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TO: Members of the Assembly Judiciary Committee

FROM: Representative André Jacque

DATE: April 11, 2013

RE: Assembly Bill 29

Chairman Ott and Committee Members:

Thank you for the opportunity to testify before you today as the author of Assembly Bill 29. This legislation revises what is known as the "collateral source rule" for personal injury cases to expand the information a jury is allowed to see during a trial in order to assist them in their deliberations and decision. Currently, the collateral source rule bars jurors from considering compensation that the plaintiff has received from other sources. In 2007, the Wisconsin Supreme Court in *Leitinger v. Dbart, Inc.*, 2007 WI 84, held that the collateral source rule prohibits parties in a personal injury action from introducing evidence of the amount actually paid by the injured person's health insurance company (a collateral source) for medical treatment rendered to prove the reasonable value of the medical treatment. In many cases this results in a significant windfall to plaintiffs and their attorneys for damages that the plaintiff never incurred. The costs of these inflated judgments are then borne by businesses and the general public in the form of increased insurance rates.

This bill provides that evidence of the amount paid for medical services by a collateral source is admissible and may (not must) be used by a jury to determine the reasonable value of medical services. To be clear, Assembly Bill 29 retains the current presumption under Wis. Stat. § 908.03 (6m) (bm), but allows for the court and the jury to be provided access to additional information through the introduction of collateral source payments as a means of rebuttal (i.e. the amount paid to the medical provider may be admitted into evidence to assist finders of fact in determining the reasonable value).

Current Wisconsin statutes already bar the collateral source rule for medical malpractice claims, but not personal injury cases. By adopting this legislation, Wisconsin would join approximately 17 other states that have adopted similar collateral source reforms, or where the courts have held that such evidence is admissible. Other Midwestern states, including Indiana, Minnesota, and Ohio have similar laws.

I recognize that a plaintiff may suffer harm so egregious or malicious that justice requires compensation above their actual costs. The determination of these non-economic or punitive damages (such as pain and suffering or physical and emotional distress) is unaffected by this legislation.

Thank you again for your time and for your consideration of Assembly Bill 29.

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Testimony of Jeffrey A. Pitman
Wisconsin Association for Justice
Before the Assembly Judiciary Committee
April 11, 2013
Regarding
2013 Assembly Bill 29

Good morning, my name is Jeff Pitman. I am a partner with the Milwaukee law firm of Pitman, Kyle, Sicula & Dentice, S.C. I am the President of the Wisconsin Association for Justice. Thank you for giving me the opportunity to speak against Assembly Bill 29.

AB-29 seeks to undo a law that has been a part of Wisconsin law since at least 1908, the Collateral Source Rule. Wisconsin courts have long recognized that an injured party has a right to recover from the wrongdoer "the reasonable value of the medical treatment reasonably required by the injury." This rule is based on "Wisconsin's significant interests in fully compensating victims of ordinary negligence."

Under the collateral source rule, the amount of damages awarded to a person injured because of another person's wrongful conduct is not reduced when the injured party receives compensation from another source, such as insurance. The reason for this rule is described in the 1908 case of *Gatzweiler v. Milwaukee Electric Railway & Light Co.*, where the Wisconsin Supreme Court said that a casualty insurance contract "is an investment contract giving to the owner or beneficiary an absolute right, *independent of the right against any third party responsible for the injury covered by the policy*." This decision was followed by *Campbell v. Sutliff* in 1927 where the Court held, "It is equally clear that the defendant is not entitled to have the damages reduced because the plaintiff had *purchased and paid for the right to have indemnity* in case he sustained accidental injuries. *The sums paid for such insurance are in the nature of an investment, which, like other investments made by the plaintiff, ought not to inure to the benefit of the defendant.* The only parties interested in such a contract of insurance are the plaintiff and the insurer."

The collateral source rule was recently reaffirmed by all the Justices currently sitting on our Supreme Court in the decision in *Orlowski v. State Farm Ins. Co.,* including those Justices with a long history of protecting the interests of Wisconsin's business community. In *Orlowski,* the court recognized the significant benefits associated with the current rule:

- First, the rule deters a wrongdoer's negligent conduct by placing the full cost of the wrongful conduct on the wrongdoer.
- Second, the rule assures that the injured party is fully compensated ("The collateral source rule protects plaintiffs by guarding against the potential misuse of collateral source evidence to deny the plaintiff full recovery to which he is entitled.")
- Third, the rule allows the injured party to receive the benefit of the premiums paid for coverage that he or she had the foresight to purchase.

In fact, the court in *Orlowski* addressed head-on the very argument raised by proponents of this change in the law, rejecting the "phantom damage" argument based on the recognition that the injured party has paid premiums for health insurance coverage and should receive the benefit of these premiums, not the wrongdoer. There is nothing irrational or unfair about a rule that prohibits a wrongdoer from benefiting from the planning and foresight of an injured party, who has the wisdom to plan ahead and purchase insurance. In addition, the proposed elimination of the collateral source rule will impose a greater burden on the health care providers that treat the injured party and the insurers that provide their medical coverage.

Changing the Law Penalizes Workers with Insurance

Explaining how the current law works and how changing the law will penalize those who buy health insurance is best shown by example. I will compare John, who has health insurance, to James, who does not have health insurance.

Responsible John and Irresponsible James are twins, each running their own small business, who were riding in the same vehicle when they were rear-ended at a very high speed by a fully loaded dump truck being driven by a drunk driver with a blood alcohol level of .33, more than 4 times the legal limit. Assume that the injuries to Responsible John and Irresponsible James were identical, including multiple spinal and joint fractures and a crushed pelvis. Assume that their surgeries, rehabilitation and lost income resulting from their injuries were identical.

Over the last 25 years, Irresponsible James never believed in purchasing health insurance, so he must now pay his medical bills out-of-pocket, and he owes the hospital, clinics and physicians $200,000.

Responsible John has always believed in having health insurance, paying premiums for more than 25 years. His health insurance carrier has had agreements in place with John's hospital, clinics, and physicians, so John's health insurance received a discount and only paid $125,000 for John's medical bills.

If the proposed change in the collateral source rule becomes the law of the State of Wisconsin, irresponsible James's case would be worth significantly more than John's case. This would be true, even though everything about the injuries is identical. This would be true even though John was the responsible brother, by purchasing health insurance over the years.

The full benefit for the reduction in the value of John's case would go to the drunk driver, rather than the injured person, John. In order to be fair to John, a jury should only hear the true value of the medical services he received, and not be swayed by any lesser value negotiated by a collateral source, thanks to his responsible decision to purchase health insurance. John invested in his health insurance, and the drunk driver should not be the beneficiary of John's having acted responsibly.

Any proposal that would allow the drunk driver to pay less to John, just because he had insurance, is stealing the premiums that John paid for that coverage! Such a change would mean that John who has worked hard, planned ahead, and made sacrifices to obtain health coverage and other benefits would receive LESS for the same injury than James, who never bothered to buy insurance. <u>That is Premium Theft.</u>

Response to the Issues Raised in Support of Changing The Law

Those advocating for a change in the law cite three reasons. First, the proponents state that the changing the law will prevent a "windfall" to the injured victim. Simply stated, this is wrong because the victim has paid thousands if not tens of thousands of dollars for health insurance premiums. The current law does not result in a windfall to anyone; rather, the current law is a common sense way to both prevent a person from being penalized for buying health insurance and prevent someone who injures another from benefiting from the injured person's foresight in buying health insurance. As explained by Justice David Prosser in 2011, a windfall would occur to a negligent driver and his auto insurance company if the collateral source rule was changed. In the case of *Fischer v. Steffen*, Steffen injured Fischer in an auto accident. Fischer incurred $12,157 in medical expenses. All of the medical expenses except $2,157 were paid by Fischer's insurance. Steffen argued that he only had to pay the amount not written off by Fischer's insurance ($2,157) rather than the amount incurred by Steffen ($12,157). Justice Prosser wrote:

> "The most striking fact about this case is that defendant Steffen caused $12,157.14 in medical expenses to Fischer but has been relieved of the burden of paying all but $2,157.14 toward these expenses. As a result, Fischer is being punished for their foresight in purchasing [ ] insurance with coverage for medical expenses, while Wilson Mutual (Steffen's auto insurance company) receives a $10,000 windfall."

Second, the proponents state that the current law results in "inflated judgments" that result in increased insurance rates. There is no evidence to support this conclusion. The collateral source rule has existed in Wisconsin for over 100 years and no Wisconsin appellate judge or Supreme Court justice has ever said that the current law results in "inflated judgments."

Third, the proponents state that a change in the law will bring Wisconsin in line with Indiana, Minnesota and Ohio. Following that logic, auto insurance premiums would likely increase as the average auto insurance premium in these three states is higher than Wisconsin. There is no correlation between the elimination of the collateral source rule and reduced insurance premiums.

Bare Evidence of Discounted Payments Arising from Third-Party Contracts Do Not Establish the Value of Medical Services

If a physician were to bill patients, so-called "phantom damages" by proponents of this bill, it would be a violation of the American Medical Society's Code of Medical Ethics Opinion E-6.05, which states, the following:

> A physician should not charge or collect an illegal or excessive fee . . . A fee is excessive when after a review of the facts a person knowledgeable as to current charges made by physicians would be left with a definite and firm conviction that the fee is in excess of a reasonable fee. Factors to be considered as guides in determining the reasonableness of a fee include the following:
> (1) The difficulty and/or uniqueness of the services performed and the time, skill, and experience required
> (2) The fee customarily charged in the locality for similar physician services
> (3) The amount of the charges involved
> (4) The quality of performance
> (5) The experience, reputation, and ability of the physician in performing the kind of services involved.

