ALAN CHARLES DELL'ARIO

1561 Third Street, Suite B
Napa, California 94559
(707) 666-5351

ATTORNEY AT LAW
CERTIFIED SPECIALIST, APPELLATE LAW
STATE BAR OF CALIFORNIA, BOARD OF LEGAL SPECIALIZATION
AND AMERICAN INSTITUTE OF APPELLATE PRACTICE
www.dellario.org - charles@dellario.org

June 22, 2017

Honorable Tani Cantil-Sakauye,
Chief Justice and Associate Justices
Supreme Court of California
350 McAllister St.
San Francisco, CA 94104

Cuevas v. Contra Costa County, A143440
Request to Depublish - CRC 8.1125

Honorable Justices:

On behalf of Brian Cuevas, his family and the Consumer Attorneys of California, counsel requests the Court order depublished the opinion in *Cuevas v. Contra Costa County* (2017) 11 Cal.App.5th 163.

Interest of Brian Cuevas and his family

Nine-year-old Brian Cuevas suffered irreversible brain injury when Dr. Teresa Madrigal, an employee of Contra Costa County, negligently managed his mother's pregnancy. His twin brother, Brandon, died *in utero*. A jury awarded Brian $55,782 past medical damages, $250,000 non-economic damages (as limited by Civil Code section 3333.2), $2,000,000 future wage loss and $9,577,000 future medical damages. (3 AA 781-782.) On appeal, the County only contested the future medical damages award. The Court of Appeal's opinion affirmed the future wage loss award and reversed the future medical damages award with directions for a new trial limited to that issue. The opinion does not address the non-economic damages or the past medical damages. The appellate court denied Brian's petition for rehearing in which he requested that it direct the uncontested future wage loss, non-economic damages and past medical damages immediately payable. The County's insurer, despite acknowledging these sums are due, has refused to pay them.

Unable to withstand the delay and uncertainty that review by this Court would entail, Brian and his family have elected not to file a petition for review but to proceed to retrial instead. Although depublication will not affect the future course of Brian's litigation, he and his family request the Court to depublish because the opinion reaches an incorrect conclusion based on the legislative history of section 3333.1, raises more questions than it answers and relies on a state of facts not supported by the record.

Interest of CAOC as Amicus Curiae

Founded in 1962, CAOC is a voluntary non-profit membership organization representing over 6,000 consumer attorneys practicing in California. Its members predominantly represent individuals subjected to consumer fraud, unlawful employment practices, personal injuries and insurance bad faith. CAOC has taken a leading role in advancing and protecting the rights of consumers, employees and injured victims in both the courts and the Legislature. CAOC joins Brian and his family in their request because the opinion creates an incorrect precedent and confusion in cases involving Civil Code 3333.1 and, more generally, future medical damages.

I. The opinion misconstrues the legislative history leading to an absurd conclusion.

The Medical Injury Compensation Reform Act (MICRA) allows the defendant to "introduce evidence of any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to . . . any health, sickness or income-disability insurance, accident insurance. . . ." (Civ. Code, § 3333.1, subd. (a).) The Court of Appeal held this language permits the introduction of future as well as past collateral source medical benefits. (*Cuevas, supra,* 11 Cal.App.5th at p. 178.) To reach this conclusion, the court first held that "amount payable as a benefit" was ambiguous.[1] Then the court examined

[1] The court relied on dicta in a footnote from *Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, 165 fn. 21, choosing to credit this dicta over the Court's more recent expression regarding the reach of section 3333.1 in *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, 552 ["defendant may introduce evidence of collateral payments and benefits provided to the plaintiff for his or her

prior versions of the bills, "including those that expressly provided that a defendant could introduce evidence of future care that '*will be provided* by a collateral source.'"[2] (*Ibid* [emphasis added].) Although the version the Legislature finally adopted did not include the "will be provided" language, the Court of Appeal concluded "the Legislature did not understand the use of 'paid or contributed' to restrict the term "amount payable" to past collateral source benefits only." (*Ibid.*) Accordingly, said the court, the trial court erred in excluding evidence of potential benefits Brian might receive under the federal Patient Protection and Affordable Care Act. (Pub.L. No. 111-148 (Mar. 23, 2010) (ACA); *Cuevas, supra*, 11 Cal.App.5th at pp. 180-181.)

