# CHALLENGING INFLATED MEDICAL EXPENSES IN CASUALTY CLAIMS

***By Robert Fuentes and Katia Alcantar***

One of the biggest problems facing trucking companies and their liability insurers in personal injury suits is outrageously inflated medical bills. The rates or list prices "charged" by hospitals and doctors are generally several times more than the amounts these providers are routinely paid in satisfaction of the bill.[1] Indeed, the Texas Supreme Court has explained that the labels for charges as "full," or "list," are misleading because they are actually paid by less than five percent of patients nationally.[2] The Texas Supreme Court even acknowledged that list prices are artificially inflated to leverage high reimbursement rates and not based on costs.[3]

We see egregious inflation of medical bills in our cases. A two-level spinal fusion takes a surgeon about 90 minutes or less to complete. While major health plans in Texas typically pay a surgeon $2,800 to $3,300 to perform this fusion, surgeons involved in personal injury litigation charge 10's of thousands of dollars. One surgeon even claimed $49,600. Likewise, we see hospital services that may collect $35,000–$40,000 in the open market that claim hundreds of thousands

[1] *Haygood v. De Escabedo*, 356 S.W.3d 390, 392 (Tex. 2011); George A. Nation, III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured,* 94 KY. L. J. 101, 120 (2005–2006) [hereinafter Nation, *Obscene Contracts*].

[2] *Daughters of Charity Health Services of Waco v. Linnstaedter*, 226 S.W.3d 409, 410 (Tex. 2007) (citing *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L. J. 101, 120 (2005–2006)); *see also Vencor Inc. v. Nat'l States Ins. Co.*, 303 F.3d 1024, 1029 n. 9 (9th Cir. 2002) ("It is worth noting that in a world in which patients are covered by Medicare and various other kinds of medical insurance schemes that negotiate rates with providers, providers' supposed ordinary or standard rates may be paid by a small minority of patients."); Ge Bai and Gerard F. Anderson, *US Hospitals Are Still Using Chargemaster Markups To Maximize Revenues*, Health Affairs 35, no. 9 (2016) ("The bottom line is that most public and commercial insurers do not pay hospitals their full chargemaster prices.") [hereinafter Bai and Anderson, *Chargemaster Markups*].

[3] *See Haygood*, 356 S.W.3d at 392 ("Charges for health care, once based on the provider's costs and profit margin, have more recently been driven by government regulation and negotiations with private insurers . . . . [Hospitals] feel financial pressure to set their 'full charges' . . . as high as possible, because the higher the 'full charge' the greater the reimbursement amount the hospital receives since reimbursement rates are often set as a percentage of the hospital's 'full charge.'"); Reinhardt, *supra* note 2, at 59; Nation, Obscene Contracts, *supra* note 4, at 120.

of dollars, including one recent case where the amount charged by the hospital for a back surgery was over $500,000.

Personal injury plaintiffs and their attorneys inflate medical bills by intentionally foregoing a plaintiff's health insurance, and by entering agreements instructing medical providers not to bill the plaintiff's health insurance. Plaintiffs and their doctors then attempt to avoid discovery of the providers' lower contractual insurance rates by claiming that, because the plaintiff did not use health insurance, these lower rates are not relevant. With rising healthcare charges,[4] lack of transparency in actual healthcare costs,[5] and the alliance between medical service providers and plaintiff attorneys who intentionally inflate plaintiffs' healthcare charges, proving a plaintiff's actual or reasonable medical expenses has become a demanding task.

Notwithstanding the fact that plaintiff attorneys and doctors are breaching ethical lines by encouraging their clients or patients to risk inflated medical debt, [6] recent case law indicates the tides are turning,[7] and there are tools available to limit defendants' exposure to unchecked medical

[4] Bai, G., & Anderson, G. F., *A More Detailed Understanding Of Factors Associated With Hospital Profitability,* HEALTH AFFAIRS, 35 no.5 (2016) ("Hospital care is the largest component in US health care spending (32 percent), and it increased by 4.1 percent from 2013 to 2014, reaching $972 billion."); *see generally* Bai, G., & Anderson, G. F., *Extreme markup: The fifty US hospitals with the highest charge-to-cost ratios,* HEALTH AFFAIRS, 34 no. 6, 922–28 (2015).

