Ensuring Transparency in Damages - CS/CS/HB 837

Background

An injured party may recover their past medical expenses (such as hospital bills, diagnostic tests, and doctor visits) as damages in a personal injury or wrongful death lawsuit. What juries most often hear at trial are the "billed" amounts or "sticker prices" of a claimant's medical treatment, which typically reflect much higher dollar amounts than what an insurer would have otherwise paid for the treatment or what the claimant would have even paid out of pocket for the treatment.

What further complicates things are letters of protection ("LOPs")—agreements wherein a claimant's medical provider agrees to suspend efforts to collect past medical bills in exchange for a right to payment from any recovery made by the claimant in litigation. LOPs typically bear a sticker price that greatly exceeds the true cost or value of medical treatment. Sometimes these LOPs are sold to factoring companies—often interested parties as they are plaintiffs' law firms or medical providers—which purchase LOPs at a discount for a right to collect each LOP's full sticker price. Regardless of what the claimant's medical provider will ultimately accept as full satisfaction of the outstanding bill, and regardless of what steeply discounted amount a factoring company might have paid for the LOP, an LOP bearing an artificially inflated amount may be admitted at trial as the claimant's evidence for the value of his medical treatment.

Consideration of such inflated amounts misleads juries into awarding excessive amounts for unpaid bills, future damages for anticipated medical expenses, and pain and suffering. CS/CS/HB 837 ("HB 837") (specifically, Section 6 of the bill) is designed to address these issues and ensure juries hear evidence of the true value of medical treatment.

Section 6: Creating Section 768.0427, Florida Statutes, to Define Evidence Necessary to Prove Medical Expenses in Personal Injury or Wrongful Death Actions

Section 6 would create new Florida statute section 768.0427, which would expressly define what evidence may be offered to prove damages for medical expenses, both future and past.

Subsection 1 (lines 444-480): **Definitions**. The statute would define several relevant terms, including "letter of protection," "factoring company," "health care coverage," and "health care provider." For example, the legislation defines a "letter of protection" as "any arrangement by which a health care provider renders treatment in exchange for a promise of payment for the claimant's medical expenses from any judgment or settlement of a personal injury or wrongful death action. The term includes any such arrangement, regardless of whether referred to as a letter of protection" (lines 475-480). The intent is to capture as broadly as possible all arrangements

which are intended to operate as LOPs, and to avoid later creative arguments that a particular agreement does not fall within the definition.

"Health care coverage" is also broadly defined to include "any third-party health care or disability services financing arrangement, including, but not limited to, arrangements with entities certified or authorized under federal law or under the Florida Insurance Code; state or federal health care benefit programs; workers' compensation; and personal injury protection)" (lines 448-453). This definition is included as part of requirements to, as described below, ensure that juries are aware of whether a plaintiff had access to health care coverage but chose not to use that coverage in favor of an LOP, and to the extent a plaintiff has access to health care coverage, existence of such health care coverage should aid in defining what evidence is admissible to prove medical damages.

Subsection 2 (lines 481-552): **Defining the Evidence Necessary to Prove Medical Damages**. Subsection 2 of proposed section 768.0427 would expressly define the evidence necessary to prove both past and future medical expenses.

Paragraph (2)(a) (lines 486-489): Past *paid* medical expenses. This provision would confirm that the evidence offered to prove the amount of damages for past medical treatment is limited to evidence of the amount actually paid, regardless of the source of payment.

Paragraph (2)(b) (lines 490-526): Past *unpaid* medical expenses—e.g., LOPs. This provision would address what evidence may be offered to prove the usual and customary amount necessary to satisfy unpaid charges for incurred medical treatment or services. As noted above, this situation most commonly arises because the claimant has gotten an LOP.

An LOP is an agreement typically negotiated by a personal injury lawyer wherein a claimant's medical provider agrees to suspend efforts to collect medical bills from the claimant while litigation is pending. In exchange, the provider receives a right to payment of their bills from any recovery by the claimant. In other words, it is an "IOU." LOPs once served a legitimate function: they provided a means for those who are uninsured or had exhausted insurance coverage, and did not have Medicaid or Medicare, to promptly receive and continue medical care during litigation regardless of financial resources. Unfortunately, however, LOPs are also used to inflate damages awards. Medical providers providing care under LOPs often "charge" many times more than the usual or customary cost of service and later accept a fraction of their billed amounts as part of an ongoing relationship with claimants' attorneys or a factoring company. For example, a medical provider may bill $10,000 for a particular therapy, but if covered by the claimant's insurer, the insurer by contract would be required to pay only $5,000 for the therapy. With the prodding of his or her attorney, the claimant may obtain a letter of protection from the medical provider that states the treatment was valued at $50,000. Notwithstanding the fact that the medical provider would customarily accept $5,000 or $10,000 for the therapy, the claimant is permitted to introduce at trial—and the jury may hear and consider—the LOP's inflated value of $50,000.