Based on the above code provisions, it would unethical for Wisconsin physicians to charge the excessive fees. Under such standard, the amount charged should be presumed to be the reasonable value of the services provided, which is what is allowed in Wis. Stat. 908.03 (6m) (bm).

While proponents argue that "paid amounts" by insurers should be used to determine the reasonable value of medical expenses, evidence of discounted fees received by providers is irrelevant to prove value because such fees do not reflect the full consideration received by providers for their services.

Discounted fees received by a provider do not constitute a measure of the fair market value of the service provided because such discounted fees do not include the full consideration received by the providers under the discounted fee arrangements.

Typically, a HMO or PPO is a network of health care providers organized to offer medical services at discounted rates. The providers within the network furnish their services at discounted rates because they expect to receive a higher volume of patients, i.e., participants in the welfare benefit plan offered by the insurance company. The increase in the volume of patients is a result of third party payers, who direct plan participants to providers in the HMO/PPO network through marketing materials and financial incentives.. The use of financial incentives and other measures to direct plan participants to providers in the HMO/PPO is known in the health care industry as "steerage." Steerage" has economic value and is consideration received by providers in addition to the discounted fees.

The discounted amounts received by the HMO/PPO provider do not reflect the full amount of consideration received by a HMO/PPO provider under the network contract. Therefore, evidence of discounted amounts paid should not be used to establish the value of medical services.

Changing the Collateral Source Rule will have the Unintended Consequence of Increasing the Costs of Healthcare in Wisconsin.

In addition, a change in current law will likely have significant consequences for health care insurers and health care providers in Wisconsin. In most personal injury claims, the interests of the health care insurers and health care providers are directly aligned with those of the injured claimant either as a result of their right of subrogation or their assertion of a lien for recovery of health care expenses.

There are numerous adverse risks to Wisconsin's business community that are the unintended consequences off this proposed change in Wisconsin law. Health insurers face the very significant risk of greater involvement in personal injury litigation as a result of expanded written discovery and depositions seeking information on the basis for their reduced reimbursements. In addition to the costs associated with this discovery, there is also substantial risk of unwanted disclosure of the confidential negotiations between health care providers and insurers that form the foundation for the contractually reduced health insurance payments. These additional costs and inconvenience will have an adverse impact on the bottom line for health insurers with subrogated claims. In addition, the proposed legislation creates additional risk of reduced recovery of claims in settlement or the extinguishment of subrogated claims after settlement. Reduced

recovery and increased costs will result in increased health insurance premiums being passed on to your constituents.

The adverse consequences of this legislation will impact not only health insurance carriers, but also health care providers. Although the legislation indicates that the bills and invoices, once submitted, create a presumption that the amount contained in the bill or invoice represents the reasonable value of the services provided, this presumption is now easily rebutted by the admission of the amounts paid by collateral sources, evidence that is currently inadmissible. Once evidence of collateral source payments is introduced in the litigation, any presumption of reasonableness of the amounts billed evaporates, and the issue of reasonableness becomes a question of fact in the lawsuit. The consequences for health care providers are significant.

First, health care providers will be subject to subpoena in every personal injury claim to testify as to the basis for the amount billed to the patient and also to testify as to the basis for the contractually negotiated reduced sum paid by the patient's insurer. In situations where there exists no health insurance or where the provider decides to forgo the submission of the bill to insurance or to government agencies for reimbursement, the health care provider lien will be subject to attack by both the defendant and the plaintiff regarding the reasonable value of the service. Evidence will now be admissible regarding amounts accepted by the provider from collateral sources such as insurance carriers and government funded health programs. These adverse consequences will only increase costs to health care providers and reduce recoveries, which will naturally be reflected in additional increased costs of healthcare to your constituents.

Retroactivity

As written, AB-29 would apply to cases that have not been filed on effective date. This means the new law will apply to cases where the injury has occurred, but a case has not been filed. This will cause every lawyer to file a lawsuit in every case to preserve the rights of theirclients. It will mean numerous cases, which could be settled without a lawsuit, will need to filed, increasing costs for both clients and for the judiciary.

The law is written so it applies retroactively. Retroactive legislation disrupts the constitutionally protected property rights of an injured person. Legislation challenged for its retroactivity is scrutinized under a much a more rigorous standard than prospective legislation. Because you are taking away someone's property rights, the Courts must consider whether this is unfair. Over the past 25 years, the Wisconsin Supreme Court has struck down retroactive legislation

on four separate occasions. The provision should be removed from the bill and the legislation, like all legislation, should apply prospectively.

Conclusion

The primary entities that benefit from the proposed change in the collateral source rule are the property and casualty insurers that provide liability coverage to the negligent parties. The legislation allows the wrongdoer and his/her insurer to benefit from the planning and foresight of the injured party and the premium funded benefits negotiated by the injured party's employer and/or insurer. Most importantly, it does so at increased cost and risk to health care insurers and health care providers in Wisconsin. It is legislation that, at first blush may seem logical, but in reality is not in the interests of Wisconsin's business community or is citizens. AB-29 should be rejected.

Wisconsin Defense Counsel

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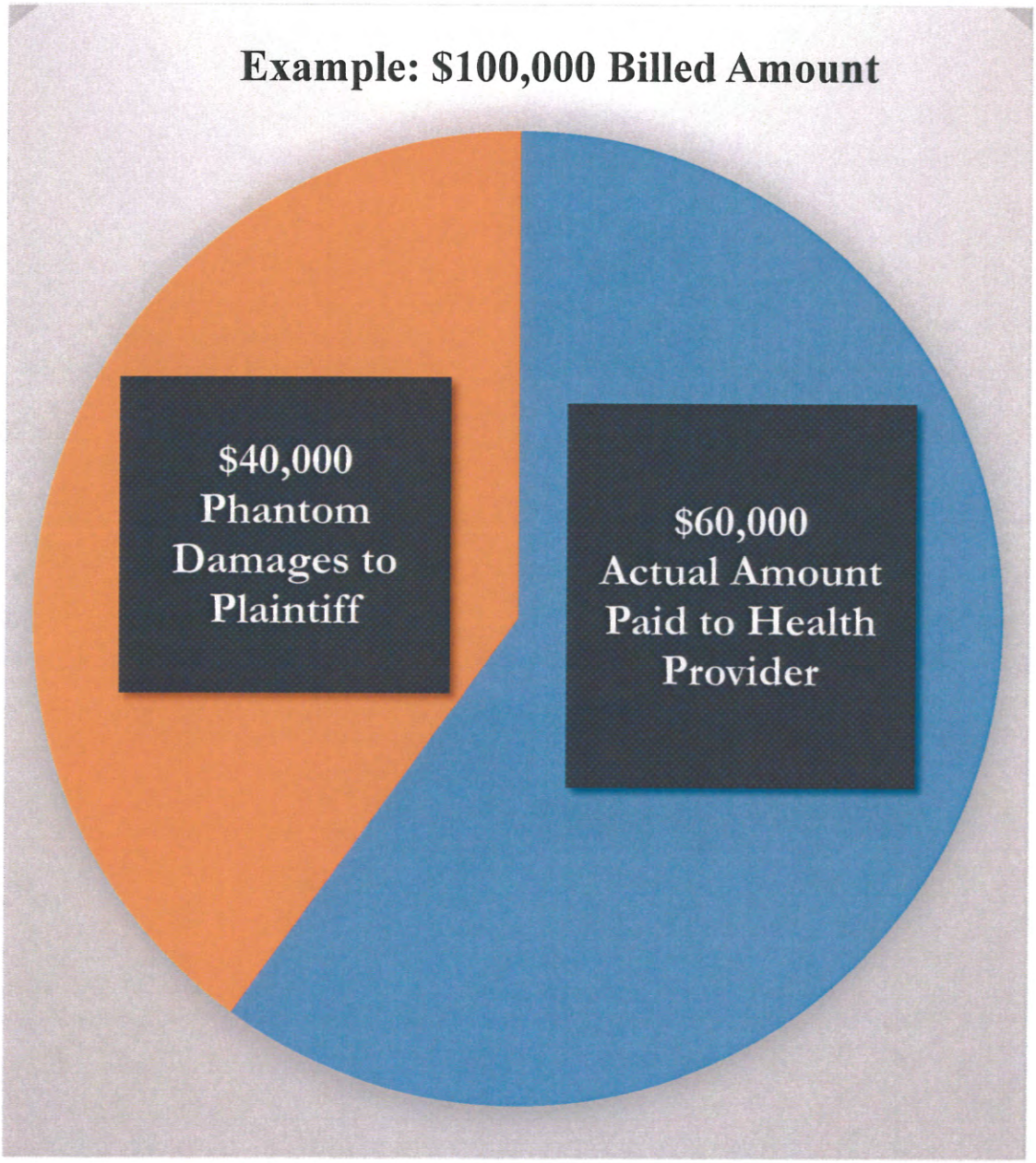

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AB 29 - Let the Jury Decide

Example of Phantom Damages

$100,000
Amount Billed by Health Provider

$60,000
Actual Amount Paid by Collateral Source (Health Insurer) to Health Provider

$40,000
"Phantom Damages" to plaintiff and plaintiff attorney

Plaintiff and attorney reap windfall of **$40,000** for medical expenses never paid to medical provider.

