Measuring the Value of Medical Services in Personal Injury Suits

Wednesday, May 9, 2018

Presented By the IADC Medical Defense and Health Law Committee

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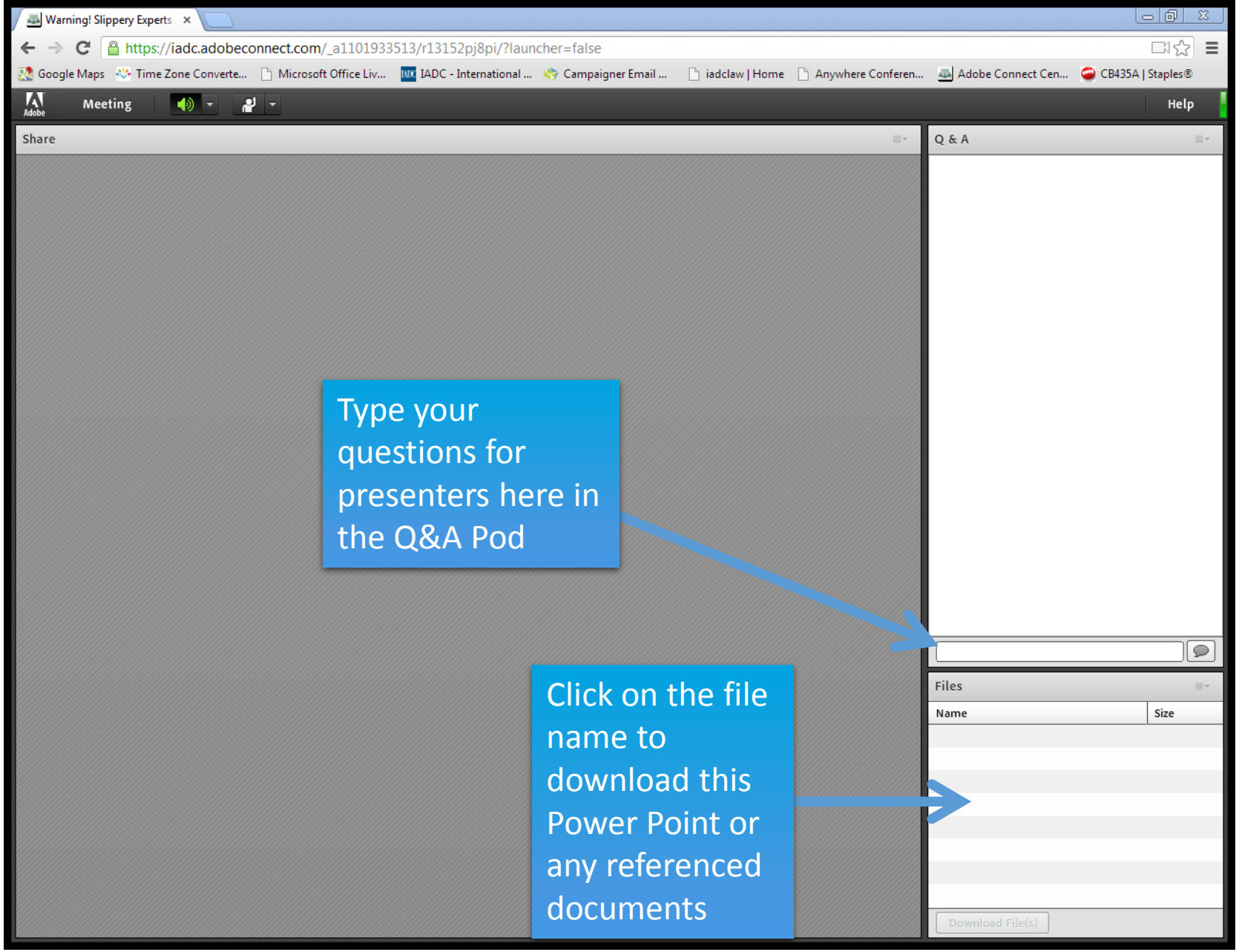
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Today's Presentation

- Landscape is changing for calculating the value of past medical bills and life care plans
- Provider charges are an inappropriate measure of the value of healthcare services
- Establishing market value for healthcare services
- Issues in the measurement of reasonable value

Landscape Is Changing For Measuring The Value Of Past Medical Bills And Life Care Plans

Use of Provider Charges

- Plaintiff attorneys often use billed charges to value medical services, although they likely understand that providers will be paid less than charges
- Life care planners often use billed charges to value future medical costs, and typically rely on the charges of one or a small number of providers
- Provider charges are no longer relevant to determine the value of medical services– virtually no one pays them
- Patients lacking insurance coverage from governmental payers (Medicare and Medicaid) or commercial health insurers no longer pay charges – cash discounts are readily available

"He falls into a pure self-pay category patient without insurance. That automatically means based on the service rendered and since he came through the emergency room and he was admitted, he would automatically get a 75 percent discount." – Billing manager at major hospital

Landscape is Changing

- Market value, rather than charges, was recognized as the standard in California in cases between health insurers and providers:
  - *Children's Hospital of Central California v. Blue Cross of California*
  - *Sanjiv Goel, M.D. v. Regal Medical Group*

- California has also led the way in recognizing that market value is an accepted method to value future medical costs in personal injury cases:
  - *Brian Cuevas v. Contra Costa County*

- Testimony on acceptability of market value for measuring future medical costs in personal injury cases has also occurred in:
  - *Georgia – Jeffrey Gaddy v. Terex Corporation*
  - *New Mexico - United Tort Claimants as Individuals v. Quorum Health Resources, LLC in re: Otero County Hospital Association*

Provider Charges Are An Inappropriate Measure Of The Value Of Healthcare Services

