HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 379 Damages for Medical or Health Care Services
SPONSOR(S): Civil Justice Subcommittee; Hood, Jr. and others
TIED BILLS: None **IDEN./SIM. BILLS:** SB 1128

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Civil Justice Subcommittee	9 Y, 4 N, As CS	Cary	Bond
2) Judiciary Committee			

SUMMARY ANALYSIS

The purpose of personal injury law is to fairly compensate a person injured due to wrongful action of another. Damages may, in appropriate circumstances, be awarded to the injured person for medical expenses, lost wages, property damage, pain and suffering, and punitive damages. This bill changes how medical expenses are calculated.

Most providers of medical services offer (or are required) to discount their standard billing rates for the benefit of Medicaid, Medicare, or an insurance company. Under current law, a jury may hear and base its award on the standard billing rate. To arrive at the final compensation award, the trial judge reduces the award by applying the appropriate discount, if any. This reduction is based on the theory that the plaintiff would otherwise receive a windfall award.

In general, this bill moves the determination of the value of medical services from the trial court judge to the jury. Where the medical bill has already been paid, the jury is informed of the actual amount and the jury may not award a higher amount. Where the services have not been paid (which may apply to past damages and will always apply to future damages), the bill provides that certain evidence may be admitted into evidence.

The bill also prohibits an injured party from being awarded reimbursement for a medical service that was not medically necessary.

The bill does not appear to have a fiscal impact on state or local governments.

The bill only applies to a cause of action that occurs after the effective date of the bill. The bill provides an effective date of upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

The purpose of personal injury law is to fairly compensate a person injured due to wrongful action of another. Damages may, in appropriate circumstances, be awarded to the injured person for medical expenses, lost wages, property damage, pain and suffering, and punitive damages.[1] This bill modifies the collateral source rule to change how medical expenses are calculated and awarded in personal injury lawsuits.

History of the Collateral Source Rule

At common law, the collateral source rule barred reduction of a personal injury verdict based on benefits received or payments made by collateral sources of indemnity. Further, the existence of such collateral sources was considered inadmissible at trial. As applied to damages in personal injury action, at common law an injured person was entitled to the full value of the medical services incurred regardless of whether the injured person ever paid the awarded sum to the medical provider.[2]

Section 768.76, F.S., created by the Tort Reform and Insurance Act of 1986,[3] redefined Florida's common law collateral source rule. The Act requires the court to reduce an "award by the total amounts which have been paid for the benefit of the claimant, or which are otherwise available to the claimant, from all collateral sources; however, there shall be no reduction for collateral sources for which a subrogation or reimbursement right exists."[4] Although a verdict may be set off under the Act, the common law collateral source rule still persists and bars the admission of the existence of collateral sources of indemnity at trial.[5]

Medical Billing

In a typical case, a plaintiff may see a health care provider within the plaintiff's Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) plan. The provider often has different rates for the same procedure based on the rate that the provider negotiated with the HMO or PPO, the rate Medicaid or Medicare will pay, or the rate that a cash customer would pay. The "list price" of the procedure is rarely the price that is actually paid, much in the same way that the list price of an automobile is often higher than the actual price that is negotiated by the purchaser. The difference is that in the medical industry it is often a third-party that negotiates down the price of the procedure rather than the patient. The difference between the amount billed and the amount paid, if awarded to a plaintiff, is sometimes referred to as "phantom damages".[6]

Current Practice

In order to honor the statutory setoff for collateral sources and honor the evidentiary rule prohibiting disclosure to the jury of the collateral source payment, the general practice in Florida courts is to accept into evidence the full list price of the medical services. Post-trial, the court hears evidence and reduces the amount of the judgment by the statutory setoff.[7] This explanation simplifies the practice and has been perhaps changed by recent case law.

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[1] Fla. Jur 2d Damages s. 7, 122.
[2] Gordon, *Goble, Thyssenkrupp, and the Collateral Source Rule: Resolving The Ongoing Conflict*, 84 Fla.B.J. 18 (December 2010).
[3] Chapter 86-160, L.O.F.
[4] Section 768.76(1), F.S.
[5] Gordon. *See also Gormley v. GTE Prods. Corp.*, 587 So.2d 455, 458 (Fla. 1991).
[6] *Goble v. Frohman*, 901 So.2d 830, 832 (Fla. 2005).
[7] *Sheffield v. Superior Ins. Co.*, 800 So.2d 197, 200 (Fla. 2001).

