

FILED
Court of Appeals
Division II
State of Washington
12/24/2018 12:00 PM

NO. 51317-0-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

CESAR BELTRAN-SERRANO,

Plaintiff/Respondent,

v.

CITY OF TACOMA

Defendant/Petitioner.

PETITIONER'S REPLY BRIEF

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APPENDIX

I. Although plaintiff had ample opportunity to move to exclude Dr. Wickizer's opinion, he did not do so and consequently, there was no motion to exclude pending before the superior court.

In his response, plaintiff suggests that the first time the City disclosed Dr. Wickizer's opinion was on August 21, 2017, when the City served plaintiff with Dr. Wickizer's declaration¹. Brief of Respondent, p. 8. This is not true. While it is correct to say that the City had not filed an amended witness disclosure identifying Dr. Wickizer, the City did disclose Dr. Wickizer as an expert and provided plaintiff with Dr. Wickizer's full report *prior to the discovery cutoff in this case*. Appendix p. 6 (PCLR case schedule); Appendix p. 8 (service of Dr. Wickizer's report); Appendix p. 29 (acknowledging receipt of Dr. Wickizer's report).

Plaintiff further asserts that he moved to exclude Wickizer's opinions at the first available opportunity. Brief of Respondent, p. 11. This assertion is also untrue. As outlined above, plaintiff was provided with Dr. Wickizer's opinion on August 8, 2017. The City then filed Dr. Wickizer's declaration in response to plaintiff's motion for partial summary judgment on August 21, 2017. Plaintiff's motion was noted for hearing on September 1, 2017. Contrary to plaintiff's assertion, plaintiff could have properly

¹ Plaintiff made this same representation to the superior court at the time of the hearing. RP 6, lines 16-17 ("And the reason for that is that he was just disclosed on August 21st."). When the City advised the court that this was not accurate, the court indicated that it was not concerned with the timing of disclosure. RP 10, lines 6-12.

moved to exclude Dr. Wickizer's opinion and could have noted such a motion to be heard on September 1, 2017, at the same time as the motion for partial summary judgment. Plaintiff, however, did not do so.

Under the Pierce County local rules² (at the time of the incident³), “[A]ll motions, except motions during trial or those motions heard by the Commissions as set forth below *shall be heard on the assigned judicial department’s motion calendar.*” (emphasis added) PCLR 7(a)(1). The Rule further provides that “[m]otions are heard on Friday mornings at 9:00 a.m., unless specifically set by the assigned judicial department.” *Id.* In order to get a motion on the court’s docket for consideration, the Rule required that the moving party file a Note for Motion Docket, along with the motion and all supporting documents, with the court six court days before the hearing date, and to serve the opposing party with all of the required documents at the same time. PCLR 7(a)(3)(A). Had plaintiff wanted to have the superior court consider a motion to exclude Dr. Wickizer’s opinions, plaintiff needed only to note, file and serve such a motion by August 24, 2017⁴. Plaintiff did

² It is unclear why plaintiff is relying upon the King County local rules, as this case was pending in the Pierce County Superior Court and is subject to the Pierce County local rules.

³ PCLR 7(a)(3) was amended, effective September 1, 2018, to require that the motion and supporting document be filed and served on the opposing party seven court days before the hearing date. At the time of the partial summary judgment in this case, PCLR 7(a)(3) required the motion and supporting documents be filed and served six court days before the hearing date.

⁴ Given that plaintiff was provided with Dr. Wickizer’s complete opinion on August 8, 2017, plaintiff had approximately two weeks to prepare a motion to exclude.

not do so and consequently, there was no motion to exclude pending before the superior court at the time the partial summary judgment was heard, a fact the superior court expressly noted. RP 16:3-15.

Moreover, exclusion of Dr. Wickizer's opinion would have required the superior court to either conduct a Frye hearing or undertake a Burnet analysis⁵. The superior court did neither because plaintiff did not file a motion to exclude under either Frye or Burnet. Plaintiff's failure to properly move to exclude Dr. Wickizer waives these arguments on appeal:

Parties generally may not raise arguments for the first time on appeal. *State v. Stoddard*, 192 Wn. App. 222, 226, 366 P.3d 474 (2016). Requiring parties to preserve their evidentiary objections at trial serves multiple functions, including allowing the trial court an opportunity to rule correctly before an issue is appealed, preserving judicial economy, facilitating appellate review, and allowing a party's opponent to fully address the issues. *Id.* at 226-27. That same logic governs in the *Frye* context: where

⁵ Frye refers to Frye v. United States, 54 App. D.C. 46, 293 F. 1013, 34 A.L.R. 145 (D.C. Cir. 1923), implicitly adopted by the Washington Supreme Court in State v. Woo, 84 Wn.2d 472, 527 P.2d 271 (1974), and explicitly approved in State v. Canaday, 90 Wn.2d 808, 585 P.2d 1185 (1978). The Frye standard requires a trial court to determine if a scientific theory or principle “has achieved general acceptance in the relevant scientific community” before admitting it into evidence. In re Det. of Thorell, 149 Wn.2d 724, 754, 72 P.3d 708 (2003) “The core concern . . . is only whether the evidence being offered is based on established scientific methodology.” Id. Burnet refers to Burnet v. Spokane Ambulance, 131 Wn.2d 484, 933 P.2d 1036 (1997). Under Burnet, and its progeny, when a superior court excludes a witness as a sanction under CR 37, the court must find an intentional nondisclosure, a willful violation of a court order, or other unconscionable conduct; further, “it must be apparent from the record that the trial court explicitly considered whether a lesser sanction would probably have sufficed,” and whether it found that the disobedient party’s refusal to obey a discovery order was willful or deliberate and substantially prejudiced the opponent’s ability to prepare for trial.” Burnet, 131 Wn.2d at 494.

a *Frye* argument was not raised below, the argument need not be considered on appeal. *State v. Newbern*, 95 Wn. App. 277, 290, 975 P.2d 1041 (1999). Although courts usually apply this rule to bar *Frye* arguments when an appellant failed to request a *Frye* hearing altogether, the rationale applies with equal strength when the appellant challenges expert testimony on grounds not raised below.

Here, Robb did not address, much less object to, Dixon's use of the U.S. Y-STR Database. Although Robb invoked *Frye*, ***he failed to allow the trial court or the State to address the argument he now makes on appeal.***

“[E]videntiary error is unpreserved unless a timely objection or motion to strike is made that states the specific ground of objection” or unless the grounds for an objection is apparent from the context. *State v. Wilbur-Bobb*, 134 Wn. App. 627, 634, 141 P.3d 665 (2006) (applied to an appeal raising *Frye*). Context did not make clear that Robb objected to the database Dixon relied on. Because Robb failed to raise this ground for objection at trial, he waived the argument and we do not address it.

(emphasis added) *State v. Robb*, 2017 Wash. App. LEXIS 5, at *12-13 (Ct. App. Jan. 4, 2017). By raising arguments directed at Dr. Wickizer’s opinion in his reply, as opposed to properly noting a motion to exclude, the plaintiff prevented both the superior court and the City from having an opportunity to “fully address the issues” at the trial court level, whether under *Frye*⁶ or

⁶ Contrary to plaintiff’s assertions, Dr. Wickizer’s methodology has been utilized by other researchers to determine reasonable value, as reported in peer reviewed literature. CP 250-260.

