By Richard J. Montes and Robert H. Wright

Phantom Medical Damages and the Five Key Pillars for a Successful Defense

For too long, plaintiffs have been allowed to control the playing field when it comes to medical damages. The result has been windfall awards that are based on inflated medical expenses that will never actually be paid.

But recently, the defense has begun to respond and has met with success. I*n Cuevas v. Contra Costa County,* 11 Cal.App.5th 163, 217 Cal.Rptr.3d 519 (2017), the California Court of Appeal reversed an award of $9.6 million for future medical expenses to permit evidence of market rates and benefits under Medicaid and the Affordable Care Act. And in *Gaddy v. Terex Corp.,* No. 1:14-cv-1928-WSD, 2017 WL 3473872 (N.D. Ga. July 21, 2017), the district court held that opinions on the market rate of medical services do not violate the collateral source rule.

The *Cuevas* and *Gaddy* decisions were the product of a strategy for defending against phantom medical damages that can be applied in other cases. As we explain, the five key pillars for that strategy have been these: the ACA's guaranteed issue requirement, an understanding of the coverage that existed before the ACA, the "reasonable value" limit on damage awards, the requirement that the plaintiff mitigate damages, and an aggressive defense to damages while working up the case.

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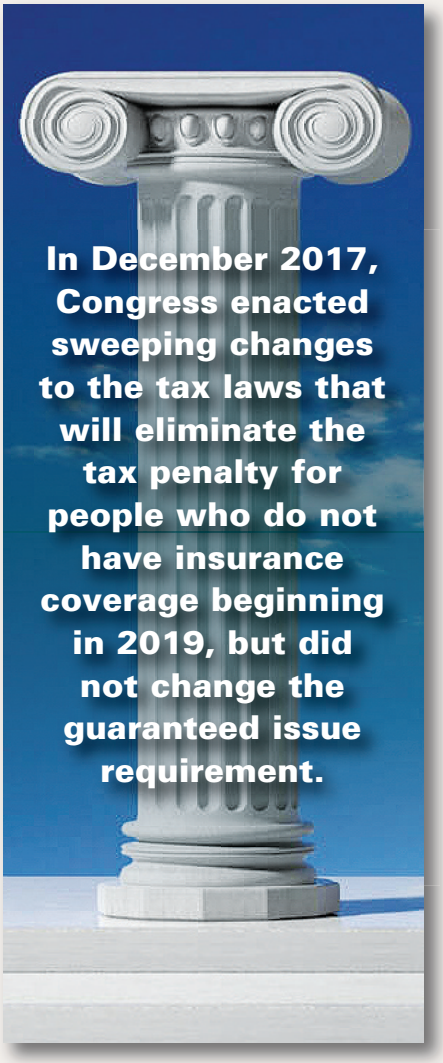
Guaranteed issue requirement

Because the ACA is a political lightning rod, successful arguments have focused on the ACA's key terms rather than the Act itself. A key term is the "guaranteed issue requirement," which bars insurers from denying coverage to individuals with preexisting conditions. *See* 42 U.S.C.A. § 300gg-19(a) to § 300gg-39(a), § 18001. Prior to the ACA, only six states had such laws.

Although there have been many proposals to repeal and replace the ACA, the guaranteed issue requirement remains popular and would be retained by most reforms. For example, both the House's American Health Care Act and the Senate's Better Care Reconciliation Act would have kept this ACA provision. In December 2017, Congress enacted sweeping changes to the tax laws that will eliminate the tax penalty for people who do not have insurance coverage beginning in 2019, but did not change the guaranteed issue requirement.

The guaranteed issue requirement has strengthened the hand of defendants in challenging phantom damages for future medical care, because the provision shows that the plaintiff has the right to obtain future care at market rates.



