

STATEMENT

Insurance Association of Connecticut

Judiciary Committee

March 23, 2012

**HB 5545, An Act Concerning Financial Liability For Ambulance Services, Evidence
Of Collateral Source Payments and Liens in Workers' Compensation Cases**
and
**SB 422, An Act Concerning Apportionment Of Damages
In Workers' Compensation Cases**

Section 1 of HB 5545

The Insurance Association of Connecticut (IAC) is opposed to Section 1 of HB 5545, which would make an individual potentially liable to an ambulance company for expenses beyond reasonable and customary charges. Section 1 would mandate that an individual pay an ambulance or emergency service provider the balance of any amount billed that is not covered by another source. Simply put, such a provider could charge anything they want to an individual and the individual would be statutorily responsible to pay that bill. As this section serves no public purpose, while driving up costs, the IAC urges your rejection of this section.

Sections 2 and 3 of HB 5545

The Insurance Association of Connecticut is opposed to Section 3 of HB 5545 which prevents extrinsic evidence to be considered regarding the reasonableness of a bill incurred in a personal injury action. Section 3 of HB 5545 seeks to improperly prohibit the trier of fact from hearing relevant information directly related to economic damages. HB 5545 prohibits the introduction of evidence regarding any reduction in a health care professional's bill from being admissible to establish reasonable and necessary medical care essentially creating an irrebuttable presumption that the bill is reasonable. This runs counter not only to Connecticut case law, but also to the Constitution. See, e.g., Vlandis v. Kline, 412 U.S. 441 (1973) ("a statute creating a presumption which operates to deny fair opportunity to rebut it violates the due process clause of the Fourteenth Amendment.")

Proscribing that the "calculation of the total amount of the bill shall not be reduced because [the provider] accepts less than the total amount of the bill or because an insurer pays less than the total

amount of the bill” infringes on the fundamental right of the defendant to cross-examine a witness. Connecticut courts have long held that “cross-examination” is an indispensable means of eliciting facts. As a substantial legal right, it may not be abrogated or abridged at the discretion of the court to the prejudice of any party.” Richmond v. Longo, 27 Conn. App. 30, 38 (1992). If the bill for a procedure is \$1,000, but the provider accepted \$500 in full settlement, this is evidence as to the reasonableness of the bill, and is fair subject for cross-examination. To deny that ability is abrogating a defendant’s right with prejudicial affect.

C.G.S. Sec. 52-174(b), which section 3 is seeking to amend, was designed with the limited purpose to permit the introduction of medical reports and bills without the need for testimony. It was intended to be a procedural device to facilitate the introduction of medical evidence at trial. It was never intended to impede the due process rights of defendants. In fact, the Connecticut Supreme Court has held that one of the reasons this section of statute is valid is because the defendant is always able to cross-examine the provider as to the reasonableness of the reports and bills. See, Struckman v. Burns, 205 Conn. 542, 552 (1987). If this ability is removed, it makes the whole statutory scheme suspect.

In any personal injury or wrongful death claim the law permits a claimant to seek recovery for “reasonable medical expenses”. Prohibiting the introduction of evidence to show that medical expenses received were less than what was billed permits recovery for “phantom damages” and unnecessarily limits a party’s ability to challenge the extent of care. Allowing the recovery of such phantom damages, as created by Section 3, creates an unearned windfall for claimants by forcing defendants to pay inflated economic damages based upon inflated medical expenses. Current law that allows the introduction of evidence of the actual medical expenses incurred assures that claimants only recover their actual out-of-pocket medical expenses. It also permits a party to be able to challenge the reasonableness of the charges and necessity of the care rendered. Why shouldn’t the trier of fact be able to hear that a medical provider’s bill was not paid in full because they charged twice what any other provider charges or that a medical provider only received “x” amount of dollars

for their services? Section 3 will result in inflated settlements and damage awards, driving up costs in Connecticut.

