Letters of Protection

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Overview of Letters of Protection

A letter of protection ("**LOP**") is a contract between an injured party and a medical doctor, stating that the patient owes the medical professional a certain amount of the proceeds of any judgment or settlement arising out of a specific lawsuit. It is effectively a note receivable, and defers payment of medical bills until the conclusion of litigation. An LOP often authorizes the party's attorney to pay the proceeds to the holder of the LOP, and the attorney will co-sign the letter, essentially serving as its guarantor. Despite this, the medical professional who performed treatment is unlikely to hold the LOP at the time of settlement. Instead, medical lien purchasing companies exist for the purpose of purchasing these notes. Medical doctors enjoy this arrangement, even though the notes are typically sold at discounted rates. For example, an LOP may state that the doctor is owed $50,000 of any judgment's proceeds. Under a typical insurance arrangement, the doctor may have only actually received $8,000 for the treatment performed. However, the treating doctor may sell the LOP to a medical lien purchasing company for $15,000 – significantly less than owed, but more than the doctor would have usually received.

LOPs are routinely used in personal injury cases, despite the fact only a small percentage of doctors will treat patients under an LOP arrangement. Plaintiffs are often advised by their attorney to seek treatment under such arrangements, even if a plaintiff otherwise has medical coverage or would normally visit a different doctor. Lawyers even refer clients who have insurance to clinics under LOPs so as to avoid damage awards at the lower rates negotiated between insurers and healthcare providers. Thus, some accident victims in Florida, under the direction of their attorney, turn down submitting claims to their own insurance companies or seeing in-network doctors who accept insurance in favor of the potential for a larger verdict or settlement under an LOP. Since the plaintiff does not expect to pay the bill, he or she may be unconcerned about excessive charges accumulating under an LOP. This is not done due to the enhanced care provided by LOP doctors, nor due to issues of convenience for the prospective patient. In actuality, oftentimes the injured party would have been treated in a nationally ranked hospital, but instead now receives treatment through a small, out-patient facility. Moreover, injured parties often end up traveling great distances for treatment from the LOP physician.

This practice is no secret. Personal injury lawyers in Florida openly tout their use of LOPs to recover non-discounted rates. For example, a Tampa personal injury law firm explains on its website that medical providers often agree to delay their collection efforts during litigation through an LOP because, if the litigation is successful, they can collect greater amounts than they typically receive from insurers. The firm also notes that if the lawsuit is not successful, the healthcare provider "often writes off the bill" because the injured person "probably cannot afford to pay" the list price for the medical care.[1]

LOPs are used to manufacture damages. In cases involving LOPs, a plaintiff's medical damages are literally what the LOP says they are. Medical damages are a fixed number, particularly past medical damages, unlike pain and suffering or past and future loss of earning capacity, which can be difficult to quantify. As such, medical damages are often used as a multiplier to determine the overall award – oftentimes a plaintiff's attorneys outright asks a jury for a multiplier of medical damages during closing argument. In practice, assuming liability, statistics show that we see multipliers of four times in South Florida and three times elsewhere in Florida. That is, if medical

[1] Scott Distasio, *Using a Letter of Protection in Personal Injury Claim*, Nov. 18, 2010, at https://distasiofirm.com/2010/11/18/using-a-letter-of-protection-in-personal-injury-claim/ (last visited Mar. 1, 2015).

damages are $100,000, in South Florida the overall verdict will likely be around $400,000, and $300,000 elsewhere in Florida. This provides significant incentives to grossly inflate LOP damages. In fact, the sole purpose of LOPs are to drive up the value of these personal injury cases, and LOPs have been incredibly successful in this endeavor.

While plaintiffs are able to introduce LOPs as a measure of damages at trial, defendants are not given an opportunity to effectively counter. Florida has limited defendant's abilities to introduce evidence of the LOP arrangement, or to introduce the actual cost a plaintiff would have been charged under other coverage arrangements.

Phantom Damages and Set Off

Florida law prohibits phantom damages, *see Goble v. Frohman*, 901 So. 2d 830 (Fla. 2005), however plaintiff attorneys successfully utilize LOPs to circumvent this limitation. Phantom damages are the difference between the amount of medical expenses billed and the amount an insurer actually pays. In Florida, a plaintiff may only recover the actual amount billed. *See Id.*

It is routine practice for a medical procedure to be billed to a patient at a much higher rate than what the medical practitioner expects to recoup. Most insurance companies have negotiated rates with hospitals regarding the amounts they are willing to pay for specific procedures. These maximum amounts a coverage plan will pay for a covered health service are called "allowed amounts."[2] Even an uninsured patient who receives treatment is often able to negotiate directly with the medical provider for significant discounts of the billed amount. As Florida recognized in *Goble*, a billed amount is an inaccurate measure of the damages an individual has sustained, as that amount is almost never the actual costs an injured party incurs.

