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On behalf of The Arizona Association of Defense Counsel

IN THE SUPREME COURT

STATE OF ARIZONA

In the Matter of:	)	
	)	
Petition to Promulgate Rule 412 Rules of Evidence	)	Supreme Court No.
	)	Comment to Petition to Add Rule 412
_____	)	

The Arizona Association of Defense Counsel opposes this petition. The AADC has over 700 members in Arizona who primarily represent defendants in civil litigation. AADC members routinely represent clients in courtrooms throughout Arizona where medical bills are claimed as economic damages. The proposed rule would have a significant and unfair impact on defendants and should be rejected. The proposed rule is contrary to the purpose and intent of our rules of evidence, and it is contrary to law.

The purpose of our rules of evidence is clear:

> These rules should be construed so as to administer every proceeding fairly, eliminate unjustifiable expense and delay, and promote the development of evidence law, to the end of ascertaining the truth and securing a just determination. A.R.Evid. 102.

The proposed rule states:

> Statements of charges for medical, hospital or other health care expenses for diagnosis or treatment occasioned by an injury are admissible into evidence. Such statements shall constitute prima facie evidence that the charges are reasonable.

To begin with, the first sentence is unclear. What does "occasioned by an injury"

mean? This seems somewhat broader than "resulting from" or "caused by." The OED defines "occasioned" as "to be the occasion or cause of; to give rise to, cause, bring about, esp. incidentally." Because in personal injury lawsuits defendants are responsible only for medical treatment that is reasonable and necessary, the first sentence should plainly circumscribe its intended application. But, as discussed below, the pernicious effect of this proposed rule comes from the second sentence that billing statements constitute prima facie evidence that the charges are reasonable.

Arizona courts and juries have long considered what "reasonable and necessary" means. For example, in *Larsen v. Decker*, 196 Ariz. 239, 995 P.2d 281 (App. 2000), the plaintiff was precluded from introducing certain medical records at trial because she failed to lay the foundation for their reasonableness and necessity. Such records are "not automatically admissible without some testimony to establish that treatment by certain doctors for injuries sustained in the auto accident was necessary." *Id.* 196 at 244, 995 P.2d at 286. Assuming that this proposed rule would apply only to those medical bills for treatment which has been determined to be reasonable and necessary, the issue is whether the bills themselves are reasonable.

The proposed Rule's second sentence uses the language "prima facie evidence" and creates a presumption that the billing charges are reasonable. It would give a procedural advantage to the plaintiff. We assume that the proposed rule, as a presumption under A.R.Evid. 301, would shift to the defendant the "burden of producing evidence to rebut the presumption." A plaintiff would not be required to establish any foundation for a billing statement. Unless the defendant then came forward with evidence to contest the bill, a jury would be instructed that the charges are presumed reasonable. Presumptions are, by their nature, evaluative and over-inclusive. The potential liability and exposure to a defendant

for these medical bills would be significant as would be the additional costs incurred in securing evidence to rebut the presumption. The presumption is contrary to which side is in the best position to secure the evidence. It is a plaintiff and plaintiff's counsel and not a defendant or defense counsel who are in the best position to seek foundation and explanation for a billing statement.

Medical bills are notoriously inflated. Courts have recognized the difference between billed charges and reasonable charges. For example, in *LaBombard v. Samaritan Health System*, 195 Ariz. 543, 551-53, 991 P.2d 246, 254-56 (App. 1998) the court held that customary charges (the amounts paid for medical services) are different from billed charges under the hospital medical lien statute. After the plaintiff presented evidence that the defendant health care provider often accepted payment of less than its billed charges from private insurers, private pay patients, and health maintenance organizations, the court remanded the case to the trial court for a factual determination of whether the defendant's "customary charges" were the same as its "billed charges," and if not, to determine the amount of the defendant's "customary charges" for services rendered to the plaintiff. *Id.* The court specifically noted that if the defendant commonly reduced its "billed charges," its "customary charges" could be lower than the amounts billed. *Id.* at 552, 991 P.2d at 255. *Compare Lopez v. Safeway Stores*, 212 Ariz. 198, 129 P.3d 487 (App. 2006) (not allowing the admission of the paid amounts but did not consider the reasonableness of the billed amounts). Recognizing this difference, by statute Arizona restricts providers from balance billing managed care enrollees. A.R.S. § 20-1072.

