MEASURING THE VALUE OF MEDICAL SERVICES IN PERSONAL INJURY SUITS

AUGUST 2017

PREPARED BY:

Henry Miller, Greg Russo, and JoAnna Younts

Copyright ©2017 by Berkeley Research Group, LLC. Except as may be expressly provided elsewhere in this publication, permission is hereby granted to produce and distribute copies of individual works from this publication for non-profit educational purposes, provided that the author, source, and copyright notice are included on each copy. This permission is in addition to rights of reproduction granted under Sections 107, 108, and other provisions of the U.S. Copyright Act and its amendments.

Disclaimer: The opinions expressed in this publication are those of the individual authors and do not represent the opinions of BRG or its other employees and affiliates. The information provided in the publication is not intended to and does not render legal, accounting, tax, or other professional advice or services, and no client relationship is established with BRG by making any information available in this publication, or from you transmitting an email or other message to us. None of the information contained herein should be used as a substitute for consultation with competent advisors.

BRG
Berkeley Research Group

Overview

Personal injury suits typically include costs for a plaintiff's future medical bills. In most cases, plaintiffs' attorneys use life care planners to estimate their clients' future medical costs. Life care planners often use the billed charges of one healthcare provider or a small number of providers as the basis for calculating the value of the services they determine the plaintiff needs. However, provider charges are not an appropriate measure of the value of healthcare services. In fact, less than 5 percent of national healthcare payments are made based on provider charges.[1] Instead, the US healthcare system uses the ***market value*** of healthcare products and services to establish payment levels. Market value should be used in personal injury cases as well.

This white paper describes reasons why provider-billed charges may be an inappropriate measure of the value of medical products and services, and how the market value of these services should be measured and applied in personal injury cases.

Provider Charges Are an Inappropriate Measure of the Value of Medical Products and Services

Provider charges are an inappropriate measure for several reasons. First, because their charges are unregulated,[2] providers can establish charges arbitrarily. Many providers establish charge levels without regard for economic marketplace principles[3] and often without considering the actual costs of products and services. Hospitals maintain what is known as a "charge description master" (CDM), or "charge master," which 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 the charge master in order for those items to then be billed. A team of hospital staff, which includes representatives from the finance and clinical departments, is typically responsible for reviewing and updating the charge master.

Provider charges are not an appropriate measure of the value of healthcare services.

However, a study conducted by the Lewin Group for the Medicare Payment Advisory Commission (MedPAC) found that less than 15 percent of hospitals ensure that their charge masters are updated according to a specific schedule and reflect current costs and market conditions.[4] The study's authors note that "[h]ospital charges have been set over several decades, long before facilities had a good sense of the costs of providing services." Further, "[w]ith inflationary increases over time being applied to thousands of [codes] and with varied methods applied to charge setting over time, it has become difficult for many hospitals to explain or rationalize the basis of their charges…which may not relate systematically to costs."

Although the Affordable Care Act requires that hospitals make charges public, and many states also have charge reporting requirements, neither federal nor state governments regulate charge levels.[5] For example, hospitals and selected other healthcare providers in several states are required to submit their charge data to a state agency, but the states only compile and publish the data; they do not regulate rates.[6] It is not unusual for a hospital to have wide variation in its charges relative to costs. A hospital may, for example, establish a price for a drug that is twenty times its cost, while charging for routine nursing care at a rate that is only twice its cost.[7]

1 George A. Nation III, "Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients" (June 10, 2013), p. 456, available at: http://www.baylor.edu/content/services/document.php/206145.pdf

2 The only exception is hospital charges in Maryland, which are regulated by the Maryland Health Services Cost Review Commission.

3 Uwe Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs* 25(1) (January 2006), 57–69, available at: http://content.healthaffairs.org/content/25/1/57.full

4 A. Dobson, Joan DaVanzo, Julia Doherty, and Myra Tanamor, "A Study of Hospital Charge Setting Practices," The Lewin Group, prepared for Medicare Payment Advisory Commission (December 2005).

5 PPACA, § 1001, 124 Stat. 119, 130-8, amended by § 10101(f), 124 Stat. 119, 885-7 (codified at 42 U.S.C. § 300gg-18). Maryland is the only exception; the state's Health Services Cost Review Commission sets hospital charges.