[5] *See* Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind A Veil of Secrecy,* 25 HEALTH AFF. 57, 59 (2006) (opining that healthcare charges are difficult to comprehend); *see generally*, Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME (February 2013).

[6] The practice of encouraging a patient to risk unnecessary medical debt contravenes American Medical Association guidelines. *See* American Medical Association Opinion 8.03, Conflicts of Interests ("Under no circumstance may physicians place their own financial interests above the welfare of their patients."); American Medical Association Opinion 9.12, Patient-Physician Relationship: Respect for Law and Human Rights ("physicians who are obligated under preexisting contractual arrangements [for instance, with insured patients] may not decline to accept patients as provided by those arrangements.").

[7] *In re N. Cypress Med. Ctr. Operating Co., Ltd.*, No. 16-0851, 2018 WL 1974376, at *1 (Tex. Apr. 27, 2018) (holding that amounts that hospital was willing to accept as payment for services rendered to the vast majority of its patients were relevant to the reasonableness of its charges for those same services to uninsured patients, and thus trial court could order hospital to produce information regarding its reimbursement rates from private insurers and public payers for the services).

expenses claimed by plaintiffs. Accordingly, this article discusses medical billing schemes and recommended strategies to challenging a plaintiff's claimed medical expenses.

To limit defendants' exposure to these inflated charges, we must show the charges are unreasonable. Recovery of medical expenses that are unreasonable is prohibited in Texas and many other states.[8] Three principal methods detailed below can be used to attack inflated medical charges and establish that they are unrecoverable as billed.

## I. Providers should be barred from recovering from insured plaintiffs amounts beyond reduced, contractual rates.

Recovery of medical expenses a health provider is not entitled to collect is barred by the Texas common-law collateral source rule.[9] As a surgeon's contract with plaintiff's health insurance company typically prohibits the surgeon from collecting the list price, the inflated list price is unrecoverable. Accordingly, a principal method to challenging inflated medical expenses is to compel key information, such as contracts and reimbursement rates, from healthcare providers and private insurance to establish that such expenses are unrecoverable.

Consider a personal injury case in which an injured plaintiff required a spinal fusion for which the surgeon billed $40,000. Plaintiff has health insurance but his surgery bill was not submitted to his health-insurance carrier. The surgeon later testifies, without further explanation, that the bill reflects a reasonable amount based on his experience in the field. This, despite

[8] To recover medical expenses, plaintiff must show they are reasonable in almost every state, including Alabama, Arizona, Arkansas, California, Colorado, Delaware, Georgia, Hawaii, Idaho, Illinois, Iowa, Indiana, Kansas, Kentucky, Maine, Mississippi, Maryland, Massachusetts, Michigan, North Dakota, Texas, Vermont, and West Virginia. *Haygood*, 356 S.W.3d at 397; *Kendall v. Hargrave*, 349 P.2d 993, 994 (Colo. 1960); MORTON F. DALLER, TORT LAW DESK REFERENCE: A FIFTY STATE COMPENDIUM 313, 336, 360, 378, 460, 481, 499, 532, 665, 902, 1264 (2017 ed. 2017); COMMERCIAL TRANSPORTATION LITIGATION COMMITTEE, DAMAGES: A STATE BY STATE SUMMARY (2014).

[9] *See Haygood*, 356 S.W.3d at 392 ("we hold that the common-law collateral source rule does not allow recovery as damages of medical expenses a health care provider is not entitled to charge").

normally accepting about $2,800 to $3,300 for performing the same surgery on other patients not involved in litigation.

As a starting point, you should discover whether plaintiff is a member of a health insurance plan. Basic interrogatories may reveal this information, in addition to other documents obtained in discovery such as employer documents or medical records. Plaintiff should also be asked at deposition to identify existing health insurance plans, how long that insurance has been in effect, and whether it is obtained through an employer, spouse, or other method. Oftentimes the plaintiff will complete intake forms wherein the plaintiff provides the health insurance plan to the treating medical provider, even though the medical provider may not use the available health insurance due to the medical provider and plaintiff attorney's coordinated effort to avoid insurance adjustments and write-offs to inflate the claimed amount.

