Dealing with the *Cuevas* decision

The basis for a legal argument that ACA insurance benefits cannot be relied upon to meet your client's future medical needs

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[Editor's note: This is Part two of an article on the *Cuevas* decision (*Cuevas v. Contra Costa County* (2017) 11 Cal.App.5th 163). Part one appeared in the October 2018 issue.]

Was *Cuevas* correct to permit evidence of ACA-based insurance on the cost of future medical care? The Patient Protection and Affordable Care Act ("ACA") was intended to make affordable medical insurance available to all Americans. The ACA is carefully designed with key provisions intended to work together to provide affordable health insurance. The ACA particularly affected the markets for individual health insurance policies. The ACA requires health insurers to accept all individual applicants and charge the same rates, regardless of pre-existing conditions. To ensure a large pool of healthy insureds, the ACA also mandates that individuals buy insurance or pay a penalty. Legally, ACA-based private insurance is the same as any other private health plan. The ACA also expanded the Medicaid program. In theory, under the ACA, every U.S. citizen will have access to some form of health insurance.

Prior to the passage of the ACA, references to the plaintiff's future medical insurance were off limits in personal injury cases. In ordinary PI cases, such references were precluded by the collateral source rule. In medical malpractice cases under MICRA, judges typically precluded mention of future health insurance as speculative, because no one could guarantee the future longevity of any insurance policy, or the specific benefits or prices for medical services under a given policy.

Soon after the ACA was implemented in 2014, the defense bar began a new argument: Since plaintiffs are now assured of future medical insurance through the ACA, shouldn't evidence of such insurance be admissible in medical

malpractice cases, due to MICRA's admission of medical insurance?

Cuevas v. Contra Costa County (2017) was a med-mal case

The recent case *Cuevas v. Contra Costa County* (2017) 11 Cal.App.5th 163, addressed whether ACA-mandated health insurance benefits should be admissible as evidence of future medical damages in medical malpractice cases. In *Cuevas*, the Court of Appeal, First District held that future medical damages, like past medical damages, may be measured by discounted insurance prices for care (considered to be "market rates"). (*Id*. at 180.) Further, the Court held that the prices for medical services under ACA-based medical insurance plans may be admissible as evidence of the value of future medical damages. (*Ibid.*) The Court generally reasoned that the ACA is now the law of the United States, and since the ACA is 1) mandatory, 2) defines certain medical insurance benefits, and 3) has specific prices, the ACA can be reliably used as evidence of a plaintiff's future medical costs. This conclusion is incorrect, principally because it relies on the shaky foundation of the ACA's durability and ability to guarantee stable prices over time.

The *Cuevas* decision has major implications for medical malpractice cases, where the collateral source rule is partially abrogated. However, *Cuevas* also made some general statements about the admissibility of medical pricing from insurance. Defense counsel may try to apply *Cuevas* to any personal injury case, even though the case itself does not say that its holdings apply outside the medical-malpractice context.

Is this approach justified? Can an injured medical malpractice plaintiff reasonably rely on the ACA to ensure discounted future medical prices? Since the *Cuevas* decision was handed down in April 2017, the ACA has been the subject of many political battles and has suffered some serious damage. The President has stated his intent to repeal the ACA, and has taken a series of steps to make it unworkable, including the repeal of the individual mandate; ending cost-sharing reduction (CSR) payments; and allowing low-cost temporary plans without full benefits to become permanent. These changes undermine the essential elements of the ACA and are destabilizing to health insurance markets. The very rationale for the appellate court decision – the ACA's reliability and durability – no longer exists. Thus, the *Cuevas* case is subject to a direct attack that it is no longer good law.

Tremendous uncertainty in ACA insurance

Given the damaged state of the ACA, there is tremendous uncertainty over future ACA plans, including: what ACA insurance plans will continue to exist; what specific items of care will be provided; the prices for plans; and the prices for specific items of care. Current plans and prices are not likely to be viable next year, let alone decades into the future. If courts follow *Cuevas* and allow evidence of ACA plans for future medical damages, despite the likelihood the ACA can't guarantee low medical prices indefinitely, plaintiffs are likely to be shortchanged on future medical damages.