6 National Conference of State Legislatures, "Transparency and Disclosure of Health Costs and Provider Payments: State Actions" (updated March 2017), available at: http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx

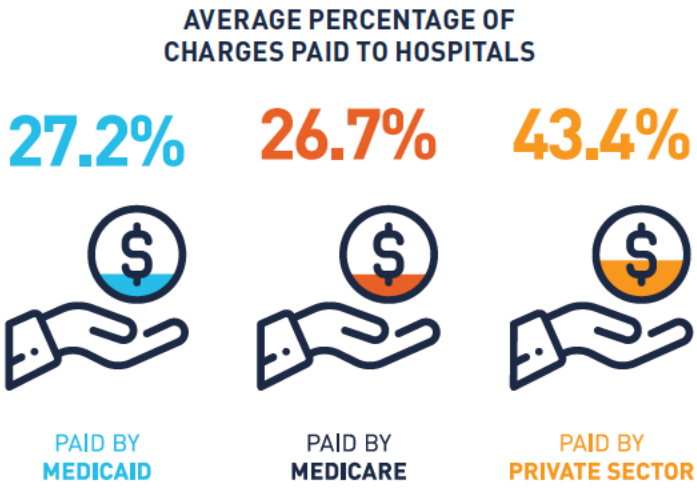
7 Florida Hospital Government & Public Affairs, "Variation in Hospital Costs and Charges," Health Issues Brief (June 2013), available at: https://www.floridahospital.com/sites/default/files/medicare_costs_hib_june_2013.pdf

While organizations such as self-insured employers and advocacy groups have begun to insist on greater transparency of healthcare prices, it is still often difficult for patients to make economic decisions regarding health services, because they frequently do not know in advance what services will be provided during a hospital stay or a physician office visit, nor the fees for these services, until after they receive care. The National Business Group on Health (NBGH), in its statement on transparency, says, "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…"[8]

The second reason why provider charges are an inappropriate measure of value is that they are rarely actually paid.[9] In a study of transparency initiatives, the US General Accountability Office (GAO) acknowledges that provider charges are often not equal to what is paid because of negotiations between payers and providers.[10] Public programs such as Medicare and Medicaid ignore providers' billed charges and establish their own payment rates. The Medicare program is required by statute to pay rates that compensate providers for the reasonable value of services provided.[11] Medicaid programs have similar requirements except that states, rather than the federal government, establish the payment rates. Commercial health plans also typically establish their own fee schedules and rates, or negotiate discounts off of the charge amounts.

Providers also often negotiate discounts for individuals without insurance. Even life care planners acknowledge that providers typically discount their charges. In a 2008 article, Maniha states that "most facilities and physicians apply a discount to 'private pay charges.'"[12]

Data provided by the Institute for Health and Socio-Economic Policy and the American Hospital Association indicate that in 2014, US hospitals were paid 26.7 percent of their billed charges by Medicare, 27.2 percent of their billed charges by Medicaid, and 43.4 percent of their charges by private- sector payers.[13] Although data are not as readily available for professional services, analysis of physician charges and payments indicates that Medicare pays 61.4 percent of the average physician charge for a routine office visit.[14]



The third reason that provider charges are not an appropriate measure of healthcare value is that the charges for the same service vary dramatically, even within the same specialty and same geography. Thus, the 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. The federal 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 percent above the national average in the Pacific census division

8 NBGH, "Policy: Transparency" (no date), available at: https://www.businessgrouphealth.org/policy/health-accounts-and-account-based-plans/transparency/

9 Reinhardt (2006); Florida Hospital Government & Public Affairs (2013).

10 GAO, *Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care* (September 2011).

11 MedPAC, *Physician and Other Health Professional Payment System* (revised October 2016), available at: http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_physician_final.pdf?sfvrsn=0

12 Ann Maniha, "Research to Another Level: Medical Coding and the Life Care Planning Process: Part I," *Journal of Life Care Planning* 7(2) (2008), 61–72 at 63.

