or some other amount, and thus presenting evidence and arguing over the "cost" for each separate part of plaintiff's life-care plan becomes an exercise in futility. If the defense can argue that health insurance, or another collateral source admissible under Civil Code section 3333.1, would be expected to pay for any such care required, there is no need to focus on whether the jury should consider amounts billed or amounts paid for future care.

The new reality: ACA (Obamacare) vs. AHCA (Trumpcare)

Before the ACA was enacted, plaintiff could argue that the plaintiff would not be able to get health insurance because of a pre-existing condition and/or the cost of such insurance would be prohibitive and speculative. That argument can no longer be made. With the *Cuevas* decision, the defense will be able to introduce evidence that health insurance is now mandatory, and without any exclusion for pre-existing conditions, that such health insurance under the ACA will provide benefits for most items on plaintiff's life-care plan. Therefore there is no reason for the jury to award any damages for most of the specific items on the plaintiff's life-care plan.

Unless the California Supreme Court overturns the *Cuevas* decision, the attention of plaintiffs' attorneys needs to focus on dealing with this new reality. Even though President Trump and the Republican-led Congress have stated their intention to repeal and replace the ACA, the Court in *Cuevas* acknowledged these statements in denying plaintiff's effort for the court to take judicial notice of President Trump's Jan. 20, 2017, executive order, and held that, "as of the writing of this opinion the ACA remains essentially intact."

However, one week after the *Cuevas* decision was released, the U.S. House of Representatives passed a bill that repeals the ACA, but their ability to pass it in the Senate will be far less certain, especially since the House bill will have a significant negative impact on those with pre-existing conditions. (Editor's note: Since this article was, written, the non-partisan Congressional Budget Office and the Joint Committee on Taxation have issued their report stating that the AHCA as passed by the House will increase the number of people who are uninsured by 23 million by 2026 relative to current law.)

By definition, any injured plaintiff in a medical-malpractice case who has future medical care needs/costs will have a significant pre-existing condition. With no control over premiums, the cost of health insurance for a medical-malpractice plaintiff with a catastrophic pre-existing condition may well approach the benefits that would be paid under such a policy. Since Civil Code section 3333.1 allows plaintiff to introduce evidence about the premiums for such health insurance (which can be done through the defense ACA expert) any eventual savings to the defendant, via an offset, would undoubtedly be less than what is available now with the ACA. It is unlikely that California will "opt-out" of the pre-existing condition exclusion with 11 health insurance carriers under Covered California. But if the ACA is repealed by law, without controls on premiums, the premium cost for any medical-malpractice plaintiff with a pre-existing condition will likely be substantial and far more than the current rates under the ACA plans.

Obviously if the U.S. Congress does pass an ACA repeal, the President will

certainly sign it, and that will change the equation with regard to the defense using the existence of the ACA to offset future medical care costs. But until that happens, it is hard to argue effectively that the ACA is not still the law of the land.

Events in Washington, DC, will have more impact on this issue than anything that can be done in Sacramento (whether the Supreme Court or the Legislature). Also, actions in Washington will likely take place before any petition to the Supreme Court to overturn *Cuevas* can be decided. Even if the trial court judge is not impressed by the future uncertainty of the ACA, any jury will certainly take such uncertainty into consideration in deciding future damages, and the jury (not the trial Judge) has the final decision about whether to "offset" plaintiff's future care costs by any policy of health insurance, including private health insurance outside of the ACA.

The collateral source rule and Civil Code section 3333.1

The *Cuevas* Court reviewed the public policy behind the collateral source rule and the exception made for medical-malpractice cases under Civil Code section 3333.1. The Court also recognized the two most important exemptions from the statute that have been confirmed by the Courts — MediCal and Regional Center. Since both of those agencies require re-payment by the plaintiff for any medical costs paid, both past and future, the jury should not be allowed to consider such sources of offset for future care costs. But for admissible collateral sources, Civil Code section 3333.1 allows the jury "to consider" such evidence, but is not required to make an offset in awarding damages. Civil Code section 3333.1 does not require the jury to deduct admissible collateral source benefits, the statute simply permits the defendant to introduce evidence that such benefits were paid. Therefore, it is left up to the jury to decide how such evidence should affect the assessment of damages (*Barme v. Wood* (1984) 37 Cal.3d 174.