I am one of the attorneys who initially tried the *Cuevas* case. This article, part of a series of articles on the implications of *Cuevas* for plaintiff's personal injury practice, will discuss the *Cuevas* decision regarding use of ACA-based medical pricing and problems with this decision. We will also discuss potential plaintiffs' arguments to block the introduction of opinions and evidence based on alleged future ACA benefits.

ACA's main provisions: Essential benefits and program supports

The Affordable Care Act ("ACA" or sometimes "Obamacare") is a regulatory overhaul for the U.S. healthcare system, intended to expand coverage of health care to more U.S. citizens. The ACA overhauled the markets for individual health insurance. Insurers in these markets are made to accept all applicants and charge the same rates regardless of pre-existing conditions or sex. To combat the resultant adverse selection (only sick people buying health insurance), the act mandates that all individuals buy insurance, and that all health care plans provide a list of "essential health benefits." To help households between 100 and 400 percent of the Federal Poverty Line afford these compulsory policies, the law provides insurance premium subsidies. Other individual market changes include health marketplaces and risk adjustment programs.

Some of the most important pillars of the ACA health care system include:
Essential health benefits – Insurance policies are required to provide essential health benefits (EHB): ambulatory patient services; prescription drugs; emergency care; hospitalization; rehabilitative services; preventive care; laboratory services; pediatric care; and maternity and newborn care.
No denial for **pre-existing conditions**, and no dropping sick patients.
State **health insurance exchanges** allow businesses and individuals to compare plans and enroll for coverage.
Low-cost plans – For lower income people, insurers must offer plans with reduced deductibles, copayments, and other means of cost sharing.
Individual mandate – People are required to purchase health insurance, or pay a non-compliance penalty. This lowers overall premiums by widening insurance risk pools to include a mix of young and old, healthy and sick.
Low-income subsidies – A subsidy system for low- and some middle-income families to help in the purchase of insurance on the state insurance exchanges.
Cost-sharing reduction payments – The U.S. government pays subsidies to insurers to reduce co-payments and deductibles to those earning 100 – 250 percent of the federal poverty line (FPL).

The parts of the ACA system are designed to work together. If any one of the ACA pillars is removed, it would cause problems with the health insurance

markets. Prices for policies could rise; or benefits will become unavailable to patients. Extreme problems could cause health insurers to leave whole states or regions, or simply to forgo participation, causing the ACA to collapse.

It should be noted that the ACA does not explicitly overturn any state law. Nothing in the Federal ACA – or of any of the California laws that support implementing the ACA in California – requires or mandates the admission of the ACA as a collateral source in medical malpractice cases, or states that the ACA in any way affects the application of Civil Code 3333.1.

The ACA has been subject to numerous political and legal attacks. Congress attempted to overturn the ACA 54 times through March 2014. The ACA had several tests at the U.S. Supreme Court. In *National Federation of Independent Business v. Sebelius* (2012) 567 U.S. 519, the Supreme Court held that the individual mandate was a proper exercise of the congressional power to tax. Later, in *King v. Burwell* (2015) 135 S.Ct. 2480, the Supreme Court upheld premium tax credits to qualifying persons in all states, both those with state exchanges and with Federal exchanges.

Cuevas's holdings on future insurance and the ACA

In our previous article in this series, we discussed the *Cuevas* trial and appellate decision, including these courts' discussions of ACA-mandated private insurance. Following is a review of the *Cuevas* decision with more detail related to the ACA benefits issue.

In *Cuevas*, plaintiff suffered loss of blood to his brain at birth, causing permanent neurological damage with cognitive and physical impairments. Plaintiff's medical experts testified plaintiff would need significant life-long medical, therapeutic, and attendant care.

The trial court considered several motions in limine on future medical expenses. Plaintiff moved *inter alia* to exclude ACA-mandated insurance benefits as speculative. Plaintiff provided expert declarations from health insurance expert Richard Lievense, and life care planning expert Jan Roughan, RN. These experts collectively testified that: 1) the ACA was subject to future political attacks, and was not reasonably certain to provide benefits for decades into the future; 2) private insurance discounts and medical pricing were highly volatile, and were not reliable to project future medical expenses; and 3) since the plaintiff was on Medi-Cal, he was ineligible for ACA-mandated private insurance. Instead of pricing based on insurance plans, plaintiff's experts used 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, based on national price surveys.