Burnet. Consequently, these arguments were not properly preserved for appeal (as they could have been) and should not be considered⁷.

II. Orders from other cases are not relevant to the issue pending before this Court.

In their response brief, plaintiff states that a number of courts have excluded Dr. Wickizer in cases where his opinion has been based on the same methodology. Brief of Respondent, p. 9-10. Plaintiff's assertion – that Wickizer's opinions are based on the same methodology in each of the cases wherein he was excluded – has no foundation in the record, as none of these orders – as well as the briefing underlying those orders – are part of the record in this case. Thus, it is unknown what Dr. Wickizer's opinions were in those other cases or the methodology that he utilized to arrive at those opinions. Similarly, it is unknown what arguments were made to the superior courts in those other matters or the basis for the decisions made by those courts. In short, the only opinion relevant to this Court's analysis is the opinion offered by Dr. Wickizer in this case and the only order relevant to this Court's analysis is the order granting plaintiff's motion for partial summary judgment in this case.

⁷ Similarly, plaintiff's arguments under ER 702 and ER 703 were not included in a properly noted motion to exclude and therefore are also waived on appeal.

III. Dr. Wickizer’s opinion does not implicate the collateral source doctrine.

In plaintiff’s response brief, plaintiff asserts that Wickizer arrived at his figure by applying the “cost-to-charge” ratio, “a number calculated from big-data insurance reimbursement rates, a collateral source benefit to which Beltran-Serrano was not entitled.”⁸ Brief of Respondent, p. 8. This statement demonstrates that plaintiff misunderstands what the cost-to-charge ratio is...and what it is not. As outlined in the City’s opening brief, the cost-to-charge ratio or CCR represents the cost of actually providing the service as compared to the charge that is levied for that service. For example, a CCR of .5 means that the cost of providing the specific service is 50% of the charge that is levied for that service. In other words, for a CCR of .5, the hospital is charging the patient twice the amount that it cost the hospital to provide that particular service. The CCR, however, is not based in insurance reimbursement rates, or payment rates from any source. As such, the CCR does not implicate the collateral source doctrine.

⁸ Similarly, plaintiff asserts that “[i]n short, Dr. Wickizer opines that the costs billed to the general public are not reasonable because they are not the actual amount paid by the public after third-parties, such as insurance, negotiate with the hospitals and secure a reduced rate of treatment.” Brief of Respondent, p. 17. Plaintiff also asserts that “Dr. Wickizer applies a group discount (the reimbursement rates for Medicare and large insurance companies)[.]” Again, this is a misapprehension of Dr. Wickizer’s opinion, as his opinion does not rely on payments made or apply the reimbursement rates from any payment source, such as Medicare or any insurance company.

As outlined in the City’s opening brief, Dr. Wickizer’s opinion is based on an unimpeachable economic principle: *the reasonable value of a good or service is determined by the cost of producing the good or service, plus the profit margin that the market will bear.* Dr. Wickizer used the medical billing records for the services provided to Mr. Beltran by the various hospitals and applied the CCR from the Federal Cost Report for each specific provider to the billed charges for the hospital services provided to Mr. Beltran. CP 251-255. By doing so, Dr. Wickizer was able to determine how much it cost⁹ *each hospital to provide the specific services rendered for Mr. Beltran.* Dr. Wickizer then added a reasonable profit margin of 5% to the actual cost of providing the specific services to Mr. Beltran¹⁰. Using this methodology (cost + profit margin = reasonable value), Dr. Wickizer opined that the reasonable value of the past medical services provided to plaintiff in this case represents approximately 33.4% of the billed amounts. CP 205.

Plaintiff also argues that Dr. Wickizer’s opinion should not be admissible because it is not based on what “medical consumers *actually pay* in relation to the amount billed for health care services and treatments”

⁹ Dr. Wickizer’s opinion is based on what it cost the hospital to provide the services, not the amount an insurance company – or any other source – paid for the service.

¹⁰ Peer reviewed literature shows that hospitals normally show a profit margin from roughly 2% for non-profit hospitals to 6% for for-profit hospitals.

(Brief of Respondent, p. 23), but this argument makes no sense in light of the collateral source doctrine. If Dr. Wickizer's opinion relied upon the actual payments made in any particular case, his opinion would be based on collateral source information and would be excludable on that basis.

Plaintiff also asserts that Dr. Wickizer's opinion is based on "speculation and conjecture regarding the cost to produce the service," but again, this statement only evidences a complete misapprehension of Dr. Wickizer's methodology. Brief of Respondent, p. 23. Dr. Wickizer does not speculate or guess what it costs each hospital to provide each service. *Id.* He relies upon the hospital's own annual report of the actual cost to the hospital to provide each service. For example, for the services provided to Mr. Beltran by Tacoma General, Dr. Wickizer relied upon *Tacoma General's* own cost report – for the year the services were provided and for each specific service identified – to determine how much it cost Tacoma General to provide the specific services that Tacoma General provided to Mr. Beltran. And contrary to plaintiff's assertion, Dr. Wickizer does not arbitrarily decide what profit margin should be allowed. Brief of Respondent, p. 23. Instead, Dr. Wickizer applied a profit margin based on the margins established by peer-reviewed literature. CP 255-56.

Plaintiff's confusion about Dr. Wickizer's methodology notwithstanding, his opinion does not implicate the collateral source

doctrine in any way, as his opinion is not based on payments made on plaintiff's behalf for the medical services at issue. Instead, his opinion is based on uncontested facts (the cost of providing the services at issue plus a profit margin, established by scientific literature) and is grounded in age-old economic theory. As such, there is no basis for exclusion of his opinions under the collateral source doctrine.

IV. Dr. Wickizer's opinion is proper expert testimony on the issue of reasonable value of the medical services provided.

Finally, plaintiff argues that Dr. Wickizer's opinion should be excluded on the basis of public policy because plaintiffs cannot control what amount is billed and because plaintiffs deserve to be "fully and adequately compensated." Plaintiff's argument, however, ignores the most relevant fact in this equation – that hospitals *do not recover (collect) the amount billed*. Instead, peer reviewed research establishes that hospitals recover (collect) approximately 38% of the amount billed.

Plaintiffs have been recovering the amount billed for years, even though the amount billed *does not fairly or accurately reflect the damages actually incurred (which is the reasonable value of the medical services)*. Plaintiffs have been able to do so because the collateral source doctrine prevents *the defendant* from proffering evidence of payments made for the services provided. Ciminski v. Sci Corp., 90 Wn.2d 802, 805, 585 P.2d 1182

(1978). As outlined in the City's opening brief, the policy underlying the rule is that the tortfeasor should not benefit from payments made by a collateral source, *to the plaintiff's detriment*. The collateral source rule, however, does not mean that plaintiffs are entitled recover damages *that are not actually incurred*.