Recent case law interpretations of s. 768.76, F.S., have created confusion in the interpretation of the statute. The Supreme Court has ruled that the collateral source rule prohibits the awarding of the value of governmental or charitable medical services, but that the value of such services should be admissible to the jury for the purpose of determining the reasonable cost of medically-necessary future care.[8] If payments were made by Medicare or other governmental plan, only the amounts actually paid should be allowed into evidence.[9] If, however, payments were made by an HMO or other health insurer, the full amount of the bills should be placed into evidence and, assuming the insurer has a right of subrogation and the providers have no right to seek payments for the balances, the amount of the contractual discounts should be set off post-verdict.[10] However, a district court of appeal issued a broader ruling relating to a patient with a non-government insurance policy, reasoning that the payment of one's insurance premiums is sufficient to have the amount of the full billed cost of treatment into evidence even without the need to calculate future medical costs.[11] Another district court of appeal has specifically allowed the jury to hear evidence of the full amount of the bill where the plaintiff did not have health insurance, reasoning that the lower price as negotiated by the plaintiff was "earned in some way" by the plaintiff rather than received from a collateral source.[12]

Medically Necessary

There is a longstanding rule that allows a plaintiff to recover against the original tortfeasor as the proximate cause of an injury sustained in the treatment of said injury.[13] The original tortfeasor remains liable unless subsequent care was "highly unusual, extraordinary or bizarre."[14]

Medical necessity is not based on the opinion of an expert, but rather it is based on the necessity of the treatment from the plaintiff's perspective.[15] Thus, even if a treatment is deemed to be medically unnecessary by expert testimony, the defendant is liable for subsequent injury as a result of the unnecessary treatment if the treatment was entered into by the plaintiff in reasonable reliance on his or her doctor's advice.[16] The court explained:

> It is certainly permissible for the defense to argue that the treatment the plaintiff underwent was not caused by the accident. It is an entirely different thing for a defendant to argue that the treatment was inappropriate and unnecessary. The defendant's argument could have led the jury to believe that if the plaintiff's doctor was wrong, the plaintiff couldn't recover damages for the treatment she underwent, even if the injuries she suffered in the car accident caused her to pursue treatment and she reasonably relied on her doctor's advice.[17]

Effect of the Bill

This bill creates s. 768.755, F.S., to modify both the limitation on recovery for medical expenses and to modify the rules of evidence regarding medical expenses.

Similar to how the enactment of s. 768.76, F.S., had the effect of abrogating the damages portion of the common law collateral source rule, the bill appears to abrogate the evidentiary effect of the common law collateral source rule. In effect, this bill completes the abrogation of the common law collateral source rule in Florida.

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[8] *Florida Physician's Ins. Reciprocal v. Stanley*, 452 So.2d 514 (Fla. 1984). *See also State Farm Mut. Auto. Ins. Co. v. Joerg*, 2013 WL 3107207 (Fla. 2d DCA 2013).
[9] *Thyssenkrupp Elevator Corp. v. Lasky*, 868 So.2d 547 (Fla. 4th DCA 2003).
[10] *Goble v. Frohman*, 901 So.2d 830, 832 (Fla. 2005).
[11] *Nationwide Mut. Fire Ins. Co. v. Harrell*, 53 So.3d 1084 (Fla. 1st DCA 2010).
[12] *See Durse v. Henn*, 68 So.3d 271 (Fla. 4th DCA 2011).
[13] *Stuart v. Hertz Corp.*, 351 So.2d 703 (Fla. 1977).
[14] *Davidson v. Gaillard*, 584 So.2d 71 (Fla. 1st DCA 1991).
[15] *Dungan v. Ford*, 632 So.2d 159, 163 (Fla 1st DCA 1994).
[16] *Costa v. Aberle*, 96 So.3d 959, 963 (Fla 4th DCA 2012).
[17] *Id.*

Limitations on Recovery

Where the medical service has been paid in full, the bill, in s. 768.755(1), F.S., limits recovery of such medical expenses to the actual amount paid.

Where no balance is due at the time of the suit, the actual amount remitted to the provider is the maximum amount that is recoverable. The bill also provides that if multiple providers have provided health care services to the claimant, evidence of how much was paid to a provider with no balance due is not admissible to determine the reasonableness of the amounts billed by another provider. These rules apply if the provider is paid by a governmental or commercial insurance payor.