Defendant also provided expert declarations, notably from ACA expert Thomas J. Dawson. Dawson opined that the ACA would remain in force and mandate health insurance benefits for plaintiff over his lifetime. Dawson identified specific California insurance plans that would allegedly be available to meet plaintiff's needs. However, Dawson's declaration did not state there was any reasonable certainty that any particular plan or price/discount structure would remain in force into the future. (As facts later showed, Dawson's confidence was misplaced, as several insurance companies have left the ACA exchanges.)

Plaintiff pointed out that the defense expert life care planner, Linda Olzack, had contradicted Dawson. Olzack testifying she could not be sure that, for any given item of future care, the discounted price under ACA-based insurance plans would remain in effect longer than a few years. This testimony contradicted Dawson's opinion that existing ACA plans could be used to reliably price plaintiff's medical needs and undermined the use of any current insurance discounts as foundation for future pricing.

After hearing argument on these issues, the trial court ruled against admitting mention of ACA insurance or related pricing at trial. The court held there were many reasons future ACA benefits may not be available into the future, including uncertainty as to particular plans and coverage, and uncertainty as to the ACA itself. The court ruled that future ACA benefits did not meet the standards of reasonable certainty for admissibility, because the long-term stability of future insurance and pricing is speculative.

At trial in September 2014, the jury delivered a plaintiff verdict. Defendant appealed the case to the First District, arguing principally that the trial court should have admitted evidence that the ACA ensures plaintiff discounted future medical prices via ACA insurance policies.

In April 2017, the Court of Appeal issued its ruling, holding that evidence of discounted prices paid by insurers constituted an admissible measure of the market value for future medical services. The Court held that, in general, "the collateral source rule is not violated when a defendant is allowed to offer evidence of the market value of future medical benefits." (*Cuevas, supra*, 11 Cal.App.5th at 180, *citing, Markow v. Rosner* (2016) 3 Cal.App.5th 1027, 1050-1051.) Further, the Court held that evidence of future medical prices available under ACA-mandated future medical insurance plans should be admissible as evidence of the "market value" of care and should have been admitted at the *Cuevas* trial. (*Ibid*.)

In so ruling, the *Cuevas* court accepted defense expert Dawson's declaration that he 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.) However, the Court did not inquire as to whether there was any foundational evidence that these plans would continue to exist and provide these benefits, and those prices, over the plaintiff's lifetime. Plaintiff's experts had strenuously contested these assumptions, and even the

defense life care planner admitted that insurance discounts were not reliable into the future. Thus, the defense opinion relied upon by the Court of Appeal lacked foundation. (See, *Sargon Enterprises, Inc. v. University of Southern Cal.* (2012) 55 Cal.4th 747 at 770 [trial court properly excluded speculative expert opinion on future damages].)

The Court discounted plaintiff's critiques of the ACA's long-term durability, 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.) The Court of Appeal noted there was political opposition to the ACA but did not believe that this opposition would damage the ACA: "It is noteworthy that this case was briefed before the 2016 presidential election, the aftermath of which did place the ACA's continued viability into question. However, in spite of recent efforts to abolish or substantially alter the ACA, as of the writing of this opinion the ACA remains essentially intact." (*Cuevas, supra* at 180.)

The Court's decision took place after the November 2016 presidential election, and after various official statements evidencing the new administration's intent to repeal the ACA. The Court noted these new political facts, but discounted their significance. (*Cuevas, supra*, 11 Cal.App.5th at 181 fn. 14.) Further, the Court of Appeal's opinion did not consider whether the administration's attacks on the ACA would disrupt the future pricing of items of medical care, or make the availability of various medical benefits uncertain, or make the existence of various medical plans uncertain.

Ongoing federal efforts to overturn or sabotage the ACA

The Court of Appeal's decision relies on its opinion that the ACA "remains essentially intact." (*Cuevas, supra*, 11 Cal.App.5th at 180.) However, since the Court of Appeal's decision in April 2017, there have been many attempts to repeal the ACA, and many federal policies have been adopted with the stated intent and direct effect of undermining the ACA. As a result, the *Cuevas* Court's foundational assessment of the ACA as "intact" can no longer be relied upon.

