Testimony Before the Maryland Senate Judicial Proceedings Committee
in Opposition to S.B. 269:
A Bill That Would Lead to Inflated Damage Awards

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On Behalf of the American Tort Reform Association
February 3, 2026

On behalf of the American Tort Reform Association (ATRA), thank you for the opportunity to testify today in opposition to S.B. 269.

ATRA is a broad-based coalition of businesses, municipalities, associations, and professional firms that share the goal of having a fair, balanced, and predictable civil justice system. I am a Maryland resident, a member of the Maryland Bar, and a partner in the Washington, D.C. office of Shook, Hardy & Bacon L.L.P.

S.B. 269 would establish a presumption in personal injury cases that charges that appear on medical bills are "fair and reasonable." This is precisely the opposite of the approach we are seeing around the country, in which states are increasingly recognizing that the reasonable value of medical treatment is reflected by amounts actually paid and accepted by healthcare providers, not a price that is listed on a bill that is rarely, if ever, paid. ATRA calls those amounts – the gap between billed rates and what is actually paid – "phantom damages" because they exist only on paper. This bill provides a presumption that billed rates are reasonable, when they often are not. The inflated verdicts and settlements that result will contribute to Marylanders paying more to drive, work, and live in our state.

Medical Bill Prices Do Not Reflect the Actual Value of Medical Care

The proposed legislation provides a presumption that charges that appear on a medical bill are fair and reasonable (and recoverable) as damages in a personal injury lawsuit. This presumption is inappropriate because it does not reflect reality.

As anyone who has read a medical bill has likely experienced, medical bills often include two sets of charges: the "billed," "gross," or "standard" rate for medical care and the amount that the healthcare provider will actually accept as payment. There is often a stark difference between these amounts, regardless of whether the bill will be paid by a private insurer, a government program, or directly by a patient.

For example, after a minor fender bender, an Emergency Room examination, plus imaging and testing to confirm there is no significant injury, might result in "billed" charges totaling $15,000. The healthcare provider, however, may accept $4,500 as full payment for that care. In cases involving more significant injuries or extended medical care or rehabilitation, billed charges can easily go into the hundreds of thousands of dollars, even when the amount accepted as full payment may be ten times less.

Here is some background on why there is often a major gap between amounts billed and paid. It is common practice for healthcare providers to set a fee for each service or treatment, typically represented by a Current Procedural Terminology (CPT) code.[1] CPT codes are uniform and set by a panel of the American Medical Association, but the amount healthcare providers charge for these services are not. Each healthcare provider

[1] *See* Am. Med. Ass'n, The CPT® Code Process (2024).

is free to set its own fee for each CPT code. Healthcare providers use a similar system to set list prices for various medical products, supplies, and services not included in CPT codes.[2] The healthcare provider records its list prices in its billing system or "chargemaster" and that "standard charge" or "gross rate" is often indicated on the provider's invoice.

List prices for healthcare services often serve as an opening offer or bid. Patients and insurers (whether private or governmental) rarely pay these "sticker prices."[3] Rather, the market sets the reasonable value of a product or service. By definition, the fair market value of a service is the amount at which a willing buyer and seller agree, in an arm's length transaction, to pay for and provide that service.[4]

Billed rates are often many multiples the amount providers routinely accept.[5] Rather, healthcare providers typically receive payment based on negotiated rates with managed care plans or schedules set by Medicare rules.[6] Likewise, uninsured patients rarely pay list prices, as healthcare providers offer programs providing subsidies or discounts to low-income patients and write off an increasing amount of bills that reflect list prices.[7] Hospital representatives caution that "[t]he chargemaster can be confusing because it's highly variable and generally not what a consumer would pay."[8]

To maximize damage awards (and contingency fees), plaintiffs' attorneys in Maryland introduce as evidence billed amounts. They will contend that a tortfeasor should not "benefit" from "negotiated rates" between a healthcare provider and insurer. But it is this very negotiation and the resulting amount paid that establishes the most reliable market-based measure of the reasonable value of medical care. The proposed legislation makes this approach even worse by making it more difficult for a defendant to challenge whether the billed amount is reasonable.

Providing That a Defendant Can "Rebut" the Presumption is Backward

That a defendant can "rebut" a presumption that charged amounts are reasonable does not alleviate these concerns. The bill provides that a party may overcome the presumption that damages should reflect whatever amount appears on a medical bill by "proving . . . that the medical bill or any charge on the medical bill . . . "is unfair, or is unreasonable." This approach flips the burden of proof on its head.