Other documents to look for during your investigation include the financial policy for the medical provider, which is typically disclosed in the medical records and their website, as well as any documents assigning health insurance benefits to the medical provider. The medical provider should be asked at deposition to confirm that they accept health insurance plans, including the plan for which plaintiff is a member, about the rates the medical provider accepts from the carrier for the same surgery, and for their opinion on the reasonableness of rates normally collected from the insurance carrier in satisfaction of similar bills.

The surgeon's contract with plaintiff's insurance carrier should be subpoenaed to confirm the amount the surgeon is allowed collect from the plaintiff for the surgery and whether the surgeon accepts payments for less than amounts billed based on the contract. The surgeon's contract with plaintiff's insurance company likely prohibits the provider from collecting the list price from

plaintiff. In that scenario, plaintiff should be barred from recovering expenses the surgeon is not entitled to collect.[10]

Regarding hospital bills, the above inquiry applies. Additionally, questions or subpoenas should seek information regarding reimbursement rates for a set list of surgical supplies used during the surgery and the brand names of the supplies, as well as any invoices or materials showing the hospital's actual costs for the supplies.

Often you will find that the plaintiff's attorney or medical provider may claim that the plaintiff never provided health insurance. However, if the record shows plaintiff submitted his health insurance information to the doctor, plaintiff testifies as to the existence of the health insurance plan, and you have other documents such as an Assignment of Benefits, then there is a fact question regarding the amounts the medical provider is legally entitled to collect under plaintiff's health insurance plan. As such, the information should be discoverable at a minimum.

**In some state, the collateral source rule should not bar discovery of insurance contracts.** Plaintiffs argue the collateral source rule bars discovery of insurance contracts and their reimbursement rates because (1) the collateral source rule precludes the admission of evidence that a source external to the injured plaintiff paid for some or all of the damages the plaintiff seeks to recover;[11] and (2) a tortfeasor should not receive the benefit of claimant's insurance, for which the injured party has paid premiums.[12] However, some states that have

[10] *See id*.; *see also infra* notes 9–15 and accompanying text.
[11] *See, e.g.*, *Haygood*, 356 S.W.3d at 392; *Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal. 4th 541, 550, 257 P.3d 1130, 1134 (2011), *reh'g denied* (Nov. 2, 2011); *Hanif v. Hous. Auth.*, 200 Cal. App. 3d 635, 639, 246 Cal. Rptr. 192, 194 (Cal. App. 1988).
[12] *Crossgrove v. Wal-Mart Stores, Inc.*, 280 P.3d 29 (Colo. Ct. App. 2010) *aff'd*, 2012 Colo. 31, 276 P.3d 562 (Colo. 2012); *see also Acuar v. Letourneau*, 260 Va. 180, 531 S.E.2d 316, 322 (2000) ("amounts written off are as much of a benefit for which [the plaintiff] paid consideration as are the actual cash payments made by his health insurance carrier to the health care providers.").

adopted the collateral source rule still give defendants the benefit of write-offs and adjustments.[13] The argument for this position is that: (1) the plaintiff receives a windfall if he is compensated for reductions in the form of write-offs or adjustments; (2) no collateral source paid the reduced amounts; (3) the plaintiff does not actually have to pay the reduced portion.[14]

In Texas, the collateral source rule does not bar discovery of insurance contracts as they are needed to determine the amount a provider is legally entitled to recover or the amount an insured claimant actually pays or incurs.[15]*In re Jarvis*, the plaintiff argued the collateral source rule barred discovery relating to contracts for payment of the services rendered to Jarvis from her medical providers and health insurance company.[16] The *Jarvis* Court held that the collateral source rule did not bar the discovery.[17] The insurance contracts were relevant and discoverable to determining amounts providers were legally entitled to collect.[18] The Jarvis court considered the Texas Supreme Court's discussion in *Haygood v. De Escabedo* of the Texas paid and incurred statute, the collateral source rule, and reasonable medical expenses.[19] In *Haygood*, the Court held that only adjusted bills were admissible at trial because they reflected what the plaintiff actually paid or incurred.[20] As the providers were not allowed to collect amounts over the adjusted rate,

