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Future medical costs post-*Corenbaum*

Past-paid medical bills and payments by private health insurance are not evidence of the future cost of care

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Following *Corenbaum v. Lampkin*, (*Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308) many defense attorneys have been raising questions in court as to what an expert may rely on when offering an opinion on the reasonable value of future medical care. Some on the defense bar have been asserting that an expert is limited to reliance on past paid amounts, while others try to use Medicare or Medi-Cal rates. Despite defense arguments, there has been no change to the foundational requirements for establishing future medical care costs. The usual, customary and reasonable rate continues to be the most accurate and reliable way to determine the reasonable value of future care.

"To be recoverable, a medical expense must be both incurred and reasonable." (*Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, 555.) In the past, California law allowed a plaintiff to recover the reasonable value of past and future medical services. After *Hanif* (*Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635) and *Howell*, a plaintiff's recovery for past medical costs is now limited to the amount actually paid or incurred, regardless of the reasonable value of the medical services. These cases did not address recovery for future medical services; however, the defense may assert these cases hold that an expert is not permitted to offer testimony or expert opinion on the usual and customary rate ("UCR") as a basis for future medical costs in a life care plan. Future medical expenses continue to be determined by their reasonable value, as they have not yet been paid or incurred. Evidence as to what future medical care will be required and how much that treatment will cost is generally introduced through expert testimony.

Recently, *Corenbaum* held that an expert cannot base his or her opinion as to the reasonable value of future medical services on the past billed amount for the same medical services. (*Corenbaum, supra,* 215 Cal.App.4th 1308.) The foundational basis of an expert's opinion can dramatically affect the expert's calculation of the reasonable value of future medical services. Defense experts often rely on irrelevant, speculative, inaccurate and prejudicial sources. Plaintiffs must be prepared to address improper arguments by the defense. These issues must be addressed in depositions and motions in limine to ensure artificially low estimates of the reasonable value of medical services are not presented to the jury.

Private health insurance

If you encounter a defense attorney who asserts that the paid amount of a medical bill from a private insurance company is a reflection of the reasonable value of future medical costs, you will need to be able to demonstrate both in law and factually that this is false. First, as a matter of law this is impermissible because by implication it will present evidence of a collateral source to the jury. It is also factually incorrect that the paid bill necessarily represents the full value received by health-care providers from the insurances company for the medical services provided.

> [F]or an expert to base an opinion as to the reasonable value of future medical services, in whole or in part, on the full amount billed for past medical services provided to a plaintiff would lead to the introduction of evidence concerning the circumstances by which a lower price was negotiated with that plaintiff's health insurer, thus violating the evidentiary aspect of the collateral source rule.

(*Corenbaum, supra,* 215 Cal.App.4th at 1332.)

Contrary to the position of many defense attorneys, this does not mean that the value of future medical services is determined by reference to past paid amounts. In fact, doing so would violate the collateral source rule if it leads "to the introduction of evidence concerning the circumstances by which a lower price will be negotiated between the plaintiff's health-care providers and health insurer." (*Ibid.*)

Actual and reasonable value

The actual amount a health-care provider is paid is not limited to the cash payments credited to patients' accounts and reflected on their bills. Health-care providers receive an annual stipend from insurance companies, often receive kickbacks based on their write-offs, and receive other valuable consideration for being a "gate keeper." Amounts listed on a patient's bill as "write-offs" or "adjustments" appear to the layperson as if they go unpaid. These amounts, however, are often paid at a later date (at the end of the contract or quarterly). These are not posted to individual patient accounts because it is not necessary and there would be additional costs involved.

In addition to hidden supplemental cash payments, medical providers accept less than their full retail charges because they receive valuable non-cash consideration from insurance companies. Examples

include promised patient volumes, more rapid payment, and shortened audit periods (*e.g.*, withdrawal of payments made in error won't be initiated more than 12 months after payment). These terms are negotiated between the provider and insurer when they enter into a contractual arrangement. At the end of the contract period, the medical provider reviews the "contractual account" to determine if any particular contract generated a profit or loss, and uses that information in subsequent negotiations.

Past paid amounts do not capture the additional funds or in-kind consideration that health-care providers receive from insurance companies as part of their business relationship. Therefore, the actual – and reasonable – value received by health-care providers under private insurance plans is higher than what is reflected as paid on patients' bills. Often, the amount ultimately paid to the health-care provider is equal to the gross billed amount.