HB 837 will address this problem by providing what evidence is admissible to establish the usual and customary amount necessary to satisfy past unpaid medical charges:

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- Subparagraph (2)(b)1. and 2. (lines 494-509): **If the clamant has health care coverage** (as defined in subsection (1)) other than Medicare or Medicaid, evidence of the **amount which such health care coverage is obligated to pay** to satisfy the claimant's incurred medical treatment or services, plus the claimant's share of medical expenses, is admissible.

  Further, **if the claimant has health care coverage but obtains treatment under an LOP** or otherwise does not submit charges for medical treatment or services to health care coverage, **evidence of the amount the claimant's health care coverage would pay the health care provider to satisfy the past unpaid medical charges under the insurance contract or regulation, plus the claimant's share of medical expenses under the insurance contract or regulation, had the claimant obtained medical services or treatment pursuant to the health care coverage**, is admissible.

  This will address the situation in which a claimant—often under the direction of his or her attorney—turns down submitting a medical expense claim to an insurer in favor of the potential for a larger verdict or settlement using the inflated sticker price of an LOP.

- Subparagraph (2)(b)3. (lines 510-515): **If the claimant does not have health care coverage**, the evidence admissible to prove past medical expenses is **evidence of 120 percent of the Medicare reimbursement rate in effect at the trial of trial for the claimant's incurred medical treatment or services**, or, if there is no applicable Medicare rate for a service, 170 percent of the applicable state Medicaid rate.

  This will ensure juries ground damages awards for past unpaid medical expenses where a claimant lacks health care coverage in a known, acceptable measure of the cost of medical care, Medicare. Medicare rates are based upon classifying healthcare services into clinically similar resource-based units. The purpose of these classifications is to ensure that Medicare payments are based on objective measures such as the provider's costs and allow for geographic adjustments. Regardless of the provider type, all Medicare fees are based upon publicly available and well-known factors that are reliable, reproducible, and independent of personal bias. Thus, Medicare rates can and do readily serve as a convenient and readily recognizable standard or "yardstick" for the value or cost of medical services. Providing for evidence of a higher percentage of that rate roughly approximates the cost of private care.

- Subparagraph (2)(b)4. (lines 516-522): **If the claimant obtains medical treatment or services under an LOP, and the health care provider subsequently transfers the right to receive payment under the LOP to a third party**, evidence of **the amount the third party paid or agreed to pay the health care provider in exchange for the right to receive payment pursuant to the LOP** is admissible.

  This would ensure that the jury sees the amount paid by a third party like a factoring company in order to obtain a right to recover under the LOP—an amount that is often much less than the "sticker price" of the LOP.

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The bill also provides that "[a]ny evidence that does not otherwise meet the requirements of this paragraph may be admitted into evidence, if it is otherwise admissible." (Lines 524-526.) So the above does not necessarily preclude the admission of other evidence relevant to the determination of damages.

Paragraph (2)(c) (lines 527-545): Future medical expenses. This provision would address what evidence may be offered to prove the usual and customary amount of damages for any future medical treatment or services.

- Subparagraph (2)(c)1. (lines 530-535): If the claimant **has health care coverage other than Medicare or Medicaid, or is eligible for any such health care coverage**, evidence of **the amount for which the future charges of health care providers could be satisfied if submitted to such health care coverage, plus the claimant's share of medical expenses under the insurance contract or regulation**, is admissible.

- Subparagraph (2)(c)2. (lines 536-541): If the claimant **does not have health care coverage**, evidence of **120 percent of the Medicare reimbursement rate in effect at the time of trial** for the medical treatment or services the claimant will receive is admissible, or, if there is no applicable Medicare rate for a service, 170 percent of the applicable state Medicaid rate.

The bill also provides that "[a]ny evidence that does not otherwise meet the requirements of this paragraph may be admitted into evidence, if it is otherwise admissible." (Lines 543-545.) So the above does not necessarily preclude the admission of other evidence relevant to the determination of damages.

Paragraph (2)(d) (lines 546-548): No duty to negotiate charges. This provision would confirm that nothing above requires a party to seek a reduction in billed charges to which the party is not contractually entitled.

Paragraph (2)(e) (lines 549-552): **Insurance contracts not affected**. This provision ensures that individual contracts between providers and licensed commercial insurers or licensed health maintenance organizations are not subject to discovery or disclosure and are not admissible into evidence.