In January 2017, President Trump announced his administration's intent to repeal the ACA. Subsequently, the president gave several executive orders intended to impede the ACA, including slashing funding for marketplace outreach, and directing the Department of HHS to release videos attacking the ACA. In the summer of 2017, the U.S. Congress made several attempts to repeal the ACA outright; these attempts narrowly failed.

In June 2017, Anthem Blue Cross announced it was exiting Ohio's ACA marketplace due to uncertainty as to whether CSRs would be paid, and an increasing lack of overall predictability. (See, "There could be a tidal wave of terrible news coming for Obamacare," 6/08/17, Business Insider, at: https://www.businessinsider.com/anthem-obamacare-exchange-exit-from-ohio-2017-6.)

In October 2017, President Trump ended cost-sharing reduction (CSR) payments to insurers – reimbursement to insurers who offered discounted health plans. Prior to this announcement, insurers repeatedly warned that if the payments were cut off, they would be forced to raise premiums to make up the financial loss. According to the CBO, ending CSRs will raise costs for consumers and further disrupt health insurance markets. The Congressional Budget Office has estimated that ending the CSR payments will raise the number of uninsured people by one million in 2018, increase marketplace premiums by 20 percent, and cause insurers to pull out of the marketplace, leaving some consumers with no marketplace plans for a period of time. Further, ending CSR payments will increase the federal deficit by $194 billion over the next ten years. (See, CBO Report, "The Effects of Terminating Payments for Cost-Sharing Reductions," 8/15/17, available from the CBO at https://www.cbo.gov/publication/53009.)

Individual mandate of ACA ends

In December 2017, Congress passed a tax reform package that included repeal of the individual mandate of the ACA. The Congressional Budget Office (CBO) estimated that repealing the ACA's individual mandate would cause 13 million fewer Americans to be insured in 2027 compared with current law. The CBO predicted that younger, healthier and wealthier people may choose to forgo coverage, changing the risk pool to include a higher percentage of sick persons. The CBO predicted that premiums in the markets would spike 10 percent without Obamacare's individual mandate, as the exchanges are left with a sicker consumer pool. (See, Mukerjee, "The GOP Tax Bill Repeals Obamacare's Individual Mandate. Here's What That Means for You," 12/20/17, Fortune Magazine, at http://fortune.com/2017/ 12/20/tax-bill-individual-mandate-obamacare/.)

On February 20, 2018, President Trump proposed to expand the use of short-term health plans as an alternative to plans that meet more stringent standards under the Affordable Care Act. Such plans do not include essential ACA benefits, including required health benefits such as maternity coverage and the guarantee of insurance regardless of health. This would let a parallel market for "skimpy plans" operate alongside the market for comprehensive individual health insurance, exposing consumers to new risks and raising premiums for people seeking comprehensive coverage, especially consumers with pre-existing conditions. (See, Abutaleb, "U.S. to extend skimpy health insurance outside of Obamacare," 2/20/18, at https://www.reuters.com/article/us-usa-healthcare-insurance/u-s-to-extend-skimpy-health-insurance-outside-of-obamacare-idUSKCN1G41SH.)

In April 2018, the Centers for Medicare and Medicaid Services (CMS) finalized health care rule changes for the individual market that will weaken benefit standards, likely harming people

with pre-existing conditions; raise new barriers for people who want to enroll in health coverage; and reduce accountability for insurers and transparency for consumers. (See, https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca.)

The federal government has also declined to defend the ACA from state lawsuits; in fact, the U.S. Department of Justice has filed briefs attacking ACA provisions. In June 2018, the DOJ filed a brief declining to defend the constitutionality of the Affordable Care Act (ACA) in an action brought by 20 states' attorneys general. In *Texas v. United States*, the states assert that the entire ACA must be struck down because the Supreme Court's 2012 decision in *National Federation of Independent Business v. Sebelius* upheld the coverage requirement under Congress's taxing power and the 2017 tax law zeroed out that tax penalty. The Trump Administration's DOJ brief asks the court to strike down two critical consumer protections: the "guaranteed issue" provision that bars insurers from denying coverage to people with pre-existing conditions and the "community rating" prohibition on charging higher premiums to people because of their health status. (https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca.)