Coverage that preexisted the ACA

The ACA continued coverage that was available before the Act's passage. Thus, each state was required to select a benchmark plan that would establish the minimum level of coverage to be provided throughout the state. The benchmark plan had to be chosen from among 10 existing plans in each state: the three largest small group plans, the three largest state employee health plans, the three largest federal employee health plans, and the largest commercial HMO plan. 45 C.F.R. § 156.100. Despite these different options, nearly every state adopted as its benchmark its largest small-group plan. As a result, the guaranteed issue requirement creates a right to a baseline level of coverage that was already available before the ACA's passage and that is generally consistent across states in terms of covered items and services.

Reasonable value

To date, the greatest progress in combating phantom medical damages has been under the umbrella of "reasonable value." A growing number of courts have begun to recognize that reasonable value is what is paid in the marketplace, not what a healthcare provider unilaterally lists as a charge. The difference between the two can be dramatic. For example, in *Luttrell v. Island Pacific Supermarkets, Inc.,* 215 Cal.App.4th 196, 155 Cal.Rptr.3d 273 (2013), the amount billed was $690,548, but the amount accepted as full payment was $138,082—a difference of 80%. In *Stayton v. Delaware Health Corp.,* 117 A.3d 521 (Del. 2015), the amount billed was $3,683,797, but the amount accepted as full payment was $262,550—a difference of 93%.

Plaintiffs often assert the collateral source rule to object to evidence of market rates. That common law rule generally prohibits a tortfeasor from attempting to reduce the plaintiff's damages by showing that the plaintiff received some compensation for his or her injuries from a source wholly independent of the tortfeasor.

However, the collateral source rule was never intended to bar evidence of reasonable value. As a result, defendants have been able to overcome these objections by keeping the discussion focused on reasonable value and resisting plaintiffs' efforts to view the issue through the prism of what may or may not constitute a collateral source. For example, when questioning the plaintiff's life care planner during trial, the defense should consider asking about the range of reasonable value and what providers *accept* for payment, rather than what the plaintiff's particular insurance will *pay* for a procedure.

Mitigation of damages

Plaintiffs ordinarily have a duty to mitigate damages by taking reasonable steps to minimize the losses caused by a defendant's actions. Because the guaranteed issue requirement makes health insurance available to everyone regardless of preexisting conditions, that requirement facilitates the plaintiff's duty to mitigate damages. In light of the guaranteed issue requirement, there is no reason why any medical expenses will ever cost more than the negotiated, discounted rates that private health insurers pay healthcare providers.

Furthermore, those operating on the plaintiff's behalf may owe the plaintiff a fiduciary duty to preserve the plaintiff's assets, minimize expenses, and maximize access to care through public and private resources. The plaintiff's representatives may thus have a fiduciary duty to prevent any unnecessary loss of amounts in the life care plan, such as would occur if inflated billed amounts were paid to healthcare providers.

Aggressive defense to damages

An aggressive defense on the issue of damages both before and during trial can be instrumental in preventing excessive medical damages awards. The defense should consider challenges to the plaintiff's life care plan on the grounds of questionable medical necessity, exaggerated frequency of care, overstated life expectancy, and inflated cost estimates that do not reflect the market rates for similar care. But the defense should go beyond just critiquing the plaintiff's life care plan and, in appropriate cases, present its own damages experts.

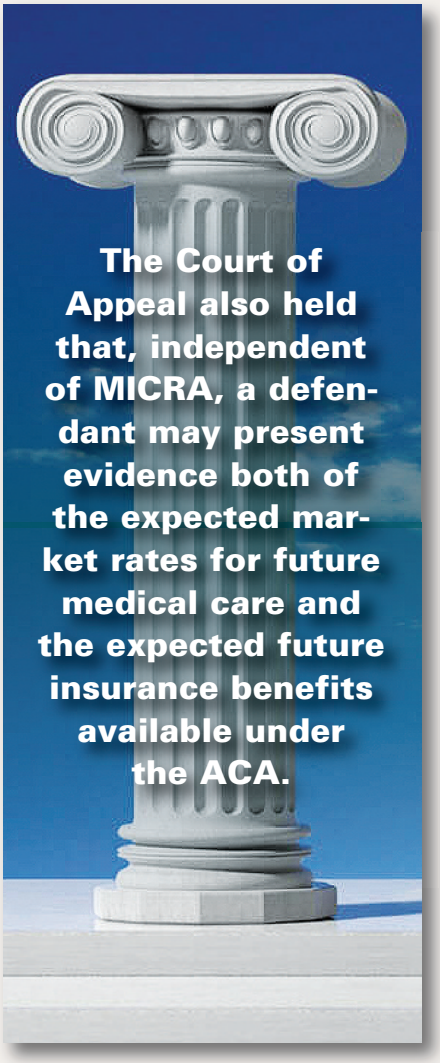
Success in using these strategies: *Cuevas v. Contra Costa County* and *Gaddy v. Terex Corporation*