A plaintiff has the burden of proving that the amount of medical charges and treatment is reasonable and necessary. (RAJI Personal Injury Damage 1 "Reasonable expenses of necessary medical care, treatment, and services rendered, and reasonably

probable to be incurred in the future.") There is a wide disparity between billed charges and what health care providers actually accept in payment. In the vast majority of cases, the "billed charges" claimed by a plaintiff are amounts that neither the plaintiff, the plaintiff's health care insurer nor anyone else will ever pay. The proposed rule change seeks a presumption for illusory charges. See Restatement (Second) of Torts § 924 (harm to person includes damages for reasonable medical and other expenses); § 911 cmt h ("If . . . the injured person paid less than the exchange rate, he can recover no more than the amount paid, except when the low rate was intended as a gift to him."). The proposed rule relieves the plaintiff from supporting the bills with competent evidence.

Here is an illustration. Several years ago, my firm represented a defendant in an automobile accident. The plaintiff disclosed medical bills for a surgery at a hospital in Tucson. We questioned those bills and deposed a representative from the hospital. The Director of Revenue Management testified that providers generally accept substantially less than the full billed charges. The amounts that providers ultimately accept are determined based on current market reality. He testified that "in today's market reality, the customary amount that [a hospital] receive[s] is something less than the billed rate." The director acknowledged that though the plaintiff's bill was $100,644.18 for his surgery, the hospital accepted as payment in full for that service $4,938.81 plus a $50.00 co-payment. The director also agreed that the current market reality where health care providers are not collecting their full billed charges for services has existed for many years. Although he estimated that in 90% of all cases the hospital accepts substantially less than the full billed charged, the hospital was still making a profit. *See also* William R. Jones, *Managed Care and the Tort System: Are We Paying Billions in Phantom Healthcare Charges*, 32 Ariz. Att. 38 (1996); John Dewar Gleissner, *Proving Medical Expenses: Time for a Change*, 28

Am. J. Trial Advoc. 649 (Spring 2005); Thomas R. Ireland, *The Concept of Reasonable Value in Personal Injury Torts,*14 J. Legal Econ. 87, 90 (March 2008) ("Prices in American medicine often have little relationship to any notion of what is reasonable or what might be the prices in a competitive market. Given the choice between $500,000 billed by medical care providers and the $100,000 paid by third party payers in my example, it is likely that $100,000 is closer to whatever proxy for 'reasonable value' or 'competitive equivalent' that we might come up with.").

These "billed charges" have been the focus of national and state attention because they do not reflect a reasonable cost of health care. Billed rates have victimized uninsured patients. State and national newspapers have reported on this story, in the context of hospital overbilling scandals, focusing specifically on the inequity of overcharging the uninsured. The *Wall Street Journal*, *USA Today*, ABC's Nightline, and CBS's 60 Minutes have reported on this and raised public awareness. They have been the subject of an oversight committee in Congress. Although these inflated charges have garnered significant attention, little has changed. Such billing and accounting gymnastics continue and are expected to continue. There is no standardization of billed amounts nor is there pricing transparency.

Courts have considered these billing charges and many have concluded that reasonableness is determined by and recovery made only for what is actually paid. The inflated billed charges are not relevant at all. California courts have carefully considered these issues for over twenty years. *See Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal.4th 541, 257 P.3d 1130 (2011) (plaintiff may recover as economic damages no more than the amounts paid by the plaintiff or plaintiff's insurer for the medical services received); *Hanif v. Housing Authority*, 200 Cal.App. 3d 635, 246 Cal.Rptr. 192 (1988).