Speculative and unreliable

A payment discount only applies if the patient is a member of the specific network. Therefore, the use of past paid amounts as the basis for an opinion as to the reasonable value of future medical care, necessarily assumes that the plaintiff will continue to have the same private health-insurance plan. As private business owners, health-care insurers have the right to change the services provided, drop particular patients, or eliminate an entire plan if it is not profitable. If the plaintiff loses coverage, the future cost of medical care will be higher than the past discounted amount. Payment discounts are negotiated between an insurance company and health-care providers based on many aspects of their business relationship. As such, there is no "standard" rate differential that can be applied. In fact, there is significant variance in payment amounts between insurance companies and even within the same insurance company. Thus, if a plaintiff changes insurer, insurance plan, or health-care providers, the cost of future care will likely not be equal to the amount paid for that care in the past.

Medicare

Using Medicare rates as the basis for an expert opinion is impermissible because it suggests the existence of a collateral source. An expert will be unable to explain his or her opinion without revealing that the plaintiff is receiving or is expected to receive public benefits. The introduction of this evidence may improperly imply that the injured plaintiff will not have to incur these costs in the future.

As with private insurance, the amount paid by Medicare for a particular service does not necessarily capture the full amount a provider receives. Hospitals that can demonstrate the cost of their providing care to Medicare patients exceeded the amount paid by Medicare reimbursement generally will receive an additional cash payment. The payment, however, is delayed – often for years – as the cost report is prepared, audited, and possibly appealed. Only after the bureaucratic process is complete may an additional cash payment be generated. These payments are not reflected in the amount paid by Medicare on a patient's bill due to the delay in receiving the funds, the posting costs, and the lack of necessity.

It is improper and speculative to assume that the current Medicare rates will remain the same into the future. The Medicare payment system is partially based on the availability of Department of Health and Human Services ("HHS") funds. When a budget is provided, the payments made for care of Medicare patients must be adjusted to fall within that budget. The HHS budget – and as a result the payments available for care to Medicare patients – is dictated by the political process and subject to change with the political moods and interests of the public and political leaders. Thus, using past or current payments by Medicare to predict the reasonable value of future medical care is highly speculative.

For personal injury plaintiffs whose recovery includes future medical expenses, Medicare has provisions for reimbursement of any medical expenses paid through Medicare. The Medicare Secondary Payor ("MSP") Program specifies the right to collect from medical providers and patients the amounts paid by Medicare for medical care. Plaintiffs are required to establish a Medicare Set Aside Arrangement, from which Medicare is reimbursed for payments it makes on the individual's behalf for medical care. The MSP program was specifically developed to allow reimbursement to Medicare for the costs of treatment and has the effect of dramatically understating the value of health care provided to Medicare patients because there is no mechanism for retro-adjusting the costs of care to include later recoveries by Medicare.

Medi-Cal

As with Medicare, using Medi-Cal rates as the basis for an expert opinion is impermissible because it suggests the existence of a collateral source. An expert will not be able to explain the basis for his or her opinion without revealing that the plaintiff will receive public benefits, improperly implying that the plaintiff will not incur these future costs.

Medi-Cal payment amounts on a patient's bill do not always convey the full payments received by a medical provider. Hospitals are eligible to participate in the Medi-Cal Disproportionate Share Hospital ("DSH") program. The DSH program makes additional payments to hospitals that successfully document higher costs based on providing care to a "disproportionate share" of Medi-Cal patients. The amount paid to the hospital is calculated as a function of the number of Medi-Cal patients served. The DSH program makes payments on a quarterly basis, which are not posted to each individual Medi-Cal patient's financial account, but rather to a "Medi-Cal contractual clearing account." These payments are not taken in to account when the reasonable value of future care is based on the amount paid for any one particular service.

Medi-Cal rates in different regions vary according to the different programs that exist in different communities. Some Medi-Cal county programs are well-funded and can provide services by offering medical providers higher rates than other communities, while others are under-funded or overburdened and unable to pay a reasonable rate to health-care providers. The Medi-Cal program is subject to decreases due to political conflicts and budgeting variations. In fact, there have been times in Medi-Cal history when providers were advised near the end of the Medi-Cal fiscal year that all budgeted monies had been exhausted and no further payments would be made for care to Medi-Cal patients until the next year's funds became available.

It is a fact that Medi-Cal pays health-care providers less than the actual cost of providing care to a Medi-Cal patient in some circumstances. There is also no legal or administrative mandate which requires a health-care provider to sign a Medi-Cal contract and treat Medi-Cal patients. As a result, an increasing number of medical providers are refusing to accept Medi-Cal patients. Patients are often too numerous to be adequately accommodated by the providers willing to take this coverage, leading to delays in treatment. Providers willing to accept Medi-Cal coverage may lack the requisite sophistication to appropriately treat a particular patient. This is not because Medi-Cal providers are per se unqualified, but rather because fewer specialists treat patients with public assistance.[1]

For personal injury plaintiffs whose recovery includes future medical expenses, Medi-Cal provisions provide for reimbursement of any medical expenses paid through Medi-Cal. Typically, a Special Needs Trust ("SNT") is established to allow the individual to preserve funds for his or her benefit, while qualifying for those resources available in the public sector. Any money in the SNT is allocated strictly to medical care, and upon the plaintiff's death, the funds remaining in the SNT are paid to the state to reimburse Medi-Cal. Thus, there is no concern that the award of future medical costs will result in a windfall to the plaintiff.