In July 2018, The Centers for Medicare & Medicaid Services (CMS) announced that Affordable Care Act risk adjustment transfers for 2017 may be delayed. Risk adjustment is a federal program that transfers revenues from insurers that enroll a healthier-than-average group of consumers to those that enroll a sicker-than-average group. By doing so, risk adjustment reduces the incentives for insurers to design plans to avoid attracting people with pre-existing conditions and other serious health needs. CMS's announcement has created uncertainty and confusion, with insurers unsure how long transfers might be delayed. (https://www.cbpp.org/ sabotage-watch-tracking-efforts-to-undermine-the-aca.)

Finally, the federal government is throwing roadblocks to ACA enrollment by starving the funding of "navigator" groups that assist people to sign up for the ACA. Since January 2017, the federal government has slashed funding for these groups. Combined with the large cut in 2017, navigator funding has now fallen more than 80 percent from its 2016 level. In September 2018, the government announced that fewer of these navigator groups would be funded. As a result, many states will have large areas with no navigators, and a few states will have no navigator program at all. This is likely to further reduce enrollment in the ACA. (See, Hellman, "Key ObamaCare groups in limbo as they await funding," 6/20/18, The Hill, accessed at: https://thehill.com/policy/healthcare/393131-key-obamacare-groups-in-limbo-as-they-await-funding; see also, https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca.)

Resulting uncertainty regarding the ACA's survival or ability to function

As noted, the U.S. President, and the leaders of Congress, have stated their intent to destroy the ACA and have taken a series of concrete steps to do so. Contrary to the sunny view of *Cuevas* defense expert Dawson, who convinced the appellate court the ACA was "here to stay," many of the essential pillars of this carefully constructed plan have been damaged or destroyed. To name a few of the more serious effects:

Essential health benefits – These are no longer mandated, as the federal government is now promoting the expansion of "skimpy plans" that lack essential health benefits.

Pre-existing conditions – The federal DOJ has filed a brief arguing to strike down the provision that bars insurers from denying coverage to people with pre-existing conditions.

Individual mandate – The 2017 tax reform ended the individual mandate. Without the mandate, policy premiums are likely to rise about 10 percent as exchanges are left with a sicker consumer pool.

Cost-sharing reduction payments – In October 2017, President Trump ended cost-sharing reduction (CSR) payments to insurers. This is likely to increase the number of uninsured, increase marketplace premiums, and cause insurers to pull out of the marketplace.

As a result of these changes and other attacks on the ACA, as well as future attacks to come, there is no reasonable expectation that the ACA private insurance benefits will continue over the course of a plaintiff's life expectancy and reliably provide the same care or prices for care. Any ACA plans that continue to be offered are likely to be highly unstable, both in prices for items of care, and in the health benefits provided.

The instability of the ACA exacerbates the inherent volatility of private medical insurance benefits, and makes projecting insurance benefits into the future nearly impossible. With or without the ACA, there is general uncertainty as to whether a 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. Now that the ACA is on the brink of destruction, there is even less predictability in future insurance rates and prices. In fact, health care prices and insurance premiums have been rising faster than inflation in recent years. (See, "Workers' health costs continue to rise, eroding wages," 10/04/18, Daily World, at http://www.thedailyworld.com/news/workers-health-costs-continue-to-rise-eroding-wages-new-survey-finds/.)

Relying on the ACA erodes medical damages

Relying on the ACA to provide future medical care at bargain prices would deeply erode plaintiff's recovery of medical damages. Where a defendant

proposes the use of discounted medical prices based on some current ACA-mandated insurance plan, defendant essentially locks plaintiff into these low prices for life. Where medical care is priced too low in calculating plaintiff's future medical costs, this can have serious consequences for the plaintiff's future care and long-term health. If prices for necessary medical care rise due to a plan change, the plaintiff must pay the difference. If the particular medical care is no longer provided on the plan, or delayed by bureaucracy, plaintiff may not have funds in the damage award to purchase necessary services privately. This deprives plaintiff of her right to full compensation for her losses, and can result in actual injury if funding cannot be found for necessary medical care.

Arguments against admission of evidence from ACA insurance

Prior to passage of the ACA, courts in malpractice cases were reluctant to allow evidence of future health insurance benefits, primarily because there was no foundation for assuming these benefits would be available or would reliably provide low prices for care. After the *Cuevas* decision, defendants in medical malpractice cases can now argue that, because of the ACA, future insurance benefits are reasonably certain and should be admissible. However, the ACA's core provisions have been crippled by series of attacks. As a result, the ACA cannot be a reliable guarantor of a plaintiff's future medical benefits.

