DETERMINING THE REASONABLE VALUE OF PAST AND FUTURE MEDICAL EXPENSES:

NEW APPROACHES FOR DETERMINING ECONOMIC DAMAGES FOR TORT CASES

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As of 2024, 170 years after the U.S. Supreme Court decision *The Propeller Monticello v. Mollison*[1] ushered in the common law collateral source rule (CSR), state and federal courts continue to confront the challenge of assessing economic (special) damages in personal injury and medical malpractice cases. As discussed in Black's Law Dictionary, 10th edition,[2] the CSR is a doctrine that states if an injured party received compensation for the injuries from a source independent of the tortfeasor, the payment should not be deducted from the damages that the tortfeasor must pay.

The CSR has been the subject of legal debate for decades and is at the heart of a legal question that continues to be debated; namely, should billed charges, amounts paid by a health insurer or some other amount be used to establish economic damages? The law in Alabama regarding recovery of economic damages pertaining to medical expenses in tort cases, like many other states, is murky. This paper discusses new approaches for considering and measuring the reasonable value of medical care that may aid Alabama defense lawyers in litigation and improve the odds of achieving reasonable and fair damage awards. Importantly, the approaches discussed here do not violate the common law CSR.

Problems with Using Billed Charges to Determine Reasonable Value

Over the past 30 years, there has been a sustained increase in hospital and physician charges. Today hospital charges for ancillary services such as operating room, anesthesia, diagnostic radiology, MRI, and pharmacy can run from 5 to 20 times more than the actual cost of providing the service. In other words, it is common for hospitals to markup their ancillary service charges over operating costs by as much as 400% to 1,900%! In one recent Colorado case on which Wickizer consulted, the hospital treating the plaintiff had annual charges for anesthesia services that were 170 times greater than the costs of providing the services. In other words, the hospital marked up anesthesia charges 16,900% over costs!

Excessive hospital charges have garnered the attention of legal scholars. In her detailed commentary on hospital pricing, Erin Fuse Brown, Associate Professor of Law and Director, Center for Law Health and Society at Georgia State University, stated, "Hospital prices [charges] are almost completely irrational. They bear no relationship to the cost of providing the services, they are opaque, and the prices vary widely among hospitals and payers."[3]

More recently, George Nation, Professor of Law and Business at Lehigh University, provided thoughtful discussion in law review articles[4] pointing out the many serious problems with using billed hospital charges to establish the reasonable value of medical care. In his recent Tulane Law Review article, Nation stated:[5]

Chargemaster-based prices [billed charges] are so high because they are set unilaterally by hospitals to be discounted in negotiations with commercial insurers. Chargemaster prices are simply made up by the provider primarily for the purpose of gaining leverage in negotiations with commercial insurers, but as a price—that is, an amount agreed upon between a willing buyer and seller—chargemaster prices are completely fictitious.

Fifty years ago, prior to the development of contemporary health insurance and payment systems, billed charges more closely approximated paid amounts, and CSR issues remained largely in the background of tort law. But over the past 50 years, the health care industry has undergone profound changes. Today billed charges are an artifact of complex financial arrangements negotiated between providers of medical care and the organizations that pay for that care. As discussed in two recent papers we prepared for the ***Journal of Legal Economics***,[6,7] hospital billed charges bear

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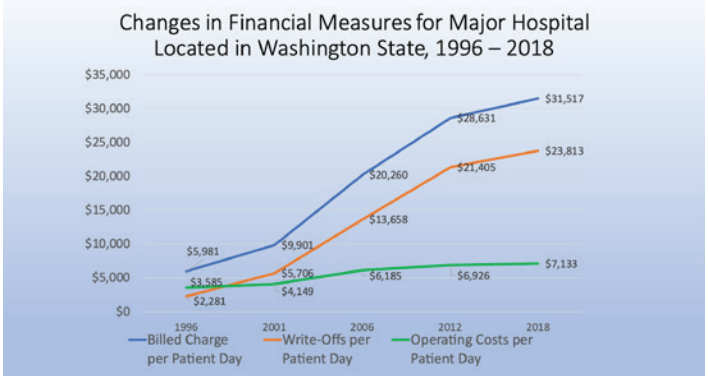
little relationship to the reasonable value of medical care. Hospitals do not expect to be paid full billed charges and, in fact, now accept, on average, as payment in full about 25% to 30% of their billed charges.[8,9]

The figure below shows trends in financial measures occurring in many hospitals. The figure represents a major community hospital located in the Puget Sound region of Washington State. It includes three measures: billed charges, write-offs (contractual allowances and patient discounts) and operating costs, calculated on a per-patient-day basis to control for changes in utilization over time. As shown, in 1996 there was little difference in billed charges, write-offs or operating costs. By 2018, billed charges were 4.4 times greater than operating costs. But hospitals do not capture that revenue because most of it is written off in the form of contractual allowances and discounts as shown in the figure. Billed charges for hospital services that are more than four time greater than corresponding operating costs do not represent the reasonable value of medical care.



In 1996 billed charges were 1.67 times operating costs. By 2018 billed charges were 4.4 times operating costs. From 1996 to 2018 operating costs increased by 99%, billed charges increased by 427%.