[13] *Stanley v. Walker*, 906 N.E.2d 852 (Ind. 2009); *Haygood*, 356 S.W.3d at 395; *Robinson v. Bates*, 112 Ohio St. 3d 17, 857 N.E.2d 1195, 1200 (2006).
[14] *See supra* note 11. In Texas, recovery of medical expenses is limited to the amount actually paid or incurred by statute. Tex. Civ. Prac. & Rem. Code § 41.010.
[15] Tex. Civ. Prac. & Rem. Code § 41.0105; *see also In re Jarvis*, 431 S.W.3d 129, 136 (Tex. App. [14th Dist.] 2013).
[16] *See id.*
[17] *Id.* at 137.
[18] *Id.*
[19] *Id.* (discussing *Haygood*, 356 S.W.3d at 395)
[20] *Haygood*, 356 S.W.3d at 395, 399–400.

plaintiff was not entitled to recover the full, unadjusted bill.[21] Otherwise, claimants would recover a windfall given inflated healthcare costs.[22]

For instance, medical providers had charged a patient four times the amount that the providers were entitled to collect.[23] Despite this, the providers testified that the charges billed to Haygood were reasonable.[24] The *Haygood* Court acknowledged that list prices are not intended to be reasonable from their onset; but are artificially inflated only to leverage higher reimbursement rates, being the amounts paid with respect to medical services.[25] It further commented that the list price for treating a patient is "generally at least double and may be up to eight times what the hospital would accept as payment in full for the same services from Medicare, Medicaid, HMOs, or private insurers."[26] The *Haygood* Court then held that only evidence of recoverable medical expenses, in that case the reduced bills, is admissible at trial.[27]

The reasoning and policies used from *Jarvis* and *Haygood* therefore support discoverability of the above-mentioned testimony, documents, and contracts. In other states where recovery of medical expenses is limited to the amount actually paid, this approach should be viable.[28] The same cannot be said for litigation in states that permit evidence of the billed amount and allow for recovery up to the billed amount based on the policy that tortfeasors should not benefit from plaintiff's insurance.[29]

---

[21] *Id.*
[22] *Id.* at 395.
[23] *Id.* at 394.
[24] *Haygood*, 356 S.W.3d at 394.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *See, e.g.*, *supra* note 11; *Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal. 4th 541, 550, 257 P.3d 1130, 1134 (2011), *reh'g denied* (Nov. 2, 2011); *Hanif v. Hous. Auth.*, 200 Cal. App. 3d 635, 639, 246 Cal. Rptr. 192, 194 (Cal. App. 1988); 12 O.S. § 3009.1 (2011).
[29] This includes Colorado. Colo. Rev. Stat § 13-21-111.6 (2008) allows a reduction of the verdict by the amount paid by the collateral source except where the payments arose from contractual obligations intended to benefit the injured

Additionally, it could be argued that plaintiff failed to mitigate his damages by failing to use means at his disposal to contractually or equitably reduce his claimed medical expenses.[30]

## II. Rates providers typically recover from private insurance carriers and Medicare should serve as an anchor.

The argument that plaintiff cannot recover expenses exceeding the allowable amount under plaintiff's available insurance contract with the provider will not apply in cases where plaintiff is uninsured. Still, even when plaintiff is uninsured, numerous cases have held that amounts typically recovered as payment in full satisfaction of the bill is relevant to determining the reasonable value of medical services.[31]

Accordingly, the surgeon or provider should be asked questions that establish how much he or she is customarily paid for similar services. At deposition, confirm they accept health insurance plans, the rates the medical provider accepts as payment from various carriers for the same surgery, and for their opinion on the reasonableness of those rates. The surgeon's contracts with the various insurance carriers should be subpoenaed to determine the rates accepted for similar services. The same inquiry is applicable to hospitals.