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[2] *See* Centers for Medicare & Medicaid Services, HCPCS Level II Coding Procedures (explaining use of the Healthcare Common Procedure Coding System (HCPCS)).

[3] *See Haygood v. De Escabedo*, 356 S.W.3d 390, 393 (Tex. 2011) (observing that healthcare provider "list" rates reflect negotiations with government programs and private insurers and are rarely collected).

[4] *See, e.g.*, Utah Code § 59-2-102(13)(a) (defining "fair market value," for taxation purposes, as "the amount at which property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy or sell and both having reasonable knowledge of the relevant facts.").

[5] *See, e.g.*, George A. Nation III, *Hospital Chargemaster Insanity: Heeling the Healers*, 43 Pepp. L. Rev. 745, 748 (2016) ("[C]hargemaster prices are insanely high, often running ten times the amount that hospitals routinely accept as full payment from insurers.").

[6] *See Daughters of Charity Health Servs. of Waco v. Linnstaedter*, 226 S.W.3d 409, 410 (Tex. 2007) ("Few patients today ever pay a hospital's full charges, due to the prevalence of Medicare, Medicaid, HMOs, and private insurers who pay discounted rates."); *see also* Centers for Medicare & Medicaid Services, *Fee Schedule - General Information*.

[7] One study found that patients with private insurance paid 41% of list prices, patients with Medicare and Medicaid paid 35% and 30% of list prices, respectively, and uninsured patients paid 39% of list prices. Glenn A. Melnick & Katya Fonkych, *Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices?*, 27 Health Aff. 116, 118 (2008).

[8] Sarah Kliff & Dan Keating, *One Hospital Charges $8,000 — Another, $38,000*, Wash. Post, May 8, 2013 (quoting Carol Steinberg, Vice President of the American Hospital Association).

Ordinarily, a plaintiff has the burden of proof and is expected to establish liability and damages. That includes proving that medical expenses incurred were both "reasonable" and "necessary." In some cases, plaintiffs and defendants may stipulate (agree) to the amount of medical damages, eliminating the need to spend time on this issue at trial. But in complex cases, or cases in which there is a significant gap between the amounts sought by the plaintiff and amounts customarily accepted by healthcare providers, it is the plaintiff, not the defendant, who must establish that the treatment was necessitated by the injury and that the cost was reasonable.

Defendants should not be placed in the position of having to prove that amounts that appear on a medical bill are unreasonable, particularly when it is common that chargemaster rates and other list prices are far higher than amounts customarily accepted as payment. In fact, if there is to be any "presumption," it should be that the amount paid or customarily accepted represents the reasonable value of medical care with the burden of proof on the plaintiff to prove otherwise.

S.B. 269 Goes in the Opposite Direction of the National Trend

As the gap between charged prices and the amount healthcare providers typically accept as full payment for their medical services has grown, states are taking the opposite approach of this bill and preventing inflated awards that raise the cost of insurance for their residents.

Since 2020, seven states have enacted legislation providing that evidence offered to prove the amount of damages for past medical treatment or services is limited to the amount actually paid, regardless of the source of payment.[9] They join others that have, through legislation, taken this approach.[10] Some of these states go further by addressing not only the value of past medical expenses, but also damages for future anticipated medical treatment. State high courts have also recently addressed the issue, rejecting use of billed rates to compute damage awards.[11]

Many other states have long determined damages for medical expenses based on the amount paid, not amounts charged. For example, the California Supreme Court has ruled that its courts do not allow recovery based on amounts that appear on medical bills "for the simple reason that the injured plaintiff did not suffer any economic loss in that amount."[12] Other examples of states that look primarily to the amount paid, rather than

[9] Ark. H.B. 1204 (2025) (amending Ark Code § 16-64-120); Fla. Stat. Ann. § 768.0427(2) (enacted 2023); Ga. S.B. 68 (2025) (to be codified at Ga. Code Ann. § 51-12-1.1); Iowa Code §§ 622.4, 668.14A (enacted 2020); La. S.B. 231 (2025) (amending La. Rev. Stat. § 9:2800.27); Mont. Code Ann § 27-1-308 (enacted 2021); Tenn. Code Ann. § 29-26-119 (enacted 2024).