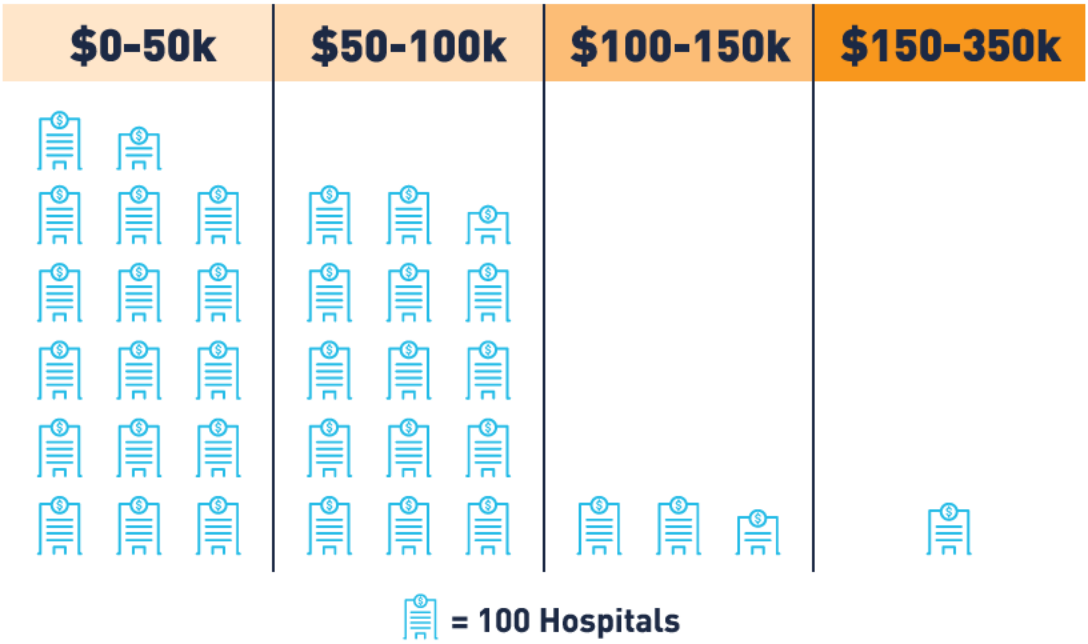
13 Institute for Health and Socio-Economic Policy and American Hospital Association, Hospital Price Gouging Driving Up Healthcare Costs (May 15, 2013); and American Hospital Association, ***Trendwatch Chartbook 2016***, Table 4.4, "Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare and Medicaid, 1996 – 2014" (2016).

14 Optum 360, *National Fee Analyzer* (2016), pp. 498 and 230.

to 27 percent below the national average in New England.[15] Even within a small geographic area, such as a county or city, there is often substantial variation across individual providers, as illustrated in the following example:

> Charges for a common inpatient procedure (major joint replacement) were investigated for a set of similar hospitals in Los Angeles, California. Charges for this procedure in 2015 varied from $69,280.00 in one hospital to $179,913.00 in a second nearby hospital, a difference of 159.7 percent.[16]

AVERAGE INPATIENT CHARGES FOR DRG 470 – MAJOR JOINT REPLACEMENT, BY HOSPITAL



Medicare Standard Analytic File, 2015.

Charges among other provider types also vary substantially. In a research letter published in the *Journal of the American Medical Association* (JAMA), researchers identified variation between Medicare reimbursement and provider charges among physicians using an "excess charges ratio" (i.e., the ratio of the physician's billed charges to the Medicare reimbursement amount). They found that the median excess charge was 2.5 times the Medicare amount and was as high as 101 times the Medicare rate across all physicians studied. There was substantial variation across specialties, with anesthesiologists, radiologists, emergency physicians, neurosurgeons, and pathologists having the highest excess charge ratios; allergy and immunology specialists, psychiatrists, family practice doctors, and dermatologists had the lowest excess charge ratios.[17]

This variation in charges across providers, as well as the reasons described above, makes it clear that it is inappropriate to use the charges from a single provider or a small number of providers to establish the value of healthcare services.

15 Z. Karaca and B. Moore, "Geographic Variation in Hospital Inpatient List Prices in the United States, 2013," Statistical Brief #209, Agency for Healthcare Research and Quality (August 2016).

16 American Hospital Directory. Available at www.ahd.com.

17 G. Bai and G. Anderson, "Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region," *Journal of the American Medical Association* (January 17, 2017).