Medicare's rates, which, unlike private insurance rates, are public and accessible on CMS.gov, should be obtained to measure the ratio by which a plaintiff's medical expenses are inflated. According to a 2013 study by the Kaiser Family Foundation,[32] 99 percent of general

party. *Barnett v. American Family Mut. Ins. Co.*, 843 P.2d 1302, 1309 (Colo. 1993); *Crossgrove v. Wal-Mart Stores, Inc.*, 280 P.3d 29 (Colo. Ct. App. 2010) *aff'd*, 2012 Colo. 31, 276 P.3d 562 (Colo. 2012); *see also Windsor School Dist. v. State*, 956 A.2d 528, 542–45 (Vt. 2008).

[30] The Supreme Court of Texas is currently considering whether insurance contracts and reimbursement rates are relevant and discoverable for purposes of proving the failure to mitigate defense. *See In re Travis County*, 03-17-00619-CV, 2017 WL 5078006, at *1 (Tex. App.—Austin Nov. 2, 2017, no pet.). Visit http://search.txcourts.gov/Case.aspx?cn=17-0947&coa=cossup for more information.

[31] *See infra* notes 18–39 and accompanying text.

[32] Kaiser Family Foundation, *Medicare Patients' Access to Physicians: A Synthesis of the Evidence* (Dec 2013) https://www.kff.org/medicare/issue-brief/medicare-patients-access-to-physicians-a-synthesis-of-the-evidence.

surgeons and 98 percent of orthopedic surgeons accept Medicare patients. Medicare rates are substantially lower than providers' list prices, and most private insurers use Medicare rates as a baseline for their contractual reimbursement rates.[33] For instance, 125% of Medicare's rates is often used to estimate a reasonable rate, as it accounts for the average difference between Medicare's rate and the average private insurance reimbursement rate (14%), an additional 10% to for the fact that the first 14% added was based on the *average* private insurance rate and many private insurers pay more, and the benefit of prompt payment that insurance companies provide (1%).[34]

Plaintiffs argue that amounts a medical provider routinely accepts for similar services in the same locale are irrelevant to the reasonableness of expenses when such amounts flow from insurance contracts to which an uninsured plaintiff is not privy. However, cases out of Texas, Georgia, Pennsylvania, Florida, and California have established that, regardless of a party being under contract or uninsured, amounts routinely accepted are relevant and discoverable. Scholars agree.[35]

---

[33] George A. Nation III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients*, 65 BAYLOR LAW REVIEW 425, 463–65 (2013) [hereinafter Nation, Fair and Reasonable] (125% of Medicare's rates commensurate with rates paid by private insurance); A Review of Hospital Billing and Collection Practices Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Commerce, 108th Cong. 21 (2004) (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Hospital Finance and Management) (noting 14 percent is added because it is the average difference between the Medicare rate and the average private insurance reimbursement rate, an additional 1 percent is added to this to account for the benefit of prompt payment that insurance companies provide, and 10 percent is added to account for the fact that the 14 percent added first was based on the average private insurance rate and many private insurers pay more).

[34] Nation, Fair and Reasonable, supra note 32, at 463–65; A Review of Hospital Billing and Collection Practices Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Commerce, 108th Cong. 21 (2004) (statement of Gerard F. Anderson, Director, Johns Hopkins Center for Hospital Finance and Management).

[35] *See, e.g.*, George A. Nation, III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients*, 65 BAYLOR L. REV. 425 (2013); *Stanley v. Walker*, 906 N.E.2d 852, 857–858 (Ind. 2009) (reasonable value of medical services is not exclusively based on actual amount paid or amount originally billed, though these figures may serve as evidence as to same); *Martinez v. Milburn Enterprises, Inc.*, 290 Kan. 572, 233 P.3d 205 (2010); *Robinson*, 857 N.E.2d at 1200–1201; *Temple University Hospital v. Healthcare Management*, 832 A.2d 501, 505 (Pa. Super. Ct. 2003); *Children's Hospital Central California v. Blue Cross of California*, 226 Cal. App. 4th 1260 (2014).