PPACA-mandated health insurance

Insurance coverage under the Patient Protection and Affordable Care Act ("PPACA") is much the same as other medical insurance. It is a product that is sold with the expectation of profitability. Each plan contains specific parameters and is evaluated each year and amended if necessary to ensure profitability. What is covered within a particular insurance plan and the terms of coverage may change, since insurance companies must, at a minimum, break even in order to provide coverage to their clients. Just as with any other private insurance, the paid amounts for health-care services under a PPACA plan are not accurate or reliable indicators of the reasonable value of future medical treatment.

Preliminarily, a plaintiff must qualify and remain eligible for PPACA coverage for the PPACA rates to be relevant. The PPACA specifically excludes from health-insurance coverage anyone eligible for Medicare or Medi-Cal. This represents a large and increasing percentage of America's population. Further, if your client becomes eligible for public health-care coverage at any point, he or she will lose PPACA coverage.

Despite recent arguments by the defense bar, the right to drop patients or plans generally persists under the PPACA. Under the PPACA, insurers have the ability to drop whole policies which are unprofitable over a year of experience. The ability of health-care insurers to drop specific services or patients and to alter coverage parameters creates uncertainty as to whether and at what price any given patient's medical care will be paid by their insurance at any given time.

The PPACA has provisions that require any PPACA-mandated policy to provide certain medical services as benefits. However, for many of these services, the insurer is permitted under the PPACA to require pre-authorization of benefits. This allows the insurer to deny approval of needed care, to delay needed care, or to reduce the frequency of the care, so that the care is provided less often than a physician has recommended for the patient. Insurers have an incentive to disapprove needed care because this reduces the availability to the patient, lowers the patient's usage of the care, and lowers the cost to the insurer. Where care can only be obtained out of network, carriers often choose to not cover this care and refuse to reimburse patients. If coverage is provided, it is typically after extensive delays.

Basing an opinion of future medical expenses on current reimbursement rates under PPACA private insurance is highly speculative. The Affordable Care Act has only recently been fully implemented. The issuing insurance companies will need to evaluate the business impact of the new legislation and will make adjustments accordingly. As with any new insurance plan, the schedule of benefits, mechanism for approval of services, and reimbursement rates will be subjectively determined and prone to change.

Usual, customary and reasonable rate average

The most reliable and accurate means of calculating future medical costs and the future rates for any particular item of future medical care is to utilize the range average of the billed rates for that health-care service as charged by medical providers in that region of the country. This range is the "usual, customary and reasonable" ("UCR") rates charged by the same or similar providers for the same or similar services in the same or a comparable medical community. The UCR takes into consideration the rates of hundreds, sometimes thousands, of charges by medical providers for medical services. This creates stability in the UCR rates because they are based on a large quantity of

charges, not a single paid or billed amount. While no one provider may skew the range, the UCR does capture real changes in how providers as a whole are adjusting their charges.

The UCR is generally considered reliable for predicting future medical expenses because it most accurately reflects what medical providers in a specific geographic area are charging for specific services. Health care is a competitive industry. Providers whose rates are too high will not be able to attract the patients necessary to remain in business. Conversely, providers who charge too little will go out of business as their costs exceed income. Research literature in the field of health-care pricing and reimbursement supports the use of UCR charged prices as the basis for future medical pricing.[2]

Use of the plaintiff's past paid medical bills, private health insurance paid rates, PPACA insurance paid rates, or Medi-Cal or Medicare rates will lead to a dramatic underestimation of the actual cost of health care. Your client will be unable to obtain necessary, quality treatment for his or her injuries in the future. To prevent the jury from being misinformed about the actual and reasonable value of future medical care, plaintiffs' attorneys must address these issues in deposition and explain the flaws and limitations of looking to past paid amounts or Medicare and Medi-Cal billing rates to courts through motions in limine.


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Endnotes

[1] Bisgaier & Rhodes, *Auditing Access to Specialty Care for Children with Public Insurance* (June 16, 2011) 364 New England Journal of Medicine 2324.

[2] University of Chicago, Booth School of Business and Center for Health and Social Sciences, The Effects of Price Transparency Regulation on Prices in the Healthcare Industry (October 2013).