What plaintiff is arguing is that he should be entitled to obtain – as a measure of damage – the total amount billed, even though the amount billed does not represent damages actually incurred, as no one pays the total amount billed. The purpose of the collateral source rule is to ensure that if there has to be a windfall, the plaintiff gets the benefit of that windfall, as opposed to the tortfeasor. But the collateral source rule was never intended to guarantee or create an unnecessary windfall.

Plaintiff's reliance on the collateral source rule in this case accomplishes two things. One, it guarantees plaintiff a windfall (a fictitious measure of damage, as opposed to the actual damages incurred). Second, it prevents the defendant from ever offering evidence on the issue of the reasonable value of medical services provided. This is not the law in Washington.

As outlined in the City's opening brief, under Washington law, the issue is not what health care providers normally charge. The issue is whether the sums requested for medical services are reasonable. Further,

Washington law does not presume that medical bills are reasonable: “medical records and bills are relevant to prove past medical expenses only if supported by additional evidence that the treatment and the bills were both necessary and reasonable.” Patterson v. Horton, 84 Wn. App. at 543. Moreover, “[p]roof of [medical expenses] need not be unreasonably exacting and may come from any witness who evidences sufficient knowledge and experience respecting the type of service rendered and the reasonable value thereof.” Kennedy v. Monroe, 15 Wn. App. 39, 49, 547 P.2d 899 (1976).

Dr. Wickizer’s opinion directly addresses the reasonable value of the medical care provided to Mr. Beltran. His opinion is grounded in both fact and long-established, well-accepted economic principles. Plaintiff did not bring a motion to exclude Dr. Wickizer’s opinions (on any basis) and consequently, the trial court was obligated to consider his opinions in the context of plaintiff’s motion for partial summary judgment. The superior court refused to do so, expressly stating that it “would not be fair.” RP 14, lines 1-5. In so doing, the superior court improperly resolved a material question of fact. This is clear error and the superior court’s order, granting plaintiff’s motion for partial summary judgment, must be reversed.

//

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DATED this 24 day of December, 2018.

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CERTIFICATE OF SERVICE

I hereby certify that I forwarded the foregoing documents:

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EXECUTED this 24 day of December, 2018, at Tacoma, WA.

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Pierce County Superior Court Civil Case 15-2-11618-1

Case Title: CESAR BELTRAN-SERRANO VS. CITY OF TACOMA
 Case Type: Personal Injury
 Access: Public
 Track Assignment: Standard
 Jury Size: 12
 Estimated Trial Length:
 Dept Judge: **14 SUSAN K. SERKO**
 Resolution:
 Completion:

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Filings

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08/16/2018  **CLERK'S PAPERS SENT**
 09/07/2018  **CLERK'S PAPERS SENT**
 09/25/2018  **REQUEST FOR COPIES OF CLERK'S PAPERS**
 10/08/2018  **REQUEST FOR CD COPY OF CLERKS PAPERS**

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Proceedings

Date	Calendar	Outcome
09/25/2015	C4 - EXPARTE CALENDAR (Rm. 105) Confirmed 10:49 Exparte Action	Held
09/25/2015	C4 - EXPARTE CALENDAR (Rm. 105) Confirmed 10:53 Exparte Action	Held
01/29/2016	DEPT 15 - JUDGE LEANDERSON (Rm. 304) Confirmed 9:00 Status Conference	Status Conf Held
04/08/2016	DEPT 15 - JUDGE LEANDERSON (Rm. 304) Unconfirmed 9:00 Motion(Compel)	Cancel via Web-Issue resolved
Scheduled By: Gisel Castro		
04/08/2016	DEPT 15 - JUDGE LEANDERSON (Rm. 304) Confirmed 9:00 Motion(Other: TO CONTINUE)	Motion Held
Scheduled By: Gisel Castro		
04/29/2016	DEPT 15 - JUDGE LEANDERSON (Rm. 304) Unconfirmed 9:00 Status Conference	Cancelled/Stricken
Scheduled By: JEAN HOMAN		
06/23/2016	DEPT 15 - JUDGE LEANDERSON (Rm. 304) Confirmed 9:00 Exparte Action	Ex-Parte w/ Order Held
06/24/2016	DEPT 15 - JUDGE LEANDERSON (Rm. 304) Confirmed 9:00 Motion(Other: EXAMINATION PURSUANT TO CR 35)	Cancel via Web-Issue resolved
Scheduled By: Gisel Castro		
07/22/2016	DEPT 14 - JUDGE SERKO (Rm. 533) Unconfirmed 9:00 Motion(Other: FOR PROTECTIVE ORDER AND TO QUASH NOTICE OF DEPOSITION OF PLAINTIFF)	Continued
Scheduled By: John Connelly		
07/29/2016	DEPT 14 - JUDGE SERKO (Rm. 533) Confirmed 9:00 Motion(Compel)	Motion Held Working Copies Provided
Scheduled By: Gisel Castro		
07/29/2016	DEPT 14 - JUDGE SERKO (Rm. 533) Confirmed 9:00 Motion(Other: FOR PROTECTIVE ORDER AND TO QUASH NOTICE OF DEPOSITION OF PLAINTIFF)	Motion Held Working Copies Provided
07/29/2016	DEPT 14 - JUDGE SERKO (Rm. 533) Confirmed 9:00 Motion(Compel)	Motion Held Working Copies Provided
Scheduled By: John Connelly		
Week Of 08/11/2016	DEPT 15 - JUDGE LEANDERSON (Rm. 304) Unconfirmed Pretrial Conference	Cancelled/Stricken
08/25/2016	DEPT 15 - JUDGE LEANDERSON (Rm. 304) Confirmed 9:00 Trial	Continued
09/16/2016	DEPT 14 - JUDGE SERKO (Rm. 533) Confirmed 9:00 Status Conference	Status Conf Held
11/28/2016	DEPT 14 - JUDGE SERKO (Rm. 533) Confirmed 9:00 Trial	Cancelled/Amend Case Sched
03/24/2017	DEPT 14 - JUDGE SERKO (Rm. 533) Unconfirmed 9:00 Motion(Amend)	Cancelled/Stricken
Scheduled By: John Connelly		
04/21/2017	DEPT 14 - JUDGE SERKO (Rm. 533) Confirmed 9:00 Motion(Amend)	Motion Held Working Copies Provided
Scheduled By: John Connelly		
07/28/2017	DEPT 14 - JUDGE SERKO (Rm. 533) Confirmed	Motion Held Working Copies Provided

9:00 Motion(Other: FOR EXAMINATION FOR PURPOSES OF PHOTOGRAPHS
PURSUANT TO CR 35)

Scheduled By: Gisel Castro

09/01/2017	DEPT 14 - JUDGE SERKO (Rm. 533) Confirmed 9:00 Motion - Part Summary Judgment	Motion Held Working Copies Provided
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Scheduled By: Gisel Castro

09/01/2017	DEPT 14 - JUDGE SERKO (Rm. 533) Confirmed 9:00 Motion - Summary Judgment	Motion Held Working Copies Provided
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Scheduled By: John Connelly