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AB 29 – Let the Jury Decide

Wisconsin Legislature Previously Eliminated the Collateral Source Rule in Medical Malpractice Cases

- There is precedent in Wisconsin for eliminating the collateral source rule.
- In 1995, the Legislature eliminated of the collateral source rule for medical malpractice cases.
- Wis. Stat. 893.55(7) states the following:

  "Evidence of any compensation for bodily injury received from sources other than the defendant to compensate the claimant for the injury is admissible in an action to recover damages for medical malpractice. This section does not limit the substantive or procedural rights of persons who have claims based upon subrogation."

- AB 29 is similar to the medical providers' collateral source law.
- Similar to s. 893.55(7), AB 29 allows the jury to see evidence of the amount billed by the medical provider and the amount paid by the collateral source (health insurer).
- Based on all the evidence, AB 29 allows the jury to determine how much the plaintiff should be reimbursed for his or her medical expenses.
- The Legislature should pass AB 29 and extend the same protection currently granted to health providers to ALL defendants.

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AB 29 – Let the Jury Decide

Dissenting Opinions by Former and Current Supreme Court Justices

In three of the major cases dealing with the collateral source rule, former Justice Diane Sykes, along with Justices Patience Roggensack and David Prosser, dissented when the majority held that the plaintiff should be awarded "phantom damages."

Leitinger v. DBart (2007 WI 84)

In *Leitinger v. DBart*, Justices Patience Roggensack and David Prosser dissented in a decision involving the collateral source rule. According to Justices Roggensack and Prosser, the majority:

> **"create[d] a new category of damages . . . by unnecessarily expanding the evidentiary component of the collateral source rule to prohibit the jury from hearing what was actually paid to cover all of [plaintiff's] medical care bills while admitting evidence of what was billed, even though no one will ever pay that amount."**

Ellsworth v. Schelbrock (2000 WI 63)

Justice Sykes – who now sits on the U.S. Court of Appeals for the Seventh Circuit – cited to a California Supreme Court decision in her dissenting opinion that had reached the opposite conclusion of the Wisconsin decision:

> "In tort actions damages are normally awarded for the purpose of compensating the plaintiff for injury suffered, i.e., restoring him as nearly as possible to his former position, or giving him some pecuniary equivalent. . . . **The primary object of an award of damages in a civil action, and the fundamental principle of which it is based, are just compensation or indemnity for the loss or injury sustained by the complainant, and no more . . . .**
>
> **Applying the above principles, it follows that an award of damages for past medical expenses in excess of what the medical care and services actually cost constitutes overcompensation.**
>
> Thus, when the evidence shows a sum certain to have been paid or incurred for past medical care and services, whether by the plaintiff or by an independent source, **that sum certain is the most the plaintiff may recover for that care despite the fact it may have been less than the prevailing market rate."**

(Over)

Koffman v. Leichtfuss (2001 WI 111)

Justice Sykes again dissented in this case dealing with the collateral source rule, arguing:

> **"[the] proper measure of medical damages is the amount reasonably and necessarily incurred for the care and treatment of the plaintiff's injuries, not an artificial, higher amount based upon what the plaintiff might have incurred if he or she had a different sort of health plan or no health plan at all."**

Conclusion

AB 29 promotes transparency and fairness by allowing the jury to see all the evidence when deciding the amount of past medical expenses.

Wisconsin Defense Counsel

Defending Individuals And Businesses In Civil Litigation

AB 29 – Let the Jury Decide

Numerous States Have Eliminated or limited Phantom Damages

- **18 States have either eliminated or limited the collateral source rule. Those states include:** Arkansas, Alabama, California, Connecticut, Florida, Idaho, Indiana, Maryland, Massachusetts, Missouri, New Hampshire, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Texas, Wisconsin (for medical malpractice cases).
- **19 States have still allow phantom damages.** Those states include: Arizona, Colorado, Delaware, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Minnesota, Mississippi, Nebraska, Oregon, South Carolina, South Dakota, Virginia, Washington.
- **In 13 states the law is uncertain or has not been addressed.** Those states include: Alaska, Michigan, Montana, Nevada, New Jersey, New Mexico, North Dakota, Rhode Island, Tennessee, Utah, Vermont, West Virginia, Wyoming.

GODFREY & KAHN S.C.

MEMORANDUM

TO: Assembly Judiciary Committee

FROM: James A. Friedman
Godfrey & Kahn, S.C.

DATE: April 11, 2013

RE: 2013 Assembly Bill 29 / Q&A

This memorandum attempts to answer some of the questions raised concerning the pending collateral source legislation, 2013 AB 29 / 2013 SB 22.

1. **Q:** Why is the Wisconsin business community supportive of 2013 AB 29 / 2013 SB 22?

A: In 2007, the Wisconsin Supreme Court, in *Leitinger v. DBart, Inc.*, 2007 WI 84, 302 Wis. 2d 110, 736 N.W.2d 1, held that the "collateral source rule" prohibits parties in a personal injury action from introducing evidence of the amount actually paid by the injured person's health insurer (or other collateral sources) for medical treatment resulting from the accident to prove the reasonable value of past medical expenses. The 2009-11 Budget Bill created Wis. Stat. § 908.03(6m)(bm), which creates an evidentiary presumption that invoices from health care providers state the reasonable value of health care services and statutorily prohibits parties from presenting evidence of payments made by collateral sources. Based on these two rules of evidence, juries only see the billed amount for past medical expenses. In reality, the amount paid by health insurers and other collateral sources as full payment for health care services, in most instances, is substantially less than the billed amount.

Hence, the judicially-created collateral source rule and the legislatively-created presumption have led to unfair and irrational results. The amounts actually paid for past medical expenses are withheld from jurors. Jurors then award verdicts to plaintiffs for past medical expenses that far exceed the amounts actually paid. After subrogated parties are reimbursed for the actual payments they have made, the plaintiffs and their personal injury attorneys receive a windfall of these "phantom damages" – the difference between the amount awarded by juries for past medical expenses and the amount paid to reimburse the subrogated parties in full. And defendants and their insurers are forced to pay excessive amounts not rationally related to plaintiffs' actual damages.

2013 AB 29 / 2013 SB 22 attempts to prevent this unfair, irrational result. It would overturn the collateral source rule and, while leaving the statutory presumption in place, it would permit parties to present to a jury the amounts actually paid by collateral sources as full payment for health care expenses resulting from accidents. That reasonable compromise in the rules of evidence already is the law with respect to medical malpractice and long-term care negligence claims.

2. **Q:** Will 2013 AB 29 / 2013 SB 22 cause defense lawyers to seek in discovery information concerning rates negotiated between health care providers and health insurers?

A: No. The collateral source legislation will have no impact whatsoever on the rules of discovery in Wisconsin. Under current law, defense counsel are entitled to seek all of the plaintiff's health care records, including billing records and payment records. In other words, defense counsel already are entitled to discover the amounts paid for health care expenses. They simply cannot introduce that evidence at trial. The legislation will have no impact on discovery.

3. **Q:** If 2013 AB 29 / 2013 SB 22 is passed, will plaintiffs forego introducing health care records into evidence at trials?

A: No. Plaintiffs still will be required to name all insurers and other collateral sources with subrogation interests as parties to personal injury lawsuits. Furthermore, in virtually all cases, it will be in plaintiffs' best interest to use treatment records, including invoices, to support their damage claims. It would be very difficult for a plaintiff to recover significant damages for pain and suffering without putting into evidence treatment records. In fact, plaintiff lawyers regularly ask juries to base their awards for pain and suffering on a multiple of past medical expenses.

4. **Q:** Will health insurers and other collateral sources have to pay for and introduce expert testimony to prove their subrogation claims?

A: No. In fact, the collateral source legislation should have just the opposite effect. The bill has no impact whatsoever on the admissibility of expert testimony. But it does permit any party to place into evidence, without the need for an expert, medical bills and payment information. At most, that would require a record custodian. If anything, expert testimony becomes less relevant under 2013 AB 29 / 2013 SB 22.

5. **Q:** Will subrogated parties recover less at trial?

A: No. Subrogated parties only are entitled to recover the amounts they actually have paid for health care expenses. The collateral source legislation does nothing to change that. Only plaintiffs and personal injury lawyers might recover less under the bill.

6. **Q:** Will subrogation attorneys seek higher contingency fees if 2013 AB 29 / 2013 SB 22 is passed?

A: No. Currently, subrogated parties only are entitled to recover the actual amounts they have paid for past medical expenses. That will not change under the collateral source legislation. Subrogation lawyers generally charge a percentage of the amount recovered. Because the potential recovery will not change, there is no reason to think that subrogation attorneys will seek higher contingency fees.

7. **Q:** Will the collateral source legislation have any impact on subrogation recoveries under self-funded employer health care plans or federally-funded health care programs?

A: No. Self-funded employer health care plans are covered by ERISA, which pre-empts state insurance laws, including Wisconsin's "made whole" doctrine. The same is true for federally-funded health care programs, including Medicare and federal employee health benefit plans. Hence, the payors under those plans are entitled to first dollar recoveries, and they do not have to prove that the plaintiff is made whole before recovering the full amount of their payments. That will not change under 2013 AB 29 / 2013 SB 22.

