In the Setting of a Lien, is the Reasonable Value of Medical Care Defined by Customary Charge Amounts?

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Under California law, a plaintiff in a personal injury case is entitled to recover the reasonable market value of their medical services causally related to that injury (*Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, 562, 564.) The reasonable market value of *anything* (including medical services) is the typical amount that willing buyers pay, and willing sellers accept when neither is under a state of compulsion. In this regard, a tort plaintiff is not entitled to recover any more in medical expense damages than the reasonable market value of necessary medical services.

When medical care is provided through a lien, the plaintiff will typically claim that the billed amounts are owed by the plaintiff and thus represent the reasonable value of plaintiff's care. As a fallback position, the plaintiff may take the position that reasonable value is equivalent to the so-called "customary charge" for that care. Although plaintiffs regularly make one or both of these arguments and the defense may also argue in favor of customary charge amounts, doing so is not consistent with the law:

> Jury instruction CACI 3903A charges the trier of fact with determining the reasonable cost of care. While "cost" can be variably interpreted, 3903A does not charge the jury with determining whether or not the charges are customary. Further, the Sources & Authorities for 3903A, as well as *Howell v. Hamilton Meats, Bermudez v. Ciolak, Pebley v. Santa Clara Organics, Qaadir v. Figuroa* and many other appellate decisions use the terms cost and value interchangeably.

There is no California law that equates the reasonable value of medical care with either billed amounts that have not been collected or customary charge amounts.

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The closest California law comes to the latter is the appellate decision in *Qaadir v. Figueroa* (2021) 67 Cal.App.5th 790, 805, where the court approved an expert opinion that incurred lien charges are customary as a necessary foundation to then argue that they should also be considered reasonable value. This said:

> There is no California law that defines what is meant by the term "customary charge."
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> If the *Qaadir* Court intended to state that customary charge amounts necessarily are the reasonable value of lien care, that is what the Court would have stated. Instead, the *Qaadir* Court reaffirmed the determination in *Pebley v Santa Clara Organics, LLC* (2018) 22 Cal. App.5th 1266 that the defense is entitled to a wide-ranging inquiry into what constitutes the reasonable value of care. *Qaadir* conflicts with holdings in other cases, including *Corenbaum v. Lampkin* (2013) 215 Cal.App.4th 1308, 1330 and *Ochoa v. Dorado* (2014) 228 Cal.App.4th 120. *Qaadir* itself even recognized that there is a "split of authority" regarding the relevance of "billed" amounts.
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> *Qaadir* also raised the consideration that that a lien may result in bias by a testifying expert who may have incentive to inflate treatment amounts (See *Qaadir*, 67 Cal.App.5th at p. 808) – and that incentive may be direct or indirect.

It should also be noted that there is no uniform methodology for determining what constitutes a customary charge amount. In fact, without defining parameters, the term "customary charge" is meaningless.

In defense of their position that charged or customary charge amounts should be considered the reasonable value of lien-based care, plaintiffs regularly point out that, according to *Pebley*, the plaintiff on a lien must be considered uninsured even if they have insurance. Here, the implication is that the existence of a lien creates a unique marketplace in which the plaintiff is exposed to and, pursuant to the lien, is contractually liable for the full amount charged. There are, however, a number of problems with this argument:

> In a bona fide marketplace, identifiable sellers and buyers agree to the terms of their transaction. In the setting of a medical lien, while the seller is the healthcare provider, who is the buyer? While the buyer appears to be the plaintiff, guided by counsel, the plaintiff expects the defendant to be the buyer. But the defendant did not participate in determining the financial terms of the transaction. This dynamic does not characterize a bona fide marketplace and from the defendant's perspective, the plaintiff's lien bill is more representative of a surprise medical bill.
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> Of still greater importance, not only will lien holders and plaintiffs' attorneys do everything possible to prevent disclosure of lien collections data, but judges have

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also been reluctant to compel such production. Thus, there is no way to test whether collected lien amounts are contingent in any way on case outcome; and when lien collections do occur, the extent to which lien charges are typically paid. In the absence of the broad availability of time and geography specific lien charge and collections data, it is not possible to determine the market value of lien services. Simply stated, it is not reasonable to argue that a unique lien marketplace exists and, while making representations regarding market value within that alleged marketplace, simultaneously preclude the analysis necessary to either verify or challenge those representations.

