Litigating the Value of Medical-Expense Damages

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Executive Summary

The plaintiffs' bar has generally shifted away from emphasizing non-economic damages to "blackboarding" large economic damages. Medical expenses are often a large component of that. Too often, the medical expense component reflects the amount billed. The issue, however, is that oftentimes, the amount billed is much higher than the amount medical providers generally will accept. The amount recoverable in personal injury should be limited to the reasonable value of the medical expenses.

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There's a common adage for buying a car: Never pay the sticker price. That's good advice for medical-expenses damages too.

It's no secret that the price of medical treatment isn't what the bill says. Medical providers commonly accept less than the billed amount. So why should billed amounts set the damages for medical expenses? They shouldn't.

The key is reasonable value. More specifically, the key is what is admissible to show the reasonable value of medical expenses. There are a couple layers to that legal onion, and the trip through them is fraught with tear-inducing peril. Some will get lost in the collateral-source rule. Others will shuck aside valid hearsay objections. But, simply put, the amount billed for medical expenses doesn't always equate to reasonable value when calculating damages.

This part is undeniable: plaintiffs can recover the reasonable value of their medical care.

A plaintiff's damages include the reasonable value of his or her medical care.[1] So reasonableness is the touchstone.

The Michigan Supreme Court, when discussing attorney fees, explained that a reasonable fee is "a fee similar to that customarily charged in the locality for similar legal services."[2] That, the Court said, may "differ from the actual fee charged."[3] It also may not be "the highest rate the attorney might otherwise command."[4]

The Supreme Court's comments on the reasonableness of fees meld with the purpose of awarding damages—compensating a loss.[5] The purpose isn't to punish the defendant.[6] And it isn't to give the plaintiff a windfall.[7] "[T]he amount of recovery for [the losses actually suffered] is inherently limited by the amount of the loss; the party may not make a profit …."[8]

So reasonable value isn't actual value or the highest possible value for a medical expense. It's something else. And whatever else it is, it cannot lead to a profit for the plaintiff. So what evidence is admissible to establish reasonable value?

In Michigan, the amount billed and the amount accepted as payment for healthcare don't stand on equal footing.

Under Michigan law, a medical bill alone is not evidence of the reasonable value of the plaintiff's medical expenses. The Supreme Court settled that point in *Herter v Detroit*, which held that it was error to admit "two bills handed [to] plaintiff by the bookkeeper of the surgeon who attended him, without evidence of the reasonable value of the service rendered."[9]

The amount actually paid, on the other hand, stands on better evidentiary footing. In *Alt v Konkle*, the Supreme Court held that the fact that "bills and charges for services … had been paid in full was some evidence of their reasonableness."[10] In other words, the amount paid for medical services is, at the very least, some evidence of reasonable value.

So, where do we get evidence of the amount paid for similar medical care? From those who pay and accept payment for those services. But how to convert those potential sources into admissible evidence isn't necessarily obvious.

Testimony, even expert testimony, about or based on what medical providers told someone they charge is inadmissible.

Litigating medical-expense damages—past or future—requires rooting out hearsay. For example, a life care planner might be prepared to testify that a particular service costs $100. When asked, they might say that they surveyed local medical providers to determine the price. For a moment, leave aside whether that's $100 billed, paid by insurers, or paid in cash. When witnesses repeat what providers said they charge as proof of what they charge, the witnesses' testimony is hearsay.[11] It's the medical provider's out-of-court statement offered for proof of the matter asserted (what the provider charges). It's classic, unequivocal hearsay.[12] There's no "price of something" exception to the rule against admitting hearsay.[13] So testimony about what providers said they charge is inadmissible.[14]

Expert testimony based on what a provider said they charge is also inadmissible. The experts likely won't express their opinion on reasonable value in terms of who they spoke to or what they reviewed. This will require some unpacking during a deposition or through voir dire of the witness during trial. But, in Michigan, the data that an expert relies on must be in evidence.[15] So, even if plaintiffs qualify their life care planners as experts, their testimony about prices based on their survey of local providers is inadmissible. Likewise, expert testimony based on their review of medical bills is inadmissible under *Herter*.

Since neither side can rely on a witness's survey of local medical providers, how can they present evidence of what is paid and accepted for medical services? One workaround would be to subpoena and present testimony from local providers about what they accept in payment for their services. That would avoid hearsay. But it's also cumbersome and time-consuming. Fortunately, there are other sources.

Private insurers frequently determine reasonable fees for medical services.

