Exploring Medicare in the context of *Audish v. Macias* (2024)

Practical tips on challenging and overcoming *Audish v. Macias*, based on a recent case tried to verdict in Orange County

By Greyson Goody

Editor's note: This is an important update to Mr. Goody's article on Audish *that appeared last month in December Plaintiff. This update includes trial strategies for dealing with this less-than-favorable opinion.*

On June 6, 2024, the Court of Appeal published its opinion in *Audish v. Macias* (2024) 102 Cal.App.5th 740. The case began as a straightforward personal-injury claim stemming from a car wreck, but quickly transformed into a battle over Medicare and future insurance eligibility. At trial, the plaintiff received a less-than-favorable jury verdict and appealed.

Central to the appeal was a claim that the trial court erred by allowing the defense attorney to ask Audish's life-care planner about his future eligibility for Medicare. Specifically, the defense questioned whether Audish would qualify for Medicare at age 65. Further, he inquired whether the life-care planner had factored Medicare rates into her projections, which she had not. This line of questioning arguably violated the collateral-source rule, with Audish arguing it jeopardized his claims and led to a verdict inconsistent with the evidence.

The Court of Appeal, however, upheld the trial court's decision. It held that "limited evidence" regarding Audish's future Medicare eligibility was permissible. Citing *Cuevas v. Contra Costa County* (2017) 11 Cal.App.5th 163, a medical malpractice case where the collateral source rule does not apply per CCP § 3333.1, the court dismissed the collateral-source rule's application in this context. While one can argue whether the decision was proper, the Supreme Court denied CAOC's request for depublication and the case's holding stands. Practitioners should now plan on how to confront it, regardless of which side of the aisle they are on.

The Secondary Payer and False Claims Acts

Anyone encountering *Audish* must be familiar with the Secondary Payer and False Claims Acts. The Secondary Payer Act is very simple. It states that Medicare is considered a "secondary payer" when payment "has been made or can reasonably be expected to be made under . . . an automobile or liability insurance policy or plan." (42 U.S.C. § 1395(b)(2).) Put simply, this means Medicare is not required to pay for medical treatment if a third party is responsible for the injury. In fact, a

Medicare beneficiary is precluded from submitting claims to Medicare that fall under the Secondary Payer Act.

In that situation, the plaintiff must *exhaust* any payments made by the third party *before* they can even submit claims to Medicare. Practically speaking, this means that any award for future medical care via settlement, verdict, or bench decision must be used before Medicare kicks in. This means that it is important to save the third-party award and have your client treat the injuries they sustained in the third-party incident, before using that money for anything else. Think Medicare Set Aside when your client settles a case, but post-verdict it can be put in a trust to protect your client from what's next.

The False Claims Act is also straightforward and applies in the event there is a third-party recovery and the plaintiff does not comply with the Secondary Payer Act. It states that "any person who . . . knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval . . . is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000 . . . plus 3 times the amount of damages which the Government sustains because of the act of that person." (31 U.S.C. § 3729.) Put simply, a person must present legal claims to Medicare through their medical provider(s). If there was a third-party recovery, and Medicare is considered a

"secondary payer," then submitting a claim to Medicare would technically be a violation of 42 U.S.C. § 1395(b)(2) and 31 U.S.C. § 3729. A Medicare recipient submitting false claims could be charged with fraud, which is a felony, and must re-pay the government treble damages for the violation.

It is extremely important to understand and be able to navigate both acts to contextualize and overcome *Audish*. Planning throughout litigation, pre-trial, and trial are key to overcoming the harsh effect Medicare rates can have on a verdict, particularly in comparison to the lien charges our clients typically incur.

Trial strategies

About a month after the *Audish* ruling, I was preparing for trial in Orange County. The implications of *Audish* loomed large over my case, which involved a 60-year-old woman injured by a security gate. She had significant future damages, and all my experts gave future medical costs based on lien/cash rates (not Medicare). To complicate things, the defense retained Dr. Henry Lubow as a billing expert, whose methodology is focused entirely on Medicare rates.

I had several conversations with other lawyers and specialists, including John Rice at the Lien Project. Most lawyers said it would be foolish to challenge *Audish* because clearly, at 65 years old, my client would be entitled to Medicare. John, however, provided me with cites to the Secondary Payer and False Claims Acts, which got the creative juices flowing. Over the next few weeks, I went back and forth about what to do, eventually settling on a plan. That plan was executed at trial and continues to evolve into what you are reading in this article.

Consider filing a motion in limine

In my trial, I did not file a motion in limine on the *Audish* issue. Instead, I wanted to blindside the defense and bait them into claiming my client's future medical costs should be reduced to Medicare numbers, then spring my trap to polarize the case. In my case, the plan worked. But there are many potential approaches that might work just as well. I'll likely try all the below in my next trial.