Other courts have similarly rejected the inflated bills as an appropriate measure of damages or determined that the collateral source does not apply. *See Bates v. Hogg*, 921 P.2d 249 (Kan. App. 1996) (collateral source rule does not apply to expenses that are never paid); *State Farm Mut. Auto. Ins. Co. v. Bowers*, 500 S.E.2d 212 (Va.1998) (only scheduled fees and co-payments accepted by health-care provers as full payment from insurer were "incurred" by insured); *Mitchell v. Hayes*, 72 F.Supp.2d 635 (W.D.Va. 1999) (collateral source rule does not allow plaintiff to introduce evidence of billed charges since no one was liable for the difference between the billed charges and the amounts actually paid; therefore the difference was not an actual loss which could support recovery of compensatory damages); *Moorhead v. Crozer Chester Medical Center*, 765 A.2d 786 (Pa. 2001) (collateral source rule does not allow plaintiff to present billed charges as evidence of damages because no collateral source paid the illusory billed charge); *Ward-Conde' v. Smith*, 19 F.Supp.2d 539 (E.D.Va. 1998) (collateral source rule does not permit a plaintiff to present billed charges as evidence of damages where she is not legally responsible for the full billed amount). *See also* Bryce Benjet, *A Review of State Law Modifying the Collateral Source Rule: Seeking Greater Fairness in Economic Damages Awards*, 76 Defense Counsel Journal 210 (April 2009).

A better approach to a rule of evidence that would reflect the reality of health care provider bills would be to state: "Amounts *actually paid* by the plaintiff or a third-party in full satisfaction of a bill for reasonable and necessary treatment shall constitute prima facie evidence of the reasonable value of such services." That would be more accurate.[1] Or, as

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[1] The Arizona Legislature is considering these issues as well. House Bill 2238 as introduced in the current session of the Arizona Legislature would add a new statute defining claims for medical expenses. It states:

suggested by Gleissner in the article cited above:

> The author proposes that the courts (through pretrial order, rule, or substantive law) accept as prima facie evidence of reasonableness the amount of actual payments by commercial health insurers, Medicare, HMOs, Blue Cross organizations, and other sophisticated payors, without requiring expert testimony. The author proposes that the necessity of medical treatment be presumed and the reimbursed charges deemed admissible under the following conditions: (1) payment has been made; (2) there is no contrary medical testimony; and (3) there is substantial evidence, based on the type of injury or condition and the treatment provided, that the treatment was necessary as a matter of common knowledge or according to the medical records from the perspective of the court or jury. 28 Am. J. Trial Advoc. at 662.

As explained by Gleissner, this would have advantage to both plaintiffs and defendants. *But see Papke v. Harbert*, 738 N.W.2d 510, 535-36 (S.D. 2007) (stating that a court should not decide the reasonable value from either the bills or the amounts paid but should leave it to the jury); *Martinez v. Milburn Enterprises, Inc.*, 233 P.3d 205 (Kansas 2010) (collateral source rule did not bar evidence of the amount originally billed or the reduced amount

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12-558. Claims for medical expenses; recovery of reasonable medical expenses; definitions

A. In any claim to recover medical expenses incurred as a result of bodily injury or wrongful death, the claimant is entitled to recover reasonable medical expenses, except that if no payments were made by the claimant or on the claimant's behalf, the claimant shall recover the usual and ordinary value of the reasonable and necessary medical expenses for which the claimant is obligated.

B. For the purposes of this section:

1. "Claim" means any legal proceeding, underinsured and uninsured motorist proceeding, arbitration or other similar proceeding in which the recovery of medical expenses for bodily injury or wrongful death is permitted.
2. "Reasonable medical expenses" means the expenses for which monies were actually paid by the claimant, the claimant's health insurance company or any other collateral source in full satisfaction of the services rendered, including any amount owed by the claimant for coinsurance or a copayment or deductible.

accepted but the reasonable value of the medical services was a question for the jury).

Petitioner wrongly claims that Arizona is unique in what is required to admit medical bills into evidence and string cites cases from several other jurisdictions. As explained in Stein's treatise:

> The advent of managed care has brought significant changes to the systems used for charging and paying for medical services, that in turn can have repercussions on the recovery for medical expenses in tort suits. . . there is no consensus on the appropriate rule among the few courts that have reached the question. Some decisions limit recovery to the sum accepted for the services, that is, the "paid charge." Other courts allow the plaintiff to recover the full amount of the billed charge. Still other courts hold that the reasonable value of the services is up to the jury.