Litigants aren't the only ones who struggle to define reasonable charges for healthcare services. Medical providers and insurers are in the same boat. For them, the issue comes up in the context of out-of-network services, i.e., when insureds receive treatment from medical providers who have not negotiated a rate with their healthcare insurers.[16] In that situation, insurers approve what they deem a "usual, customary and reasonable fee" (UCR)—an industry term.[17] To determine the UCR, insurers use data services that compile billed rates (also called the "usual and customary" rates) in a given area.[18] Insurers then generally approve either the rate at a specific percentile (typically the 75th or 80th percentile) from that data or the rate that the provider actually charged, whichever is less.[19]

Several national services compile data on healthcare charges. The best known may be FAIR Health, Inc. It's the product of a settlement between UnitedHealth Group and the New York State Attorney General.[20] FairHealth's prices are based on billed amounts.[21] It's useful for insurers determining the UCR.[22] It's not useful for determining what insurers pay and providers accept for in-network services. Several courts have held that, based on hearsay and other objections, FairHealth's data isn't admissible to show the reasonableness of a charge.[23]

The Health Care Cost Institute's web service, Guroo.com, provides estimated costs based on the actual amounts paid by insurers. The costs are only estimates because the data is adjusted for inflation. For several reasons, Guroo's cost estimates likely aren't admissible and are informational only. For example, FairHealth reports that an MRI brain scan without contrast costs $3,296 out of network or uninsured. Guroo reports that the same test costs an average of $777.

The collateral-source rule isn't an obstacle to using evidence of the amount paid to establish the reasonable value of medical expenses.

Let's pause before discussing the mechanics of presenting testimony on what is actually paid for various services. There's an elephant in the room. It's the common-law collateral-source rule. And it has divided courts throughout the country on this topic.[24]

The collateral-source rule prohibits the argument that the plaintiff has no damages because a third party (typically an insurer) compensated him.[25] Using past payments to show reasonable value is different from using it to eliminate damages.[26] That point stands out when you move away from what a particular plaintiff's insurer paid for that plaintiff's specific medical care.

For a moment, forget what the plaintiff in your case was billed and what anyone actually paid for those billed services. Think in terms of what the market pays for each medical service in general. The market includes what private insurers and Medicare would pay for the medical service, regardless whether it's provided to the plaintiff or a different patient. Some courts won't grasp the difference. But some will. More important, Michigan law compels consideration of the amount actually paid for a service to determine its reasonable value.[27]

Evidence of what insurers and Medicare pay doesn't eliminate the plaintiff's damages; it shows reasonable value.[28] So it doesn't violate the collateral-source rule.

Using private insurance rates or payments to establish reasonable value.

As the comparison between FairHealth and Guroo demonstrates, insurers typically pay much less for in-network services. Those rates may be closer to the 50th percentile than the 80th percentile.[29] But how can you get and present evidence of those rates?

Private insurers won't simply give you a payment schedule in response to a subpoena, probably.[30] They have a proprietary interest in keeping that information confidential. So sending a subpoena will likely lead to a long, expensive fight that won't produce usable information.

There are medical billing experts—people whose job it is to set, negotiate, and obtain payment schedules with insurers. Such an expert may be able to provide information on private insurer rates. But their testimony likely comes encumbered with the foundation and hearsay problems discussed earlier.

The best, most unobjectionable avenue to private insurer rates may be to ask any medical provider who testifies in the case (e.g., standard-of-care, causation, or damages experts) what they accept in payment for their medical services. They may know which insurance they accept and what those insurers pay for their services. And odds are they provide services relevant to the plaintiff's care.

Asking the medical providers involved in the case what they accept as payment for their services is no different than subpoenaing and asking local providers. It's unlikely to cover the full gambit of charges that the plaintiff claims he or she needed and will need in the future. But it can illustrate the point that the amount accepted in payment is far less than the amount billed.

Using Medicare rates or payments to establish reasonable value

Medicare is the largest single payer for medical services in the United States.[31] So it provides a useful source of determining reasonable fees for healthcare. Since 1992, Medicare has used and published its fees, which are adjusted for location.[32]

Using Medicare rates has a few benefits. First, Medicare payment schedules are self-authenticating public records.[33] Second, the Medicare fee schedules don't carry hearsay burdens like other evidence.[34] Third, Medicare rates, which may be less than what private insurers pay,[35] are, under *Alt*, evidence of reasonable value.

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To use the Medicare fees, you're going to need a translator. In particular, you'll need someone who knows the current procedural terminology (CPT) codes for each service. Most life care planners know those codes.

Once you have someone who can decipher the CPT codes and fee schedules, there are two ways to use Medicare fees. A life care planner could create a report using those figures or prepare a report that mirrors the plaintiff's life care plan but uses Medicare rates to show the differences in value. Alternatively, you could use a few prominent examples to cross-examine the plaintiff's life care planner or other damages expert (if they're familiar with CPT codes and Medicare payment schedules).

Medicare is not the end-all, be-all of reasonable value. It's a data point, one that typically falls well below the billed amount, which shows that damages claims based on billed amounts are inflated and unreliable.

Conclusion

The plaintiffs' bar has generally shifted away from emphasizing non-economic damages to "blackboarding" large economic damages. Medical expenses are often a large component of that. Too often, the medical expense component reflects the amount billed.