8. **Q:** Will subrogated parties recover less in settlements under 2013 AB 29 / 2013 SB 22?

A: Probably not. The pending collateral source legislation would have no legal impact on settlement negotiations in personal injury actions. In fact, the only changes to the statutes would be in the evidence code. In other words, the proposed legislation should have no impact unless the case goes to trial. At trial, only plaintiffs and personal injury lawyers should recover less, because a jury verdict, by definition, makes a plaintiff whole. Hence, following a trial, a subrogated party usually is entitled to a full recovery.

For the most part, settlement negotiations are driven by possible outcomes at trial. Under current law and under the collateral source legislation, subrogated parties only may recover amounts they actually pay. Hence, there is no reason to think that settlement negotiations will be significantly affected by 2013 AB 29 / 2013 SB 22. Those negotiations only will be affected if subrogation attorneys permit them to be.

JAF:jls

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Testimony Presented to
Assembly Committee on Judiciary
In opposition to Assembly Bill 29

Presented by Peter Farrow
Chief Executive Officer,
Group Health Cooperative of Eau Claire
April 11, 2013

Thank you Chairperson Ott and members of the Committee for the opportunity to present testimony before your committee today. My name is Peter Farrow. I am the Chief Executive Officer of Group Health Cooperative of Eau Claire. I am testifying on behalf of Group Health Cooperative and the Wisconsin Association of Health Plans (WAHP), of which I am the Board president. I am presenting testimony today in opposition to AB 29.

By way of background, Group Health Cooperative of Eau Claire is a non-profit cooperative that provides health insurance coverage to 65,000 residents of Western Wisconsin through both commercial and government coverage, and administers coverage for another 50,000 Wisconsin residents. We are a member-governed plan, meaning our board of directors is comprised completely of members covered by Group Health Cooperative. I have been CEO and general manager for 14 years. Prior to that, I served for five years as the Assistant Deputy Insurance Commissioner for the Wisconsin Office of the Commissioner of Insurance.

The relationship between health insurance coverage, liability insurance coverage for injuries, third party liability and subrogation is a very complex one. In the interest of brevity, I will not try to explain the intricacies of the issue. What I will attempt to do is share the health plan perspective and share our opinion of what legislation like this would do to health insurance costs, and legal costs that would likely result from these changes.

The process for paying health insurance costs for an injury is different than many other liability situations. For example, most people assume that the economic damages, those actually incurred by the injured party, would be considered and paid before the non-economic damages such as pain and suffering. However, because of Wisconsin's made-whole law, the interests of the plaintiff, and whether they will be made whole for all of their economic and non-economic costs, is considered before the interests of a subrogated third party, such as the health insurer who covered all of the medical costs related to the injury.

Further, the plaintiff has the right to determine the resolution of the claim. So, if the plaintiff decides to settle out of court for a lesser amount, subrogated interests may or may not be covered by the settlement because the claims of the subrogated insurer may be dismissed if the plaintiff is not made whole.

Let me start by saying that I do not doubt that the parties who support this legislation are attempting to change a process which they perceive to be broken, because they feel that if actual medical payments were considered, awards would be reduced and they would save costs. This is a very complex issue, and it is easy to overlook the downstream effect. The question is what the net result truly would be. I believe that the effect of this legislation would be to:

- Shift more than $50 million in expense to the Wisconsin businesses and individuals who purchase health insurance,
- Increase state budget costs by millions of dollars for Medicaid by all but eliminating subrogation recoveries in the Wisconsin Medicaid Program, and
- Increase overall legal expenses related to these cases.

Shift more than $50 million in expense to Wisconsin businesses and individuals who purchase health insurance.

Supporters of the legislation have stated that it would not affect the rights of health insurers. That is cleverly written and true, but it would greatly affect our interest and ability to recover payments made in injury cases. Right now, on average, we collect about 60% of the costs of claims related to injuries where a third-party liability has primary responsibility for payment. That is under the current system where solely billed charges are considered in evidence.

The reason we don't recover full costs is two-fold:

1. Wisconsin's made-whole law requires that the plaintiff be made whole for any damages they incur, whether economic or non-economic, before considering the interests of subrogated parties, such as the health insurer that paid all the claims.
2. Most of these cases settle out of court for a lower amount, so the full cost is rarely recovered by the plaintiff.

If this legislation were enacted, and the actual payments were considered, it would reduce indicated medical costs by perhaps ten to twenty percent for commercial, and far more for Medicare or Medicaid. Someone has to lose in that equation. It will likely be both the plaintiff and the health insurer. But, since the health insurer is last in line to recover, we will lose the most. If recoveries for insurers drop by 30 to 40%, I estimate that the net impact on Wisconsin health insurance consumers would be in excess of $50 million.

Increase state budget costs by millions of dollars for Medicaid by all but eliminating subrogation recoveries in the Wisconsin Medicaid Program.

If actual costs for recoveries were considered for individuals covered by Medicaid, it would reduce awards by 60-80%. However, because Medicaid is a payor of last resort, the made-whole provision of state law do not apply, meaning typically Medicaid, and the Medicaid managed care plans, will recover a slightly higher percentage but a lower amount. But, since the awards will be cut dramatically, it is likely that attorneys will not pursue these cases, thus dramatically reducing the number of contested cases and as a result the recoveries for Medicaid. It is difficult for me to quantify the impact, but I expect it would increase net costs to the program by more than $10 million. In short, taxpayers bear more of the burden of the injury.

Increase overall legal expenses related to these cases.

While supporters of the legislation have suggested the change would decrease legal costs, as one of the parties involved in these cases, I expect it will actually increase costs. This effect will happen in two ways. First, because the potential upper limit of awards will be lower, it will become more difficult to settle these cases, meaning many more will go to trial or require more in depth discovery. Second, insurers and subrogated parties typically are in a cooperative position with plaintiffs and plaintiffs' counsel in these situations, and do not contest made-whole hearings very often (even though we recover far less than our actual expenses). As a result of this legislation, I expect that subrogated parties would find themselves contesting far more plaintiff made-whole hearings and would be investing far more actual legal expense to protect their interests to recover expenses.

Conclusion.

At a time when health insurance costs continue to rise due to medical inflation, and the implementation of the Affordable Care Act will raise overall insurance costs through expanded federal fees and expanded benefits. I do not believe the Legislature wants to further aggravate health care coverage costs for Wisconsin businesses and individuals. I urge you to oppose further consideration of AB 29.

I would be happy to answer any questions you may have now or at any time. Please feel free to contact me at 715-852-2070 at your convenience. Thank you for your consideration and your attention.

WISCONSIN CIVIL JUSTICE COUNCIL, INC.

Promoting Fairness and Equity in Wisconsin's Civil Justice System

TESTIMONY OF THOMAS E. GOSS, JR. TO THE ASSEMBLY JUDICIARY COMMITTEE REGARDING SB22/AB29

April 11, 2013

My name is Thomas E. Goss, Jr., and I wish to thank you for allowing me to testify on Senate Bill 22/Assembly Bill 29, which, among other things, addresses evidence the trier of fact may consider in determining the reasonable value of the injured person's medical and healthcare expenses.

I am a member of the law firm of Mueller, Goss & Possi, S.C., in Milwaukee, Wisconsin. I have been practicing law in the State of Wisconsin since 1979 and the emphasis of my practice involves personal injury litigation, primarily for the defense, and insurance coverage issues.

I was counsel of record for the insurer involved in a recent appeal before the Wisconsin Supreme Court in *Orlowski v. State Farm Mut. Auto. Ins. Co.,* 2012 WI 21, 339 Wis.2d 1, 810 N.W.2d 775, where the court held the collateral source rule applies to underinsured motorist cases and overruled *Heritage Mut. Ins. Co. v. Graser,* 2002 WI App. 125, 254 Wis.2d 851, 647 N.W.2d 385, to the extent it held the collateral source rule had no application in cases involving underinsured motorist coverage. My testimony represents my views and not the view of any of my clients.

My testimony will address the following areas:

1. The history in Wisconsin pertaining to the determination of the reasonable value of medical and healthcare expenses and application of the collateral source rule in personal injury actions.
2. Why this legislation is a fair, reasonable and balanced compromise concerning the determination of reasonable value of medical and healthcare expenses in personal injury actions.

I. HISTORY CONCERNING THE MEASURE OF MEDICAL AND HEALTHCARE EXPENSES AND APPLICATION OF THE COLLATERAL SOURCE RULE.

The Wisconsin Supreme Court formally adopted the collateral source rule in *Cunnien v. Superior Iron Works,* 175 Wis. 172, 184 N.W.2d 767 (1921). That rule provides benefits an injured person receives from sources that have nothing to do with the tortfeasor may not be used to reduce the tortfeasor's liability to the injured person. A tortfeasor is not given credit for payments or benefits conferred upon the injured person by any person other than the tortfeasor or someone identified with the tortfeasor (such as the tortfeasor's insurance company). *Leitinger v. DBart, Inc.,* 2007 WI 84, ¶26, 302 Wis.2d 110, 736 N.W.2d 1.

That rule is applied even where an injured person may experience a double recovery, one recovery from the collateral source and a second recovery from the tortfeasor. That result is upheld on the basis the injured person, not the tortfeasor, should benefit from the collateral source. *Id.*, at ¶34.

