Letters of Protection, Deferred Medical Payments, and the Law

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Abstract: Texas defendants found liable in personal injury lawsuits owe past medical damages that the plaintiff paid or incurred but not charges that are written off. The "incurred" language of the law has produced an unintended consequence: plaintiffs can generate higher damage awards when they *incur* medical bills that remain unpaid until the case is over. This article explores what happens when plaintiffs incur unpaid medical expenses by entering into contracts, called "letters of protection," that defer medical payments until the case resolves. A substantial disparity can result when calculating damages using the provider's full incurred charge instead of the discounted fee. Letters of protection are a great resource for people who cannot pay for medical care or require providers who incorporate the medical-legal issues during their care. However, in the wrong hands these contracts can encourage overtreatment and excessive damages. Given the benefits but also the potential for abuse, letters of protection raise significant legal, economic, and health consequences.

Introduction

The authors of this article practice law in Texas where, in addition to commercial disputes and transactions, they frequently represent plaintiffs and defendants in personal injury matters. In the process of representing both sides of the docket they have observed how clients can benefit and face a significant downside when medical care involves deferred payment agreements, also known as "letters of protection." This article addresses some of the questions raised by deferred medical payments in litigated matters and shares information and suggestions on how to best handle these agreements, regardless of which side of the docket you find yourself.

A letter of protection is a short, often incomplete agreement entered into between an injured individual and a medical care provider willing to contract for deferred payments of the care he or she provides. Many of these contracts are truly "letters" addressed to the provider and signed by the attorney in order to "protect" the provider's right to be paid by the plaintiff later for the medical care provided. The letter format and purpose of it has led to naming these agreements "letters of protection."[2]

In most situations before the case fully resolves, medical bills subject to a letter of protection remain unpaid at their maximum charged value. Compare a typical insurance pay scenario where a surgeon might charge $8,000 for a minor operation but eventually will accept

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[2] *See Sealift, Inc. v. Satterly*, No. 14-03-00051-CV, 2003 Tex. App. LEXIS 6054, at *7 n.2 (App.—Houston [14th Dist.] July 17, 2003) ("'Letters of protection' sometimes used by attorneys in personal injury litigation to guarantee payment to healthcare providers from the proceeds of any future recovery.").

$2,500 as payment because that is the usual and customary payment in the medical services market for that surgery. Under a letter of protection, the same surgeon can charge as much as $42,000 for the exact same surgery yet offer no apparent discount before the case resolves. Because of the deferred nature of the surgeon's payment under a letter of protection, the lawsuit's damage calculation by law will include the full value actually charged.[3] This creates an obvious and significant disparity in charges depending on who is paying and, consequently, arguments about the reasonableness of the billed charges are being litigated more and more in lawsuits that involve letters of protection.[4]

Indeed, many defendants now know from prior experience that deferred medical payment agreements incorporate oral or post-resolution understandings that modify the contracts before final payment is made. The modifications typically occur during negotiations that take place after a final settlement or jury damage award. When negotiations regarding the unpaid bills finally take place, the final accounting associated with letter of protection based care often includes discounts similar to what happens when private insurance companies or Medicare pays the bills.[5]

Because plaintiffs owe the full value of their undiscounted medical bills under letters of protection, a significant difference results between the eventual discounted payment they will pay and the full value of the bills used to calculate damages. The defendant suffers a real detriment then because the parties calculate damages using an artificially high billed value, instead of the usual and customary price for medical services. Experts and treating providers alike, including the plaintiff's treating providers in many case, agree that there is a range of accepted prices that most market participants accept (which is usually lower than the full charges submitted by providers when their services will be paid subject to a letter of protection).

With a focus on the growing disparity between the market price for medical services and the incurred bills associated with letters of protection, this paper addresses the statutory and evidentiary issues that arise when medical charges remain unpaid at their full value in Texas personal injury lawsuits. Of note, the care provided by letters of protection involves the same important decisions related to diagnosis and treatment as care paid for by any other means, yet

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[3] Under Texas law, charged bills that remain unpaid at the time of a damages calculation are considered incurred medical expenses and therefore are subject to recovery at their full charge as part of any final economic damages award. Texas Civil Practices and Remedies Code 41.0105 (interpretation of the word "actually," discussed *infra* below, has not been fully vetted by Texas courts with respect to its application when letters of protection are in force).

[4] To recover past medical expenses as damages, plaintiff must present evidence that the medical expenses were reasonable and necessary. In *McGinty v. Hennen*, 372 S.W.3d 625, 627 (Tex. 2012), the Court confirmed that mere proof of the amount charged or paid for medical services does not prove reasonableness and that evidence must confirm that the charges are reasonable. What represents "reasonable and necessary" can be determined by expert testimony or by submitting affidavits that comply with Texas Civil Practice and Remedies Code Section 18.001. *In re Mendez*, 234 S.W.3d 105, 108 (Tex. App.— El Paso 2007, no pet.). In a strange twist, defense counsel may need to present a billing expert to testify on what the reasonable market rate is for care provided since providers working pursuant to letters of protection will likely conclude that the fees they charge are reasonable.

[5] The accepted practice in the health care industry is to charge more for services than providers know they will recover, which creates confusion and gaps between what is charged versus what is actually paid when determining what damages are appropriate and associated with reasonable, usual and customary payments. *See Haygood v. De Escabedo*, 356 S.W.3d 390, 390 (Tex. 2011) ("Health care providers set charges they maintain are reasonable while agreeing to reimbursement at much lower rates determined by insurers to be reasonable, resulting in great disparities between amounts billed and payments accepted.").

based on the authors' experience, some of that care including extensive physical therapy visits, subjectively derived psychological evaluations, opioid-based pain management, and steroid injection pain relief may result in suboptimal care, or care that is not generally accepted practice in the relevant medical community.

Are deferred medical payment agreements helpful for the plaintiff?

Yes. For plaintiffs without the ability to pay for treatment, care provided under a letter of protection can be very important. In fact, such contracts may be the only chance the plaintiff has to get the appropriate medical care he or she deserves.

There are additional reasons plaintiffs may prefer letters of protection aside from the lack of options or a desire to inflate damages by keeping bills incurred and unpaid. Plaintiffs have needs due to their lawsuits that other patients do not: they need their care to be as consistent as possible with the legal theory of their case. All too often a provider can unknowingly fail to address important issues that they do not normally focus on; for example, the cause of the injury or its impact on pre-existing conditions. As a result, plaintiffs benefit from providers who prepare medical records that clearly state the cause and extent of injury, and identify any future needs required because of those injuries suffered. These providers can also address in their records any pre-existing conditions that are aggravated by the injury-causing event. Such providers generally offer supportive testimony at trial as well, which obviates the need for expensive medical experts that would be required to prove their medical damages.