09/15/2017	DEPT 14 - JUDGE SERKO (Rm. 533) Confirmed 9:00 Motion(Other: MOTION TO CERTIFY ISSUE AND STAY PROCEEDINGS)	Motion Held Working Copies Provided
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Scheduled By: John Connelly

09/25/2017	DEPT 14 - JUDGE SERKO (Rm. 533) Confirmed 3:13 Exparte Action	Ex-Parte w/ Order Held
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10/09/2017	DEPT 14 - JUDGE SERKO (Rm. 533) Confirmed 9:00 Trial	Cancelled/Stricken Working Copies Provided
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12/08/2017	DEPT 14 - JUDGE SERKO (Rm. 533) Confirmed 9:00 Mandatory - Court Review Hrg	Fail to Appear-Party(ies)
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01/18/2019	DEPT 14 - JUDGE SERKO (Rm. 533) Confirmed 9:00 Mandatory - Court Review Hrg	
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WORKING COPY

Pending Case Schedule Items

Event	Schedule Date
Mandatory - Court Review Hrg	01/18/2019

Judgments

Cause #	Status	Signed	Effective	Filed
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This calendar lists Confirmed and Unconfirmed Proceedings. Attorneys may **obtain access rights** to confirm/strike selected proceedings. Currently, any proceedings for the Commissioners' calendars can be stricken, but only Show Cause proceedings for the Commissioners' calendars can be confirmed.

Unconfirmed Proceedings will not be heard unless confirmed as required by **the Local Rules of the Superior Court for Pierce County** .

- Hearing and location information displayed in this calendar is subject to change without notice. Any changes to this information after the creation date and time may not display in current version.
- Confidential cases and Juvenile Offender proceeding information is not displayed on this calendar. Confidential case types are: Adoption, Paternity, Involuntary Commitment, Dependency, and Truancy.
- The names provided in this calendar cannot be associated with any particular individuals without individual case research.
- Neither the court nor clerk makes any representation as to the accuracy and completeness of the data except for court purposes.

Created: Thursday December 20, 2018 9:42AM

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THE STATE OF WASHINGTON
PIERCE COUNTY

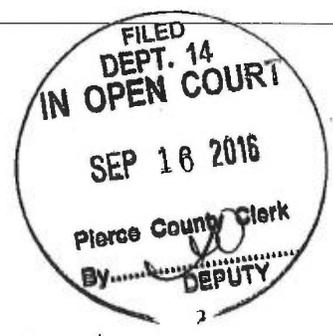
No. 15-2-11618-1
**ORDER AMENDING
CASE SCHEDULE**

CESAR BELTRAN SERKANO
Plaintiff(s)
vs.
CITY OF TACOMA
Defendant(s)

Type of Case: PIN
Estimated Trial (days):
Track Assignment: Standard
Assigned Department: 14 - Judge SUSAN K. SERKO
Docket Code: ORACS

Confirmation of Joinder of Parties, Claims and Defenses	02/06/17
Plaintiff's/Petitioner's Disclosure of Primary Witnesses	04/03/17
Defendant's/Respondent's Disclosure of Primary Witnesses	05/01/17
Disclosure of Rebuttal Witnesses	06/19/17
Deadline for Filing Motion to Adjust Trial Date	07/17/17
Discovery Cutoff	08/21/17
Exchange of Witness and Exhibit Lists and Documentary Exhibits	09/04/17
Deadline for Hearing Dispositive Pretrial Motions	09/11/17
Deadline to file Certificate or Declaration re: Alternative Dispute Resolution (PCLR 16 (c)(3))	09/11/17
Joint Statement of Evidence	09/11/17
Trial	10/09/17 9:00

Unless otherwise instructed, ALL Attorneys/Parties shall report to the trial court at 9:00 AM on the date of trial.



NOTICE TO PLAINTIFF/PETITIONER

If the case has been filed, the plaintiff shall serve a copy of the Case Schedule on the defendant(s) with the summons and complaint/petition: Provided that in those cases where service is by publication the plaintiff shall serve the Case Schedule within five (5) court days of service of the defendant's first response/appearance. If the case has not been filed, but an initial pleading is served, the Case Schedule shall be served within five (5) court days of filing. See PCLR 3.

NOTICE TO ALL PARTIES

All attorneys and parties shall make themselves familiar with the Pierce County Local Rules, particularly those relating to case scheduling. Compliance with the scheduling rules is mandatory and failure to comply shall result in sanctions appropriate to the violation. If a statement of arbitrability is filed, PCLR 3 does not apply while the case is in arbitration.

DATED: 9/16/16



Judge Susan K. Serko
Department 14 (253) 798-3646

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR PIERCE COUNTY

0081

CESAR BELTRAN-SERRANO

Plaintiff(s)

vs.

CITY OF TACOMA

Defendant(s)

No. 15-2-11618-1

**ORDER AMENDING
CASE SCHEDULE**

Type of Case: PIN

Estimated Trial (days):

Track Assignment: Standard

Assigned Department: 14 - Judge SUSAN K. SERKO

Docket Code: ORACS

15973

CC: JEAN P HOMAN, Atty
John Robert Connelly JR, Atty
Micah R LeBank, Atty

9/20/2016

Homan, Jean (Legal)

From: Black, Staci (Legal)
Sent: Tuesday, August 8, 2017 1:48 PM
To: Micah LeBank; Jack Connelly; Meaghan Driscoll
Cc: Pamela Wells; Homan, Jean (Legal); Castro, Gisel (Legal)
Subject: Beltran v. COT - Dr. Wickizer Report
Attachments: Dr. Wickizer Report.pdf

Attached please find Dr. Wickizer's report.

Thank you,
Staci

Staci Black, Paralegal
Tacoma City Attorney's Office
747 Market Street, Suite 1120
Tacoma, WA 98402
(253) 591-5885 office
(253) 591-5268 direct
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FINAL REPORT
ANALYSIS OF DAMAGES FOR MEDICAL EXPENSES

Beltran v City of Tacoma

Thomas Wickizer, PHD, M.P.H.
Professor
College of Public Health
The Ohio State University
Affiliate Professor
Department of Health Services
University of Washington

August 4, 2017

On June 29, 2013, Cesar Beltran, a 53-year-old mentally ill individual, was walking southbound on Portland Ave. in Tacoma. Mr. Beltran encountered Michel Volk, a City of Tacoma police officer. Mr. Beltran allegedly presented a direct and serious, physical threat to Officer Volk, resulting in Officer Volk shooting him. On March 15, 2017, Cesar Beltran filed suit (Case No: 15-2-11618-1) in Pierce County Superior Court for general and special damages arising from the June 29, 2013 incident.