In *Leitinger*, the court observed the collateral source rule, as a rule of damages, denies the tortfeasor credit for payments or benefits conferred upon the plaintiff by any person other than the tortfeasor and, as a rule of evidence, the collateral source rule generally precludes introduction of evidence regarding benefits the plaintiff obtained from sources collateral to the tortfeasor. *Id.*, at ¶28-30.

In Wisconsin, the proper measure of damages for medical treatment rendered in a personal injury action is the reasonable value of the medical treatment reasonably required by the injury. *Leitinger*, ¶23. The court, in *Leitinger,* noted while the actual amount paid for medical services may reflect the reasonable value of the treatment rendered, the focus is on reasonable value not the actual charge. *Id.*

That statement finds considerable support in the court's prior decisions: *Lautenschlager v. Hamburg,* 41 Wis.2d 623, 630, 65 N.W.2d 129 (1979) (medical expenses are recoverable as part of compensatory damages to the extent of the amount reasonably and necessarily paid or incurred for treatment, with the amount paid or liability incurred is merely evidence which can go to the jury to assist it in arriving at a reasonable award); *Thoreson v. Milwaukee & S. Transport Corp.*, 56 Wis.2d 231, 243, 2001 N.W.2d 745 (1972), (general rule is that a plaintiff injured by the tortious conduct of another is entitled to recover the reasonable value of his medical costs reasonably required by the injury which, in most cases, would be the actual expense).

In bodily injury litigation prior to 2000, it was a rare situation where a plaintiff would argue for a recovery of medical expenses in excess of the amount actually incurred. This point was also noted by the *Thoreson* court, when it described the three typical situations where a plaintiff sought to recover damages for expenses never in fact incurred, as being: (1) gratuitously rendered hospital and medical expenses; (2) services rendered gratuitously to a member of an association; and (3) service gratuitously rendered by the plaintiff's spouse. *Id.,* at 243-244. During that time period, the courts consistently rejected defense arguments that the amount a plaintiff could recover for medical and healthcare expenses would be subject to reduction by collateral source payments.

In *Ellsworth v. Schelbrock,* 2000 WI 63, 235 Wis.2d 678, 611 N.W.2d 764, the plaintiff argued she was entitled to recover the full amount of the reasonable value of medical and healthcare services provided, even though she never incurred any obligation to pay that amount, due to the involvement of public assistance. This appears to be the first time that type of argument was raised involving a non-gratuitous collateral source situation. In a 4-3 decision, the supreme court agreed with the plaintiff's position, which meant she was entitled to recover over $597,000 in claimed medical expense despite the Medical Assistance payment of $355,000, which capped her personal exposure, amounting to over a $240,000 windfall on her part.

Following *Ellsworth*, the plaintiffs advanced similar arguments concerning the involvement of private health insurance payments and the supreme court went along with those arguments as well. *Koffman v. Leichtfuss,* 2001 WI 111, 246 Wis.2d 31, 630 N.W.2d 201 (plaintiff is entitled to seek recovery of the reasonable value of medical services without limitation to the amount paid by the plaintiff's health insurer in full satisfaction of the charges); *Leitinger v. DBart, Inc.*, 2007 WI 84, ¶28, 302 Wis.2d 110, 736 N.W.2d 1 (evidence of the amount of actually paid by a plaintiff's health insurer for the plaintiff's medical treatment is inadmissible in a personal injury action, for purposes of establishing the reasonable value of the medical treatment rendered).

The reason for this new approach was primarily driven by the billing practices of the healthcare providers. In the past, the healthcare providers generally expected to be paid what was billed and the plaintiffs argued the amount they had actually paid reflected the reasonable value of the services provided. Recently,

however, the expectation of payment by a healthcare provider is less clear, which was also noted by the Wisconsin Supreme Court in *Koffman*, ¶21:

The modern health care system employs a myriad of health care finance arrangements. As part of the system, negotiated and contracted discounts between health care providers and insurers are increasingly prevalent. Pursuant to these agreements, an insurer's liability for the medical expenses billed to its insured is often satisfied at discounted rates, with the remainder being "written-off" by the health care provider. In 2009, the Wisconsin Legislature created sec. 908.03(6m)(bm), Stats., which provides that the amounts billed by a healthcare provider are presumed to state the reasonable value of the services rendered and while a defendant may rebut that presumption, in doing so it may not present evidence of payments made or benefits conferred by collateral sources.

With the enactment of sec. 908.03(6m)(bm), Stats., the legislature determined a healthcare provider's billing statements or invoices are presumed to state the reasonable value of the healthcare services provided. That presumption is difficult to understand, in light of the reality of the prevalence of discounted rates and write-offs that apply, and would seem to make as much sense as stating sticker prices on new cars are presumed to state the reasonable value.

The problem, however, goes deeper, because the statutory presumption, as now written, has the effect of misleading a jury into believing the plaintiff's actual bill or invoice is as stated, when that is hardly ever the case. Most jurors would believe the invoice would constitute a financial obligation on the part of the plaintiff when, in the vast majority of cases, it does not.

This misunderstanding is further reinforced by the standard instruction given to juries in this state, pertaining to past healthcare expenses, which states the plaintiff is entitled to an award for those medical and healthcare expenses it finds has reasonably and necessarily been incurred from the date of the accident, and that the billing statements for healthcare services the plaintiff has received since the accident have been admitted into evidence, which would establish the reasonable value, if not rebutted. Wis. JI-Civil 1756 *Personal Injuries Past Health Care Expenses.*

Finally, that statute prevents a defendant from bringing to the jury's attention the amounts actually paid and written-off, in attempting to rebut that presumption. These factors combine to ensure that the statutory presumption cannot be rebutted, by making it virtually impossible for a defendant to effectively establish reasonable value of the services provided which, in turn, provides the typical plaintiff with a significant windfall.

II. THE LEGISLATION REFLECTS A FAIR, MIDDLE-GROUND APPROACH TO THE DETERMINATION OF REASONABLE VALUE OF MEDICAL AND HEALTHCARE SERVICES PROVIDED.

This legislation does not limit a plaintiff's recovery of medical and healthcare expenses to the amount actually incurred, which was the usual outcome prior to 2000. Rather, it follows the established standard, entitling the plaintiff to recover the reasonable value of the medical and healthcare services provided. Also to the plaintiff's benefit, it leaves intact the presumption that billing statements or invoices are presumed to state the reasonable value of the healthcare services provided, if not rebutted.

What it does do is provide a defendant with the opportunity of introducing evidence of payments and benefits provided to the plaintiff by collateral sources, in assisting the trier of fact in its determining the reasonable value of the medical services provided. That really is no different than a plaintiff's ability, in the

past, to introduce evidence of the amount paid or liability incurred in assisting a jury to determine the reasonable value of the medical services provided. *Lautenschlager,* at 630. A defendant's ability to introduce that evidence will further prevent the trier of fact (especially a jury) from being improperly mislead concerning the extent of the plaintiff's actual obligations with respect to the bills and invoices introduced by the plaintiff at trial.

Furthermore, the legislature, in passing a bill along these lines, is not entering into uncharted territory. That is because since 1995 a similar standard has applied, in medical malpractice actions, based on the enactment of 893.55(7), which provides:

> Evidence of any compensation for bodily injury received from sources other than the defendant to compensate the claimant for injury is admissible in an action to recover damages for medical malpractice. This section does not limit the substantive or procedural rights of persons who have claims based upon subrogation.

In *Lagerstrom v. Myrtl Werth Hosp.-Mayo Health Sys.,* 2005 WI 124, 285 Wis.2d 1, 700 N.W.2d 201, the supreme court discussed the effect of that statute in the determination of reasonable value of medical and healthcare services provided. That discussion closely parallels the language contained in this legislation.

NFIB
The Voice of Small Business.

Wisconsin

Statement Before the
Assembly Committee on Judiciary

By

Bill G. Smith
State Director
National Federation of Independent Business
Wisconsin Chapter

Thursday, April 11, 2013
Assembly Bill 29

Mr. Chairman, thank you for scheduling today's hearing, and thank you to members of the Committee for your consideration of Assembly Bill 29.

I appear today as President of the Wisconsin Civil Justice Council, an organization formed in 2009 to promote legislation that will help achieve fairness and equity within our judicial system, to reduce unnecessary litigation costs, and enhance Wisconsin's image as a rewarding place to live, work, start and grow a business. The Civil Justice Council speaks with one voice on behalf of 18 diverse statewide organizations that provide policy guidance and serve on our Board of Directors.

I also appear today as State Director for nearly 12,000 small and independent business owners who live and work in our state, and are members of the National Federation of Independent Business, in support of passage of AB 29.

I am accompanied by Attorney Thomas Goss, Mueller, Goss & Possi, who will testify on behalf of the Wisconsin Civil Justice Council.

Thank you.

The Cap Times
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Bill G. Smith, Jerry Deschane and Scott Manley: Eliminate 'phantom damages' and let the jury decide

APRIL 07, 2013 4:30 AM • BILL G. SMITH, JERRY DESCHANE AND SCOTT MANLEY | WISCONSIN CIVIL JUSTICE COUNCIL INC. EXECUTIVE OFFICERS

Under current Wisconsin law, plaintiffs and their attorneys reap significant windfalls in personal injury cases because the jury never gets to see evidence of the amount actually paid to the medical provider for the plaintiff's injuries. Instead, due to a number of Wisconsin Supreme Court decisions, the jury is only allowed to see the billed amount, which is typically significantly more than what was actually paid.