Market Value of Medical Products and Services Is the Appropriate Measure of the Value of Medical Goods and Services

If provider-billed charges are inappropriate, it is necessary to turn to other measures. Underlying these measures is the premise that the value of healthcare services is the amount that willing buyers pay and willing sellers accept. The willing buyer/willing seller concept is rooted in neoclassical economics and is a key part of US tax law.[18] It can also be found in legal decisions on the value of healthcare services.[19]

The concept of "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."

The concept of "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."[20] Although most often applied to consumer purchases such as real estate, automobiles, and other products and services, the concept of willing buyer and seller also forms the underpinnings of contract negotiations between health insurance companies and healthcare providers. As described previously, although providers may establish a roster of charges for specific items and services, such as a hospital charge master, these charges are often either not considered or heavily discounted in contractual agreements between payers and providers. Indeed, what is listed in the chargemaster is not what patients and payers will actually pay.[21]

The Internal Revenue Service (IRS) addresses the issue of willing buyer/willing seller in Treasury Regulation §1.170A-1(c)(2) regarding fair market value: "The price at which the property would change hands between a willing buyer and a willing seller, when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge of the relevant facts." Although the regulation is most often applied in determining the tax obligation of buyers and sellers in business appraisal transactions, the concept can also be applied to the purchase of services, including healthcare services; services are simply substituted for property.[22] The concept was supported in the opinion of the Court of Appeals of California in *Children's Hospital Central California v. Blue Cross of California*.[23] At issue was the reasonable value of post-stabilization emergency medical services provided by the hospital to California Medicaid[24] patients enrolled in Blue Cross's Medi-Cal managed care plan. While the trial court had determined that the value of the medical services should be established based on the hospital's full billed charges, the appeals court disagreed, citing the argument that the price agreed upon by a willing buyer and willing seller should be the basis for the value of the services:

> Accordingly, although Hospital's full billed charges were relevant to the issue of the reasonable and customary value of the services, they were not determinative. Analogizing this situation to other quantum meruit cases, relevant evidence would include the full range of fees that Hospital both charges and accepts as payment for similar services. 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

18 See, for example, descriptions of the work of Eugen Bohm-Bawerk in Robert B. Ekelund and Robert F. Hebert, *A History of Economic Theory and Method: Sixth Edition,* Long Grove, IL: Waveland Press (2014), pp. 353–355; and Revenue Ruling 59-60, Internal Revenue Code, Section 2031.

19 This point was emphasized in the appellate opinion for *Children's Hospital Central California v. Blue Cross of California et al.* Court of Appeals, State of California, Fifth Appellate District, No. F065603.

20 Merriam-Webster, legal definition of "market value" (updated July 26, 2017), available at: https://www.merriam-webster.com/dictionary/market%20value

21 C. Pallary, "Deconstructing the enigmatic hospital chargemaster," *Becker's Hospital CFO Report* (September 4, 2015), available at: http://www.beckershospitalreview.com/finance/deconstructing-the-enigmatic-hospital-chargemaster.html

22 T. Smith and M. Dietrich, *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation* (2012), pp. 140–141.

23 *Children's Hospital Central California v. Blue Cross of California et al.*, Court of Appeals, State of California, Fifth Appellate District, No. F065603.

24 The California Medicaid program is called "Medi-Cal."

> 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.[25]

Thus, if the basis for determining the value of healthcare services is willing buyers and sellers, then the data used to establish value should be the prices agreed upon by these willing buyers and sellers. These "market values" are often calculated using Medicare payment rates as a benchmark. Because Medicare is the largest payer for healthcare services, and because Medicare rates are designed to cover provider costs, rates paid by Medicare are often used as a starting point to calculate rates paid by others.