As discussed in WASHINGTON PRACTICE WPI 30.07.01, Washington State statute RCW 4.56.250(1) (a) defines economic damages that in some circumstances may be recoverable from an accident as “objectively verifiable monetary losses, including medical expenses.” Medical expenses must be both reasonable and necessary to be recovered as damages. The burden of proving reasonableness and necessity of past medical expenses rests with the plaintiff. *See Patterson v. Horton*, 84 Wn. App 531, 929 P.2d 1125 (1997). To prove the reasonableness and necessity of past medical expenses, the plaintiff may not rely solely on his or her own testimony as to amounts incurred. *See Nelson v. Fairfield*, 40 Wn.2d, 496, 244 P.2d 302 (1952). Nor can the plaintiff rely solely on medical records and bills, as “...medical records and bills are relevant to prove past medical expenses only if supported by additional evidence that the treatment and the bills were both necessary and reasonable.” *See Patterson*, supra at 543. The court in *Hayes v. Wieber Enterprises Inc.*, 105 Wn. App. 611,616, 20 P.3rd 496 (2001) stated, “And the amount actually billed or paid is not itself determinative. The question is whether the sums requested for medical services are reasonable.” Generally, expert testimony will be necessary to establish the reasonableness and necessity of medical expenses *See Lakes v. Von Der Mehden*, 117 Wn. App 212, 70 P.3rd 154 (2003).

Ms. Jean Holman of the Tacoma City Attorney Office requested that I review and analyze the billing records for past medical services provided by Tacoma General Hospital and Western State Hospital to Cesar Beltran after June 29, 2013, and provide my expert opinion regarding the reasonableness of economic damages claimed by the plaintiff for past medical expenses. I received the billing records for past medical care provided to Cesar Beltran from legal staff of the Tacoma City Attorney.

I am a health economist with over 20 years of research and teaching experience at the University of Washington (1989 – 2009) and now at The Ohio State University (2009 – 2015). I have served as an expert witness or legal consultant in similar cases in both Washington State and Oregon. By way of background, I have published peer-reviewed articles on health care expenditures (Feldstein and Wickizer, 1995), hospital expenditures and cost containment programs (Wickizer et al., 1989; Wickizer, Wheeler and Feldstein, 1991; Wheeler and Wickizer 1990; Wickizer and Feldstein, 1995). More recently, I have performed a cost of illness study (Wickizer 2013) and analyzed the cost savings of quality improvement programs in Washington State (Wickizer et al. 2011). In much of my teaching and research over the years, I have had to consider the question of what constitutes efficiency in the production and consumption of health care services. That question is conceptually related to the issue of “reasonable value” in the context of *Beltran v City of Tacoma*.

Beltran Medical Bills

I received the billing records for a number of health care providers that provided medical care to Cesar Beltran after June 29, 2013. Defense counsel Holman requested that I limit my analysis to the hospital care provided to Plaintiff Beltran. Two hospitals provided medical care to Mr. Beltran. Tacoma General Hospital provided initial inpatient care; Western State Hospital provided subsequent inpatient mental health care. A breakdown of the total charges for these two hospitals is shown in Table 1. As shown, the total (aggregate) billed charge was \$756,714.64. Tacoma General Hospital accounts for 93.4% of the total billed hospital charges.

Table 1. Summary of Billed Hospital Charges

Provider	Billed Charge
Tacoma General Hospital	\$706,999.15
Western State Hospital	\$49,715.49
TOTAL	\$756,714.64

As discussed in later sections of this report, the total billed charge shown in Table 1 (\$756,714.64) does not represent the “reasonable value” of economic damages arising from Cesar Beltran’s medical expenses. As noted earlier, I offer no formal opinion regarding whether the medical services incurred were medically necessary. In the next two sections of this report, I discuss why billed charges are not reasonable. Following this, I describe the methods I used to estimate the “reasonable value” of economic damages arising from medical expenses for hospital care received by Cesar Beltran. I then present the results of my analysis, and provide a summary of my findings, along with my opinion regarding the reasonable value of medical expenses incurred by Cesar Beltran.

Economic Theory and the Value of Goods and Services

The field of micro economics provides the theoretical basis for understanding the valuation of goods and services produced in a market economy. This brief discussion provides a context for understanding why provider charges are not a valid measure of reasonable value of medical expenses.

Micro economics focuses on the study of the behavior and choices of consumers and firms as they interact in markets. Of particular importance to economics is the setting of prices for goods in competitive markets, characterized as having many sellers and buyers, complete information on goods and services that allow consumers to judge quality and value, and no barriers to entry or exit. Competitive markets exhibit both allocative and production efficiency. The prices of goods and services and the quantities produced and consumed are determined by supply and demand. The price of a good or service produced and sold in a competitive market will normally reflect the marginal cost (and minimum long run average cost) of producing that good or service.

From a common sense viewpoint, most people would agree the price they pay for a good or service, including medical care, should bear some relationship to the cost of producing that good or service. To give a simple example, consider the purchase of reading glasses available in most drugstores. In general, prices of reading glasses are around \$15 to \$20. A knowledgeable buyer would not pay \$50 to \$60 (a mark-up on the order of 300%) for conventional reading glasses. If

a drug store attempted to sell reading glasses for \$60, most buyers would decline to pay that price and would go to the another drugstore to shop for a cheaper pair of glasses they considered to represent the “reasonable value” of reading glasses.

Medical care is produced and consumed in a market context very different from that of other goods and services. Most hospital markets and physician markets bear little resemblance to competitive markets. Typically, in markets that have limited competition the prices charged for goods and services will be above (marginal) costs—often far above costs—and the prices observed in these markets will not be considered efficient or “reasonable.”

Economic theory indicates that in a competitive market the prices of goods and services will represent “reasonable value” in that they will reflect marginal and long-run average costs. As discussed below, in most health care markets only limited competition prevails, and billed charges bear little resemblance to actual costs. For example, in Washington State the general mark-up of hospital billed charges over costs is 300%, and at some hospitals the mark-up exceeds 400%. No informed person would consider a mark-up of this magnitude to represent the reasonable value of care. Because health care markets do not exhibit the characteristics of competitive markets, provider (billed) charges do not provide a useful measure of “reasonable value” of economic loss arising from medical expenses from a market or social perspective, and do not do so in the present legal case.

Nature of Health Care Markets and Implications for Determining Reasonable Value of Medical Expenses

It is well understood by the health policy makers, researchers, and analysts that health care markets, due to their distinctive features, do not resemble competitive markets. In the great majority of health care markets, especially hospital markets, there are not many suppliers of medical care, entry into the health care market is limited, and consumers certainly do not have complete information on prices and quality. Further, many hospitals and other health care organizations are non-profit rather than for-profit, so standard assumptions about firm market behavior do not apply.

A fundamental assumption of classic economic theory is that supply and demand are independent. No one seller and no single consumer can influence price because they represent but a very small portion of the market. This assumption has been challenged in health care, and empirical evidence supports the notion that, at least to some extent, physicians (and perhaps hospitals) can “induce” demand, and thereby affect utilization (Rice 1983; Fuchs 1978; Fahs 1992; Wilson and Tedeschi 1984).

Hospital charges, and other provider charges, do not reflect the workings of supply and demand factors. Provider charges (list prices) often reflect provider efforts to maintain needed revenue in the face of having to accept discounts from payers. Many payers use fee schedules to pay for care, which require providers to accept contractual discounts. Since providers know they will have to accept discounted fees from payers, they increase their charges to make up for what they may lose on the discounted fees, fee schedules, or prospectively set prices. It is not uncommon for hospitals and physicians to accept discounted fees ranging from 30% to 70% off of their billed charges.