The court cited no authority for this conclusion. Under the court's analysis, the Legislature took out express language relating to future benefits all the while intending that the Act apply to them. This result directly contradicts the well-settled principle that "[t]he rejection by the Legislature of a specific provision contained in an act as originally introduced is most persuasive to the conclusion that the act should not be construed to include the omitted provision." (Citations.)"(*Beverly v. Anderson* (1999) 76 Cal.App.4th 480, 485-486; accord *Doe v. Saenz* (2006) 140 Cal.App.4th 960, 984.) The court's rationale makes no sense and creates confusion for trial courts and practitioners.

II. The opinion raises more questions than it answers.

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injury"] (*Howell*).

[2] Six versions of the statute prior to that ultimately enacted contained explicit language permitting evidence of future collateral sources as potential sources of payment to the plaintiff.

> The purpose of this section is to eliminate duplicate payment or recovery for the cost of medical care in actions for personal injuries against health care providers or health care institutions when such care has already been *or will be provided* by a collateral source.

(Assm. Bill Nos. 21, 27, 1943, 1997; Sen. Bill No. 597 (1975-1976 2d Ex. Sess.)[emphasis added].)

A. Who determines whether there is "any amount payable" to the plaintiff in the future?

i. Whether or not there is a benefit "payable" is a preliminary fact.

Even if the Court of Appeal is correct that "payable" as used in section 3333.1 includes future payables, the opinion fails to address the critical issue of whether "payability" is an Evidence Code section 403 or section 405 "preliminary fact." This issue will arise in every case where the defense seeks to introduce evidence of benefits "payable."

A "'preliminary fact' means a fact upon the existence or nonexistence of which depends the admissibility or inadmissibility of evidence." (Evid. Code, § 400.) Section 3333.1 does not permit the defense to introduce evidence of any potential insurance but of "any amount payable." The question of whether any amount is "payable" is a preliminary fact which the defendant must establish before any evidence of future insurance benefits is admissible. This "payability" needs to be established to at least the same degree of certainty that the plaintiff must establish his damages–reasonable certainty. (CACI 3903A.)

In civil cases generally, Section 403, subdivision (a) specifies four situations in which the jury makes the ultimate determination of the existence of a preliminary fact.[3] In such a case, the trial court determines under section 402, outside the presence of the jury, whether the proponent can produce "evidence sufficient to sustain a finding of the existence of the

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[3] "(1) The relevance of the proffered evidence depends on the existence of the preliminary fact;

(2) The preliminary fact is the personal knowledge of a witness concerning the subject matter of his testimony;

(3) The preliminary fact is the authenticity of a writing; or

(4) The proffered evidence is of a statement or other conduct of a particular person and the preliminary fact is whether that person made the statement or so conducted himself."

preliminary fact." (*Ibid.*) If so, the jury receives the evidence and the court instructs the jury to disregard it if it finds the proponent has not met its burden regarding the existence of the preliminary fact or if the court ultimately finds the preliminary fact has not been established as a matter of law. (§ 403, subd. (c).)

In situations not covered by section 403, section 405 applies. The trial "court shall determine the existence or nonexistence of the preliminary fact and shall admit or exclude the proffered evidence as required by the rule of law under which the question arises." (Evid. Code, § 405.)

The opinion seemingly treats the question of "payability" as a section-403 preliminary fact even though none of the four statutory criteria for allowing the evidence to go to the jury are present. (11 Cal.App.4th at p. 180 ["Defendant presented evidence sufficient to support the continued viability of the ACA . . ."].) Yet the opinion does not discuss this issue at all in terms of the Evidence Code and offers no guidance on how the issue is to be addressed.

ii. Does MICRA create an exception to the rule that experts may not offer opinions about what the law is?

The Court of Appeal treated the declaration of defense expert Dawson as conclusive[4] on the question of ACA's continued viability and "that plaintiff will be able to acquire comprehensive health insurance notwithstanding his disability." (11 Cal.App. 5th p. 180.) This expands the permissible scope of expert testimony beyond all known boundaries.