Although trial court judges will now likely admit evidence about the ACA as an offset against future medical care damages, as an affirmative defense, the defendant will have the burden of proof on this issue which requires a special jury instruction and/or a modification of CACI 3903A to add this burden. The plaintiff can cross-examine the defense ACA expert and still argue the issue before the jury, since the offset is not required.

The public policy part of Civil Code section 3333.1 is based on the concept that if a plaintiff does not have to repay any collateral source for medical care payments, under Civil Code section 3333.1 (b) then it would be appropriate for the jury to consider such collateral source payments as an offset for such medical care costs. In non-medical-malpractice cases, where Civil Code section 3333.1 (b) does not apply, most health insurers routinely seek repayment for any medical care costs paid, and thus the jury cannot consider such health insurance in awarded damages for medical care costs. Instead, the plaintiff attorney can "increase" the damages to the plaintiff by negotiating with the collateral source over the amount of their lien.

The other issue considered by the *Cuevas* court was whether Civil Code section 3333.1 applies to both future and past damages. The Court reviewed this issue in some detail, including references to the original *Fein* decision in 1984, and several subsequent Federal court decisions that specifically held that Civil Code Sec. 3333.1 applies to future damages. The Court also reviewed the legislative history, with regard to the intent of the statute and concluded that "section 3333.1 permits introduction of evidence regarding future as well as past medical benefits." It will be a very difficult uphill battle to convince the Supreme Court otherwise.

Maximizing damages for future care costs

Despite the *Cuevas* ruling and the admissibility of evidence about future payments for plaintiff's medical care costs as an offset against the plaintiff's proposed life-care plan, plaintiff can still maximize damages for a catastrophic injury case by recognizing the limitations of the ACA. Further, the defense expert on the ACA can be used to produce much of the evidence needed to argue future damages.

First, in any case where MediCal has paid for plaintiff's past damages, and would be expected to continue with such payments, the ACA is essentially irrelevant. Anyone covered by MediCal is already included in the ACA requirement for health insurance and to change from MediCal to a private plan under Covered California (the ACA health exchange in California) requires being off MediCal for at least 6 months. Thus, a trial judge is far more likely to exclude any evidence about the ACA in a case where MediCal is already involved. The defense would need to prove there is some public policy benefit to moving a plaintiff from MediCal to a private health insurance policy under the ACA.

Second, even in those cases where MediCal is not involved and a private health insurance policy exists or would under the ACA, the defense expert will readily admit that while most of the items on the plaintiff's life-care plan would be covered under the ACA, attendant care would not be. The *Cuevas* court acknowledged this fact when it stated "attendant care was priced at the same amount in both parties' life-care plan, presumably because it is not covered by MediCal or any ACA-sponsored private health insurance." Since in any catastrophic injury medical-malpractice case, the cost of home attendant care represents more than 85 percent of the total cost of plaintiff's life-care plan, the *Cuevas* decision would not change this fact. It would force the defense into arguing that "private hire" is somehow better or safer for an injured plaintiff, which is an argument that does not play well with most jurors.

Most defense life-care planners recognize the practical difficulties with "private hire" home health care by having 10 percent agency hire as part of their plan.

This also allows the plaintiff to use the fact that agency hire costs for either a CNA or LVN are far more similar among various agencies that can provide such care, and there is no issue about "amounts billed vs. amounts paid," since health insurance is rarely involved in such care. The one exception is MediCal, where the agency rate paid by MediCal for an LVN is about $30 per hour, but the private pay cost is about $40 to $45 per hour. But since the defense would be prohibited from referencing MediCal in any case where MediCal has been involved for past care, it would be very difficult for them to present evidence about the "MediCal rate" for attendant care, and far easier for the plaintiff to introduce and use the evidence of the agency rate, and get the defense expert to agree to that cost.