Further, there is wide variation from hospital to hospital and from physician to physician in billed charges. Uwe Reinhardt, a nationally known and respected health economist at Princeton, provided a thoughtful discussion of how providers set charges and why provider charges typically do not represent the value of efficiently produced health care services (Reinhardt 1987). Reinhardt documented significant variation in the prices charged for different surgical procedures and high mark-ups in the laboratory and other services. For example, the prevailing charge for a single view chest X-ray varied six-fold, while the charge for a brief follow-up hospital visit varied by almost five-fold.

In a more recent analysis, Reinhardt (2006) discussed pricing of hospital services. He noted that every hospital has a “chargemaster,” which lists the charges for every procedure and supply provided. Hospitals enter into voluntary contracts with multiple health plans and payers that stipulate what the hospital will accept as payment for a given procedure. In a sense, these contracts provide some “market measure” of the hospital’s valuation of its services. Using national data, Reinhardt reported that hospitals accepted (from all payers) an average of 38% of

their billed charges. The decision by hospitals to accept 38% of their charges as payment, a form of market test, reinforces my opinion that billed charges do not represent the reasonable value of medical care. The fact is virtually nobody pays full hospital charges.

One recent article in the New York Times (May 8, 2013) drew wide attention for highlighting the great variation in hospital billed charges and billed charges in relation to Medicare payments. The article noted, “In one Dallas hospital the average bill for treating simple pneumonia was \$14,610, while another [hospital] charged \$38,000. The issue of hospital pricing has also been examined and reported by the Seattle Times (October 1, 2014, “With Huge Variability in Hospital Prices, Patients Must Beware). The Seattle Times article noted that from hospital to hospital in Washington charges can vary three- to fourfold.

An article by Beth Kutscher, titled “Hospitals say outpatient list prices are irrelevant,” published in June 8, 2013 of Modern Healthcare noted, “The [hospital] charges are an artifact of a broken system...they were developed as a method for entering into negotiations with third-party payers and will become even less relevant under healthcare reform's new payment models..... I'm not aware of anyone who pays 100% of charges.”

Hospital charges vary widely even within a small geographic area. The federal government has begun releasing data on hospital billed charges for 100 common diagnoses for Medicare patients. As part of my analysis, I obtained Medicare billing data for 2014 for four common diagnoses for hospitals located in different areas within the greater Puget Sound area, including Everett, Federal Way and Tacoma. As shown in Table 2, hospital billed charges vary significantly among Puget Sound hospitals. For example, the billed charge for DRG 470 (Major Joint Replacement) varied from a high of \$91,784 (Tacoma General) to a low of \$41,122 (Virginia Mason). Similarly, for DRG 238 (Major CVD [cardiovascular disease] Procedure), billed charges ranged from \$159,162 (St. Joseph) to \$71,473 (Virginia Mason). *If billed charges were used as the metric to evaluate the reasonable value of medical expenses for DRG 470, would a patient hospitalized in Tacoma General deserve 2.23 times the award for economic damages as a patient hospitalized in Virginia Mason, despite the fact that Virginia Mason is widely respected nationally as an excellent hospital?*

Table 2. Hospital Billed Charges for Medicare Patients for Selected Puget Sound Hospitals

Hospital	DRG 460: Spinal Fusion	DRG 470:Major Joint Replacement	DRG 871: Septicemia or Severe Sepsis	DRG 238: Major CVD Procedure
Harborview Medical Center	\$159,027	\$89,267	\$63,816	\$135,930
Northwest Hospital	\$90,966	\$59,267	---	---
Overlake Medical Center	\$112,427	\$51,667	\$38,992	\$82,087
Providence Regional Medical Center	\$139,606	\$59,338	\$40,318	\$127,104
St. Francis Medical Center	\$142,730	\$81,003	\$57,484	---
St. Joseph Hospital	\$130,283	\$76,620	\$67,939	\$159,162
Swedish Medical Center	\$165,079	\$72,103	\$52,725	\$150,840
Swedish Medical Center (Cherry Hill)	\$116,649	---	\$69,094	\$152,756
Tacoma General Hospital	\$150,614	\$91,784	\$52,671	\$153,984
UW Medical Center	\$86,516	\$54,642	\$46,676	\$85,735
Virginia Mason Hospital	\$95,683	\$41,122	\$37,445	\$71,473
Ratio of Highest to Lowest Charge	1.90:1.00	2.23:1.00	1.84:1.00	2.23:1.00

The variation in hospital charges and the amounts charged largely reflect a “system problem” in terms of reimbursement and the process used by insurance carriers and health plans to contract with hospitals and other providers. In part, to make up for the lack of payment from public payers, hospitals increase charges (list prices on their chargemaster) and attempt to pass these higher charges on to private insurance carriers and health plans.

In cases similar to this case, plaintiffs’ attorneys often rely on physicians to provide expert witness testimony to assert that billed charges are reasonable and represent the “reasonable value” of care received by the plaintiff. This is done in the absence of any external measure or criteria related to reasonable value as discussed in *Hayes v. Wieber Enterprises Inc.* and *Patterson v. Horton*, 1997. Rather, plaintiff expert witnesses review the plaintiff’s billed charges and assert these charges are generally “in line” with similar billed charges. There are at least two important flaws inherent in this approach. First, it does not comport with the established fact, as

discussed above, that billed charges vary greatly from hospital to hospital and provider to provider. Second, whether a particular hospital or physician bill is “in line” with other hospital or physician charges is irrelevant for establishing reasonable value. Similarity does not imply reasonableness, contrary to the views of plaintiff expert witnesses.

The above discussion points out the problem of using provider billed charges to establish the reasonable value of medical care. Excessive billed charges and the great variability in these charges largely reflect forces in the larger health care system related to reimbursement formulas and selective payer contracting. And, as noted earlier, virtually nobody pays full hospital charges. If nobody pays hospital billed charges, it is counterintuitive to argue they represent reasonable value. To restate a central thesis of this report: hospital and physician billed charges bear little relationship to the resources used to provide care and do not represent reasonable value of medical services. What then is an alternative approach to establishing the reasonable value of hospital medical expenses for Cesar Beltran?

The actual cost of hospital services provides a more valid measure of the reasonable value of health care resource consumption than billed charges (Lave et al. 1994, 2009 Reinhardt 1987). Below I describe the method I used to estimate the reasonable value of medical expenses for care the plaintiff alleges is recoverable in this case. This method adjusts the billed charges to derive estimates of hospital inpatient and outpatient costs for hospital services provided to Cesar Beltran.

METHOD OF ESTIMATING REASONABLE CHARGES

Cesar Beltran was admitted to Tacoma General Hospital on June 29, 2013. He remained there through August 22, 2013. The Tacoma General Hospital billing records include charges for: (1) intensive care unit (ICU) room and board (R&B) services; (2) standard R&B inpatient services; and (3) ancillary inpatient services, including x-ray, laboratory, operating room, pharmacy, and medical supplies. Charges shown in the hospital billing records were adjusted using per diem cost information and cost-to-charge ratios (CCRs) reported on the hospital Federal Cost Report. Hospital cost reports are filed annually and adhere to strict standardized accounting rules. The

reports are also subject to audit and include cost and revenue information for all patients receiving inpatient or outpatient care. These adjusted charges approximate the different costs of hospital services and provide a more valid estimate of “reasonable value” than billed charges.