Medical bills are analogous to the price of a car. A consumer almost never pays the full sticker price of an automobile; instead, they pay a lesser negotiated amount. This is also the case with medical expenses. Medical providers and health insurers typically have negotiated rates and therefore the amount actually paid to the medical provider by the insurer is typically less than amount billed.

Legislation (SB 22/AB 29) introduced by Sen. Paul Farrow, R-Pewaukee, and Rep. Andre Jacque, R-DePere, allows for greater transparency in the courtroom by allowing the jury to see both the amount billed by the medical provider and the amount actually paid. Based on this evidence, the jury is then allowed to determine how much the plaintiff should be reimbursed for his or her medical expenses.

Many other states have begun to end this practice of hiding the evidence from the juries. In fact, courts and legislatures in other states have gone much further than Wisconsin's proposed law by stipulating that the plaintiff should only be reimbursed the amount that was paid to the medical provider. Those states include California, Connecticut, Massachusetts and Florida, to name just a few. Roughly half the states have adopted this approach.

Wisconsin currently has a law similar to the proposed legislation in the area of medical malpractice. In cases where a plaintiff incurs medical expenses due to injuries caused by medical malpractice, the jury is allowed to see evidence of the amount paid to the medical provider. SB 22 and AB 29 would extend that law to all personal injury cases.

The purpose of economic damages in personal injury cases is to make the plaintiff whole; that is, to ensure that the plaintiff is reimbursed for out-of-pocket expenses incurred as a result of the accident. Economic damages are not intended to enrich the plaintiff and his or her attorney.

Plaintiffs are, however, typically entitled to extra compensation through non-economic damages, such as pain and suffering, and even punitive damages in certain cases. These extra damages are on top of the out-of-pocket damages a plaintiff receives in the same accident.

Unfortunately, Wisconsin law continues to allow plaintiffs and their attorneys in personal injury cases to receive windfalls by concealing from the jury the true cost of the plaintiff's medical expenses. Some courts have referred to these windfalls as "phantom damages," because the plaintiff never has to pay the full billed amount, yet the plaintiff and his or her attorney are awarded the full sticker price.

This is bad public policy. Everyone who purchases insurance ultimately pays higher premiums when plaintiffs and their attorneys are paid these phantom damages. The proposed legislation promotes transparency in the courtroom and allows the jury to decide how much the plaintiff should be reimbursed for their medical expenses.

Please contact your legislator and ask that he or she support SB 22 and AB 29 to help keep insurance costs low for all consumers.

Bill G. Smith is the Wisconsin state director of the National Federation of Independent Business. Jerry Deschane is executive vice president of the Wisconsin Builders Association. Scott Manley is vice president of government relations for the Wisconsin Manufacturers and Commerce. All three are executive officers of the Wisconsin Civil Justice Council Inc. www.wisciviljusticecouncil.org.

FALK
LEGAL GROUP

Testimony Presented to
Assembly Committee on Judiciary
In Opposition to Assembly Bill 29

Presented By
Matthew R. Falk
Managing Attorney/Owner
Falk Legal Group LLC

Thursday, April 11, 2013

❖ Introduction

Members of the Committee, Chairperson Ott, thank you for the opportunity to present testimony before the committee today. My name is Matthew R. Falk. I am an attorney with the law firm of Falk Legal Group. One of my specialties is insurance subrogation. That specialty includes health subrogation. I represent national insurers, including large health insurers, self-funded ERISA plans, third party administrators, Medicare Advantage Organizations, and local Wisconsin insurers like Group Health Cooperative of Eau Claire. I am presenting testimony today in opposition to AB 29.

I have been practicing in Wisconsin since 1994. I am certified by the National Association of Subrogation Professionals as a Certified Subrogation Recovery Professional. I also serve as the co-chair of the National Association of Subrogation Professionals Wisconsin Chapter. I am called to speak on the topic of insurance subrogation and my speaking engagements include the State Bar of Wisconsin (Annual Torts Update on Subrogation) and the National Conference for the NASP (Health Track Past Chair and Current Speaker). I am a recognized expert in insurance subrogation.

❖ Subrogation and Reimbursement Claims Reduce Costs

The elimination of the collateral source doctrine will not benefit Wisconsin's business community. If subrogation recoveries go down, premiums go up. Wisconsin's business community does not want higher premiums.

Subrogation recoveries are an important component in calculating the cost of insurance premiums. An insurance company sets its rates based on historical net costs. For example, if a health insurer had one hundred policyholders in a given experience period, and experienced a total of $20,000 in claim costs, it will set its actuarial premiums at $200 per policyholder. By comparison, if the same insurance company experienced $20,000 in claim costs and received $5,000 in subrogation, it will set its actuarial premiums at $150 per policyholder. As a source of revenue, subrogation operates to reduce the actual past cost total used in the calculation of probable future insurable risk or loss on which future premiums will be based.

❖ **The Proposed Legislation Increases the Costs for Health Insurers doing Business in Wisconsin.**

Health insurers face the very significant risk of greater involvement in personal injury litigation as a result of expanded written discovery and depositions. In addition to the costs associated with this discovery, there is also substantial risk of unwanted disclosure of the confidential negotiations between health care providers and insurers that form the foundation for the contractually reduced payments. These additional costs and inconvenience will have an adverse impact on health insurers. In addition, the proposed legislation creates additional risk of reduced recovery of claims in settlement or the extinguishment of subrogated claims after settlement. It does not stop with the health insurer.

Hospital and other medical care providers need to gear up to produce witnesses to justify their charges too. Although the legislation indicates that the bills and invoices, once submitted, create a presumption that the amount contained in the bill or invoice represents the reasonable value of the services provided, **this presumption is now easily rebutted by the admission of the amounts paid by collateral sources, evidence that is currently inadmissible.** Once evidence of collateral source payments is introduced in the litigation, any presumption of reasonableness of the amounts billed evaporates, and the issue of reasonableness becomes a question of fact in the litigation. The consequences for health care providers are significant.

First, health care providers will be subject to subpoena in every personal injury claim to testify as to the basis for the amount billed to the patient and also to testify as to the basis for the contractually negotiated reduced sum paid by the patient's insurer. In situations where there exists no health insurance or where the provider decides to forgo the submission of the bill to insurance or to government agencies for reimbursement, the health care provider lien will be subject to attack by both the defendant and the plaintiff regarding the reasonable value of the service. Evidence will now be admissible regarding amounts accepted by the provider from collateral sources such as insurance carriers and government funded health programs, such as Medicaid and Medicare. These adverse consequences will only increase costs to health care providers and reduce recoveries, which will naturally be reflected in additional increased costs of healthcare in Wisconsin.

From the context of the health insurer, both counsel for the injured party and counsel for the liability insurer will seek discovery of the commercial sensitive and proprietary agreements between health care providers and health insurers or self-funded plans and their third party administrators. Counsel for the injured party will use that information to claim that the charged amount, not the negotiated and discounted paid amount, represents the reasonable value of the

care. Counsel for the liability carrier will attempt to use this protected information to show that the negotiated rates represent the reasonable value of the care. Hence, the health insurer will be required to present and to defend its proprietary networks.

❖ **The Legislation Eliminates the Financial Incentive for the Injured Party to Pursue Past Medical Care Claims**

Proponents of the bill mistakenly assume that counsel for the injured party will continue to bear the burden of proving past medical care claims in litigation in order to prove the nature and extent of the injuries suffered by the plaintiff. That is true where the medical experts and associated claims make that financially prudent. However, the proposed legislative change presents health insurers with a significant risk that the injured party will forego introducing evidence of past medical expenses at trial.

Typically, past medical expenses have been proven at trial by the plaintiff. In addition, the costs of introducing medical evidence to support a claim for past medical expenses have typically been borne by the plaintiff. The incentive on the part of the plaintiff to do so was the potential recovery of the full value of the medical bills incurred. The proposed legislation removes that incentive for the plaintiff. As a consequence, the health insurer will likely bear an increased burden in proving up past medical care claims at trial, along with increased costs.

❖ **Health Insurers Face Increased Litigation Costs**

This scenario creates a big problem for health insurers since the proposed legislation will increase the cost necessary to proving up their subrogation claims while increase the exposure of losing their interest through a *Rimes* hearing – losing the interest and the increased costs.

If the injured party decides that the burden associated with procurement of the medical testimony is cost prohibitive, then the health insurer has a choice: forego the recovery or retain competent medical testimony to prove its claim. In those cases where the plaintiff decides that no incentive exists to prove past medical expenses, that burden will have to be assumed by the health insurance carrier. Any fees and costs associated with proving up these past medical expenses will now be shifted to the health insurer or other collateral source payer.

The health insurer can advance those costs and pursue a third party recovery. However, Wisconsin law, generally speaking, permits the injured party to compromise the claim, agree to hold the liability insurer harmless from the health insurer's claim, and seek a judicial determination that the injured party is not made whole. This results in the loss of the subrogation interest and the substantial costs, typically $3,000 to $4,000, associated with the production of the medical testimony.