***Subsection (3) (lines 553-601)*: Required Disclosures Concerning LOPs**. Subsection (3) states that certain items relating to LOPs are subject to disclosure; specifically, the claimant must disclose, as a condition precedent to asserting any claim for medical expenses for treatment rendered under an LOP:

- A copy of the LOP (line 558).

- All billings for the claimant's medical expenses, which must be itemized and, to the extent applicable, coded according to certain standard coding systems, e.g., the American Medical Association's Current Procedural Terminology (CPT), or the Healthcare Common Procedure Coding System (HCPCS), in effect for the year in which services are rendered (lines 562-566). CPT and HCPCS codes are standard medical billing codes which would

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enable one to compare the cost of medical care associated with a particular CPT or HCPCS code across providers to assess whether the cost was reasonable or not. CPT and HCPCS coding would be required for providers billing at the provider level. Similar coding information would be required for health care providers billing at the facility level, depending upon the setting (clinical, outpatient, or inpatient) (lines 567-580).

- If the health care provider sells the accounts receivable for the claimant's medical expenses to a factoring company or other third party:
    - The name of the factoring company or other third party who purchased such accounts (lines 584-585); and
    - The dollar amount for which the factoring company or other third party purchased such accounts, including any discount provided below the invoice amount (lines 586-588).
- Whether the claimant, at the time medical treatment was rendered, had health care coverage and, if so, the identity of such coverage (lines 589-591).
- Whether the claimant was referred for treatment under the LOP and, if so, the identity of who made such referral (lines 592-594). If the referral is made by the claimant's attorney, disclosure of the referral is permitted, and evidence of such referral is admissible notwithstanding any provision of the Evidence Code concerning the attorney-client privilege, specifically section 90.502, Florida Statutes. Moreover, the financial relationship between a law firm and a medical provider—including the number of referrals, frequency, and financial benefit obtained—is relevant to the issue of the bias of a testifying medical provider. (Lines 594-601.)

  This is meant to address the Florida Supreme Court's ruling in *Worley v. Central Florida Young Men's Christian Association*, 228 So. 3d 18 (Fla. 2017), in which the Court held that a defendant is not permitted to inquire through discovery about any referral relationship that might exist between a plaintiff's attorney and the plaintiff's treating physician—the type of relationship that might give rise to an LOP—because it is protected by the attorney-client privilege. However, such evidence is critical to the question of a treating physician's bias, in addition to the larger determination whether the medical expenses presented by a plaintiff in an LOP are reasonable or not. HB 837 would confirm that the cozy relationships that often exist between medical providers and plaintiffs' attorneys are subject to discovery and may not be shielded by the attorney-client privilege.

These required disclosures will ensure defendants have a full picture of the "value" of medical expenses, including those claimed by a plaintiff as reflected in an LOP, as well as what health care coverage a plaintiff was otherwise entitled to. And, as noted above, subsection (2) ensures that the above information is admissible at trial.

***Subsection (4) (lines 602-617)*: Ensuring the Damages Recoverable Reflect the True Cost of Medical Care**. Proposed subsection (4) of section 768.0427 states that the medical expense

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damages that a claimant may ultimately recover in a personal injury or wrongful death action "may not include any amount in excess of the evidence of medical treatment and services expenses admitted pursuant to subsection (2), and also may not exceed the sum of the following:

(a) Amounts actually paid by or on behalf of the claimant to a health care provider who rendered medical treatment or services;

(b) Amounts necessary to satisfy charges for medical treatment or services that are due and owing but at the time of trial are not yet satisfied; and

(c) Amounts necessary to provide for any reasonable and necessary medical treatment or services the claim will receive in the future" (lines 605-617).

This provision ensures that the damages ultimately recovered by a plaintiff do not exceed any of the amounts reflected in the evidence admissible to show medical damages, including, for example, where the claimant has health care coverage but obtains treatment under an LOP, the amount that the claimant's health care coverage would have paid to satisfy the medical charge otherwise reflected in the LOP. Subsection (4) also adds considerations to ensure that medical damages reflect the true cost of medical care, including by ensuring that the medical damages a plaintiff receives are no more than what was actually paid on behalf of the claimant to a health care provider for that medical service.

Conclusion

HB 837 would ensure juries base damages awards on the true cost of medical treatment, and not inflated medical bills, by defining the evidence admitted to prove medical expenses. With these changes, a claimant could not only admit as evidence of his or her damages the amount included in an LOP, or the amount reflected in an excessive medical bill, notwithstanding the lesser amount the claimant's insurer would pay or that would customarily be accepted by other providers for the same treatment or service. The Florida Justice Reform Institute asks the Legislature to pass HB 837 to ensure transparency in medical damages awards.

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