Most recently, in *In Re North Cypress Medical Center*, the Texas Supreme Court held that providers' contracts with private insurance carriers and their reimbursement rates are relevant and discoverable.[36] In that case, Crystal Roberts sued North Cypress Medical Center seeking a declaratory judgment that North Cypress's charges were unreasonable and thus unrecoverable.[37] To prove the charges were unreasonable, Roberts requested North Cypress' contracts and reimbursement rates with all the major health insurance carriers and Medicare.[38] After the trial court ordered North Cypress to comply, North Cypress appealed, claiming that because Roberts did not have health insurance and is not a Medicare recipient, its reimbursement rates with these payers are not relevant.[39]

The Texas Supreme Court disagreed, concluding that:

> The charges themselves are not dispositive of what is reasonable, irrespective of whether the patient being charged has insurance. By contrast, a hospital's reimbursements from private insurers and public payers comprise the vast majority of its payments for services rendered. We fail to see how the amounts a hospital accepts as payment from most of its patients are wholly irrelevant to the reasonableness of its charges to other patients for the same services.[40]

The Court also noted that "[w]e disagree that rates a hospital does not expect to collect are more relevant than amounts they accept."[41]

In *Bowen v. The Medical Center, Inc*., the Georgia Supreme Court examined whether information from The Medical Center's ("TMC") pricing agreements with Medicare, Medicaid, and private insurers was discoverable.[42] Bowen was uninsured and injured in an automobile accident. After she was treated, TMC billed her $21,409.59 and filed a hospital lien.[43] Unable to

[36] *In re N. Cypress Med. Ctr. Operating Co., Ltd.*, 16-0851, 2018 WL 1974376, at *7 (Tex. Apr. 27, 2018).
[37] *Id.* at *1.
[38] *Id.*
[39] *Id.* at *1-*2.
[40] *Id.* at *4.
[41] *Id.* at n. 11.
[42] *Bowen v. The Medical Center, Inc.*, 773 S.E.2d 692, 693 (Ga. 2015).
[43] *Id.*

settle TMC's lien, Bowen sought to invalidate it by alleging that the bill did not reflect the reasonable value of her treatment.[44] To prove the TMC's charges were unreasonable, Bowen requested amounts TMC charged for similar treatments to both insured and uninsured patients and sought TMC's pricing agreements with private health insurance carriers.[45] TMC objected to the discovery, and Bowen moved to compel, which the trial court granted.[46] TMC appealed.[47]

On appeal, the Georgia Supreme Court focused on whether the information requested was "relevant" in the broad sense of discovery rather than in "the narrower trial sense of [the reasonableness of TMC's charges]."[48] The court cited the statutory rule that parties in Georgia may obtain discovery on "any matter, not privileged, which is relevant to the subject matter involved in the pending action."[49]

The court concluded that, although amounts TMC had charged other patients for the same type of care may not be dispositive of whether Bowen's charges were "reasonable," that did not mean the amounts TMC charged other patients were "entirely irrelevant."[50] Bowen was therefore entitled to see what the information and documents showed to determine whether the discovery supported her claims that charges were unreasonable.[51]

In *Children's Hospital Central California v. Blue Cross of California*, the Court of Appeals for the Fifth District of California held that the trial court improperly limited evidence of the

---

[44] *Id.*
[45] *Id.*
[46] *Id.*
[47] *Id.*
[48] *Id.* at 696.
[49] *Id.* at 695. This rule is identical to Tex. R. Civ. P. 192.3(a).
[50] *Id.* at 697.
[51] *Id.*; A Pennsylvania Superior court stated that calculating a reasonable value will consider "what the services are ordinarily worth in the community. Services are worth what people ordinarily pay for them . . . While the Hospital's published rates for services may be the same or less than rates at other Philadelphia hospitals, the more important question is what healthcare providers actually receive for those services." *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alternatives, Inc.*, 832 A.2d 501 (Pa. Super. Ct. 2003). As the hospital in that case rarely recovered its published rates, the Court stated that "those rates cannot be considered the value of the benefit conferred because that is not what people in the community ordinarily pay for medical services." *Id.*

reasonable and customary value of a hospital's "full billed charges."[52] During the discovery period, the hospital objected, on grounds that they were irrelevant, to Blue Cross's requests inquiring into its contracts with other insurance carriers, the number of patients receiving care for whom Hospital actually collected list prices, and the name of any non-contracted managed care organization that paid Hospital's list prices.[53] The trial court denied Blue Cross's motion to compel and at trial, Hospital supported its damages claim by arguing its list prices "represented the reasonable and customary value of the services provided."[54]