2 Stein on Personal Injury Damages § 7:36 (3d ed. updated 2012). Jurisdictions have addressed the issue differently. For example, the proposed rule mirrors Indiana Rule of Evidence 413. Indiana, however, holds that the negotiated discount rates are not collateral sources and defendants may introduce evidence of the amount of money actually paid. *Stanley v. Walker*, 906 N.E.2d 852 (Ind. 2009). Such bills are also still subject to exclusion as hearsay. *Barrix v. Jackson*, 973 N.E.2d 22 (Ind. App. 2012). Similarly, Ohio has a statute regarding the admissibility of medical or funeral expenses as prima facie evidence of reasonableness. Both the original medical bill and amount actually paid are admissible to prove the reasonableness of the medical expenses. *Robinson v. Bates*, 857 N.E.2d 1195 (Ohio 2006). Texas, on the other hand, has a statute that limits recovery of medical or health care expenses "to the amount actually paid or incurred by or on behalf of the claimant." *Haygood v. De Escabedo*, 356 S.W.3d 390 (2011). Bills that were not actually paid are not relevant and are inadmissible.

Medical bills are also notoriously uncertain. Consider the recent study on the price of a total hip arthroplasty published this past February in the Journal of the American Medical Association. (Published online February 11, 2013) The study selected hospitals from each state. The study found it difficult to obtain price information and prices for top-ranked hospitals varied from $12,500 to $105,000 and non-top-ranked hospitals ranged from $11,100 to $125,798. The study concluded:

> [W]e have found that despite a growing interest in price transparency, obtaining price information for a common medical procedure (THA) is very difficult. We also observed enormous variation in price estimates across hospitals. Our results demonstrate that many health care providers are not able to provide reasonable price quotes.

The study noted that its findings supported the 2011 Government Accountability Office study on the difficulty in obtaining accurate pricing information. Often patients never know what their medical bills are until they later receive them in the mail and note the remarkable difference between the "billed charges" and what their insurer actually paid in full settlement of the bill. One would be hard pressed to find any other service with such gross disparity in billing. Until health care providers become more transparent and bills actually reflect the value of services, such bills are not competent evidence of much of anything.

In personal injury litigation, the dispute over billed v. paid charges will not be solved with a newly minted rule of evidence giving a presumption to billed charges. It is the plaintiff's burden to show that medical costs that he or she seeks to recover from the defendant are both reasonable and necessary. It is not an unfair burden. The proposed rule

gives an advantage to charges that will never be paid by anyone.[2] That is why they are referred to as illusory or phantom charges, and there is no sound policy justification for constructing a new rule that gives such advantage. Plaintiffs have met and will continue to meet the required burden of proof without the new proposed rule.

The AADC respectfully requests that the Court reject the proposed rule. Our rules of evidence should not give advantage to billing statements that are not transparent and often do not reflect the reasonable value of services received.

DATED this ____ day of _____, 2013.

HUMPHREY & PETERSEN, P.C.

BY: _____
ANDREW PETERSEN
On Behalf of The Arizona Association of Defense Counsel

COPY of the foregoing mailed
this ___ day of _____, 2013 to:

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_____

2 I recognize that some take offense at the terms "phantom" or "illusory" and question the use of such language. *See* Lori A. Roberts, *Rhetoric, Reality, and the Wrongful Abrogation of the Collateral Source Rule in Personal Injury Cases*, 31 Review of Litigation 99 (Winter 2012). Unanswered by Ms. Roberts is what better term describes bills that are often multiple times more than the costs of such services and do not reflect the reasonable value of the services or what is actually paid in the marketplace. Ms. Roberts argues that such bills are "real" because absent a third-party payment such as an insurer or government program "the patient would be responsible for satisfying." Such reasoning glosses over the actual value or reasonableness of the services provided and whether there is any other bargained for exchange. Under this reasoning, neither the plaintiff nor the defendant could contest such billing statements.