❖ **Subrogation Recoveries Will Go Down**

The proposed legislation creates an argument for liability insurers to reduce the injured party's claim for past medical expenses. The argument creates an issue where one presently does not exist: whether the paid versus charged amounts reflect the reasonable value of the past medical

care. The proposed legislation increases the risk of a made whole ruling. Under the proposed legislation, an injured party may enter into settlements for less than the value of the amounts billed for medical services in order to avoid the risk of a reduced recovery at trial. In a situation where the plaintiff chooses to settle a claim for past medical expenses for the amounts paid by the health insurance carrier, the plaintiff has the right to claim that she has not been made "whole" by the settlement based on this compromise. If the trial court agrees, the lien of the health insurance carrier may be substantially reduced or extinguished altogether. This significant impact on the right of subrogation is another adverse consequence not addressed by proponents of this legislation.

- **Wisconsin Should Rejects an Insurance Penalty: The Collateral Source Rule Makes Sense**

Wisconsin law has long recognized that an injured party has a right to recover from the wrongdoer "the reasonable value of the medical treatment reasonably required by the injury." *Orlowski v. State Farm Ins. Co.,* 212 WI 21, ¶21, 339 Wis.2d 1, 810 N.W.2d 775. This rule is based on "Wisconsin's significant interests in fully compensating victims of ordinary negligence." *Id.* at ¶26. Some proponents of the legislation incorrectly characterize this law as allowing a "windfall" because it permits an injured party to recover past medical expenses that exceed the amount actually paid by the injured party's insurer. No one disputes that the law does not apply to uninsured citizens of Wisconsin. Instead, it would only apply to folks that pay premiums in order to obtain health insurance to cover care for injuries caused by a wrongdoer. Alas, is there something unfair about a rule that prohibits a wrongdoer from benefitting from the injured party's purchase of insurance?

- **Proponents of the Bill Believe that Hospital and Other Medical Charges Are Excessive**

Wisconsin liability insurers contend that liability insurers are being forced to pay "excessive amounts" for the injured party's past and future medical care. The bases for that premise is the contention that hospitals, doctors and other medical care professionals charge too much for their services. The casualty insurers, in turn, want to benefit from the proprietary and negotiated rates that help reduce premiums for Wisconsin businesses. Liability insurers want to enjoy a reduction in its exposure at the cost of health insurers. Of course, health insurers will have to pass this cost on to Wisconsin businesses.

Under Wisconsin law, a liability insurer can retain experts to challenge the reasonableness and necessity of the medical charges associated with a plaintiff's past medical care. As a result, if the liability insurer thinks that provider X's charges are too high, the law entitles the insurance company to offer expert testimony to challenge those charges. What the law prohibits is the liability insurer from using, as a basis for its opinion testimony, the negotiated rates of the health insurance or government entity that paid for the care.

In truth, if liability insurers want to negotiate discounted rates with providers, the law permits them to do just that. What the law should not permit is the liability insurer getting something for nothing, i.e. getting the benefit of the negotiated rates from the health insurer without the corresponding cost obligation.

❖ **Wisconsin Businesses That Self Insure Will Also Be Losers if the Proposed Legislation Becomes Law.**

The proposed legislation equally effects self-funded ERISA plans and others whose subrogation interests trump the application of Wisconsin's made whole rule. If no financial incentive exists to procure medical testimony, then that burden will have to be borne by the self-funded or federally-funded plan. Although the subrogation recovery may not be affected, the costs of obtaining that recovery will certainly increase. In addition, self-funded and government funded plans will also be subject to discovery regarding the basis of the reduced rates paid to the provider, in the same manner as an insured health plan. The increased costs of pursuing subrogation liens, whether they be incurred on the part of self- funded, government-funded or insured plans cannot be ignored.

❖ **Any Analogy to Medical Negligence Cases Misses the Mark**

Any analogy to medical negligence cases as a window for how collateral benefits will be handled in the context of other personal injury litigation misses the mark. In medical negligence cases, the defense may introduce evidence of collateral payments. However, that admission must be relevant and supported by competent expert testimony. I have been involved in tort litigation for nearly twenty years, including numerous medical negligence trials. I have yet to hear doctors or a hospital representative claim that their own charged medical care is unreasonable in amount and that the jury should accept the discounted rate, not the hospital's charge. It simply does not happen. As a result, the admission of this testimony is rare.

As the son of a doctor and the brother of another, I know that doctors, hospitals and other medical care providers believe strongly in the oath they take to care for the injured. Collateral source legislation is not the proper method for address rising medical costs. Instead, they should engage in a dialog with these professionals and not infringe on the proprietary rights of Wisconsin's health insurers.

❖ **The Proposed Amendment Only Makes Mater Worse for Health Insurers**

The proposed amendments to the proposed legislation do not solve the problems set forth above nor does it eliminate either the "made whole" or the "common fund" doctrines. Those doctrines present common defenses to subrogation and reimbursement claims. Instead, the proposed amendment to the proposed legislation only makes it worse for health insurers. It would virtually eliminate small accident claims. The following example bears that out.

Assume a Plaintiff sustains personal injuries as a result of a motor vehicle accident. Further, assume that no liability issue exists but that the liability insurer contests the extent of the medicals (paid versus charged amounts) and the amount of the injured party's non-economic damages, i.e. pain and suffering. Let's assume the injured party's health insurer pays $9,000 of

the claimed past medical expenses. Finally, the injured party retains a personal injury attorney, who charges a one third fee, and who incurs $2,000 in litigation costs. If we assume that the case resolves for $25,000, the proposed legislation would result in the following breakdown:

Gross Settlement:	$25,000
Fees/Costs	($10,333)(1/3 fee $8,333 plus $2,000 in litigation costs)
Net to Injured person	$14,667

The Plaintiff's attorney would have to pay the health insurer $9,000 out of the $10,333 fee. That leaves $1,333 to cover the $10,333 fees and costs. The math simply does not work. What attorney would take that case? Why would a health insurer agree that its payments are limited to whatever contingent fee agreement between the injured party and her insurer?

The probable results include the following: (1) The courthouse will be closed to people injured in small accidents. Health insurers, on the other hand, would be required to pursue the subrogation claims independently if that were to be the law; and (2) Injured parties will enter into retainer agreements that carve out past medical bills paid by collateral sources. This will have the same effect as result number (1) and, further, expose the health insurers to the same discovery and other burdens set forth in the above testimony.

Good morning.

My name is Karen Kentopp. My husband Herman and I live in the Village of Jackson, Washington County. I am here today in opposition to the proposed change to Wisconsin's collateral source rule.

To provide some background, my career included being a director and secretary for Pilgrim Lutheran Church and a secretary at Concordia University in Mequon in Advancement and at the School of Nursing. Herm worked for 25 years as the Director of Auxiliary Services at Concordia.

Herm and I are now retired. I stay active by volunteering at St. Joseph's Hospital West Bend and for the children's choir at Living Word Church.

During our careers, Herm and I bought health insurance through Concordia. Part of our premiums was paid by Concordia in recognition of our work and part was taken directly from our paychecks.

During our careers, Herm and I paid over $75,000 in health insurance premiums. Given our chosen professions at Concordia, paying these premiums was a financial hardship. But Herm and I always paid because it was the responsible thing to do.

Herm and I also paid into the Medicare system. While no one likes to pay taxes, Herm and I didn't complain because we knew that someday we would probably need Medicare.

To this day, Herm and I still pay for Medicare. We pay $200 per month in Medicare premiums.

We also pay for private supplemental insurance through Physicians Mutual because Medicare's coverage is not the best. This private insurance costs us $508 per month.

Putting these together, Herm and I pay $8,496 every year from our retirement savings for health insurance. Paying this amount is not easy during retirement. But, again, we do so because it is the responsible thing to do.

As everyone here knows, paying for health insurance means that our health insurance companies will negotiate with our medical providers to accept a discounted amount for their services. This is what we have paid our health insurance companies to do. The alternative would be for us to have no health insurance and have no one to negotiate a discount for the medical care we need.

Fortunately, Herm and I have been blessed with good health. We have paid much more in health insurance premium then we have ever used.

I have osteoarthritis, a genetic condition that runs in my family. After years of chasing after my children and grandchildren, the cartilage in my left hip wore down. My doctor recommended a total hip replacement and this was done on March 25, 2012.

Less than 1 month later, the hip implant that was put inside me was recalled because metal was sheering off and it was deteriorating. The metal debris lodged in the tissue around my hip. The company that made the implant knew about these problems long before my surgery. My doctor said he never would have used this implant had he been told.

The implant had to be removed less than 1 year after it was put in. My physician told me that the metal debris and deterioration damaged my muscle. ~~The~~ infection was ~~so bad that I had to leave~~ the hospital with an ~~IV catheter that was threaded near my heart~~ so I could get antibiotics. Thanks to the wonderful care of my physicians, nurses and therapists, and a walker and cane, I am on the road to recovery. However, I may need additional surgery to remove some pseudo tumors in my upper thigh area caused by the defective implant.

This medical care came at a cost. The bills for my surgeries, physician appointments and therapy are still coming in but will total around $50,000. Because of the health insurance Herm and I paid for, the total amount paid will be around $20,000.

The issues as I understand them are twofold. First, what is the reasonable value of the medical care I received? I don't understand why anyone would suggest that the amounts billed from the doctors and nurses who cared for me were not reasonable.