Charges are Unregulated and Lack Transparency

- Provider charges are unregulated
  - Neither the federal nor state governments regulate provider charges
  - Many providers establish charges without regard for prevailing economic principles in the marketplace
  - Charges are often established without regard to underlying cost
- Lack of transparency
  - Some states have charge reporting requirements for hospitals and other providers
  - Provider charges generally not published

"The healthcare market is uniquely difficult to navigate and often people don't know the true costs of services until after they have received them. Complicating the lack of transparency is the wide variety in pricing."– National Business Group on Health

Charges are Often Established Arbitrarily

- Hospitals maintain what is known as a “charge description master” (CDM), or “charge master”
  - Contains thousands of individual items and the charges associated with them
  - Every possible billable item and service provided by a hospital must be included in order for those items to then be billed
- Less than 15% of hospitals ensure that their charge masters are updated according to a specific schedule and reflect current costs and market conditions

“…[i]t has become difficult for many hospitals to explain or rationalize the basis of their charges…which may not relate systematically to costs.” – Medicare Payment Advisory Commission (MedPAC)

Charges Vary Across Providers

- Charges for the same service vary dramatically, even within the same specialty and same geography
  - Use of charges from a single provider or a small number of providers to establish value could result in estimates that are too high or too low
- Agency for Healthcare Research and Quality (AHRQ) found substantial variation in mean inpatient charges per stay across census divisions in 2013
  - Inpatient charges varied from 37% above the national average in the Pacific census division to 27% below the national average in New England

2016 Charges for Lumbar Fusion Surgery at 2 New York City Hospitals:

NYU Langone Medical Center	***$216,526***
The Mount Sinai Hospital	***$ 82,705***

Charges are Rarely Paid

- Payers and providers negotiate rates, often without regard for the billed charges
  - US Government Accountability Office (GAO) acknowledges that this practice is widespread
- Payers also establish their own fee schedules or payment approaches that ignore providers' billed charges
  - Medicare is required by statute to pay rates that compensate providers for the reasonable value of services provided
  - Medicaid rate setting is similar to Medicare except that states, rather than the federal government, establish the payment rates
  - Commercial health plans typically establish their own fee schedules and rates

SSA 1814(b) The amount paid to any provider of services …with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1813, 1886 and 1895 be:

(1) except as provided in paragraph (3), the lesser of (A) the reasonable cost of such services, …or (B) the customary charges with respect to such services;

Payments are Well Below Charges

- US hospital payments as percentage of charges (on average):[1]
  - Medicare: 26.7% of billed charges
  - Medicaid: 27.2% of billed charges
  - Commercial: 43.4% of billed charges
- Analysis of physician charges and payments indicates that Medicare pays 61.4% of the average physician charge for a routine office visit[2]

[1] American Hospital Association, Trendwatch Chartbook 2016, Supplementary Data Tables, Trends in Hospital Financing, Table 4.4.
[2] Optum 360, National Fee Analyzer, 2016.

Market Value of Medical Products And Services

“Willing Buyer/Seller” Concept

- “Market value” is defined as “the price at which a buyer is ready and willing to buy and a seller is ready and willing to sell”
  - Most often applied to consumer purchases
  - Also forms underpinnings of contract negotiations between health insurance companies and healthcare providers
- Concept supported in the opinion of the Court of Appeals of California in *Children’s Hospital Central California v. Blue Cross of California*

“The scope of the rates accepted by or paid to Hospital by other payors indicates the value of the services in the marketplace. From that evidence, along with evidence of any other factors that are relevant to the situation, the trier of fact can determine the reasonable value of the particular services that were provided, i.e., the price that a willing buyer will pay and a willing seller will accept in an arm’s length transaction.” -- Court of Appeals, State of California, Fifth Appellate District, No. F065603

Data Used to Determine Market Value

- Provider costs
  - Medicare pays for the reasonable costs of an efficient hospital
  - MedPAC found that Medicare reimbursement rates to physicians adequately covers their costs
- Medicare rates
  - Medicare is the largest single payer for healthcare services
  - Rates paid by Medicare are often used as a starting point to calculate rates paid by others
- Medicare data are available by hospital and locality
- Private sector rates
  - Physicians: 128% of Medicare rate on average
  - Hospitals: 162% of Medicare on average

Uninsured and Fair Pricing Laws

- Uninsured individuals are often able to negotiate rates with providers that are equivalent to Medicare or Medicaid, i.e., to cover provider costs
- 10 states have fair pricing laws
  - California passed Fair Pricing Act in 2006: maximum price that hospitals can charge uninsured patients cannot exceed the amount that the hospital would receive from any government-sponsored program such as Medicare or Medicaid
  - 9 other states, including New York, Illinois, and Colorado, also have fair pricing laws

Other Products and Services

- Other methods are used to calculate the reasonable value of other healthcare products and services:
  - Drugs:
    - Use of generics
    - Retail costs are readily available
  - Durable Medical Equipment:
    - Retail costs are readily available
    - Issue arises when life care planner identifies specific product
  - Home/Attendant Care:
    - Agency rates vs. direct hire rates
    - Direct hire rate must include payroll taxes and case manager costs
    - Use of Bureau of Labor Statistics data for specific geographic areas

Issues In the Measurement of Reasonable Value

Issues In the Measurement of Reasonable Value

- Does the use of Medicare data imply involvement of a collateral source?
- Does the use of market value based on insurer payments apply to uninsured patients as well?
- Can market value amounts be guaranteed?
- Does use of market value assure a plaintiff that he/she can use providers of their own choosing?
- How accurate is the determination of 128 percent of Medicare for professional costs?
- Is this just an exercise in trying to reduce the value of past or future medical bills?

Questions for Presenters?

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