First, attack *Audish* by filing a motion in limine. If you would like mine, reach out and I'd be happy to send it. This will help educate your judge so she knows the practical effects (and side effects) of the Medicare system. It helps create a good record to appeal and overturn the case, which in my opinion, was wrongfully decided. The Court of Appeal was not presented with, or familiar with, the Secondary Payer and False Claims Acts. Even the de-publication requests submitted by practitioners in California did not go as deep as referencing the False Claims Act, which criminally punishes plaintiffs for using Medicare improperly. Make sure you have a clear and concise breakdown of what really happens if your plaintiff does what the defense is fighting for.

Moreover, the *Audish* court misinterpreted the medical-malpractice cases it relied on. In those cases, the collateral-source rule does not apply. In fact, when medical insurance is introduced in medical-malpractice cases, the plaintiff gets to counter that with the cost of paying for health insurance – which is again not applicable in a personal-injury case.

Finally, Medicare is not available to every plaintiff. Eligibility requires the applicant to be either a U.S. citizen or an alien permanently residing in the U.S. for five continuous years. If your client does not fall into that group, they are not even eligible for Medicare. You will be hamstrung to argue this as a person's immigration status is inadmissible in personal injury cases. (Evid. Code, § 351.2.)

Let's be clear, however, you are unlikely to get your motion in limine granted given *Audish* is binding precedent. The real purpose of filing it is to educate the judge, make a good record for appeal, and strike fear in the heart of your opponent.

Prepare every witness to rebut defense claims

Second, educate your witnesses about all the above (and below), so they are prepared to testify. If you have a client who is a Medicare recipient, make sure they understand the acts as well. No matter who is on the stand, they need to be prepared for the defense cross-examination related to Medicare rates. Where liability is reasonably disputed, or the plaintiff had priors and treated through Medicare for those specific body parts, you will need to be especially prepared. That's where things get murky, the below plan can get thrown off the rails, and a good defense attorney can take advantage.

I have started asking treating physicians about this issue in depositions. Videotape the depositions and play them at trial in lieu of live testimony. Treating physicians can educate the jury on why Medicare is not reasonable, why it doesn't apply, and lay the groundwork for a good defense against the opposing billing expert. See my article in the Daily Journal titled "Billing Experts – Directs and Crosses" from September 1, 2023, if you want some quick tips.

Let the cat out of the bag

Sometimes the defense gets tricky and will wait to raise the Medicare issue in their case-in-chief. Because I saw the benefit of using the arguments discussed here to polarize the case, I did not file any motions in limine or requests for judicial notice until we discussed the Acts on the record. To that end, I prepared our billing expert to affirmatively testify about the issues since we were nearing the end of our case-in-chief and Defendant had not brought the issue up. His testimony not only gave clarity to the issue, but was a huge shock to the defense. Here is the simple interplay:
Q: Now, moving forward, Francesca's almost 60 years old. In five or six years,

she's going to be 65. Now, the defense is going to claim her future damages should be paid by Medicare. In your opinion, should they?

A: Absolutely not.

Q: Tell us why.

A: Medicare – again, what is Medicare? It's a federal taxpayer-funded safety net for health care. Medicare acts in tort cases such as this as a "Secondary payor." Why? To protect taxpayer money.

So, if someone else is responsible for hurting a Medicare beneficiary, Medicare requires, through their contract, for that provider to not bill them until all payments related to that third party have been exhausted. So, never should Medicare ever be billed when there's a third-party responsibility for the injuries sustained. This is called the Secondary Payer Act.

Now, if there were an award to be given through future medical for these services, it would be required of the Medicare beneficiary to not bill Medicare related to those injuries sustained through a third party. And so, she would be barred from billing Medicare for anything related to the neck and back. And if she did try to bill Medicare, she could be subject to the False Claims Act which would result in felonies and prosecution. So, I would say no.

Establish the law with requests for judicial notice

Third, either during or after your witness designated to discuss Medicare takes the stand, file two requests for judicial notice. Again, if you'd like these, reach out and I'll send them. Not only will this give you leeway to question the defense witness on it, but it will permit you to argue the issue in closing arguments. Once the defense argues Medicare should be considered, you have a bevy of great arguments illustrating the depths the defense will go to try to avoid responsibility.