The second issue as I understand it is who benefits from the $30,000 difference between the amounts billed and paid for my medical care. The choices are either me and Herm or the company that made the implant.

I am not a doctor or a lawyer and I have never worked for an insurance company; but from the standpoint as someone who worked hard and took responsibility to buy health insurance, the answer is this: The right to receive a discount for my medical care belongs to me. Herm and I paid for that right.

It is my understanding that liability insurance companies, like the insurance company for the manufacturer of my deteriorated hip implant, want the Wisconsin legislature to change the law so they can argue that they get to benefit from the difference between the amounts billed and paid for my medical care. I've heard that the liability insurance companies call this difference a phantom damage.

I assure you there is nothing phantom about my medical bills; there is nothing phantom about the over $75,000 Herm and I paid in health insurance premiums during our careers; and there is nothing phantom about the over $8,000 Herm and I now pay every year in health insurance premiums. I assure you these are all very real.

I ask this Committee to not take away the right that Herm and I paid for. I urge this Committee to not change Wisconsin's collateral source rule.

Good Morning Council and Representative Ott:

My name is Mark Perelshtein. I live in Grafton, WI with my wife and two kids. I am the owner of Badger Dental Laboratories, which is a small dental lab in Milwaukee that at the time of my accident had 10 employees. I started it in 1993 with my wife, and grew it to a successful family supporting business. Like other small business owners, my wife and I are the A-Z at the business. I make the products which consist of small crowns, bridges and specialized parts for dentists and orthodontists, while my wife runs the business aspect of the lab. I'm here today to ask you to consider my story and urge elected officials to vote against changing a law that has been the law in Wisconsin for over 100 years.

On the morning of November 10th, 2011, I came to a stop while traveling southbound on Highway 43, due to congested traffic. A car rear ended me going upwards of 50 MPH. I was taken to the emergency room with a head injury, back, neck and hand pain.

I saw my Doctor a few days later and was diagnosed with a bulging disc in my neck, a concussion and a contusion to my right hand. I sure didn't need the doctor to tell me that something was very wrong with my hand; the swelling around the wrist, the tingling in my fingers and numbness in my finger tips, told me everything. My doctor immediately began a course of anti-inflammatory medication and physical therapy for my neck, right shoulder and hand. For the first week after the accident, I could hardly sleep. I had a consistent headache and would often wake up from pain and muscle spasms. Over the course two months of physical therapy 2-3 times per week, my neck and body pain slowly subsided and was able to return to work part-time. But the roller coaster ride with my right hand was just beginning.

The swelling and pain in my right hand was persistent, and no one could tell me what the cause of it was. With advice of my doctor I continued physical therapy for my right hand and shoulder for about two more months, two to three times per week with little to no results for my hand to feel better. My hand constantly hurt, I couldn't move it around due to the pain and swelling. I lost the feeling in my finger tips and sure couldn't perform my job as a 20 + year certified ceramist. This in essence means that I am a dental technition that works with brushes and instruments for fine detailed work. My primary doctor referred me to a hand specialist for an Electromyography, or EMG. For ones that don't know what an EMG is, it is a measurement of how fast the nerves receive and send signals to and from certain parts of the body. This entails needle like probes being pushed through the skin down to the nerves and, well you get the picture of just how painful it was. The EMG revealed that I had moderate to severe nerve damage thought to be from carpal tunnel syndrome caused by the accident and that I needed surgery. I was told recovery would be 6 to 8 weeks and therapy for months after that. Concerned for my business and knowing that I am in essence the business, I tried to delay the surgery as long as possible, but when the specialist informed me that my symptoms would only get worse and I would risk permanent nerve damage if I didn't have the surgery, my wife and I scheduled it. It was at this point we knew our business was in jeopardy.

I had surgery on my hand October 3rd, 2012. After approximately 6 to 8 weeks of healing post op, and another two months of therapy and not being able to work. The time line takes us into February 2013. My hand was not improving, still experiencing pain, swelling and numbness. I requested that an MRI

be done which to everyone's surprise revealed a broken bone floating in my hand, which you guessed will require another surgery to remove it. I currently have surgery set for April 17th and will be spending the next two months in a cast unable to work to which I touched on previously to what my profession is, and what my family depends on.

To date I have accumulated around $20,000 in medical bills from doctors and hospitals. My health insurance company has paid around $11,000 to satisfy a portion of those bills. I anticipate these numbers will both double after my second surgery, to $40,000 in med. bills and $22,000 paid by my health insurance. After my first surgery my health insurance premiums doubled- from $850 per month to $1,700 per month. If we all do the math, I have paid over $16,000 in premiums since the date of my accident in late 2011.

This guy that caused this accident has ruined my business and threatens to financially wreck my family. My business went from over $600,000 in revenues in 2011, to around $300,000 in 2012 and still continues to collapse. I've had to lay off half of my staff, and haven't been able to take a salary for over a year. I have a private disability policy that I've paid about $150 a month in premiums for many years. I recently started receiving $2000 in disability payments, but even with those payments I face the very real possibility of being forced to close the business.

Under current law, the bills are presumed to be the reasonable value of the care I received. The proposed change in the law would allow the jury to hear what my health insurance paid on those bills and consider that, as the reasonable value of the care. The jury would not be able to hear that I have to pay back over $22,000 to my health insurance company.

As a small business owner, I know how volume business affects the prices of goods and services. The health insurance companies pay a reduced amount because of the contracts they negotiate with the providers. I have paid over $16,000 in health insurance premiums since the accident. Why should the guy that caused this accident and ruined my company and my life get the benefit of me paying those insurance premiums? If anyone is to get the benefit of the difference between what is billed and what is paid, it should **not** be the guy who rear ends someone going 50 MPH on the highway while texting. It should be the hardworking small business owner paying $1700 per month in premiums that creates the difference in what is billed and what is paid. I can't help but to feel that the guy that has caused this chaos for my business and my family is stealing the money I have spent on premiums for the past 16+ months as I've watched my business and health deteriorate. That's not right.

Had I got in this same accident and received the same injuries and **not** had the forethought to have health insurance, the person that caused this would be responsible for the entirety of the medical bills, but since I do pay a super high premium to make sure my family has health insurance, they are off the hook for the full amount. They get the benefit of my premium payments. That's just not acceptable.

I would like to thank the members of the Assembly judiciary Committee, and particularly Representative Ott as my Representative, and to consider my story and many stories just like mine from around the state before allowing bad drivers to benefit from our hard work and the money we have paid in health insurance premiums.

Supreme Court of Wisconsin

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A. John Voelker
Director of State Courts

April 11, 2013

The Honorable Jim Ott
Chair, Assembly Committee on Judiciary
Room 317 North, State Capitol
Madison, Wisconsin 53702

RE: Assembly Bill 29, Relating to the Collateral Source Rule

Dear Representative Ott:

I regret that I will be unavailable to testify at today's public hearing on Assembly Bill 29 relating to the collateral source rule. Please accept this testimony on behalf of the Legislative Committee of the Wisconsin Judicial Conference and on behalf of the court system.

The Legislative Committee has not taken a position to either support or oppose AB 29 but does want to raise a question relating to Section 3, the initial applicability clause, and the impact that section may have on the court system. My office has brought this issue to the attention of the primary Assembly and Senate authors and asked them to consider changing this provision.

The initial applicability clause of AB 29 reads: "This act first applies to actions filed on the effective date of this subsection." We would suggest that a change be made to make the bill clearly prospective by having it first apply to a cause of action that accrues on the effective date. That is a common initial applicability provision that is often used in civil litigation. In fact, you may notice that the other bill you have scheduled for today's public hearing, AB 139, has this language in its initial applicability provision; it first applies to a cause of action that accrues on the effective date.

The impact of the initial applicability provision in AB 29 is that it will, at least temporarily, distort the normal pattern of settlement of personal injury claims before filing of actions in circuit court. As you are probably aware, most civil claims are settled without resort to lawsuits. Wisconsin courts rely on the system of pre-trial settlements to keep their workload lower than it would be if every possible claim was put into suit.

To illustrate this pattern, one need only look at the areas of automobile crashes. The largest percentage of personal injury actions filed in Wisconsin circuit courts – about 60 percent – relate to injuries from automobile crashes. In 2012, there were 6,350 civil actions alleging personal injury or property damage filed in the state. Of those, 3,720 cases were identified as involving personal injuries from an automobile crash. But we know from Wisconsin Department of

Transportation data that there are about 30,000 automobile crashes each year that involve injuries or death and about 75,000 crashes that involve property damage. Only a small percentage of these crashes result in civil actions filed in circuit court.

If AB 29 passes with its current initial applicability provision, we anticipate a substantial increase in civil action filings, as claimants attempt to avoid the consequences of the change in the law relating to collateral source payments. It is difficult to make an accurate estimate, but it will likely involve several hundred additional cases. We recognize this will be a temporary situation, but it will certainly distort the normal statistics involving civil actions and will require court resources – judges and clerks – to process these additional cases. Over time, the number of actions filed is likely to revert to its current filing pattern,

This distortion of the system, however, would be avoided if the initial applicability provision was changed to causes of action that accrue on the effective date.

For these reasons, we would urge you to consider amending the initial applicability provision of AB 29. If you have any questions, please feel free to contact my office or our legislative liaison, Nancy Rottier.

Very truly yours,

John Voelker
Director of State Courts

cc: Members, Assembly Committee on Judiciary