The ACA is a statute. Interpreting its provisions is a question of law, not one of expert opinion. (*California Teachers Assn. v. San Diego Community College Dist*. (1981) 28 Cal.3d 692, 699.) The interpretation of the ACA is a legal question for the court.

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[4] At the same time, the Court of Appeal ignored altogether the conflicting opinion of Brian's expert Lawrence Lievense. (Pet. for Rehng, 5/12/17 at 13-14.) Apparently the trial court was required, as a matter of law, to accept one expert's view in derogation of the others. This is not the law.

Likewise, the interpretation of any insurance contract offered for sale under the ACA is a question of law. (*Bank of the West v. Superior Court* (1992) 2 Cal.4th 1254, 1264.) "[T]he meaning of the [insurance] policy is a question of law about which expert opinion testimony is inappropriate."].)[5]

"Each courtroom comes equipped with a 'legal expert' called a judge." (*Summers v. A.L. Gilbert Co.* (1999) 69 Cal.App.4th 1165, 1181.) "[A]n expert may not testify about issues of law or draw legal conclusions." (*Nevarrez v. San Marino Skilled Nursing and Wellness Centre* (2013) 221 Cal.App.4th 102, 122.) Dawson's opinions are legal conclusions without evidentiary value. Yet the Court of Appeal accepted Dawson's opinion as "sufficient evidence of continued viability of the ACA as well as its application to plaintiff's circumstances." (11 Cal.App. 5th at p. 180.) But even if the Dawson's opinion could properly be considered as evidence, the trial court was not required to accept it. (*Sanchez, supra*, 64 Cal.4th at p. 675 ["the jury is free to reject the expert's opinion"].) The Court of Appeal never even acknowledges this fundamental principle.

An expert's declaration is not evidence of what the ACA statutory provisions mean or what policies issued pursuant to the ACA provide. Those are questions of law. Under well-settled principles of statutory and contract interpretation as well as of the scope of expert opinion, the court should not have accorded his declaration such a conclusive effect. The opinion creates an unprecedented exception to these established principles that this Court should not countenance.

B. How does a plaintiff exercise her right to submit evidence of what she has "paid or contributed?"

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[5] The County's failure to proffer an actual policy for which Brian would be eligible that provided coverage for his needs (as opposed to an expert's hearsay recitation of what such a policy might contain) was a failure of proof. (See *People v. Sanchez* (2016) 63 Cal.4th 665, 686 ["What an expert *cannot* do is relate as true case-specific facts asserted in hearsay statements." [court emphasis]](*Sanchez*).)

The opinion also does not discuss the proof issues regarding the plaintiff's statutory right to submit evidence of "any amount which the plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence." (§ 3333.1, subd. (a).) Is the plaintiff supposed to anticipate whatever policy the defense contends will be payable? Or does the plaintiff simply lose the right to show this offset since under current insurance underwriting, plaintiff will not have "paid" anything for future medical insurance at the time of trial?

The defendant retains the burden to present evidence of the existence of the preliminary fact of "payability" to the satisfaction of the trial court before the jury hears the evidence under either section 403 or 405. If section 403 applies, then the plaintiff will necessarily litigate the question with its own coverage experts and cross-examination of the defense experts leading to an entire mini-trial on the issue. If section 405 applies, the entire issue will be determined by the trial court subject to abuse-of-discretion review. And the defense, not the plaintiff, should be required to show how much this insurance will cost. But nothing in the opinion acknowledges these questions, much less answers them.

C. Does the trial court retain the discretion accorded under Evidence Code section 352 to exclude evidence of future benefits where appropriate?

Nothing in Civil Code section 3333.1 vitiates the trial court's discretion to exclude the evidence under section 352. (See *Moore v. Mercer* (2016) 4 Cal.App.5th 424, 441 [probative med-lien evidence properly excluded "because the admission of the evidence would necessitate the trial of innumerable collateral issues"].) Plaintiffs seemingly remain free to argue this issue, too.