The jury awarded Hospital the amount of its full-billed charges less the amount that Blue Cross had already paid.[55] On appeal, the Court of Appeals stated "[a]ll rates that are the result of contract or negotiation, including rates paid by government payors, are relevant to the determination of reasonable value."[56] "The full range of fees is relevant. The scope of the rates accepted by or paid to Hospital by other payors indicates the value of those services in the marketplace."[57]

These courts have recognized amounts a medical provider routinely accepts and market charges for the same services in the same locale are relevant to both insured and uninsured patients. Therefore, health insurance data and differential pricing are relevant to determining true and reasonable medical costs and should be discoverable.

[52] *Children's Hosp. Cent. California v. Blue Cross of California*, 226 Cal. App. 4th 1260, 172 Cal. Rptr. 3d 861 (2014).
[53] *Id.* at 1268.
[54] *Id.* at 1269–70.
[55] *Id.*
[56] *Id.* at 1270.
[57] *Id.* at 1277 (emphasis added).

### III. Exclude or cross-examine the expert based on bias or unreliable methodology.

Defense counsel should move to exclude expert testimony supporting the reasonableness of the bills based on the expert's unreliable methodology and bias. Evidence showing the degree of inflation of Plaintiff's medical bills and ethical guidelines applicable to the doctor's billing practices may be used to paint the jury a vivid picture of the doctor's bias and lack of credibility and the unreasonableness of plaintiff's medical expenses.

Inquiry should be made into the surgeon's methodology in pricing his services. Determine whether the surgeon relied on a particular book or formula, how the book or formula was used, and what database was used to input figures into the formula. The expert's inability to answer these questions will show the unreliability of the foundation for his expert opinion on reasonableness of the bills.

Investigate the frequency at which the surgeon testifies in lawsuits at the request of plaintiff's attorney, and payments for such testimony. A subpoena to the firm's often-used court reporter may reveal this information. There should also be invoices from the medical provider to the attorney and 1099's that may reveal the number of times and amounts paid for prior testimony in similar lawsuits. A subpoena to the surgeon's office or hospital should request written correspondence to or from plaintiff or his attorney relating to charges for medical services provided to plaintiff.

Cross-examine the doctor regarding the ethics of billing patients involved in litigation at inflated rates, which unnecessarily increases the patient's medical debt, as a means to secure enormous profit from the patient's award. The American Medical Association ("AMA") criticizes medical practices that put profit over patient. The AMA opined: "Under no circumstance may

physicians place their own financial interests above the welfare of their patients"[58] and "physicians who are obligated under preexisting contractual arrangements [for instance, with insured patients] may not decline to accept patients as provided by those arrangements"[59].

Similarly, the lawyer-doctor referrals and lawyer-driven medical treatment appear to contravene the Federal Trade Commission's understanding of the "corporate practice of medicine" doctrine:

> It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy.[60]

The reality is, this prospect of recovering enormous profit from a plaintiff's award has caused doctors involved in personal injury litigation to put profit over patient: they issue egregiously inflated bills even if it means that the patient may incur unnecessary medical debt in consequence. And, Doctors engaged in this practice become repeat players, continually issuing inflated bills to maintain their profitable business relationship with the law firms that refer plaintiffs to them and drive the treatment.

## IV. Conclusion

We must keep pushing to expose and end this unjustifiable scheme to artificially inflate medical expenses in personal injury litigation. Demanding the information outlined in this article

[58] *See* American Medical Association Opinion 8.03, Conflicts of Interests.
[59] *See* American Medical Association Opinion 9.12, Patient-Physician Relationship: Respect for Law and Human Rights.
[60] *In re Am. Med. Ass'n*, 94 F.T.C. 701, 1011 n.59 (1979).

will help expose the current practice of physicians and plaintiff lawyers coalescing and creating unethical financial relationships. Without more, litigants are exposed to medical bills that are unchecked and only require the *ipse dixit* from the medical provider that these medical charges are reasonable.