Are providers paid better under a letter of protection than under an insurance agreement?

Yes. Because providers agree to defer payment, they understand that they will usually receive higher rates of pay under letters of protection than they would receive if the bills were submitted to an insurance carrier or Medicare for payment.[6] With letters of protection, providers can set their charges far higher than insurance companies will pay, and see what happens. The ultimate amount that a medical provider will accept as payment (though almost never stated expressly in the letter of protection) depends on the amount of settlement, past dealings with the attorney, statutory liens, contractual subrogation claims, and any unpaid medical bills from other providers.

Is a letter of protection the same as a deferred medical payment agreement?

Yes. The most common name for these agreements is a letter of protection, which is a term that predates the 2003 tort reform law passed by the Texas State Legislature. Many other states refer to these agreements as letters of protection, and fewer as deferred medical payments or

[6] Sometimes the provider enters into a side contract with a third party to get paid up front and at or near the provider's usual and customary rate. The third party then assumes the right to full payment and might add on 20 or 50 times the value paid to the provider as the final "full charge" for the services. This process can result in a real deviation from the medical services market price for the service. *See Huston v. United Parcel Service, Inc*., 2014 Tex. App. LEXIS 4567 (Tex. App. – Houston [1st Dist.] pet. denied) (appellate court found harmless error and refused to rule on the trial court's decision to limit medical damages to payments some of plaintiff's providers received after a third party company, A/R Net, purchased the providers' accounts receivable at a discounted rate and retained the claim for the bills at their maximum charge).

medical liens. In any case, the technical impact of a letter of protection is to defer medical charges until the conclusion of a litigated matter. Because the contract defers payment, they are not subject to the collateral source rule since they are not paid or subject to insurance laws requiring prompt payments.[7]

Is a letter of protection considered a private pay agreement between a patient and provider?

Yes. Regardless of what the parties call the contract, it is a "private pay" agreement since the patient will, in the end, have to pay the bill out of his or her own funds. In other words, since the providers are not going to be paid by large health insurance companies like Blue Cross Blue Shield, workers compensation insurance, or a federal organization like Medicare or Medicaid, payment relies on an agreement between patient and provider.

Should attorneys treat private pay agreements differently from insurance agreements?

Yes. From a plaintiff's perspective, letters of protection are a handy alternative to Medicare or worker's compensation insurance. Experienced plaintiffs' attorneys are aware that dealing with Medicare liens is a frustrating process. Treatment under letters of protection avoids or minimizes the complications that arise with insurance payments because the parties are subject to unregulated contractual terms and can easily modify the terms by agreement (after the fact) with terms acceptable to both sides. The provider also has far less billing hassles that are more frequently dealt with when being paid by large insurance companies.

Of course in theory, there should be no major difference between private pay agreements and large payor agreements, as long as the market participants treat all parties fairly. If this were true, defendants would have little concern whether the plaintiff relies on a letter of protection or insurance. In practice, however, unchecked private pay contracts can encourage overcharges as well as excessive treatment, and this may be due to the fact that there is less oversight from the individual payor.[8] This shift to a "what the market will bear" approach, when arriving at the private pay pricing, compared with the usual and customary market price, has become a significant problem or a boon for damages calculations, depending upon which side of the argument you sit.

As the saying attributed to Yogi Berra goes, "In theory there is no difference between theory and practice. In practice, there is." With the letters of protection practice that is developing

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[7] Insurance companies negotiate discounts usually according to pre-existing arrangements with the providers and then pay the bills relatively quickly. *See Rutherford v. Joe Rud Trucking, Inc*., No. SA-13-CA-856-FB (HJB), 2015 U.S. Dist. LEXIS 181688 (W.D. Tex. 2015), explaining how courts treat medical insurance for purposes of calculating damages and holding: "Under the collateral source rule, insurance payments to or for a plaintiff are not credited to damages awarded against the defendant. Accordingly, any payments made for Plaintiffs' medical expenses would not limit the damages to be awarded. Of course, Plaintiffs are limited in their damages to those medical expenses 'actually paid or incurred.' *See* Tex. Civ. Prac. & Rem. Code § 41.0105. And the Texas Supreme Court has interpreted 'actually paid and incurred' to mean medical 'expenses that have been or will be paid, and excludes the difference between such amount and charges the service provider bills but has no right to be paid.'" *Id.* at *8-9 (citing *Haygood v. De Escabedo*, 356 S.W.3d 390, 394-95 (Tex. 2012)).

[8] In fact, in many instances the plaintiff, as payor of the letter of protection, is completely unaware of the nuances of the contract entered into on his or her behalf, or what the full charges are for the services they receive. This is because unlike with customary medical care arrangements, the letter of protection providers rarely if ever submit their bills to the plaintiff while the lawsuit is ongoing.

in Texas, there is someone footing the bill: the plaintiff, who can be rather uneducated about medical billing and uninformed about the obligation to pay. There is also someone responsible for paying the bill: the defendant, typically, who has little or no say in the contract terms and is unable to negotiate for lower payments. In fact, there is a *de facto* "anti-negotiation" stance before the case resolves since medical bills charged at the highest value serve to improve plaintiff's overall damages award.

There is, of course, the chance that both parties will suffer from these private arrangements because even though the defendant may end up paying a higher damages award, the plaintiff still bears responsibility for the medical charges. Furthermore, the plaintiff may actually end up paying a bill that exceeds what she or he should have paid, based on reasonable and customary charges for the work performed. And of course, if the case results in a defense verdict, by most contracts the plaintiff must still foot the bill, which can be particularly unfortunate if the care offered was unnecessary, excessive, or resulted in overcharges.

Are attorneys personally bound by their clients' deferred medical payment agreements?

It depends. The language of the contract governs. If the attorney drafts the agreement, he or she will rarely be subject to its terms. This gives rise to a potential concern when employing deferred medical payments: they are generally negotiated by individuals, lawyers and providers, who stand to gain from them without much significant downside. For example, the attorney gains by obtaining a higher percentage of recovery since incurred charges generate larger damages awards than discounted paid bills do. The provider gains by charging a fee that is above the usual and customary price and avoids the hassle of dealing with insurance companies. True, the provider faces some downside if there is no monetary award in the case, but most deferred payment agreements permit the provider to recover directly from the patient as needed. In the end, the parties themselves tend to face the most significant downsides when letters of protection are involved.