Information used to perform the adjustment is listed in Worksheets C and D of the Federal Cost Report. I used information from Worksheet D to obtain per diem costs for R&B services listed on the hospital billing records. The per diem costs, as reported in the Federal Cost Report, were then multiplied by the relevant length of stay for each hospitalization to derive R&B cost estimates. To estimate the costs of hospital ancillary services, e.g., laboratory, radiology, pharmacy, I followed the conventional method of applying CCRs, as reported in the Federal Cost Report, to the charges listed on the hospital billing records. CCRs are generated by dividing allowable costs for each ancillary service cost center by the charges attributed to that center, and are reported on Worksheet C (column 9) of the Federal Cost Report. To provide an example, assume a billing record showed a \$10,000 charge for hospital laboratory services and the CCR for the laboratory services was 0.50. The adjusted (reasonable) charge would then be \$5,000 ($\$10,000 \times 0.50$). By summing the adjusted charges over relevant ancillary service cost centers, one obtains an estimate of the total cost for ancillary hospital services incurred by a patient. Adding these cost estimates to the cost estimates for R&B services provides an estimate of total hospital costs incurred by a patient.

The approach I have taken using CCRs to estimate reasonable value has been widely used by researchers conducting various studies aimed at assessing the value of resource consumption for the treatment of various diseases and conditions or performing some type of economic analysis. These studies have been published in leading peer-reviewed medical and health services journals. For example, Maeda et al. (2012) estimated the increase in hospital cost per case in a national study using CCRs to adjust billed charges. The researchers emphasize the advantages of estimating costs at the department, or service cost level, as opposed to the hospital overall level. This is the same cost estimation method I use. Other researchers (Ruhnke et al. 2010; Sheyn et al. 2017; Doupnik et al. 2016; Stey et al. 2015) have also used CCRs to estimate the value resource consumption for different conditions. In sum, my empirical method of estimating

reasonable value by applying CCRs to billed charges is well known, widely used, and reported in the peer-reviewed literature.

RESULTS

Tacoma General Hospital: Cesar Beltran was admitted to Tacoma General Hospital on June 29, 2013. He received intermittent outpatient care there and was subsequently readmitted for a nine-day stay on February 12, 2014. The billed charges and corresponding reasonable charges for this care are shown in Tables 3-6. As shown in Table 3, the total billed charge for the initial hospitalization on June 29, 2013 was \$616,444.45. The corresponding reasonable charge is **\$172,112.34**. It should be noted some of the cost-to-charge ratios (CCRs) shown in Table 3 are as low as 0.04 to 0.20. These CCRs imply a mark-up of charges over costs of **400% to over 2000%**. No objective person would consider mark-ups in this range to represent anything remotely approaching reasonable value.

Table 3. Estimated Cost of Inpatient Care Provided by Tacoma General Hospital for Admission on June 29, 2013

Revenue Code	Description	Cost-to-Charge Ratio or Per Diem Cost	Billed Charge	Reasonable Charge
120	Room & Board, 43 days @ \$1,812 per day	\$1,061.00	\$77,916.00	\$45,623.00
200	Room & Board, 7 days @ \$4,300 per day	\$1,538.39	\$30,100.00	\$10,768.73
200	Room & Board, 4 days @ \$4,991 per day	\$1,538.39	\$19,964.00	\$6,153.56
250	Pharmacy	0.249	\$20,111.45	\$5,007.75
272	Medical/Surgical Supplies	0.643	\$47,284.00	\$30,403.61
300	Laboratory	0.160	\$38,782.00	\$6,205.12
320	Radiology	0.222	\$13,571.00	\$3,012.76
350	CT Scan	0.039	\$58,526.00	\$2,282.51
360	Operating Room	0.149	\$75,744.00	\$11,285.86
370	Anesthesia	0.200	\$18,027.00	\$3,605.40
390	Blood Storage/Processing	0.257	\$75,279.00	\$19,346.70

400	Other Imaging	0.222	\$1,466.00	\$325.45
410	Respiratory Services	0.130	\$36,021.00	\$4,682.73
420	Physical Therapy	0.312	\$1,294.00	\$403.73
430	Occupational Therapy	0.257	\$1,043.00	\$268.05
450	Emergency Room	0.127	\$15,322.00	\$1,945.89
480	Cardiology	0.400	\$6,001.00	\$2,400.40
636	Drugs	0.249	\$44,869.00	\$11,172.38
680	Trauma	0.127	\$19,238.00	\$2,443.23
710	Recovery Room	0.160	\$6,440.00	\$1,030.40
730	EKG/ECG	0.105	\$113.00	\$11.87
750	Gastro-intestinal	0.400	\$5,713.00	\$2,285.20
760	Treatment/Observation Room	0.400	\$677.00	\$270.80
920	Other Diagnostic	0.400	\$2,943.00	\$1,177.20
TOTAL			\$616,444.45	\$172,112.34

The estimated reasonable value for outpatient services provided by Tacoma General Hospital is shown in Table 4. As shown, the total billed charge was \$20,727.30. The corresponding reasonable charge is **\$3,831.25**. Note there were several services, with a total billed charge of approximately \$2,000, which had a CPT code but no hospital revenue code. These services were excluded from Table 4.

Table 4. Estimated Cost of Outpatient Services Provided by Tacoma General Hospital

Date of Service	Revenue Code	Service Description	Cost-to-Charge Ratio	Billed Charge	Reasonable Charge
9/9/2013	510	Clinic	0.400	\$120.00	\$48.00
10/1/2013	250	Pharmacy	0.249	\$7.00	\$1.74
10/1/2013	250	Pharmacy	0.249	\$200.00	\$49.80
10/1/2013	272	Medical/Surgical Supplies	0.643	\$846.00	\$543.98
10/1/2013	320	Radiology	0.222	\$857.00	\$190.25
10/1/2013	370	Anesthesia	0.200	\$792.00	\$158.40
10/1/2013	636	Drugs	0.249	\$125.00	\$31.13
10/1/2013	710	Recovery Room	0.160	\$1,932.00	\$309.12
10/1/2013	710	Recovery Room	0.160	\$745.00	\$119.20
10/1/2013	750	Gastro-intestinal Services	0.400	\$3,153.00	\$1,261.20