The Court of Appeal decision in *Cuevas v. Contra Costa County,* 11 Cal.App.5th 163, 217 Cal.Rptr.3d 519 (2017), shows the progress that can be made when these five strategies are used to fight phantom damage awards. In this medical professional liability (MPL) action, plaintiff sued Contra Costa County for injuries he sustained at birth. Plaintiff was 6 years old at the time of trial. Although developmentally delayed, plaintiff could walk, run, feed himself, sleep unattended, and use playground equipment. Plaintiff was covered by Medi-Cal and had incurred $56,000 in medical expenses since birth.

Plaintiff's expert Jan Roughan produced a life care plan claiming nearly $285 million in future care expenses, with a present value of $29 million. The county retained life care planner Linda Olzack, who prepared life care plans showing alternative cost models, including self-pay, insurance, and Medicaid pricing. The County also brought in Thomas Dawson, a healthcare policy expert, to speak on the ACA and healthcare marketplace.

The trial court granted plaintiff's motion to preclude the county's experts on the basis of the collateral source rule. After a lengthy trial, the jury awarded plaintiff nearly $9.6 million as the present cash value of his future medical expenses. The county appealed, arguing that the trial court erred by excluding evidence of collateral source benefits available to plaintiff for his future care, and by excluding evidence of lower rates that plaintiff would pay for his future care under Medicaid or a private insurance policy secured under the ACA.

The Court of Appeal reversed the judgment and remanded for a new trial on the issue of future medical damages. The court held that the California MPL statute (MICRA), which allows defendants to offer evidence of collateral source benefits in MPL actions, applies not just to past medical benefits, but also to future medical benefits. *See* Cal. Civ. Code § 3333.1.



The Court of Appeal also held that, independent of MICRA, a defendant may present evidence both of the expected market rates for future medical care and the expected future insurance benefits available under the ACA. The trial court thus erred by excluding the county's evidence regarding the lower negotiated rates that will be paid for future medical care under Medicaid and under privately negotiated healthcare agreements with insurers under the ACA. The Court of Appeal recognized the ongoing efforts to repeal the ACA, but noted that the ACA nonetheless remains the law of the land.

In *Gaddy v. Terex Corp.,* No. 1:14-cv-1928-WSD, 2017 WL 3473872 (N.D. Ga. July 21, 2017), the district court ruled that the defendant's healthcare economist, Henry Miller, MD, could testify as to the reasonable value of plaintiff's future medical care costs. As a result, the jury was able to hear that the market value of the plaintiff's life care plan was about $2.9 million, rather than the $6.5 million claimed by plaintiff. The court held that Dr. Miller's opinion would assist the trier of fact in determining the reasonableness of the plaintiff's claimed future medical expenses. The court also rejected plaintiff's argument that the testimony would violate the collateral source rule: "[O]pinions of the market rates paid for care by all market payers do not violate the collateral source rule, because they are not offered as evidence of payments by a third party to reduce the defendant's liability for damages—they are instead offered to establish the reasonableness of the amount of damages." *Id.* at *3.

The *Cuevas* and *Gaddy* decisions join a growing body of favorable law on the admissibility of testimony regarding the ACA and the rates paid in the healthcare market. As these cases show, the defense should stay the course. We have seen that a consistent defense strategy can produce good results. Moreover, what happens in Congress regarding the ACA should not change the importance of focusing on these five strategies to defeat phantom damages. PIAA

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