In *Goble*, Florida courts recognized the need for a set off of "the amount of the contractual discount, for which no right of reimbursement or subrogation exists," against an award of compensatory damages. *Goble*, 901 So. 2d at 833. Thus, as for **paid** medical expenses, defendants are able to set off the costs of a discount against the billed amount. As such, a plaintiff only recovers the actual cost of the medical procedures. This is important, because the purpose of compensatory tort damages is to "compensate" the plaintiff, "it is not the purpose of such damages to punish defendants or bestow a windfall upon plaintiffs." *Fla. Physician's Ins. Reciprocal v. Stanley*, 452 So. 2d 514, 516 (Fla. 1984) (quoting *Peterson v. Lou Bachrodt Chevrolet Co.*, 392 N.E. 2d 1, 5 (Ill. 1979)).

As such, Florida courts recognize both that plaintiffs should not receive a windfall when recovering damages, and that the billed amount of a medical procedure is an inaccurate measure of actual costs. Yet, LOPs provide a convenient avenue for a plaintiff attorneys to circumvent these principles. Unlike the medical bills in *Goble*, LOPs represent bills that are not yet paid. This distinction is key: LOPs represent **unpaid** medical bills. Thus whereas with paid medical bills a defendant can know for certain the actual costs incurred and seek an appropriate set off, with LOPs the actual costs are still yet to be determined. Therefore, defendants are unable to obtain a set off of the discounted rate, and plaintiffs can still effectively seek phantom damages in this manner. Again, this is of extreme importance because the past medical bills rate is often used simply as a multiplier when determining other damages, such as pain and suffering or lost earning capacity.

[2] These may also be called "eligible expense," payment allowance," "or negotiated rate. *See* https://www.healthcare.gov/glossary/allowed-amount/

Setting the past medical damages at the billed amount, which represents an amount significantly higher than what a plaintiff or an insurer would actually be required to pay, results in vast overpays to plaintiffs and their counsel. These damages have no basis in reality, and serve to drastically drives up the amount of damages a plaintiff recovers, which is the hidden goal of LOPs. Simply put, the sole purpose of LOPs are to craft damages beyond those an injured party actually incurs. Florida courts have made clear that a plaintiff should only be compensated for his or her actual loss, and LOPs clearly go against this spirit.

Florida Employers as an Example

This is not a theoretical problem, either, but instead one with real-world consequences that Florida employers face every day. With over 140,000 employees in Florida, Publix Supermarkets, Inc. is one the largest employer in all of Florida, and maintains locations across the state – from Pensacola all the way down to Key West. Publix brings unique perspective to the discussion, as Publix understands the medical damages issue from three vantage points: from the medical bills it sees through its self-insured health insurance program, from the worker's compensation angle, and from the liability claims against it.

Lauren McBride, an attorney in Publix's risk management division, testified before the Florida House Civil Justice Subcommittee on February 20, 2019. McBride discussed the issue of LOPs in regard to lawsuits involving Publix's liability for personal injuries, stating that the "single-most impactful factor in [liability claims are] letters of protection." In fact, sixty-two percent of Publix's lawsuits in Florida involve LOPs. Of these lawsuits involving LOPs, 61% of the individual plaintiffs had some medical coverage available, either Medicaid, Medicare, or private insurance.

Publix maintains operations in six states outside of Florida, and, as such, is able to provide insight regarding the outcomes of claims in different jurisdictions. McBride testified that the cost to resolve a litigated claim in Florida is sixty-five percent higher than it costs in any of Publix's other states of operation. Comparing the costs to metro-Atlanta, it costs forty percent more to resolve a claim in Florida. Costs are even higher in South Florida: it costs fifty percent more to resolve a claim in South Florida than in the rest of the state. McBride further testified that the reason claims cost much more in Florida are due to LOPs, which are not frequently used in other states, though McBride stated Publix is beginning to see them in use in Georgia.

To further highlight the extreme disparity between LOPs and reality, McBride told the story of a customer who was injured at Publix in a slip and fall. The woman injured her knees, requiring a knee scope in each knee. For the first procedure, the woman received care from a doctor she had seen in the past, and it was performed at a well-known, national hospital using her insurance. The second knee scope was performed at an out-patient facility under an LOP arrangement, even though the physician typically accepted her insurance carrier. The first surgery was billed at $19,000, though the actual amount paid by the insurer, i.e. the allowed amount, was $3,400. The second procedure was billed at $59,000. Why utilize the LOP? Because, again, past medical damages are often used as a multiplier for the overall verdict. In the first instance, the multiplier would only have resulted in a verdict of $13,600. The second, however, results in a verdict of $236,000, a difference of over $220,000.

Furthermore, McBride told a story of a plaintiff who posted on social media that her attorney advised that if she had neck surgery performed, she would receive more money in her final verdict.

The LOP system encourages and incentivizes plaintiffs to seek additional procedures and continue to drive up medical bills, and make it difficult for companies like Publix to resolve cases early or reasonably.