Approaches to Estimating the Reasonable Value of Past Medical Expenses

New thinking and empirical approaches are needed to assess the reasonable value of medical expenses that may be recoverable as economic damages in tort cases. In his 2022 ***Journal of Legal Economics*** paper, Wickizer put forth the following principle to advance thinking about how to establish economic damages in tort cases: ***In the absence of a competitive market price for medical care the reasonable value of treatment should have some relationship or direct link to the underlying value of resources used to provide that treatment.*** Consistent with this principle, Wickizer developed approaches for measuring the reasonable value of past medical expenses for hospitals and physicians.

Measuring Past Medical Expenses for Hospital Care

Since 1996 every Medicare-certified hospital in the U.S. has been required to prepare an annual Medicare Cost Report. Cost Reports have been widely used by researchers and analysts to determine the value of medical care provided by hospitals and to examine different financial performance measures.[10,11] They are publicly available from the Centers for Medicare and Medicaid Services via the Healthcare Cost Report Information System (HCRIS) or can be purchased online for a modest fee (www.costreportdata.com). Cost Reports contain detailed data on facility characteristics, utilization, costs and charges by cost center, and financial statement information for ***all patients*** receiving hospital inpatient or outpatient treatment during a given fiscal year. The reported operating expenses (costs) are inclusive and take account of all indirect (overhead) expenses and capital depreciation. Cost Reports are required to follow strict accounting procedures and are subject to audit.

Cost Reports include cost-to-charge ratios (CCRs) found on Worksheet C. CCRs are shown for almost all major medical services provided by the hospital. Applying CCRs to billed charges through standard Excel Spreadsheet analysis allows an analyst to estimate the actual cost of providing a plaintiff's medical care. That cost estimate is the best, practical measure of the reasonable value of medical care because it represents the value of resources used to provide treatment. Other financial measures, such as the billed charge markup and billed charge ratio, can easily be calculated to provide useful information supporting the argument that hospital billed charges are excessive and should not be used to assess economic damages that may be recoverable.

Measuring Past Medical Expenses for Physician Care

Prior to 1992 physician services were paid by Medicare based on customary, prevailing, and reasonable (CPR) charges, also known as usual, customary and reasonable (UCR) charges. That payment method proved to be highly inflationary and led to distorted payments that favored specialists performing procedures and penalized primary care physicians performing evaluation and management services. In response to problems resulting from the charge-based CPR payment system, the federal government initiated a major research and development program under the direction of a research team at Harvard University to create a new resource-based, physician payment system.[12]

The work of the Harvard team resulted in the development of the Resource-Based Relative Value Scale (RBRVS), which measures the ***relative value*** of resources used to provide physician medical services. The RBRVS generated a relative value unit (RVU) for each of three main resource inputs required to produce physician services: (1) work of the physician, (2) practice expenses, and (3) professional liability insurance. The RVUs for the three inputs are summed to produce a total RVU for each medical service. On January 1, 1992, Medicare implemented the new physician payment system based on the RBRVS.

RVUs are adjusted for local practice cost differences, summed, and then multiplied by a conversion factor to create the payment rate. The RBRVS payment system has several advantages. Most important, its foundation is based on the ***valuation of resources*** needed to provide medical services. A service with 6.00 RVUs indicates the resources needed to deliver that service are 3 times greater than those needed for a service with 2.00 RVUs. RVU values for each medical service included in the Medicare Physician Payment System can easily be obtained by querying the Medicare Physician Payment System.

RVUs are multiplied by a conversion factor (CF) to obtain the payment rate for medical services provided by physicians and other clinicians. Because of Congressional mandates requiring budget neutrality for physician payments, Medicare has kept the CF artificially low at approximately $35.00. That limitation, however, is easily overcome by using a higher CF. Wickizer has used the Medical Care Price Index (MCPI) to adjust the CF upwards to approximately $75 to account for medical cost inflation not incorporated in the Medicare Physician Payment System.

Estimating the Reasonable Value of Future Medical Expenses

In our forthcoming ***Journal of Legal Economics*** paper,[13] we discussed

issues and problems related to estimating the reasonable value of future medical expenses, which often represent claims substantially greater than amounts claimed for past medical expenses. Space limitations here allow for only a brief discussion of valuing future medical expenses. Claims for economic damages related to future medical expenses are based on life care plans (LCP) prepared by vocational experts, rehabilitation experts, physicians and other clinicians, or certified life care planners. Claims for future medical expenses, like past medical expenses, must be based on the ***reasonable value*** of medical care. LCPs share many of the same problems as claims for past medical expenses because they are based on the implicit–and unjustified–assumption that full billed charges will be required to ensure a plaintiff will have adequate access to future medical care that may be needed. The assumption that full billed charges will be needed to ensure access to future medical care does not comport with the facts. It is known, as the authors have documented,[14] the great majority of hospitals and physicians, in fact, accept Medicare base payment rates, which typically represent 20% to 35% of billed charges. And many hospitals offer discounts up to 60% off the billed charge for payments made on a cash basis.[15]

Further problems often arise with the preparation of LCPs. One such problem is the failure of LCPs to account for a plaintiff's health status in determining his or her expected work life or life expectancy. Plaintiff life care planners typically use data from the Social Security Administration or the Bureau of Labor Statistics to estimate expected work life or life expectancy. But such data are based on an "average healthy person," not a person that may have sustained a serious injury and have medical comorbidities. The result may be overstated estimates of work life or life expectancy, thus inflating projections of future medical expenses. Data from ongoing surveys, such as the University of Michigan Health and Retirement Survey, are available and can be used to develop valid estimates of expected work life and life expectancy.