Defense attorneys generally loathe discussing damages in front of a jury. But whether it's blocking efforts to use billed amounts through *Herter* and hearsay objections, or demonstrating that the billed amounts aren't reality though medical provider testimony about the rates they accept or Medicare rates, there are ways to burst the billed amount bubble without belaboring the point to a jury. So, just like buying a car, when you're litigating medical-expense damages, don't pay the sticker price.

Endnotes

1 M Civ JI 50.05, cmt, citing *Herter v Detroit,* 245 Mich 425; 222 NW 774 (1929)

2 *Smith v Khouri*, 481 Mich 519, 528; 751 NW2d 472 (2008).

3 *Id.*

4 *Id.*

5 *Rafferty v Markovitz*, 461 Mich 265, 270–271; 602 NW2d 367 (1999).

6 *Rafferty*, 461 Mich at 270–271; *McAuley v Gen Motors Corp*, 457 Mich 513, 519-520; 578 NW2d 282 (1998).

7 *Lawrence C Young, Inc v Servair, Inc,* 33 Mich App 643, 645; 190 NW2d 316 (1971).

8 *McAuley*, 457 Mich at 520.

9 *Herter v Detroit,* 245 Mich 425; 222 NW 774 (1929).

10 *Alt v Konkle*, 237 Mich 264, 270; 211 NW 661 (1927); see *id.*, quoting *Dewhirst v Leopold*, 194 Cal 424; 229 P 30 (1924) ("Amounts paid for medical treatment and attention are some evidence of reasonable value thereof, and sufficient in absence of showing to contrary.").

11 MRE 801.

12 MRE 801(c) ("'Hearsay' is a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted.").

13 MRE 803.

14 MRE 802.

15 MRE 703; see *People v Fackelman*, 489 Mich 515, 534; 802 NW2d 552 (2011) ("[MRE 703] permits 'an expert's opinion only if that opinion is based exclusively on evidence that has been introduced into evidence in some way other than through the expert's hearsay testimony.'"), quoting 468 Mich xcv, xcvi (staff comment to the 2003 amendment of MRE 703).

16 Research and Planning Consultants, LP, *Determining Usual, Customary, and Reasonable Charges for Healthcare Services* (July 2019), p. 1.

17 *Id.*, p. 2.

18 *Id.*, pp. 2-3.

19 See *id.*, pp. 3-5, for an excellent explanation of this process and percentiles in general.

20 *Folweiler Chiropractic, PS v Fair Health, Inc*, unpublished opinion of the Washington Court of Appeals, issued June 4, 2018 (Docket No. 75864-1-I); 2018 WL 2684374, *1.

21 *Id.* ("The database includes the actual, nondiscounted fees charged by providers before network discounts or other allowances are applied.").

22 Research and Planning Consultants, LP, *Determining Usual, Customary, and Reasonable Charges for Healthcare Services* (July 2019), p. 11.

23 See, e.g., *Patriot All Pro Physical Therapy Centers, Inc. v Vermont Mut Ins Grp*, 2017 Mass App Div 195 (Dist. Ct. 2017); *Lomibo LLC v Vermont Mut Ins Grp*, 2018 Mass App Div 79 (Dist. Ct. 2018).

24 See *Slayton v Del Health Corp*, 117 A3d 521, 527 (Del, 2015) ("Even though the collateral source rule has been recognized by most states, it has not been uniformly applied to healthcare provider write-offs." (footnote omitted)).

25 *Tebo v Havlik*, 418 Mich 350, 366; 343 NW2d 181 (1984) ("The common-law collateral source rule provides that the recovery of damages from a tortfeasor is not reduced by the plaintiff's receipt of money in compensation for his injuries from other sources.").

26 *Stanley v Walker,* 906 NE2d 852, 857–858 (Ind, 2009).

27 See *Alt*, 237 Mich at 270; see also MCL 600.1482 (codifying this requirement for medical-malpractice cases).

28 *Gaddy v Terex Corp*, unpublished opinion of the United States District Court for the Northern District of Georgia, issued July 21, 2017 (Docket No. 1:14-CV-1928-WSD); 2017 WL 3473872, *3 ("The Court finds these opinions 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.").

29 See Davis, James B. Ed. Medical Fees 2015, pp. 2-3 ("HMOs and other managed care groups typically negotiate fees that are closer to the 50th percentile for a given area.").

30 We haven't tried. They might readily hand over this information, but that seems unlikely.

31 Research and Planning Consultants, LP, *Determining Usual, Customary, and Reasonable Charges for Healthcare Services* (July 2019), p. 7.

32 It's an exceedingly complex system, which the American Medical Association describes here: RBRVS Overview, American Medical Association, https://www.ama-assn.org/about/rvs-update-committee-ruc/rbrvs-overview.

33 MRE 902, 1005.

34 MRE 803(8) (public records), (6) (business records).

35 *Gaddy v Terex Corp*, unpublished opinion of the United States District Court for the Northern District of Georgia, issued July 21, 2017 (Docket No. 1:14-CV-1928-WSD); 2017 WL 3473872, *3 (expert testified that "private sector professional fees are paid at a rate equal to 128 percent of the Medicare rate for various services and items").