Do you have examples of where courts held attorneys responsible for a letter of protection?

Yes. Whether the attorney is liable depends on whether the letter of protection is a valid contract. For example, in *Hays & Martin, L.L.P. v. Ubinas-Brache*, 192 S.W.3d 631, 635 (Tex. App.—Dallas 2006), the Dallas Court of Appeals held that a law firm was liable to a medical provider for an unpaid bill, subject to a letter of protection executed by an attorney at the law firm. The medical provider requested a letter of protection before he performed a surgery on the plaintiff and in response, the attorney sent the provider a "letter promising protection for all medical bills related to [plaintiff's] accident at the time of settlement." The key issue was whether there was mutual assent between the attorney and medical provider such that a valid contract was formed. The Dallas Appeals Court held for the medical provider.

By contrast, in *Advantage Physical Therapy, Inc. v. Cruse*, 165 S.W.3d 21, 23 (Tex. App.—Houston [14th Dist.] 2005), the 14th Court of Appeals held that an unsolicited letter of protection did not create a contract between an attorney and a medical provider when the attorney sent the letter of protection to the provider but the provider did not communicate acceptance of the

offer to the attorney. This genre of cases appears to turn on the mutual assent of the parties. To be safe, a prudent plaintiff attorney should always clarify their role in securing the contract.

How do plaintiff attorneys make sure letter of protection providers are paid?

To avoid confusion, plaintiff attorneys should negotiate any discount and pay the letter of protection based providers directly from the settlement proceeds rather than depend on the client to settle the bill. Thus, after settlement or a verdict, the attorney can send a request for reduction to the provider. Once a reduction, if any, is agreed upon, the attorney should memorialize the modification in writing. This will prevent the provider from attempting to seek further recovery in the future. When a reduction agreement is reached, the attorney then can include the balance owed to the provider in the closing statement to the client and pay the medical provider from the settlement funds or trial award.

Do providers subject to a letter of protection routinely discount their fees?

Yes. Although this is almost never discussed or addressed in the contract itself, discounts of letter of protection based care are very common. The discount typically results due to an ongoing relationship between the provider and the counsel, or, if the relationship between the attorney and provider is newly established, the discount may be negotiated after the case resolves.

Can the provider seek the full amount charged under a letter of protection?

Yes. Since it is presumably a contract between two consenting parties, the terms related to full payment, or any potential discount, will govern. In other words, the provider could seek to enforce the entire amount of the charges billed if that is what the contract allows, which might include a bill that is ten or even fifty times higher than what most providers would accept for payment in the usual and customary medical services market. More commonly, however, upwards of 30% to 50% of the billed charges is discounted, following the case's resolution.

Are these discounts similar to "write-offs" doctors agree to when insurance pays the bill?

Yes. Discounts are endemic in the medical field. With almost all medical care, there is a "billed" amount and then the amount the provider is willing to accept for payment. Every medical provider has a fee schedule that indicates what they bill for each service. Interestingly, what the provider accepts as payment depends on who pays the bill. If the patient pays with health insurance, the provider applies the contractual discounts with those payors. If the patient pays with Medicare, the provider applies the statutory rates. If the patient is private-pay or cash-pay, a discount will usually be applied for some determined percentage or range of percentages. Letter of protection care generally falls into the private or cash-pay category, and the patient should normally expect a discount before final payment is made.

Can you explain these type of contracts with some examples?

As discussed above, the attorney most commonly drafts the agreements and places it on his or her firm letterhead. Letters of protection can be extremely brief or more detailed and they

are usually flexible in nature. They can also be fashioned to address the concerns of a particular provider or client, but it is good practice to use a standard form letter so that the agreements do not vary from case to case.

The terms of the agreement tend to be short and to the point: (1) my client has been injured; (2) the right to recover against the defendant is being litigated; (3) in the event of resolution, your charged bills will be paid; and (4) to the extent they are not paid, the client is responsible for payment. The letter often also includes language that the provider's bill may be reduced based on the amount of settlement, amount of other outstanding medical bills, and/or the reasonableness of the charges. Attorneys should also include language that the providers will be paid after the attorney's fees and costs are deducted and that the patient/client is responsible for any portion of the bill that cannot be paid out of the settlement. Here are some examples.

Introductory Paragraph

The introductory paragraph defines who the author of the letter is, who he or she represents, what the suit is about, and why the letter was sent. Example:

> *This office represents John Smith in relation to the injuries he sustained as plaintiff in the above referenced incident on January 1, 2017. I write to request that any fees for services you render to Mr. Smith shall only be paid out of proceeds recovered on his behalf and out of his share of the proceeds after attorney's fees and expenses are deducted from any gross settlement or judgment.*

Pro-rata Payment/Lien Priority Paragraph

It is good practice to also include language that limits payment subject to conditions presented by the lawsuit as well as subject to any liens on the settlement or judgment that arise from other providers or other debtors. Examples:

> *If Mr. Smith's case is settled for an amount below the amount necessary to pay all medical providers in full, you will receive a pro-rata share to participate equitably in the available funds.*
>
> *If the gross settlement is less than the total outstanding charges owed to all healthcare providers covered by a letter of protection or covered by any subrogation claim or statutory lien, such funds will be distributed on a pro rata basis.*
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> *Statutory liens and insurance subrogation claims required by law to be paid on a priority basis including, but not limited to, Medicare, a subrogated insurer, or worker's compensation statutory liens, will be deducted from the gross proceeds collected before funds are disbursed.*

Agreement to Provide Medical Records and Bills

It is also a good idea to include a clause that permits access to the provider's ongoing charges and records. Example:

> *You agree to furnish our firm with periodic updates of outstanding charges. Our firm will use our best efforts to request a balance confirmation when recovery is imminent. If our firm fails to receive a response within seven (7) days of the mailing or faxing of our firm's balance request, our firm will be entitled to assume that the actual balance is the same as provided in the last received report.*
>
> *Please forward all communication and billing statements to this office.*
>
> *You agree to promptly forward all medical records, billing statements, and corresponding affidavits to our office at the conclusion of Mr. Smith's treatment.*

Agreement not to Pursue Collection While Case is Pending

Because deferred payments usually result in higher damages, plaintiff's attorney will often include the following language to ensure no early payment results. This is helpful to protect plaintiffs against credit blemishes from collection efforts. Example:

> *In consideration of this agreement, you agree not to pursue collection of this bill from Mr. Smith while awaiting resolution of his legal claim. If you attempt collections or refer outstanding charges to a collection agency, this agreement is null and void.*

Client Liable for Unpaid Amounts

Most providers will not enter into an agreement where they must accept the risk of defense verdict, or recovered funds that are lower than the medical expenses incurred. A prudent attorney will also expressly absolve himself or herself from any obligation to pay for the services rendered. Example:

> *Should this case not reach settlement or a successful verdict, Mr. Smith remains liable ultimately for the bill. Upon notice from this office that this matter has concluded in an unsuccessful verdict, you may pursue collection directly from Mr. Smith.*
>
> *THIS FIRM DOES NOT ASSUME RESPONSIBILITY FOR THE PAYMENT OF FEES OR SERVICES RENDERED TO OUR CLIENT.*

Allowance of Unilateral Bill Reduction

An additional clause can include reference to a reduction in the fees in keeping with reasonable terms. Example:

> *If compensation is recovered on Mr. Smith's behalf, your fees will be reimbursed from any money recovered, provided said recovery is reasonable. Whether or not said recovery is reasonable shall be determined at the sole discretion of this law firm.*

It may become necessary for our firm to reduce the amount of your bill to a reasonable amount.

The letter can conclude with an appreciation for the expected services and a signature block. A signature line for the medical provider and/or plaintiff can also be included.

Do deferred medical payments result in increased damages?

Generally, yes, as discussed above. This is why the defendant, to counter those damages, must present testimony from billing experts or well-informed treating providers as to what the market price is for the services provided. The jury can then determine if the damages claimed are reasonable or above market rates. In their defense cases, the authors routinely see charges in excess of the usual and customary paid charges for common procedures. One way to compare reasonable and customary charges is to access data from one of the larger medical payment market resources, such as the one maintained by CMS (Centers for Medicare and Medicaid Services).[9] The American Medical Association serves in an advisory capacity to CMS when evaluating its database. The CMS database is not the only resource available for comparing the charges for the provider's services with others similarly situated. Experts in the field of medical services billing and reimbursement can also rely on their years of practice, or discussions with providers in the same community, to confirm whether or not the deferred bills are reasonable or in excess of the usual and customary fees typical in the market.

What is a factoring arrangement?

Factoring arrangements, in the context of personal injury lawsuits, are different than letters of protection and deferred payment agreements because they actually loan money to the plaintiff to help assist with life needs, medical payments, or other costs associated with injuries and a change in life circumstances. Sometimes factoring agencies will enter into letters of protection on behalf of the plaintiff with preferred providers in their networks, thereby providing the attorney distance from the actual transaction for medical services and any after-resolution negotiations that will further reduce the billed charges. At other times, a factoring company will buy up the providers bills and maintain the full amount as payable. In this way, factoring companies serve as middle-men and are useful in certain situations, such as where a medical provider will not perform a service without payment up-front. They may not be necessary in situations, for example, where a medical provider will agree to deferred payment and the attorney is comfortable assuming negotiation for reducing the bills at the conclusion of the litigation.

Are deferred medical payment agreements and factoring arrangements the same?

No. As discussed, factoring arrangements are a form of monetary loan, whereas deferred medical payment agreements delay the payment of specific services provided to plaintiff.

Are deferred medical payment agreements considered a collateral source?

[9] The CMS website can be found at this address: https://www.cms.gov/.

No. Letters of protection and deferred payment agreements are not considered a "collateral source" because, unlike when a health insurance carrier pays a portion of the plaintiff's medical bill, the plaintiff has received no benefit for which defendant could credit towards the damages awarded. The letter of protection is simply an agreement that the medical provider will be paid at a later date.[10]

The Texas Supreme Court recently addressed collateral sources associated with medical services that are paid, versus those which are incurred and remain unpaid: "The collateral source rule reflects the position of the law that a benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor. To impose liability for medical expenses that a health care provider is not entitled to charge does not prevent a windfall to a tortfeasor; it creates one for a claimant." *Haygood v. De Escabedo*, 356 S.W.3d 390, 395 (Tex. 2011). The Court held that the collateral source rule remains in effect under the facts and any evidence regarding insurance payments or adjustments of the medical bills should be excluded, clarifying that "the common-law collateral source rule does not allow recovery as damages of medical expenses a health care provider is not entitled to charge." *Id.*, at 396.

The *Haygood* decision also addressed the modifying impact of the word "actually" on what "incurred" means for purposes of TCPR 41.0105 without further ruling on how a defendant may prove that a medical provider is not legally entitled to the full charge, such as by offering into evidence the terms of how the bill will be paid.[11] Thus, the courts at this time have left this question unresolved, though it is not uncommon for defendants to depose a medical provider to, among other things, explore the relationship between the provider and the attorney and any reductions commonly accepted for letter of protection or cash-pay patients.[12] Such testimony can also be used to establish bias.[13]

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[10] For an example of a Motion to Exclude Collateral Source Evidence containing a comprehensive list of collateral source supporting case law, see this helpful form published online by Earl Drott Law: http://www.earldrottlaw.com/plaintiff-s-motion-to-exclude-collateral-source-evid.html.

[11] *Haygood*, 356 S.W.3d at 396-397, finding that since "actually" modifies "incurred" in the statute, "[It refers] to expenses that are to be paid, not merely included in an invoice and then adjusted by required credits. Thus 'actually paid and incurred' means expenses that have been or will be paid, and excludes the difference between such amount and charges the service provider bills but has no right to be paid."

[12] Inquiry into several topics known to the provider may result, such as what is reasonable for the services provided in the market where the provider works, information about what the provider accepts as reductions from the full charges with either insurance companies or private pay agreements with patients, whether those reductions are different and if so why, whether the provider drafts his or her own letters of protection or uses the same one with different attorneys, how much the provider accepts for the service as payment if the payor is Medicare or an insurance company, how much the provider accepted from patients or their insurance providers for the same procedure in the past, and whether the provider has ever received the full charged value of the bill from any other patient and if so, how many and when.

[13] The authors found no Texas published opinions addressing the issue of relying on letter of protection contracts to show bias, though Florida courts have confirmed this approach. *See Brown v. Mittleman*, 152 So. 3d 602, 604 (Fla. 4th DCA 2014) ("The financial relationship between the treating doctor and the plaintiff's attorneys in present and past cases created the potential for bias and discovery of such a relationship is permissible.") Defendant may argue providers are biased because they have a stake in the outcome – more services equal more charges and higher charges equal a higher settlement/verdict value, from which the provider can take its portion.