In addition, there is no reason to have less suspicion about charges rendered in the setting of a lien than about billed charges in the absence of a lien:

Not only did *Howell v. Hamilton* Meats emphasize that billed charges are "insincere" in that they are often inflated and bear little relation to the true market value, California courts have repeatedly reaffirmed that amounts charged do not define the reasonable value of medical care. (See, e.g., *Corenbaum v. Lampkin; Children's Hospital Central California v. Blue Cross of California* (2014) 226 Cal. App.4th 1260, 1268 [hospital was paid full "billed" amount "less than 5 percent" of the time]; *Goel vs Regal Med Med. Grp., Inc.* (2017) 11 Cal.App.5th 1054.)

In California, truly uninsured patients rarely pay full charges for their medical care. Instead, pursuant to robust charity laws and financial screening to determine ability to pay, they more commonly pay something between nothing and the Medicare allowable amount. Lien charges likewise are not entitled to any presumption that they will necessarily be collected and thus reflect market value. In this regard, it is notable that the *Pebley* court did not conclude that the plaintiff on a lien should be considered responsible for the full amount of their medical bill(s). Instead, the *Pebley* court stated that the defense was entitled to a wide-ranging inquiry into what constitutes the reasonable value of the lien care.

With specific regard to *Howell vs Hamilton Meats*, while plaintiffs regularly point out that this case dealt with contracted care, it is important to note that the majority opinion includes four very relevant general statements regarding charges for medical care, and spoke specifically about uninsured patients:

"While a medical care provider's billed price for particular services may constitute some *evidence* of reasonable value, it does not establish that value as a matter of law." (*Howell*, at 541, 567.)

"With so much variation [in charged amounts], making any broad

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generalization about the relationship between the value or cost of medical services and the amounts providers bill for them – other than that the relationship is not always a close one – would be perilous." (*Howell*, at 562.)

"Nor do the chargemaster rates ... necessarily represent the amount an uninsured patient will pay"; noting that uninsured patients often pay less than contracted insured rates, and adding, "Because so many patients, insured, *uninsured*, and recipients under government health care programs, pay discounted rates, hospital bills have been called 'insincere, in the sense that they would yield truly enormous profits if those prices were actually paid." (*Howell* at 561.)

The measure of damages applies "equally to those with *and without* medical insurance." (*Howell* at p. 559, fn. 6.)

Given that lien providers regularly testify that they "charge" all patients the same amounts, *Howell* should apply whether the charges are in the setting of contracted care or a lien.

Because California law offers no foundation for claiming that charged amounts represent reasonable value, what about actual charge versus collections experience?

> In fact, payment of the charged amount – whether customary or not – is exceptionally uncommon (AMA J Ethics. 2015;17(11):1046-1052. doi: 10.1001/journalofethics.2015.17.11.stas1-1511).
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> There is no database for lien collections and there are no publications regarding lien collections.
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> While lien providers will do everything possible to keep from revealing their actual collections experience, in the experience of this author (HWL) with orders to compel such data, actual lien collections are a very small percentage of the charged amount.

Some have posited that, because out-of-network (OON) medical care does not involve a payer-provider contract, the historically used OON usual, customary and reasonable (UCR) charge calculation should be used to determine the reasonable value of lien-based care. However, this argument has multiple flaws:

1. While per *Pebley*, the plaintiff treating on a lien is deemed to be uninsured, UCR calculations apply to an *insured* person with a healthcare policy that

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includes OON benefits. Opting to use an insurance benefit computation to define the market value of lien-based care would appear to contradict any argument against using insurance contracted payment amounts to define the market value of lien-based care.

2. As a best estimate, only less than 7% of fee-for-service expenditures are for OON care (10.1377/hlthaff.2019.01776 HEALTHAFFAIRS39, NO. 6(2020): 1032–1041). Are we to ignore the fact that the overwhelming majority of fee-for-service transactions in our multi-trillion healthcare marketplace are not OON and instead attempt to base reasonable value on a very small fraction of that marketplace?

3. The majority of OON care appears to be in the form of surprise medical bills (Bernstein J. Not the Last Word: Surprise Medical Bills are Hardly Charitable. Clin Orthop Relat Res. 2020 Oct;478(10):2213-2217) which, per California's AB72, are generally to be compensated at the in-network payment amount for the insured's payer or 125% of the Medicare allowable amount, whichever is greater.

4. While a UCR calculation may be used to determine a situation specific customary charge amount, it does not provide a basis for determining reasonable value:

   As discussed in Fair Health's publication regarding Types of Out-Of-Network Reimbursement (*https://www.fairhealthconsumer.org/insurance-basics/your-costs/types-of-out-of-network-reimbursement*), the insurance industry does not have a uniform methodology for calculating UCR amounts. Further, even those insurers that do provide OON benefits may use different UCR methodologies across their different healthcare policies.

