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2025

LEGISLATURE OF NEBRASKA

ONE HUNDRED NINTH LEGISLATURE

FIRST SESSION

LEGISLATIVE BILL 205

Introduced by Bosn, 25.

Read first time January 14, 2025

Committee:

A BILL FOR AN ACT relating to civil actions; to provide requirements for admissibility of evidence relating to damages for past or future medical expenses; to require certain disclosures by claimants in certain cases; to provide limitations on damages for medical expenses; to provide for a cap on noneconomic damages in certain civil actions against commercial motor vehicle carriers; and to provide duties for courts.

Be it enacted by the people of the State of Nebraska,

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Section 1. For purposes of sections 1 to 4 of this act:

(1) Claimant means a person seeking damages for medical expenses in a personal injury or wrongful death action;

(2) Factoring company means a person who purchases a health care provider's accounts receivable at a discount below the invoice value of such accounts;

(3) Health care coverage means any third-party health care or disability services financing arrangement, including, but not limited to, arrangements with entities certified or authorized under state or federal law; state or federal health care benefit programs; workers' compensation; and personal injury protection;

(4) Health care provider means any of the following professionals and entities, and professionals and entities similarly licensed in another jurisdiction:

(a) A facility licensed under the Health Care Facility Licensure Act and its clinical and nonclinical staff providing inpatient or outpatient services;

(b) A health care professional licensed under the Uniform Credentialing Act;

(c) A professional health care service entity as defined in section 71-7910.01;

(d) An organization or association of health care professionals licensed under the Uniform Credentialing Act;

(e) A clinical laboratory providing services in this state or services to health care providers in this state, if the clinical laboratory is certified by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services under the federal Clinical Laboratories Improvement Act of 1967, as amended, and any rules issued thereunder, as such act and rules existed on January 1, 2025;

(f) A federally qualified health center as defined in 42 U.S.C.

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1396d(l)(2)(B), as such section existed on January 1, 2025; and

(g) A home health aide as defined in section 71-6602; and

(5) Letter of protection means any arrangement by which a health care provider renders treatment in exchange for a promise of payment for the claimant's medical expenses from any judgment or settlement of a personal injury or wrongful death action. The term includes any such arrangement, regardless of whether referred to as a letter of protection.

Sec. 2. (1) Evidence offered to prove the amount of damages for past or future medical treatment or services in a personal injury or wrongful death action shall only be admissible as provided in this section.

(2) Evidence offered to prove the amount of damages for charges for past medical treatment or services that have been satisfied is limited to evidence of the amount actually paid, regardless of the source of payment.

(3) Evidence offered to prove the amount necessary to satisfy unpaid charges incurred for medical treatment or services is limited to the following:

(a) If the claimant has health care coverage other than medicare or medicaid, evidence of the amount which such health care coverage is obligated to pay the health care provider to satisfy such charges, plus the claimant's share of such charges;

(b) If the claimant has health care coverage but obtains treatment under a letter of protection or otherwise does not submit charges for any health care provider's medical treatment or services to health care coverage, evidence of the amount the claimant's health care coverage would pay the health care provider to satisfy such past unpaid charges, plus the claimant's share of such charges, had the claimant obtained medical services or treatment pursuant to the health care coverage;

(c) If the claimant does not have health care coverage or has health care coverage through medicare or medicaid, evidence of one hundred

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twenty percent of the medicare reimbursement rate in effect on the date of the claimant's incurred medical treatment or services or, if there is no applicable medicare rate for a medical treatment or service, one hundred seventy percent of the applicable state medicaid rate in effect on such date;

(d) If the claimant obtains medical treatment or services under a letter of protection and the health care provider subsequently transfers the right to receive payment under the letter of protection to a third party, evidence of the amount the third party paid or agreed to pay the health care provider in exchange for the right to receive payment pursuant to the letter of protection; and

(e) Any evidence of reasonable amounts billed to the claimant for medically necessary treatment or medically necessary services provided to the claimant.