12/9/2013	510	Clinic	0.400	\$173.00	\$69.20
3/24/2014	510	Clinic	0.400	\$104.00	\$41.60
10/26/2015	250	Pharmacy	0.249	\$14.00	\$3.49
10/26/2015	301	Laboratory	0.160	\$104.00	\$16.64
10/26/2015	301	Laboratory	0.160	\$84.00	\$13.44
10/26/2015	305	Laboratory	0.160	\$95.00	\$15.20
10/26/2015	306	Laboratory	0.160	\$98.00	\$15.68
10/26/2015	307	Laboratory	0.160	\$39.00	\$6.24
10/26/2015	352	CT Scan	0.039	\$7,156.00	\$279.08
10/26/2015	450	Emergency Room	0.127	\$318.00	\$40.39
10/26/2015	450	Emergency Room	0.127	\$660.00	\$83.82
10/26/2015	450	Emergency Room	0.127	\$1,635.00	\$207.65
10/26/2015	636	Drugs	0.249	\$77.55	\$19.31
10/26/2015	636	Drugs	0.249	\$125.00	\$31.13
10/26/2015	636	Drugs	0.249	\$108.90	\$27.12
10/26/2015	636	Drugs	0.249	\$77.85	\$19.38
10/27/2015	302	Laboratory	0.160	\$176.00	\$28.16
10/27/2015	402	Other Imaging	0.222	\$905.00	\$200.91
TOTAL				\$20,727.30	\$3,831.25

Table 5 shows the billed charges and corresponding reasonable charges for the second admission on February 12, 2014. As shown, the total billed charge was \$69,827.40. The reasonable charge is **\$20,255.33**.

Table 5. Estimated Cost of Inpatient Care Provided by Tacoma General Hospital for Admission on February 12, 2014

Revenue Code	Description	Cost-to-Charge Ratio or Per Diem Cost	Billed Charge	Reasonable Charge
120	Room & Board,9 days @\$2,029 per day	\$1,097.91	\$18,261.00	\$9,881.19
250	Pharmacy	0.218	\$2,845.25	\$620.26
272	Medical/Surgical Supplies	0.643	\$3,313.00	\$2,130.26
300	Laboratory	0.156	\$1,643.00	\$256.31

360	Operating Room	0.149	\$28,940.00	\$4,312.06
370	Anesthesia	0.200	\$4,360.00	\$872.00
420	Physical Therapy	0.317	\$374.00	\$118.56
430	Occupational Therapy	0.281	\$726.15	\$204.05
510	Clinic	0.774	\$126.00	\$97.52
636	Drugs	0.218	\$4,985.00	\$1,086.73
710	Recovery Room	0.159	\$4,254.00	\$676.39
TOTAL			\$69,827.40	\$20,255.33

Table 6 provides a summary of the aggregate billed charges and corresponding reasonable charges for Tacoma General Hospital. As shown, the aggregate billed charge was \$706,999.15. The corresponding reasonable charge is **\$196,198.91**.

Table 6. Summary of Charges for Tacoma General Hospital

Date of Service	Billed Charge	Reasonable Charge
6/29/13-8/22/13	\$616,444.45	\$172,112.34
2/12/14-2/21/14	\$69,827.40	\$20,255.33
Outpatient Services	\$20,727.30	\$3,831.25
TOTAL	\$706,999.15	\$196,198.91

Western State Hospital: Cesar Beltran was hospitalized in Western State Hospital on February 12, 2014. The billed charges and corresponding reasonable charges are shown in Table 7. As shown, the total billed charge was \$49,715.49. The reasonable charge is **\$44,710.47**. I made only a limited adjustment to the billed charge for Western State Hospital. The reason for this is that the billing practices of Western State are quite different from those of Tacoma General. Almost all of the charges for Western State represent Room & Board (R&B) charges, and there was only a small mark-up for these charges over per-diem R&B costs, as reported on the hospital Federal Cost Report. This should make clear the extent of my adjustment for billed charges is solely a function of the degree to which hospitals mark up charges over costs. Tacoma General

Hospital has high mark-ups, so my adjustment of billed charges to estimate reasonable value was greater as compared to Western State Hospital.

Table 7. Estimated Cost of Care Provided by Western State Hospital for Admission on February 12, 2014

Revenue Code	Description	Cost-to-Charge Ratio or Per Diem Cost	Billed Charge	Reasonable Charge
120	Room & Board, 56 days @\$541 per day	\$518.38	\$30,296.00	\$29,029.28
120	Room & Board, 26 days @\$549 per day	\$518.38	\$14,274.00	\$13,477.88
300	Laboratory	0.581	\$660.77	\$383.91
320	Radiology	0.433	\$773.22	\$334.80
900	Psychiatry	0.400	\$938.86	\$375.54
920	Other Diagnostic	0.400	\$2,772.64	\$1,109.06
TOTAL			\$49,715.49	\$44,710.47

SUMMARY AND CONCLUSION

Medical expenses are economic damages, providing these expenses are reasonable. As discussed earlier, billed charges do not represent the reasonable value of economic loss arising from medical care. I provided an alternative method of estimating that value. In the prior tables, I presented estimates of the reasonable value of economic loss for hospital medical care services received by Cesar Beltran after June 29, 2013.

A summary of the estimates of reasonable value generated by my analysis is presented below in Table 8. As shown, the total (aggregate) billed amount for the care analyzed in this report is \$756,714.64. The adjusted reasonable value of this care is **\$240,909.38**. My estimate does not incorporate a profit margin one might argue hospitals deserve in considering the reasonable value of care. Bazolli et al. (2014) recently analyzed hospital profit margins, based on a national sample of hospitals. The researchers found hospital profit margins to range from roughly two

percent for non-profit hospitals to six-percent for for-profit hospitals. For the purpose of this report, I make the liberal assumption Tacoma General Hospital and Western State Hospital had a profit margin of 5%. I therefore increased my reasonable value estimate from \$240,909.38 to **\$252,954.85** ($\$240,909.38 \times 1.05$).

Table 8. Summary of Hospital Charges

Provider	Billed Charge	Reasonable Charge
Tacoma General Hospital	\$706,999.15	\$196,198.91
Western State Hospital	\$49,715.49	\$44,710.47
TOTAL	\$756,714.64	\$240,909.38

My estimate of reasonable value (\$252,954.85) represents 33.4% of total billed charges (\$756,714.64), a figure almost as high as what hospitals across the nation accept (38%) as payment for medical care services. To restate a principal theme of this report, billed charges bear little relationship to the value of services provided to patients. A “market test” of this assertion is what hospitals accept from payers (38% of charges) as payment in full for services provided to patients.

Three other points, discussed earlier in this report, should be emphasized: (1) virtually nobody pays full billed charges for hospital care; (2) the mark-ups of billed charges over costs for some services at Tacoma General Hospital, which accounted for the great majority of all billed charges, exceeded 500%, a mark-up few, if any, informed persons would consider reasonable; and (3) even within the Puget Sound area, hospital billed charges exhibit substantial variation for patients with the same diagnosis, raising further questions about the validity of using billed charges as a measure of “reasonable value.”

Based on the information provided in this report, it is my opinion the figure generated from my analysis (\$252,954.85), which includes a profit margin of 5 percent, is fully consistent with the concept of reasonable value as applied by Washington State courts in legal cases such as Beltran v City of Tacoma.

A handwritten signature in black ink, appearing to read "Tom Wickizer". The signature is written in a cursive style with a horizontal line extending from the end of the name.

Thomas Wickizer, PHD

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Received. Thank you.

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Attached please find Dr. Wickizer's report.

Thank you,
Staci

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