Are letters of protection discoverable and are they permissible evidence at trial?

An answer to these questions depends on the arguments presented by the parties, the court's ruling based on the facts and law presented, and the evolving case law in this area, which remains underdeveloped. Because the documents often exist in written form and are retained in the case file of the provider, Texas Rules of Evidence govern whether letters of protection are considered relevant and admissible evidence. Because there are few, if any, published opinions on the evidentiary issues related to letters of protection, the following analysis is subject to revision, after confirmation and more clear guidance from the courts.

Evidence Rule 401

Rule 401 provides as follows: "Evidence is relevant if: (a) it has any tendency to make a fact more or less probable than it would be without the evidence; and (b) the fact is of consequence in determining the action." Similarly, The Texas Rules of Civil Procedure permit discovery of "any matter that is not privileged and is relevant to the subject matter of the pending action." Texas Rules of Civil Procedure 192.3(a).

Plaintiff will argue letters of protection are not relevant, since they do not address the care of the patient and are merely a method for payment that is subject to the collateral source rule. Defendant will argue they are relevant to show bias, reasonableness of the services and charges, to detail the nature of the contract and modifications that result following the case's resolution, and to explore any pre-existing understandings established between the provider and plaintiff's attorney.

In a recent case involving a request for discovery of insurance contracts in order to demonstrate the terms of payment between the insurance carrier and the provider, a Houston court of appeals upheld the lower court's decision to permit discovery of the contracts in place between plaintiff's insurance company and plaintiff's medical providers. *In Re Jarvis*, 2013 Tex. App. LEXIS 11281 (Tex. App. – Houston [14th Dist.] 2013, no writ). In particular, the court held that defendant had a right to discover if the managed care contracts between the insurance company and the medical providers required the providers to accept a discount of the full charged value of their bills. This case provides further support for a defendant's effort to discover the letter of protection and its modifying terms. Whether or not discoverable, plaintiff's counsel will argue this opinion does not suggest documents detailing payment formulas are admissible evidence.

Another Texas court limited discovery from a chiropractor under a letter of protection. In *In re Siroosian*, 449 S.W.3d 920, 924 (Tex. App.—Fort Worth 2014) the Fort Worth Appeals Court held discovery was overbroad and not relevant when defendant sought discovery from a letter of protection chiropractor for "information about accounts receivable, collections under letters of protection, and revenue reports for patients other than the plaintiff…, as well as identification of the software utilized by [the chiropractic clinic] and [the chiropractor's] thoughts on the impact of a letter of protection." The court cited the Texas Supreme Court's decision in *In re Nat'l Lloyds Ins. Co*., 449 S.W.3d 486, 487 (Tex. 2014) to support its holding. Justice Terrie Livingston offered a concurring and dissenting opinion in the case, pointing out that discovery of the provider's knowledge of subsequent collection efforts and patient recovery of

damages in other cases where letters of protection were issued *should* be allowed because "defendant's counsel specifically disclaimed seeking any patient names or records; instead, he was seeking to use questions with a narrowed scope to discover the witness's potential bias in this particular case by seeking to discover whether collection efforts or billing-related matters were handled differently because of this particular plaintiff's lawyer." *In re Siroosian* at 929.

Justice Livingston's dissent supports the argument that discovery of letters of protection information is relevant to show bias on the part of the provider based on the payment arrangement with the plaintiff. That said, discovery issues relating to letters of protection remain surprisingly unaddressed for the most part by the courts in Texas. The case law that does exist, as described above, leaves unclear what type of discovery is appropriate with deferred medical contracts.

Evidence Rule 403 and hearsay

Though excluding letters of protection and related discovery may be difficult outright, defendant still faces an admissibility burden with respect to their content and circumstances as evidence. Rule of Evidence 403 provides: "The court may exclude relevant evidence if its probative value is substantially outweighed by a danger of one or more of the following: unfair prejudice, confusing the issues, misleading the jury, undue delay, or needlessly presenting cumulative evidence." Clearly, the plaintiff will argue Rule 403 governs. Furthermore, hearsay objections will also be strenuously argued by the plaintiff and the court's ruling on them will be fact, dependent based on the terms of the agreement, the contents of documents, and the role the agreements play.

For purposes of Rule 403, plaintiff will argue that producing the letters of protection will unfairly prejudice the proceedings, confuse the issues, and mislead the jury away from the issue of treatment. For example, references to the plaintiff being referred to the medical provider by an attorney is more prejudicial than probative under Rule 403; to offer such evidence would be prejudicial, nonprobative suspicion and "some suspicion linked to other suspicion produces only more suspicion, which is not the same as some evidence." *Browning-Ferris, Inc. v. Reyna*, 865 S.W.2d 925, 927 (Tex. 1993). Defendant will argue that the probative value is a showing of bias, reasonableness of fees, as well as the course of dealing to modify the full charge before final payment.

As for hearsay objections, any proffer of a letter of protection for its truth will result in significant objection from plaintiff. Such hearsay objections will be addressed by the circumstances leading up to the letter, what the offer of proof relates to, e.g., notice versus truth, and whether any hearsay exceptions apply. Again, the courts are silent on how hearsay objections, to the extent argued, will be resolved as they relate to letters of protection and related evidence.

Evidence Rule 409

Rule 409 provides: "Evidence of furnishing, promising to pay, or offering to pay medical, hospital, or similar expenses resulting from an injury is not admissible to prove liability for the injury."

Plaintiff will argue this evidence rule also excludes any evidence related to letters of protection and their terms. However, defendant will argue the purpose of the evidence is not to prove liability, but rather, to show bias and demonstrate that the charge as stated does not represent the actually incurred value of the bill.

Evidence Rule 411

Rule 411 provides: "Evidence that a person was or was not insured against liability is not admissible to prove whether the person acted negligently or otherwise wrongfully. But the court may admit this evidence for another purpose, such as proving a witness's bias or prejudice or, if disputed, proving agency, ownership, or control."

The long-standing rule holds that error results when either party mentions the presence or absence of insurance coverage during trial of a personal injury cause of action; if insurance is mentioned, the trial court may either order a mistrial or instruct the jury not to consider the improper statement. *Dennis v. Hulse*, 362 S.W.2d 308, 309 (Tex. 1962). Plaintiff's counsel may attempt to argue this rule governs a letter of protection, however, the letter does not insure the plaintiff. Instead, the letter of protection defers payment. Therefore, this rule should not govern.