[10] *See, e.g.*, N.C. Gen. Stat. Ann. ch. 8C, Rule 414 (enacted 2011); Okla. Stat. Ann. tit. 12, § 3009.1 (enacted 2011); Tex. Civ. Prac. & Rem. Code Ann. § 41.0105 (enacted 2003).

[11] *See, e.g., Gardner v. Norman*, 2025 UT 47, ¶¶ 4, 41, -- P.3d -- (Utah Oct. 30, 2025) ("The gross charge does not reflect [the plaintiff's] past medical expenses because neither he nor his insurance were ever obligated to pay that amount," and finding that, instead, "the amount of the negotiated charge reflects the actual loss incurred, which is the measure of special damages.").

[12] *Howell v. Hamilton Meats & Provisions, Inc.*, 257 P.3d 1130, 1133 (Cal. 2011). Rather, "a personal injury plaintiff may recover *the lesser* of (a) the amount paid or incurred for medical services, and (b) the reasonable value of the services." *Id*. at 1138 (emphasis in original).

the amount billed, when awarding damages for medical care include Connecticut, New Jersey, New York,[13] and Pennsylvania.[14]

ATRA is not aware of any state that has passed legislation providing a presumption that amounts billed for medical treatment are fair and reasonable.

The Presumption May Facilitate Abuse

ATRA is also concerned that the bill's presumption that the charged amount that appears on a medical bill is fair and reasonable could facilitate the type of manipulation, abuse, and even outright fraud we have seen in some states. That is because the higher the amount that appears on the bill, the larger the damage award (or settlement demand), even if the amount listed is excessive and never collected.

Some personal injury attorneys have relationships with medical clinics. They refer their clients to these clinics, which may charge high rates and even, sometimes, provide medically unnecessary surgeries or unnecessary prolong treatment (such as rehabilitative care) to run up damages in a personal injury lawsuit. In some instances, patients are instructed not to use their family doctors or submit a claim to insurance. Through a "letter of protection," the medical provider agrees to be paid out of the patient's expected recovery. When the case ends, the plaintiff may find that all or most of the recovery will go to pay back these inflated medical bills and attorney contingency fees.[15]

Some states recently required disclosure of such arrangements in court.[16] Instead, the proposed legislation provides bills that result from such schemes with a presumption of reasonableness.

What it Means to Marylanders

What does this mean for Marylanders? The presumption of reasonableness provided by S.B. 269 makes it more likely that plaintiffs in personal injury claims will receive damages for medical care based on charged rates that far exceed the actual value of the treatment they received. This change will increase settlement amounts and damage awards in a wide range of personal injury cases. These increased costs will be reflected in higher insurance rates for Maryland drivers, homeowners, and businesses, while providing no compelling benefit to injured parties, who already receive what a jury determines is the reasonable value of medical services.

For these reasons, ATRA respectfully requests an unfavorable report.

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[13] Connecticut, New Jersey, and New York admit medical bills, but the court, post-trial, reduces the amount awarded to deduct amounts that were not actually paid due to discounts, write-offs, or other adjustments.

[14] In Pennsylvania, an injured party may only recover "the amount paid for the medical services." *Moorhead v. Crozer Chester Med. Ctr.*, 765 A.2d 786, 789-90 (Pa. 2001), *abrogated on other grounds by Northbrook Life Ins. Co. v. Commonwealth*, 949 A.2d 333 (Pa. 2008); *see also Sliker v. Nat'l Feeding Sys., Inc.*, 2015 WL 13779690, at *8 (Pa. Com. Pl. Oct. 19, 2015) ("the amount paid and accepted by a health care provider as payment in full for medical services [i]s the amount plaintiff was entitled to recover as compensatory medical damages.").

[15] *See, e.g.*, Carleen Bongat, *Allstate Scores Major Win as Appeals Court Revives $4.7 Million Fraud Suit*, Insurance Business, Jan. 16, 2026 (Houston, Texas); Riley Brennan, *Uber Accuses Prominent Phila. Firm of Inflating Injuries, Medical Treatments in Alleged Scheme*, Law.com, Sept. 18, 2025 (Philadelphia, Pennsylvania); Fred Schulte, *Crash Course: Injured Patients Who Sign 'Letters of Protection' May Face High Medical Bills and Risks*, KFF Health News, Dec. 21, 2021 (Florida).

[16] *See* Fla. Stat. Ann. § 768.0427(3) (enacted 2023); Ga. S.B. 68 (2025) (to be codified at Ga. Code Ann. § 51-12-1.1(d)).