Even if the ACA exists in precisely the same form as it did when the case was tried in the summer of 2014, coverages and carriers will have changed. If the ACA no longer exists in the same form or at all, amounts that may have been payable under the 2014 ACA are irrelevant. In other words, what happens in the future is inherently speculative, yet the opinion fails to address the issue prospectively. The opinion seems to address these points by pointing to the uncertainty about benefits and future needs, but does not take

into account the statutory language that limits the defendant's right to introduce evidence of what is "payable." Nothing is "payable" unless it is due or required to be paid.

D. Does the opinion apply to all cases involving future medical damages or just those subject to section 3333.1?

"[T]he language of an opinion must be construed with reference to the facts presented by the case, and the positive authority of a decision is coextensive only with such facts." (*Brown v. Kelly Broadcasting Co.* (1989) 48 Cal.3d 711, 734-735.) Applying this principle, the opinion only constitutes precedent for medical-malpractice cases. But the opinion's language is more sweeping. "[T]he collateral source rule is not violated when a defendant is allowed to offer evidence of the market value of future medical benefits." (11 Cal.App.5th at p. 180.) This statement is unnecessary to the decision because the collateral source rule is not applicable to future medical benefits under the court's interpretation of section 3333.1. Notwithstanding, at least one commentator has already described the opinion as applicable to all future damages. (B. Fagel, Medical malpractice damages after the *Cuevas* case, *Plaintiff* (June 2017) 47.)

Did the Court of Appeal intend to create a sweeping new rule, effectively applying the principles of *Howell* to future medical damages? This Court expressly declined to rule on what evidence might be admissible on the issue of future medical damages. "We express no opinion as to [the billed amount's] relevance or admissibility on other issues, such as noneconomic damages or future medical expenses." (*Howell, supra,* 52 Cal.4th at p. 567.)

The Court of Appeal confirmed that section 3333.1 does not apply to Medi-Cal payments so that a defendant ought not to be permitted to introduce "market value" evidence that reflects Medi-Cal reimbursement levels. (11 Cal.App.5th at p. 181.) And if such evidence is admissible, how does the plaintiff rebut it without dragging the trial into the exact morass that the evidentiary aspect of the collateral source rule precludes? (*Howell, supra*, 52 Cal.4th at p. 552.) Any dispute between the plaintiff and defendant over availability of coverage, or the application of such coverage to a specific future medical need, or the reimbursement rate to the provider would

necessarily involve and violate the evidentiary aspect of the collateral source rule because it would permit "showing the circumstances by which that price was determined, including that it was negotiated and paid by the plaintiff's health insurer." (*Ibid.*) *Howell* expressly left this part of the rule undisturbed. "Evidence that such payments were made in whole or in part by an insurer remains, however, generally inadmissible under the evidentiary aspect of the collateral source rule." (52 Cal.4th at p. 567.)

Moreover, Medi-Cal-generated "market value" is irrelevant under ACA-sponsored private insurance. One cannot have both.[6]

. . .

According to the National Practitioner Databank, California doctors reported 15,078 malpractice payouts in the ten years ending 2016, totaling nearly $2.7 billion.[7] Future medical damages occasioned by malpractice is a big issue. The Court of Appeal's opinion is the first to address the applicability of section 3333.1 to future payable benefits but does so in a way that ignores settled rules of statutory interpretation. The opinion raises far more questions than it answers, creating uncertainty for trial courts, practitioners and litigants. Brian Cuevas, his family, and the Consumer Attorneys of California urge the Court to order the opinion depublished.

Respectfully,

Alan Charles Dell'Ario

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[6] Under 42 C.F.R. §403, subd. (a), the states must provide Medicaid to eligible individuals. 45 C.F.R. § 155.305 subd. (c) provides that Medicaid recipients are not eligible for ACA insurance. Section 155.310, subd. (d)(3) requires the states to notify ACA providers if a covered person becomes Medicaid-eligible. (See also 45 C.F.R. § 155.345 [coordination of Medicaid and ACA benefits].) To the extent Dawson's declaration was to the contrary, it is not substantial evidence.

[7] https://www.npdb.hrsa.gov/resources/npdbstats/npdb Statistics.jsp#ContentTop (as of 6-19-2017).