So, what to do when a defendant cites *Cuevas* to introduce ACA insurance plans, or prices from these plans, for your client's future medical expenses? The problems cited above suggest two lines of attack: 1) Note that the ACA itself is damaged and unreliable, and future ACA benefits are speculative; and, 2) Note that private insurance prices and discounts are inherently volatile and are not reliable for future pricing, compared to UCR rates based on a review of market prices. Both of these arguments attack the foundation for any defense expert testimony on alleged ACA-based low prices for plaintiff's future care.

First, the basis for the *Cuevas* decision was the alleged durability of the ACA – that it was "essentially intact" despite multiple challenges. (*Cuevas, supra*, 11 Cal.App.5th at 180.) This was not quite true in April 2017, and is definitely untrue now. Essential pillars of the ACA program have been damaged or struck down. This suggests that *Cuevas* was either wrongly decided, or has been overtaken by changes to the law. It would be unjust to force plaintiffs to rely on the ACA as a limit on their future damages, and expert testimony relying on the ACA should be excluded as speculative.

Defendants are likely to argue that *Cuevas* is controlling, and that it is improper to speculate about future changes in the law, such as future changes to the ACA. (See, *Dist. of Columbia Court of Appeals v. Feldman* (1983) 460 U.S. 462, 477.) However, at this point there have *already been dramatic changes* to the law, which have damaged the ability of the ACA to provide the intended benefits. Further, ongoing political uncertainty is likely to cause market instability, making price continuity unlikely. Courts have a duty to assess the ACA in light of the current status of the law and the effect of the recent changes. At this point, it is more speculative to assume that all promised ACA benefits will continue – that is, that the current prices and services will be available decades into the future from the damaged ACA insurance marketplace.

The second approach is to question the foundation for relying on private insurance discounts, pricing, and benefits, as a measure of the value of future medical damages. Private insurance markets have an inherent variability and volatility. Discounts on medical prices vary, such that paid prices can amount to anything from 20 to 100 pecrent of the charged amounts. This has been true under the ACA to date and is likely to remain true given the changes wrought by successive political regimes. Given this inherent variability, it is unfair to pick a current discounted price for services and project it into the future, particularly over the decades of your client's life expectancy. Defense experts should not be permitted to speculate that any given insurance discount will last for 10, 20, 30, 40 or more years into the future, as any honest expert will tell you that such discounts can't be predicted even five years from now.

Defense experts who seek to offer ACA-based medical pricing should face sharp questioning at their expert deposition. Expert testimony must be based on reliable foundational materials. (Evid. Code., § 801.) These experts should state their basis for assuming that, given the enormous problems with the ACA and ongoing attacks on the program, the ACA will nevertheless continue to ensure insurance benefits will be available for the plaintiff for five, 10, 20, or 40 years into the future. They should state why they believe that any particular insurance policy will endure over time. They should identify any point where they assume discounted insurance prices for care, and show their foundational basis for assuming any given discount will continue for years.

Before trial, motions in limine should be filed to preclude any expert testimony relying on the ACA or prices from ACA-based insurance plans, based on the serious foundational issues and the speculative nature of ACA-derived benefits. (Evid. Code, §§ 802, 803.) "[T]he matter relied on [by the expert] must provide a reasonable basis for the particular opinion offered . . . expert opinion based on speculation or conjecture is inadmissible." (*Sargon, supra,* 55 Cal.4th 747 at 770.)

Finally, plaintiff's attorneys should point out that the *Cuevas* decision approved plaintiff's expert's use of UCR pricing as the basis for future medical prices. (*Cuevas, supra,* 11 Cal.App.5th at 182.) So, a plaintiff's life care planner is fully justified in using UCR pricing.

Plaintiff should argue that this method uses a broader source of medical prices and is inherently more stable and reliable than the use of private insurance discounts.

I hope that this discussion is useful in your practice, and sparks discussion about the implications of the *Cuevas* case and ways to resist inappropriate use of the ACA. We will explore more issues raised by *Cuevas* in the next article in the series.


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