Cross-examining experts regarding Medicare

Remember, many defense billing experts, like Dr. Lubow and some of his newer protégés, give the opinion Medicare rates should apply even when the plaintiff is not a Medicare beneficiary. If that is the case, a good cross-examination can undercut their claims and polarize the issue. Consider the following subjects and if you would like a cross-examination of a defense billing expert, please reach out. As my good friend Ognian Gavrilov once told me, "crossing billing experts is just basic economics":

1) Who is entitled to Medicare; folks who are 65 years+ or have end-stage renal failure (among other things);
   a. Is plaintiff 65+?
   b. Does plaintiff have end-stage renal failure?
   c. Is plaintiff even qualified to submit claims to Medicare?
2) Do the treating physicians accept Medicare?
   a. If not, there is no expectation they would accept the defense rates.
   b. If so, establish the following:
      i. Medicare is, in essence, charity care and the only way to make money is to treat *en masse*, which sacrifices quality care.
      ii. Medicare is a small percentage of their practice and a way to "give back."
3) What if the treating physicians had to accept Medicare rates for every patient?
   a. Would they have trouble covering their overhead? Would they have to lay off staff, nurses, and other doctors?
   b. Establish how much it costs to run a clinic, a surgery center, or a hospital. Show that profits can't be made unless the doctor has a wide variety of incomes (lien, cash, insurance, and government payers);
   c. See if the defense billing expert knows whether your specific treaters profit from treating Medicare patients. They won't.
4) What is the future of Medicare?
   a. The Medicare Insurance Fund is on the brink of collapse;
      i. By 2032, Medicare will be spending $3 billion more every year than it generates;
      ii. The fund is projected to run dry by 2036;
      iii. Donald Trump was just elected, and he proposes to cut and eventually get rid of social services like Medicare.
5) Using Medicare rates for every doctor is the same as socialized healthcare;
   a. The defense methodology doesn't consider the experience of the doctor;
      i. It pays the same whether the physician is a 25-year award-winning neurosurgeon or fresh out of residency.
   b. The defense methodology does not consider the quality of care;
      i. It pays the same whether the physician has a clean record or has five medical-board complaints and 25 malpractice suits.
   c. The defense methodology leads to lower-quality care;
      i. The only way for doctors to make money with Medicare rates is by treating in bulk, which therefore sacrifices quality care for injury victims.

There are countless ways to attack Medicare rates, and these are just some of them. Most have to do with using your treating physicians to undercut that defense expert opinion with the above. I have also recently considered not designating a competing billing expert because even on the plaintiff side, your expert's methodology will not consider the experience or quality of the doctors, which undercuts a good cross and makes you look like a

hypocrite. I'm now of the opinion you probably don't need a billing expert to succeed in the medical-billing arena at trial.

Special jury instruction

Before closing arguments, request a special jury instruction. In my recent case, the judge was prepared to instruct the jury: "For any damages awarded for the injuries sustained in this case, [Plaintiff] must exhaust the award prior to being able to treat through Medicare." Ultimately, this instruction was never given to the jury because the defendants chose to withdraw their claim altogether after I completed the above plan. You can defeat this argument too, then wrap it up with a bow in closing.

Closing arguments

Now it is time for closing arguments. Here, you can take all the polarized evidence you have obtained from your expert, the defense expert, the requests for judicial notice, and your special instruction.

When you argue, make very clear that the defense claims your client wasn't injured, didn't need treatment or surgery, and future care is unnecessary. They further suggest Medicare (i.e., the taxpayers) should shoulder the financial burden for her damages, rather than the responsible party. Even more outrageous, they want your client to consider fraudulently billing Medicare, risking severe legal consequences, including potential felony charges and significant fines.

And let's not forget the looming Medicare crisis. Taxpayers might end up funding her future medical treatment through a system on the brink of collapse, with the Medicare Insurance Fund projected to run dry in the next 10 years. Even now, Medicare is spending more every year than the revenue it generates. Our political representatives are pushing for cuts to Medicare, which signals that big changes are on the way.

In fact, doctors today are getting paid less and less for treating Medicare patients because the well has run dry. Just last year there was a big cut in the reimbursement rates, and we can expect much more over the next four years. There is a reason many doctors don't accept Medicare, as payments continue to shrink, requiring higher patient loads and sacrificing quality care.

It is my hope that this article helped you understand the interplay between your client's damages and Medicare. If just one of you can use this to put the issue to bed in your case, I'll consider it a win. But if we all can employ these defenses to *Audish*, I have the utmost confidence that the next case that gets taken up on appeal will lead to it being overturned, which would be the proper path the appellate (or supreme) courts should take. In sum, I humbly thank you for reading and look forward to your continued successes.


Goody

Greyson Goody is a partner and trial attorney at Goody Law Group *where focuses on prosecuting personal-injury cases. His first trial as lead counsel was in* Pebley v. Santa Clara Organics, *which is now binding law cited in every personal-injury case in California. He is an associate in ABOTA and a member of CAALA and CAOC.*