   Historically, for a particular service, many insurers with OON benefits would equate UCR with the time and geography specific charge for that service at the 70th or 80th percentile. Increasingly however, the shrinking number of insurers that provide OON benefits are utilizing a multiple of Medicare (for example, 130%) to represent their UCR charge.

   Regardless how UCR is calculated, the UCR charge amount does not tell us what OON medical providers typically *receive as payment* – the market value of their services under the binding *Howell* rationale. As a result, even if we could agree on a uniform UCR calculation, the UCR value alone cannot be extrapolated to arrive at a market value for OON services – let alone lien-based services.

   Allowing tort plaintiffs to recover medical expense damages based on an OON benefit set at the 70th or 80th percentile – or still higher – only serves to guarantee that they will be overcompensated – a violation of those basic tort principles that forbid windfall recovery.

If foundation for equating charged amounts with reasonable value cannot be found in either California law or actual healthcare practices, what about healthcare economics literature? In fact, as summarized by healthcare economist, John Schneider, PhD , in an article entitled, The Economics of Reasonable Value and the Valuation of Medical Losses, "Medical billed and charged amounts are not good indicators of reasonable value because they do not reflect actual transacted amounts and that runs counter to the willing to pay approach to determining value, and more generally runs counter to all of economic and business theory on value."

In the final analysis then, what role should lien "charges" – whether customary or not – play in determining the reasonable value of lien care? The answer, none.

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For the same good or service, because medical providers can and do charge whatever they wish to charge, the resultant broad variation in charged amounts makes it virtually impossible to argue that there is a relationship between charged amounts and reasonable value.

The amount charged is simply not relevant to a determination of reasonable value. Instead, reasonable value is based on the good or service being sold, the geographic region of the sale, when the sale occurs, and the then current market value for that good or service. In turn, for any given good or service, its market value is a community-based determination that is defined by what most buyers are willing to pay and what most sellers are willing to accept as payment in full.

Despite the collective foregoing, many attorneys defend the use of customary charge amounts by noting that most "billing experts" equate reasonable value with customary charge amounts. As opposed to a reasonable value expert, I am not certain exactly what qualifies someone to be a "billing expert." Nevertheless, most with this title do testify based on their determination of customary *charge* amounts. However:

> This testimony lacks foundation in either California law or healthcare. This testimony fails to understand the legal significance of "market value" as used in *Howell* and more broadly, in economics.
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> As noted in an article entitled, "An Analysis of Usual, Customary, and Reasonable Charges in Life Care Planning (Journal of Life Care Planning, Special Issue: Life Care Plan Costing, volume 20, Number 2, 2022), using as defense the fact that others do it this way is "backwards logic." If the fact that many others do something provides sufficient foundation for continued belief, then doctors would still be treating patients with arsenic, bloodletting and leeches and most would still believe that the earth is both flat and the center of the universe.

In summary, there is simply no reasonable foundation for the common testimony that the reasonable value of lien-based care can be equated with customary charge amounts – however they are defined.

The latter observation leads to a consideration of the 2003 California Appellate Court decision, *Jennings vs Palomar-Pomerado*, where the court determined that an expert's opinion is conclusory when it is "unaccompanied by a reasoned explanation connecting the factual predicates to the ultimate conclusion ...." (*Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1117.) In this regard, if the billing expert's ultimate conclusion is that the reasonable value of plaintiff's care is $X, what are the alleged factual predicates upon which that is based? For the expert who has based this conclusion on customary charge amounts, there are necessarily 3:

1. There is a relationship between customary charge amounts and the reasonable value of medical care. As previously established however, there is no such relationship.

2. The customary charge for a given service is the time and geography specific charge at the X percentile (billing experts typically utilize a percentile between the 75th and the 95th):

   > As a hypothetical, assume that the curve below plots the distribution of charges for a particular service. It can be readily determined that a charge above the 75th percentile cannot be considered customary for that service. If anything, it is unusually high. As a result, alleged factual predicate #2 is false.

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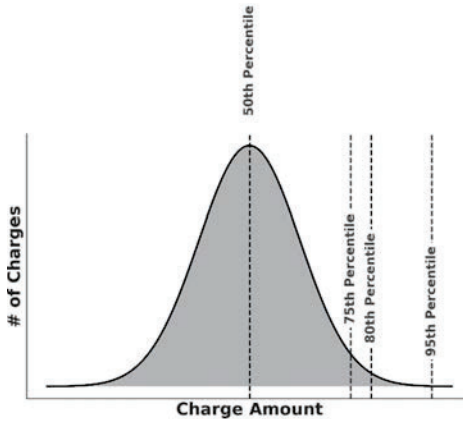

3. The reasonable value of a medical service is its time and geography specific customary charge amount.

   Because reasonable value = market value, the only way to prove that the customary charge for a lien-based service equals its reasonable value is to establish that, in the setting of a lien, the customary charge amount is regularly paid to and accepted as payment in full by lien providers. However, doing so cannot be accomplished and alleged factual predicate #3 cannot be established as factual.