Section 2 of HB 5545 would statutorily permit a collateral source reduction that is already permitted in Connecticut, (see Hassett v. City of New Haven, 91 Conn. App. 245 (2005)). The reduction does very little to negate the impact of Section 3. The damage will already be done. Although Section 2 does no harm, it is not necessary and does not make Section 3 palliative. The IAC urges your rejection of Section 3 of HB 5545.

Section 4 of HB 5545 and SB 422

The IAC is opposed to Section 4 of HB 5545 which seeks to have the effect of the changes made to Sec. 31-293 last year apply retroactively.

Retroactively amending the effectiveness of a public act that has been law for almost a full year is fundamentally unfair. Sec. 31-293 was amended last year mandating a one-third reduction of all private sector workers' compensation liens. The scope of the mandate was limited to the private sector because the legislature acknowledged the significant cost impact the change would have had to the state and municipalities. With the passage of PA 11-205, the private sector has already had to absorb costs that it cannot recoup. Section 4 of HB 5545's retroactivity will result in an even greater financial burden to the private sector. This is fundamentally unfair and potentially impossible to administer. Costs have already been incurred. Counsel retained. Negotiations are taking place or complete. Claims have been settled and closed. What is to happen to those claims? Is the private sector expected to go back, reopen those claims? Such a proposition will cost the private business sector even more, that it will never be able to recoup.

The changes made to Sec. 31-293 by PA 11-205 impact a lien holder's right to contract as it is statutorily forced to enter into a contract with an attorney it did not choose, may not want, and at a rate set by law. Although Sec. 31-293, as amended by PA 11-205, does not prohibit a lien holder from retaining their own counsel to protect their lien, the changes made last year, and proposed by Section 4, make it cost prohibitive, essentially chilling their constitutional right to counsel and due process.

SB 422 seeks to reduce the chilling effect of PA 11-205 by bringing some parity back to the worker's compensation subrogation system.

A rationale advanced in support of the passage of PA 11-205, and Section 4, is that the attorney for the plaintiff does all the work to procure the employer's lien and therefore should be paid for such efforts. While the insurance industry is sympathetic to that concept, pursuant to current law, independent counsel must be retained to protect the priority of one's lien which is one of the items that SB 422 seeks to correct. Furthermore, there are many circumstances under which a lien holder will decide to retain counsel of its own to protect its interest. That can be done at minimal cost if the lien holder controls the contractual relationship with the counsel it chooses. SB 422 eliminates the chilling effect of the changes made to 31-273 by permitting a lien holder to retain counsel of their own choosing without the consequence of suffering a significant financial loss in doing so. If the lien holder hires their own counsel to protect their lien or recovers their lien through their own efforts, they should not be statutorily mandated to pay one-third of that recovery to the injured employee whom they have already paid 100% of their workers' compensation benefits. If the lien holder chooses to use plaintiff's counsel to pursue their lien, then and only then, should the mandatory reduction apply.

The rationale behind the mandate that any workers' compensation lien be paid in full was so that no one person was permitted to receive a windfall and to make the workers' compensation system whole. One of the principle purposes of Sec. 31-273 is "that an employee should not receive workers' compensation payments in addition to the full amount of damages for the same injury for a third party tortfeasor. Allowing a plaintiff the opportunity to recover reasonable and necessary expenditures she incurred by pursuing an action against the party responsible for the injury encourages a fair result" covering both the employee's and employer's interest. (See Yeagar v. Alvarez, 134 Conn. App. 112, 122 (March 6, 2012)). The changes made last year to Sec. 31-273 improperly ignored that rationale by permitting one class of workers to receive a windfall at the expense of the rest of the workers' compensation system. SB 422 seeks to remove that windfall and properly classify the reduction, if

applicable, to cover the reasonable and necessary expenditures incurred for pursuing the action against the responsible third party.

The IAC urges rejection of Sections 1, 3 and 4 of HB 5545 and respectfully requests your support for SB 422.