Exclusion of evidence subject to the collateral source rule

Plaintiff attorneys will also assert that letters of protection are collateral sources and any evidence related to them should be excluded from trial. As stated by the Houston court of appeals: "The collateral source rule is both a rule of evidence and damages. Generally, it precludes a tortfeasor from obtaining the benefit of, or even mentioning, payments to the injured party from sources other than the tortfeasor. In other words, the defendant is not entitled to present evidence of, or obtain an offset for, funds received by the plaintiff from a collateral source." *Taylor v. Am. Fabritech, Inc*., 132 S.W.3d 613, 626 (Tex. App.—Houston [14th Dist.] 2004, pet. denied); *see also Big Bird Tree Serv. v. Gallegos*, 365 S.W.3d 173(Tex. App. –Dallas 2012, no pet. h.) (the court considered whether the trial court erred by permitting plaintiff to submit affidavits at trial from hospital providers for the full billed charges despite the presence of significant write offs due to an indigent charity program, and cited both the *Haygood* decision and the collateral source rule to support its holding that TCRP 41.0105 does not preclude recovery of the full billed charges under the facts since holding otherwise would permit a tortfeasor to "avoid liability for medical expenses born by a charity program designed to benefit indigent patients.").

While these cases support compelling arguments in favor of presenting the full charges of the provider's bills, defense attorneys will object indicating there is no third party payor involved in letter of protection care and there is also no payment made, as in the *Big Bird* case.

Are deferred payment services governed by Texas Civil Practice and Remedies Code 18.001?

Yes. The legislature designed Section 18.001 to simplify the process by which plaintiffs may prove-up the reasonableness of medical charges and the necessity of the medical care plaintiffs receive, regardless of who provides the service or how and when it gets paid. According to Section 18.001, if the appropriate affidavits are served on the defendants 30 days before the first

day the evidence is presented, then the defendant has 30 days within which to "controvert" the affidavit, otherwise the 18.001 affidavit is rebuttable evidence that the medical bills are reasonable and necessary.

Interestingly, the affiant of the initial affidavit need only be the person who provided the service or the person in charge of records showing what services were provided and which charges were made (essentially, a custodian of records).[14] By contrast, the affiant who authors a controverting affidavit *must* be "qualified, by knowledge, skill, experience, training, education, or other expertise, to testify in contravention of all or part of any of the matters contained in the initial affidavit." *See* Tex. Civ. Prac. Rem. Code § 18.001(f). The statute therefore favors plaintiffs and imposes on defendant a significant burden when locating a provider who is qualified to controvert the medical records and fees affidavits.

Defendants who receive Section 18.001 affidavits are well served to immediately review them to determine if they should be controverted. Retaining qualified individuals to controvert affidavits can be costly and time consuming, which works to plaintiff's advantage. In our experience, it is not uncommon for plaintiffs to get creative when serving affidavits so that they are more likely to be overlooked by defense counsel. From a defense perspective, high, unpaid charges should be a red flag that a controverting expert should be available, even if affidavits have not yet been served, or are served with minimal care indicated initially.

Are deferred payment agreements substitutes for Section 18.001 affidavits?

No. Letters of protection in no way substitute for Section 18.001 affidavits. Attorneys using letter of protection providers can expedite the process by requiring the providers to complete affidavits and return to the law firm when the client/patient is discharged from treatment as part of the letter of protection agreement. Defendant can review the bills submitted from the letter of protection provider to check if the coding used is correct, and to see if any clear defects are present in the bill, since it will never be submitted through a more formal process, such as the insurance carriers or Medicare require.

Do deferred medical payments prove that the care provided was reasonable and necessary?

No. They are only agreements between consenting parties to obtain medical services for payment. The reasonableness of the care provided is not presumed by the law, though defendant must object to any effort to prove reasonableness without appropriate evidence at trial; otherwise, the opportunity is waived.

Do deferred medical payment arrangements prove that the fees charged were reasonable?

No. Similar to the reasonableness of the care, fees charged must be proven reasonable as well. On their own, deferred medical agreements do not prove the charges are reasonable.

[14] The affidavit must also include an itemized statement of the service and charge. Plaintiff attorneys should pay special attention to the requirements of Section 18.001, as any flaw is a potential ground for the defendant to have the affidavits struck. This can result in a significant setback if affidavits are served close to trial for strategic purposes.

Furthermore, if affidavits as to the fees reasonableness are properly contested pre-trial by the defendant, then the plaintiff has the burden of proving the fee charged was reasonable. However, the courts have offered little guidance on what the extent of that evidence must be based upon when presenting evidence to the jury.

Do you have examples of how Section 18.001 applies to deferred medical payments?

There are two aspects to the 18.001 affidavit: (1) necessity of services, and (2) reasonableness of charges. Both come into play when dealing with letter of protection providers.

A simple example of a necessity of services issue is the extensive after-accident care of a chiropractor or physical therapist. After a typical sprain or strain of the back, it is common for a general practitioner to recommend physical therapy and less so, chiropractic care. The usual and customary guidelines for such care may include ten or twelve sessions, where some improvement is noted during each visit. Following a four to six-week period, a reevaluation may result in additional visits but frequently the reevaluation results in a release of the patient to perform in home exercises.

By contrast, a plaintiff may attempt to submit affidavits indicating that twenty or more chiropractor or physical therapy sessions were performed. This situation would trigger a challenge on the necessity of services at least, and likely a challenge to the charges as well, if they exceed the usual and customary charges for similar services in the local market.

An example of the reasonableness of charges issue, which is commonly attacked by defense counsel, arises when a provider bills significantly higher than they or other providers in the geographical area would charge when rendering services to cash-pay or health insurance patients. This aspect of a controverting affidavit can be challenging because the affiant must possess special knowledge of the standards in the area where the provider works, as well as the costs of care in that area.

Here are steps that describe the process of accepting or challenging the reasonableness of the medical bill charges as submitted by affidavit:

First, affidavits are served by plaintiff's counsel as to some or all of the treating providers.

Second, defendant either: (1) objects, arguing the affidavits do not meet the 18.001 requirements on their face; or (2) accepts the affidavits as reasonable and necessary charges for services rendered; or (3) retains an expert or experts to controvert the reasonableness of the charges using a formula based on some percentage of the charges from the CMS or similar database.

Third, plaintiff then either: (1) accepts that the bills must be proven up at trial as reasonable charges; or (2) files a motion to strike the controverting affidavit, arguing that CMS and private insurance rates are an inappropriate measure of the market, or that doctors can charge what the private-pay patient agrees to, and may even indicate that private-pay or

letter of protection patients must be charged higher rates because of the risks and delay involved.