In its 2017 Report to the Congress, MedPAC found that Medicare physician payments averaged 78 percent of commercial payments; conversely, commercial/private-sector fees are paid at a rate equal to 128 percent of the Medicare rate on average.[26] Private-sector hospital rates are also often established based on a percentage of the Medicare rate. According to the American Hospital Association, commercial plan hospital reimbursement in 2014 averaged 162 percent of Medicare rates.[27]

As described previously, the Medicare program is required by statute to reimburse providers for the value of services provided.[28] According to the American Hospital Association, the average Medicare payment-to-cost ratio for hospitals in the US in 2014 was 88.5 percent, meaning that hospitals were reimbursed 88.5 percent of their costs by the Medicare program on average.[29] Although similar data are not tracked for physicians, in its 2017 Report to the Congress, MedPAC maintains that Medicare payments are adequate for physicians, meaning that for most providers, Medicare reimbursement covers their costs plus a small profit margin.[30] Individuals without insurance are often able to negotiate a payment that is no greater than the provider's Medicare or Medicaid rate, which generally allows the provider to cover its costs to treat the patient. In 2006, the State of California passed the Fair Pricing Act, in which the 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.[31] Nine other states, including New York, Illinois, and Colorado, also have fair pricing laws.[32] These laws allow uninsured patients to pay what government plans pay rather than provider charges, which, as has been described, are often many multiples of the Medicare or Medicaid rate.

If the basis for determining the value of healthcare services is willing buyers and sellers, then the data used to establish value should be the prices agreed upon by these willing buyers and sellers. These "market values" are often calculated using Medicare payment rates as a benchmark.

25 Id. at 15.

26 MedPAC, Report to the Congress (March 2017), p. 98.

27 American Hospital Association (2016).

28 MedPAC (2016).

29 American Hospital Association (2016).

30 MedPAC (2017), p. 98.

31 G. Melnick and K. Fonkych, "Fair Pricing Law Prompts Most California Hospitals to Adopt Policies to Protect Uninsured Patients from High Charges," *Health Affairs* 32(6) (June 2013), 1101–1108.

32 Michael M. Batty and Benedic N. Ippolito, *Financial Incentives, Hospital Care, and Health Outcomes: Evidence from Fair Pricing Laws*, Finance and Economics Discussion Series 2015-107, Washington: Board of Governors of the Federal Reserve System (2015), available at: http://dx.doi.org/10.17016/FEDS.2015.107

Conclusion

While there is a need to measure the future value of medical services in personal injury cases, the prevailing method for doing so—using provider-billed charges—is neither appropriate nor accurate. Provider charges are often established arbitrarily, do not relate to actual costs, are rarely paid, and vary dramatically across providers.

The *market value* for healthcare services should be used as an alternative. In the general healthcare market, the prevailing method for paying for services is based on the market value of those services that is agreed upon between willing buyers (insurers and patients) and willing sellers (providers). Whether the willing buyer is a government program, a commercial health plan, or an uninsured patient, the billed charge that is presented is almost always ignored, negotiated, or discounted to a level that reflects the agreed-upon value of the services delivered. These prices include fee schedules, negotiated rates, and discounts that have been established by payers and providers in the marketplace. These prices can be applied in personal injury cases in order to establish the value of future medical services that are more accurate and better reflect the actual costs of providing the services.

About the Authors

Henry Miller is a managing director in the Phoenix office of Berkley Research Group (BRG). He has more than 45 years of experience working on healthcare issues for the federal government, state governments, health insurers, healthcare providers, and attorneys. He has testified in the US Congress, state legislatures, and federal, state, and local courts. He has been retained to examine past and future costs related to personal injuries in more than one hundred cases.

Greg Russo is a managing director in BRG's Washington, DC office, who specializes in providing strategic advice and offering expert witness testimony to healthcare organizations through his use of complex data analyses, financial modeling, and understanding of the healthcare marketplace.

JoAnna Younts is a director in BRG's Washington, DC, office. She has worked with numerous payers and providers on healthcare cost analyses and reimbursement issues.

About Berkeley Research Group

Berkeley Research Group, LLC (www.thinkbrg.com) is a leading global strategic advisory and expert consulting firm that provides independent advice, data analytics, authoritative studies, expert testimony, investigations, and regulatory and dispute consulting to Fortune 500 corporations, financial institutions, government agencies, major law firms, and regulatory bodies around the world. BRG experts and consultants combine intellectual rigor with practical, real-world experience and an in-depth understanding of industries and markets. Their expertise spans economics and finance, data analytics and statistics, and public policy in many of the major sectors of our economy, including healthcare, banking, information technology, energy, construction, and real estate. BRG is headquartered in Emeryville, California, with offices across the United States and in Asia, Australia, Canada, Latin America, the Middle East, and the United Kingdom.

BRG
Berkeley Research Group

THINK**BRG**.COM