(4) Evidence offered to prove the amount of damages for any unpaid charges for future medical treatment or services the claimant will receive is limited to the following:

(a) If the claimant has health care coverage, other than medicare or medicaid, or is eligible for any such health care coverage, evidence of the amount for which such future charges of health care providers could be satisfied if submitted to such health care coverage, plus the claimant's share of such charges;

(b) If the claimant does not have health care coverage, has health care coverage through medicare or medicaid, or is eligible for such coverage through medicare or medicaid, evidence of one hundred twenty percent of the medicare reimbursement rate in effect at the time of trial for the medical treatment or services the claimant will receive or, if there is no applicable medicare rate for a medical treatment or service, one hundred seventy percent of the applicable state medicaid rate in effect at such time; and

(c) Any evidence of reasonable future amounts to be billed to the

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claimant for medically necessary treatment or medically necessary services.

(5) This section does not impose an affirmative duty upon any party to seek a reduction in billed charges to which the party is not contractually entitled.

(6) Individual contracts between health care providers and authorized commercial insurers or authorized health maintenance organizations are not subject to discovery or disclosure and are not admissible into evidence to prove the amount of damages for past or future medical treatment or services in a personal injury or wrongful death action.

Sec. 3. In a personal injury or wrongful death action, as a condition precedent to asserting any claim for expenses for medical treatment or services rendered under a letter of protection, the claimant shall disclose:

(1) A copy of the letter of protection;

(2) All billings for such medical expenses, which must be itemized and, to the extent applicable, coded according to:

(a) For health care providers billing at the provider level, the American Medical Association's Current Procedural Terminology (CPT), or the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System (HCPCS), in effect on the date the medical treatment or services were rendered;

(b) For health care providers billing at the facility level for expenses incurred in a clinical or outpatient setting, including when billing through an Ambulatory Payment Classification (APC) or Enhanced Ambulatory Patient Grouping (EAPG), the International Classification of Diseases (ICD) diagnosis code and, if applicable, the American Medical Association's Current Procedural Terminology (CPT), in effect on the date the medical treatment or services were rendered; and

(c) For health care providers billing at the facility level for

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expenses incurred in an inpatient setting, including when billing through a Diagnosis Related Group (DRG), the International Classification of Diseases (ICD) diagnosis and procedure codes in effect on the date on which the claimant is discharged;

(3) If the health care provider sells the accounts receivable for the claimant's medical expenses to a factoring company or other third party:

(a) The name of the factoring company or other third party who purchased such accounts; and

(b) The dollar amount for which the factoring company or other third party purchased such accounts, including any discount provided below the invoice amount;

(4) Whether the claimant, at the time medical treatment or services were rendered, had health care coverage and, if so, the identity of such coverage; and

(5) Whether the claimant was referred for medical treatment or services under a letter of protection and, if so, the identity of the person who made the referral. If the referral is made by the claimant's attorney, disclosure of the referral is permitted, and evidence of such referral is admissible notwithstanding any attorney-client privilege asserted. In such situation, the financial relationship between a law firm and a health care provider, including the number of referrals, frequency, and financial benefit obtained, is relevant to the issue of the bias of a testifying health care provider.

Sec. 4. The damages that may be recovered by a claimant in a personal injury or wrongful death action for the reasonable and necessary cost or value of past or future medical treatment or services shall not:

(1) Include any amount in excess of the evidence of charges for medical treatment or services admitted pursuant to section 2 of this act; or

(2) Exceed the sum of the following:

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(a) Amounts actually paid by or on behalf of the claimant to a health care provider who rendered medical treatment or services;

(b) Amounts necessary to satisfy charges for medical treatment or services that are due and owing but at the time of trial are not yet satisfied; and

(c) Amounts necessary to provide for any reasonable and necessary medical treatment or services the claimant will receive in the future.

Sec. 5. (1) For purposes of this section:

(a) Commercial motor vehicle has the same meaning as in section 60-316; and

(b) Commercial motor vehicle carrier means any person that transports property by commercial motor vehicle upon the public highways.

(2) The total amount recoverable per plaintiff for noneconomic damages in a civil action for personal injury or death involving a commercial motor vehicle requiring a commercial driver's license, whether in tort or otherwise, is one million dollars. This limit on damages applies regardless of the number of derivative claims or theories of liability in the civil action.

(3) In a civil action subject to the limit provided in subsection (2) of this section:

(a) If the action is tried before a jury, the jury shall first make a finding as to noneconomic damages without regard to the limit in subsection (2) of this section. If the noneconomic damages exceed such limit, the court shall then reduce the award to comply with such limit; and

(b) If the action is tried without a jury, the court shall first make a finding as to noneconomic damages without regard to the limit in subsection (2) of this section. If the noneconomic damages exceed such limit, the court shall then reduce the award to comply with such limit.