When affidavits and controverting affidavits are challenged, the outcome will largely depend on the court unless the parties make some alternative arrangement, such as a Rule 11 agreement to address the issues again during pre-trial motion practice.

With regard to necessity of services, the following sequence of steps generally occur:

First, plaintiff serves affidavits attesting to the reasonableness and necessity of the services provided.

Second, defendant then can either: (1) object to the affidavits on their face; (2) accept that the services were necessary, or (3) retain a medical provider or providers, for example, a general practitioner or an orthopedist, to controvert the necessity of some or all of Plaintiff's medical care – this can include services provided by EMS, hospital providers, chiropractors, radiologists, pain management specialists, and/or orthopedic or other specialties. The affiant provider or providers assess all medical records, including any available pre-incident medical records, and then reach conclusions as to whether the services rendered were justified or unnecessary. The opinion is included in the controverting affidavit.

Third, plaintiff then can either: (1) do nothing; or (2) object to the controverting affidavit as not conforming to 18.001 on its face; or (3) file a motion to strike the controverting affidavit, arguing that the provider is not qualified to controvert the necessity of medical care rendered by plaintiff's physicians or his opinions are not reliable. For example, plaintiff can argue that a defense provider is not qualified to controvert services rendered by one or more of plaintiff's providers because the defense provider/affiant is not the same type of medical provider; the leading case law on this is *Hong v. Bennett*, 209 S.W.3d 795, 803 (Tex. App.—Fort Worth 2006) (chiropractor not qualified to testify as to care and billing rendered by medical doctor and radiologist).

As indicated, if controverting affidavits are served but not challenged, the plaintiff will need to prove the necessity of the services and reasonableness of charges by testimony from the medical provider. TCPRC 18.001 does not specify when plaintiffs should assert objections to controverting affidavits. Plaintiffs should look at their scheduling order for guidance.

What role does TCPRC 18.001 play in proving the services and charges of letter of protection based care are reasonable and necessary?

Once properly submitted, affidavits conforming to TCPRC 18.001 will provide rebuttable evidence to the jury that the services and charges were reasonable and necessary unless the affidavits are controverted. If they are controverted with controverting affidavits, then the plaintiff will have to prove their reasonableness and necessity by appropriate trial or deposition testimony.

What is the relationship between letters of protection and TCPRC 41.0105?

Texas Civil Practices and Remedies Code 41.0150 explicitly provides that "in addition to any other limitation under law, recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant." Tex. Civ. Prac. & Rem. Code § 41.0105. *See Henderson v. Spann*, 367 S.W.3d 301(Tex.App. –Amarillo March 27, 2012, pet. denied) (appellate court held reversible error for trial court to permit evidence of full, unadjusted charges for medical services and the trial court's exclusion of defendant's offer of the adjusted values into evidence was an abuse of discretion).[15] Interestingly, though plaintiff's providers had already been paid for their services, one Texas appellate court affirmed the trial court's determination that the full medical expenses remained incurred at trial because a third party factoring company purchased them. *See Katy Springs Manufacturing, Inc. v. Favalora*, 476 S.W.3d 579 (Tex. App.—Houston [14th Dist.] 2015)(holding: "In a factoring case, where the record indicates that the claimant remains liable for the amounts originally billed by the medical provider, such amounts are recoverable medical expenses under section 41.0105, and evidence showing the amounts billed by the medical provider is admissible."); *but see, Huston v. United Parcel Service, Inc*., *supra* (appellate court did not address the trial court's refusal to admit into evidence the full charges plaintiff's providers sold at a discount to A/R Net, a factoring company).

Of note, letters of protection can offer plaintiff a loop hole to the *Haygood* holding and the apparent intent of TCPR 41.0105 related to whether plaintiffs should receive a windfall by maintaining incurred but unpaid full medical bills until after the litigation is over.

Defendant understands this approach is necessary for plaintiffs without health insurance who do not have the resources to wait years to be reimbursed for their medical care, but due to its practical application, the approach presents an opportunity for abuse. For example, the authors observe that plaintiffs that have insurance are still opting for letter of protection based care. The question posed by this trend toward letter of protection care is twofold: (1) is incurring unpaid charges that are negotiated after the case resolves, a reasonable approach to a proper damages calculation? And perhaps more importantly (2) is there a danger in limiting plaintiff's access to only those providers who will work for, and may be biased by, the promise of payment at some time in the undetermined future? Time, and more experience, will tell. Though currently undecided, the door is now open for defendants to argue that letter of protection providers who generate bills over and above market prices have no right to be paid the full bill, especially if the provider and attorney have a side agreement when they sign the letter of protection that the full-billed amount will never be paid.

From a plaintiff perspective, letters of protection afford plaintiffs quality care that they may not otherwise receive and the corresponding increased price for the services addresses this fact. For example, uninsured plaintiffs have little option other than to obtain letter of protection treatment. Furthermore, some medical providers, e.g., hospitals, will often not accept a patient's health insurance when a third party is responsible for the injury. In these instances, a letter of protection may be the only way to obtain care or prevent the filing of a lien and/or collection efforts

[15] For an excellent review of this statute's language and the many issues related to it that have been addressed by the courts in Texas, see Joe Escobedo, Jr.'s Update on Paid or Incurred and Expedited Trials, found on the Escobedo & Cardenas, L.L.P. website: http://escobedocardenas.com/cle-papers/update-on-paid-or-incurred-and-expedited-trials/.

while litigation is pending. Also, more and more doctors are refusing to treat individuals who are involved in active lawsuits related to their injuries. This may be to avoid the risk of being called to deposition or trial, but it can restrict plaintiff's choice of care providers. In this light, the risks taken by providers who are willing to treat plaintiffs and accept delayed payment may be the justification for higher billed fees than what is seen in the health insurance or cash-pay market outside of the litigation context.

Can I use a Section 18.001 affidavit to show that a letter of protection provider has a legal right to be paid the full amount billed?

Yes, but it is likely not conclusive. TCPRC 18.001 affidavits, the text of which are set out in 18.002, can explicitly state that "the total amount paid for the services was $ _____ and the amount currently unpaid but which has a right to be paid after any adjustments or credits is $_____." However, 18.002(b-2) provides that "if a medical bill or other itemized statement attached to an affidavit … reflects a charge that is not recoverable, the reference to that charge is not admissible."