Conclusion

Determining the reasonable value of medical care for the purpose of establishing fair claims for economic (special) damages that may be recoverable continues to pose challenges for the legal system. We believe the use of billed charges alone to establish claims for past and future medical expenses is invalid and inconsistent with the widely accepted, legal concept of reasonable value. Alternative approaches for estimating economic damages are available and should be used. It is time for new thinking and use of new approaches to assess economic damages for past and future medical expenses to ensure damage awards are fair and consistent with the concept of reasonable value.

Endnotes

1 ***The Propeller Monticello v. Mollison***, 58 U.S. (17 How.) 152.
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4 George Nation, ***Hospitals Use the Pernicious Chargemaster Pricing System to Take Advantage of Accident Victims: Stopping Abusive Hospital Billing***. 66 DRAKE L.R., 645-672 (2018).
5 George Nation, ***The Valuation of Medical Expense Damages in Tort: Debunking the Myth That Chargemaster-Based "Billed Charges" Are Relevant to Determining the Reasonable Value of Medical Care***. 95 Tulane L.R., 938-990 (2021).
6 Thomas Wickizer, ***Determining the Reasonable Value of Medical Care in Personal Injury Cases and Medical Malpractice: A New Cost-Based Model***. 28 J. LEG. ECON. 29-51 (2022).
7 Thomas Wickizer & Daniel Thompson, ***Measuring Past and Future Medical Expenses in Personal Injury and Medical Malpractice Cases: Time for a Course Correction***. 30 J. LEG. ECON (forthcoming).
8 ***Id.***
9 Uwe Reinhardt, ***The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy***. 25 HEALTH AFF. 57-69 (2006).
10 Jared Maeda, et al., ***What Hospital Inpatient Services Contributed Most to the 2001- 2006 Growth in Cost Per Case***? 47 HEALTH SERV RES 1814-1835 (2012).
11 Gregory Runke, et al., ***Trends in Mortality and Medical Spending in Patients Hospitalized for Community-Acquired Pneumonia: 1993-2005***. 48 MED CARE 1111-1116 (2010).
12 William Hsiao, et al., ***An Overview of the Development and Refinement of the Resource-Based Relative Value Scale***. 30 MED CARE NS1-NS12 (1992).
13 Thomas Wickizer & Daniel Thompson, ***supra*** note 7.
14 ***Id.***
15 ***Id.***

Dr. Thomas Wickizer *is a Professor Emeritus and Academy Professor in the College of Public Health at The Ohio State University in Columbus, Ohio. Formerly, he was the College's Stephen F. Loebs Distinguished Professor of Health Services Management and Policy and chair of the Division of Health Services Management and Policy. He joined the faculty at Ohio State University College of Public Health in October 2009 after serving on the faculty at the University of Washington School of Public Health for 20 years. Wickizer has authored or co-authored over 135 peer-reviewed papers.*
Wickizer's legal work has focused on establishing the reasonable value of past and future medical expenses for the purpose of assessing potentially recoverable economic damages in personal injury and medical malpractice cases. He has served as a legal consultant or expert witness for over 80 cases in Washington State, Oregon, Illinois, Utah, Idaho, and California. Wickizer's legal work has also included scholarship that has contributed to the field of forensic economics. His paper titled "Determining the Reasonable Value of Medical Care in Personal Injury Cases and Medical Malpractice: A New Cost-Based Model," published in the Journal of Legal Economics (2022), presents a new method of assessing past hospital expenses potentially recoverable as economic damages in tort cases. His more recent paper (forthcoming), also published in the Journal of Legal Economics, examines issues and methods related to assessing past and future medical expenses.

Creating and building DeeGee Rehabilitation has been a challenging endeavour for ***Dan Thompson****. As his practice has grown, he has gathered a team of Research Assistants and Rehabilitation Experts who assist him on specific cases and projects. Through all the years, his work has been fulfilling and has offered the opportunity to make a difference and be a source of life-affirming support for others. As a quadriplegic himself, he intimately understands the problem solving necessary to succeed despite having a disability. As a Life Care Planner and Rehabilitation Expert, he has the knowledge and capability to assess the depth and breadth of the needs for injured individuals. His extensive experience working within the litigation arena for over 12 years, as well as dealing with his own injury for over 30 years, has given him the skills, intelligence and discernment to offer an unbiased and truthful assessment with regard to damages. His extensive experience working within the litigation arena for over 12 years, as well as dealing with his own injury for over 30 years, has given him the skills, intelligence and discernment to offer an unbiased and truthful assessment with regard to damages.*