What insurance "would be expected to pay"

In those cases where the plaintiff (or the plaintiff's parents in the case of a birth injury) has private health insurance, the effect of the *Cuevas* case is that the defendant will be allowed, through their ACA expert, to introduce evidence about what amounts the insurance "would be expected to pay." If an item of medical need is a covered benefit, the actual future cost of such an item, whether as an amount billed or paid is irrelevant, since the insurance would cover and pay that cost. Thus, the plaintiff would be limited to evidence of co-pays, deductibles, and the cost of insurance, and the defense expert would presumably present such evidence. In such cases the plaintiff should focus on what the insurance would not be expected to cover, either by contract or practice, and plaintiff could use cross examination of the defense ACA expert for that purpose.

There are 10 specific benefits required by the ACA for private health insurance under the ACA, and the defense expert can be cross-examined about the specifics of those benefits and the probability that insurance would actually pay for those items. The defense would have the burden of showing that the language of each specific health insurance contract is sufficient to prove that such future payments would be reasonably certain to be paid. While hospitalizations, doctor visits, and other items would likely be covered and paid, if there have been any problems with payments for past care costs or benefits (and no case has no problems) that evidence can be used to challenge the probability that health insurance under the ACA would pay for such items in the future. At a minimum, the defense ACA expert would concede that no contract of health insurance will pay for the cost of attendant care in the home required for the plaintiff's condition.

Jurors skeptical of health insurance

Beyond that, they may be forced to admit that many of the specifics on the life-care plan, e.g., physical, occupational, speech therapies, braces or other equipment may not be covered, in the future, even if some have been paid for or provided in the past. Jurors are very suspicious of any health insurance companies and many have had problems with denials of medical benefits payments, or have had to fight with their health insurer to get benefits paid. In voir dire, jurors can be asked about such problems with their own health insurance, and the fact that the defense wants to use "health insurance" to pay for many items of plaintiff's future care needs may not sit well with such jurors. Many jurors still like their individual doctor when asked during voir dire, but no one likes their health insurance company.

Conclusion: An opportunity to argue the health-care system

It may seem useful to challenge the *Cuevas* case (if that can even be done since the Supreme Court is unlikely to grant review), or even to continue to make the same arguments in motions in limine about excluding evidence of future medical care collateral sources because Civil Code section 3333.1 does not apply to future damages. Still, it is far more beneficial to deal directly with the challenges and the opportunities presented by the *Cuevas* decision.

Long before the ACA came into existence, jurors were receptive to the idea that health insurance as an offset for plaintiffs' future medical care costs was somewhat speculative. In catastrophic medical-malpractice cases, the jurors almost always awarded the amount asked for by the plaintiff's life-care plan. For years, the defense has been adamant that they need to find a better way to present damages in such cases. They think they have found it in the ACA, and will do anything they need to defend that position.

Four different entities, including the CMA, CHA, Civil Justice Association, California Chamber of Commerce, and the Southern California Defense Counsel filed Amicus briefs on behalf of the defendant in *Cuevas*. But ultimately in front of a jury, by aligning their position with that of the health insurers, the defendants in medical-malpractice cases will have to defend the actions of such profit-making companies when asking the jurors to "consider" any offset for future medical care cost damages for the plaintiff. Obviously, for future damages the issue of what benefits will actually be paid can still be very effectively argued that unless such payments are reasonably certain to be paid, they should not even be considered by the jury.

If viewed from the proper perspective, the *Cuevas* decision may offer a new opportunity to be able to argue the inequities of the health care/health insurance system and put the medical-malpractice defendants in bed with the health insurance companies in the eyes of the jury. In every medical-malpractice case the defense makes a motion in limine to exclude any evidence about the defendant's liability insurance, but with

evidence of health insurance coming into evidence, the defense will have to keep the jury from thinking that insurance — whether health or liability – is all part of the health care industry and that if there is insurance to pay for future medical care costs there must also be insurance to pay for the injuries cause by the defendant's negligence. Carefully used at trial, the evidence about health insurance and the ACA may actually backfire on the defense goal of lowering the amount of plaintiff's damages for future medical care costs.


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