In an attempt to "comport with Section 41.0105 of the Civil Practice and Remedies Code, which allows evidence of only those medical expenses that have been paid or will be paid, after any required credits or adjustments," Texas Rule of Evidence 902(10) was amended in 2013 to include an affidavit with the "right to be paid" language. The comment corresponding to the amendment also stated that "the records attached to the affidavit must also meet the admissibility standard of *Haygood*, 356 S.W.3d at 399-400 ("Only evidence of recoverable medical expenses is admissible at trial.")." However, the "right to be paid" language in TRE 902(10) was taken out in 2014, noted to be redundant because the language was added to TCPRC 18.001(b-2). Following that logic, it appears that 18.002(b-2) affidavits would show prima facie evidence that a provider has the right to be paid the billed amount, subject to a challenge that a portion of the bills does not meet the *Haygood* standard of recoverable medical expenses. Case law in this area, as previously mentioned, remains underdeveloped as of now.

Do other states address letters of protection or deferred medical payment arrangements?

Florida case law is significantly more developed in the area of letters or protection as compared to Texas. In Florida, defendants may use a letter of protection to impeach the plaintiff's doctor on the issue of bias because the letter of protection gives that physician a financial stake in the outcome of the litigation. *See Pack v. Geico Gen. Ins*., 119 So. 3d 1284, 1287 (Fla. 4th DCA 2013); see also *Brown v. Mittleman*, 152 So. 3d 602, infra. A significant body of dicta and factual references to letters of protection also appears in multiple Florida published cases. It will be determined if Texas courts will look to Florida written opinions for guidance in their own decision making about this topic.

California's Supreme Court addressed the impact of a provider accepting a lower fee than the full charge for the services as being paid in full, and whether that impacted the evidence at trial in 2011. *See Howell v. Hamilton Meats & Provisions Inc*., 52 Cal.4th 541 (2011) (evidence of the charged amount of medical treatment was inadmissible where plaintiff's medical provider accepted as payment in full an amount less than the charged amount). The *Howell* decision has

prompted a flurry of new cases that adopt or distinguish its ruling as it relates to the type of issues raised in Texas by letters of protection. For example, a recent appellate decision in California demonstrated that, absent evidence of a reasonable market value for the services put on by the defendant, the plaintiff could present the full charged value as damages. *See Uspenskaya v. Meline*, 241 Cal.App.4th 996 (2015) (court affirmed as appropriate plaintiff's entry into evidence of the full value of billed charges that a factoring company purchased from the providers at a discount because defendant failed to present evidence that contradicted the full charge as reasonable).

For now, it is unclear whether Texas will follow Florida or California law, or any other state decision, on issues raised by letters of protection. Thus, it remains unclear whether Texas courts will follow a more narrowed approach to discovery that seeks to explore the attorney-provider relationships underlying most letters of protection, or will proceed in the way Florida has, with more open discovery and evidentiary opportunities that defendants may rely on to show bias and unreasonableness of the services and charges.

Do the Texas federal courts address deferred medical payment arrangements?

Yes. A recent federal case on letters of protection is *Rutherford v. Joe Rud Trucking, Inc*., No. SA-13-CA-856-FB (HJB), 2015 U.S. Dist. LEXIS 181688 (W.D. Tex. 2015). In *Rutherford,* the Western District Court rejected the defendants' summary judgment argument that the plaintiffs failed to mitigate their damages "by not submitting their medical bills to their insurance provider for reimbursement, and submitting them instead to their counsel." *Id*. at *7-8. The Western District Court held that defendants failed to provide any evidence that the medical service provider in question would have charged a different amount to Plaintiffs' private insurance carrier." *Id*. at *9. This seems to leave the door wide open for a challenge to letter of protection charges when it is known that plaintiffs have health insurance and some evidence can be obtained that their damages would be reduced, had they submitted their bills to their health insurance carrier.

In *Galaviz v. C.R. Eng. Inc*., No. A-12-MC-82 LY, 2012 U.S. Dist. LEXIS 53866 (W.D. Tex. 2012) the magistrate judge denied the plaintiffs' motion to quash deposition on written questions directed at a medical factoring company using deferred payment agreements, Key Health, which sought discovery of "the amounts initially charged by the medical/healthcare provider, the amounts paid by Key Health to the medical/healthcare provider, and the amounts not being requested by Key Health after the purchase of the medical/healthcare provider's accounts receivable." *Id*. at *4. In their briefing, the defendants did not argue that plaintiffs were not entitled to recover amounts that would be written-off by the medical/healthcare providers, pursuant to TCRPC 41.0105, but rather that the discovery was sought to determine the *reasonableness* of the charges, pursuant to TCPRC 18.001. *Id.* at *8. The court was convinced by defendants' argument that the discovery would show the reasonableness/unreasonableness of the charges for TCPRC 18.001 purposes but noted that a determination as to the recovery of amounts that would be written-off would be premature. *Id*.

Texas federal law, much like state law, remains relatively open on its position with respect to the many issues surrounding the admissibility of letters of protection related care. Because federal courts appear to favor defendants, defendants may be encouraged to remove personal injury lawsuits to federal court when diversity jurisdiction is available, as federal court may at least

provide better discovery access to documentation and a factual understanding of letters of protection based care.

Must the plaintiff pay the full value claimed by the deferred medical payment arrangements?

Yes, and no, as described above. The terms of most letters of protection indicate the plaintiff must pay the full value claimed unless circumstances allow a modification of the charge after the services, such as at the conclusion of the lawsuit when a lower than expected settlement results. To the extent there are modifying arrangements, either express or implied, these are rarely if ever discussed or identified in the course of producing the letter of protection.

Conclusion

Letters of Protection can serve a critical role for indigent or insurance-less plaintiffs who need medical care. That said, they can also result in an abuse of the medical payment system by excessively inflating charges for medical services. To the extent they also result in excessive or unnecessary care, the problem ought to be receiving greater attention by both the legal system and the medical system. As a result of the issues raised in this article, both plaintiff and defense counsel are best served by better understanding these agreements, their benefits, and the potential downsides associated with damages that are never actually incurred, or worse, care that is excessive, suboptimal, and even iatrogenic.

In the end, we all deserve access to reasonable care that providers offer at a fair price. Let us hope that moving forward, both parties and the courts work together to reduce the downsides described here. Ultimately, the abuse and misuse of unreasonable incurred and unpaid medical bills can jeopardize the same benefits that these private pay agreements can offer to injured individuals who truly need their assistance.