In summary, testimony regarding the reasonable value of medical care that is based on customary charge amounts is without valid foundational basis and should be excluded as nothing more than conclusory.

So how *should* we go about determining the reasonable value of lien-based medical care? While plaintiff and defense may differ on what care should be considered causally related and medically necessary, once each side makes their determination, the next steps in a reasonably sophisticated reasonable value analysis are fairly uniform:

Any billed-for medical goods/services that were not actually provided need to be removed from the analysis.

Any duplicate billing (often in the form of "unbundling" or billing for overhead that is elsewhere accounted for) needs to be removed.

The assignment of medical bill codes or English-language descriptors that imply a higher-level product or service than was actually provided (so-called, "up-coding") needs to be corrected. Similarly, erroneous bill codes or English-language descriptors need to be corrected.

The next step is to determine the time and geography specific market value of the plaintiff's past and/or proposed future medical care. Consistent with *Howell v. Hamilton Meats, Stokes v. Muschinske* and healthcare economics literature, we should turn to the multi-trillion fee-for-service healthcare marketplace where, through billions of annual healthcare transactions, medical providers themselves define what they typically receive and accept as payment in full. And in fact, these amounts can be established or reasonably approximated.

A reasonable question is, why is there so much resistance to simply accepting the foregoing as the best means of determining the reasonable value of lien-based care?

Because "customary charge" amounts typically result in a far larger medical damages claim, I suspect that clients' and attorneys' self-interest make accepting the foregoing an uphill battle.

Defense attorneys, judges, arbitrators and mediators may have simply succumbed to having heard so often that customary charge amounts represent the reasonable value of care that they have come to believe it to be true.

Towards tacitly believing that customary charge amounts represent the reasonable value of medical care, consider both your experience and the likely experience of jurors with typical consumer purchases:

For the vast majority of our typical purchases (gasoline, milk, bread, etc.),

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the amount charged is about the same wherever we go: i.e. the amount charged is a customary charge. Further, all of the vendors accept the amount charged as payment in full. As a result, the customary charge is also the reasonable value.

Given this common experience, it is not surprising that when jurors are advised of amounts charged for medical services and are told that these amounts are regularly charged by others and that the providers expect to collect these amounts, that they are so readily co-opted into believing that, just as with their common daily purchases, the amounts charged for the plaintiff's care should be equated with reasonable value.

In contrast with gasoline, milk and bread, we actually do encounter frequent instances where it is abundantly clear that there is little or no relationship between amounts charged and reasonable value. Consider, for example, those instances where, for the same good, there can be a wide difference in the amounts charged by various vendors. In such an instance, it cannot logically be said that the *value* of that good fluctuates with the amount charged. Instead, the reasonable value of the good is static and reasonable value must be measured by an objective standard rather than by divergent vendor pricing. For example, a sporting goods store that routinely distributes 40% off coupons for regularly priced merchandise may post a "regular" price of $50 for a sleeping bag, while another big box retailer sells the same sleeping bag for $30. The first store's "regular" price cannot blindly be accepted as the "value" of the sleeping bag. While the provision of healthcare services carries this separation to an extreme, other examples include pre-pandemic automobiles and real estate, as well as jewelry and furniture.

Although analogies can be fraught with hazard, let me use the core elements of the following analogy to underscore the lack of relationship between charged amounts and reasonable value: just as medical providers can charge whatever they wish, homeowners can list the sale of their home for whatever they want. Consider that you own a home in a neighborhood where the homes typically sell for $400,000 and your home is comparable to the others in your neighborhood. Should you decide to sell, there is nothing to stop you from listing it for $1 million. But when a real estate appraiser is sent out ***to determine the reasonable value*** of your home, your listing price will play no role in their determination of reasonable value. Instead, reasonable value will be based on what comparable homes in your neighborhood typically sell for. And if your home is lost in a fire after you list it for sale in that amount, trying to recover $1 million from your insurer will more likely result in an insurance fraud charge than the $600,000 windfall you are seeking. Just as in healthcare, the amount charged is simply not relevant to a determination of reasonable value.

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