Recent Case Law

Importantly, the Supreme Court has ruled that a plaintiff does not have to provide to defendants information regarding the relationship between the plaintiff's law firm and the treating physician. *See Worley v. Young Men's Christian Ass'n*, 228 So. 3d 18 (Fla. 2017). The underlying facts of *Worley* were that of a routine trip and fall case; Ms. Worley fell in YMCA's parking lot and injured her knee. *Id*. at 20. Despite being advised to see a specialist concerning pain in her knee, Ms. Worley waited for multiple months, claiming she lacked either health insurance or the means to pay out-of-pocket. *Id*. However, after retaining the law firm Morgan & Morgan, Ms. Worley was treated by various doctors at Sea Spine Orthopedic Institute, Underwood Surgery Center, and Sanctuary Surgical & Anesthesia. *Id*. Thereafter, the underlying suit was filed, seeking damages, including the costs of treatment from these providers. *Id*. YMCA repeatedly sought during discovery to uncover the relationship between Morgan & Morgan and the treating physicians, suspecting there to be a "cozy agreement" between these entities, due to the high costs of the medical bills. *Id*. at 20-21. Ms. Worley objected, claiming attorney-client privilege. *Id*. The supreme court agreed, despite the fact that such arrangements show clear issues of potential bias. *Id*. at 24. The court therein stated that bias could be shown by other methods, for instance, "medical bills that are higher than normal can be presented to dispute the physician's testimony regarding the necessity of treatment and the appropriate amount of damages." *Id*. Though, without being able to introduce the standard costs actually paid for such procedures, it is questionable how effective presenting such bills would actually be.

Additionally, *Joerg v. State Farm Mut. Auto. Ins. Co.*, 176 So. 3d 1247 (Fla. 2015) further hindered defendants, this time on the issue of future damages. In *Joerg*, a plaintiff was injured after being struck by an automobile, and brought a negligence action against the driver. *Id*. at 1252. The plaintiff was entitled to reimbursement from Medicare, due to developmental disabilities. *Id*. Since future medical costs were fixed by the Medicare fee schedules, defendant State Farm attempted to introduce into evidence the plaintiff's future Medicare or Medicaid benefits. *Id*. However, this attempt was denied by the trial court. *Id*. The supreme court agreed with the trial court that exclusion of these benefits was proper, partly on the grounds that it would be "absolutely speculative to attempt to calculate damage awards based on benefits that a plaintiff has not yet received and may never receive, should either the plaintiff's eligibility or the benefits themselves become insufficient or cease to continue." *Id*. at 1255. As a Medicare eligible patient, the future cost of medical expenses were known; simply put, they were his future Medicare benefits. Despite this, the supreme court's ruling hinders defendant's ability to present accurate measures of damages to a jury, and leads to windfalls in damages to plaintiffs.

These cases evidence that the playing field is not even for plaintiffs and defendants. Much pertinent, relevant, and useful injury information remains in the shadows during trial. A plaintiff does not have to make aware to the jury that a relationship exists between the plaintiff's law firm and treating physicians; a plaintiff does not have to make known any fee scheduled future benefits, such as Medicare or Medicaid; and a plaintiff does not have to inform the jury of the standard measure of the actual cost a patient would be billed for treatments received. These all work to the

benefit of plaintiffs, and drive monetary verdicts well beyond the actual costs and damages incurred, and defendants do not have a meaningful way to provide competing evidence to a jury.

Legislative Proposal

Fortunately, Senator Kelli Stargel has proposed a bill that would remedy many of the issue regarding letters of protection. The bill provides that for a plaintiff in a personal injury or wrongful death suit who has contractually agreed to defer payment until a settlement or verdict, evidence must be introduced at trial regarding the usual and customary rates for such services in the plaintiff's geographic area. The bill would require these rates to be the range of allowed amount benchmarks from the 50th through 95th percentile ranks as reported by a statistically reliable benchmarking database maintained by an independent, nonprofit organization designated by the Commissioner of Insurance Regulation.

One such organization is FAIR Health, which is an independent non-profit based in New York that collects and manages the nation's largest database of privately billed health insurance claims. Using FAIR Health's database, one can look at the cost of medical procedures in one's geographic area, and can see the 50th and 95th percentile ranks of the cost. This would allow a jury to get a more full picture of the actual costs of the medical procedures at issue in the area, and not solely be stuck having to gauge whether the billed rate in an LOP accurately portrays the actual medical costs incurred by a patient.

The bill does would not tie a jury's hands behind its back, or require a specific outcome. It simply is looking to provide the jury with more information about a complex, confusing, and unknown topic. The bill would simply introduce more information for the jury's disposal. It helps even the playing field between plaintiffs and defendants; plaintiffs can utilize LOPs to show the jury the amount billed for a procedure, and defendants could then introduce the amount typically paid in the area. It would then be up to the jury to decide what to do with this information.

This would put a significant damper on the use of LOPs in Florida. A typical juror knows roughly how much a gallon of gas or a carton of milk costs, but, like many of us, is clueless as to the cost of medical procedures. Providing a juror some standards for the actual costs of a procedure would grant him or her a more thorough overall understanding of the actual damages a plaintiff has incurred. This would enable the jury to make a more accurate assessment of the damages the plaintiff should receive, including non-medical damages such as pain and suffering. Furthermore, the bill furthers the court's intent and rationale in *Goble*, and helps to create an objectively more fair legal system.