Where a medical provider claims a balance due or where a claim is for future services, the bill allows the parties to introduce into evidence:

- The usual and customary charges of providers in the same geographic area for the same or similar services;
- Amounts billed by the provider for services, including amounts billed under an agreement between the provider and the claimant; and
- Amounts the provider received in compensation for the sale of an agreement between the provider and the claimant.

The bill does not appear to impose a standard for the court to use in weighing the evidence introduced in such a situation.

The bill allows reference to Medicare and Medicaid, licensed commercial health insurers, amounts received from private individuals on a self-payment basis, and amounts that the provider received in compensation for the sale of an agreement between the provider and claimant when determining the usual and customary rate.

If Medicaid, Medicare, or a payor regulated under the Florida Insurance Code has covered the plaintiff's medical services and has given the notice of lien or subrogation in the action, the bill, in s. 768.755(3), F.S., limits the amount recoverable and admissible into evidence to that amount plus the amount of any copayments or deductibles paid by the claimant.

Admission of Evidence

The bill, in s. 768.755(2), F.S., makes individual contracts between providers and insurers or HMOs not subject to discovery or disclosure. It also prohibits such contracts from being admitted as evidence in an action to which this bill applies.

Medically Necessary

The bill creates s. 768.755(1), F.S., to impose a preponderance of the evidence standard for determining if a medical service is medically necessary. Unlike current law, where medical necessity is essentially a subjective test based on the reasonable belief of the patient, the bill requires the claimant to prove that a procedure was medically necessary. The defendant may rebut the plaintiff's assertion of medical necessity through expert testimony of a health care provider licensed and practicing in the same specialty as the provider who provided the service. If the jury determines that any medical services were not medically necessary, the bill appears to provide that a plaintiff may not recover damages for those services.

Applicability

The bill, according to s. 768.755(4), F.S., is prospective and only applies to causes of action that arise after the effective date of the bill. The bill applies only to personal injury or wrongful death actions and does not affect compensation paid to providers for medical or health care services.

B. SECTION DIRECTORY:

Section 1 creates s. 768.755, F.S., relating to damages recoverable for medical or health care services.

Section 2 provides direction to the Division of Law Revision and Information.

Section 3 provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill does not appear to have any impact on state revenues.

2. Expenditures:

The bill does not appear to have any impact on state expenditures.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

The bill does not appear to have any impact on local government revenues.

2. Expenditures:

The bill does not appear to have any impact on local government expenditures.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill does not appear to have any direct economic impact on the private sector.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

The bill appears to abrogate the remainder of the common law collateral source rule as it relates to personal injury or wrongful death causes of action. The Florida Supreme Court upheld an earlier statute partially abrogating the collateral source rule against a challenge on equal protection grounds. The plaintiffs in that case argued that the distinction between medical practitioners and other members of the public was arbitrary and unreasonable. The court determined that the collateral source rule did not implicate a suspect class or fundamental right and thus applied a rational basis test and upheld the statute. However, in the passage of that bill, unlike this bill, the Legislature spelled out the legitimate state interests, which were discussed by the Court.[18] The Supreme Court also addressed challenges based on access to courts, separation of power, and the Court's

[18] *Pinillos v. Cedars of Lebanon Hospital Corp.*, 403 So.2d 365, 367 (Fla. 1981).

exclusive rulemaking authority and dismissed them as being "without merit."[19] A District Court of Appeal also dismissed a claim based on due process in another case.[20]

There is a balance between enactments of the Legislature and rules promulgated the Florida Supreme Court on matters relating to evidence. The Legislature has enacted and continues to revise ch. 90, F.S. (the Evidence Code), and the Florida Supreme Court tends to adopt these changes as rules. The Florida Supreme Court regularly adopts amendments to the Evidence Code as rules of court when it is determined that the matter is procedural rather than substantive. If the Florida Supreme Court views the changes in this bill as an infringement upon the Court's authority over practice and procedure, however, it may refuse to adopt the changes in the bill as a rule.

B. RULE-MAKING AUTHORITY:

The bill does not appear to create a need for executive branch rulemaking or rulemaking authority. The bill appears to require court rulemaking.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 18, 2014, the Civil Justice Subcommittee adopted a proposed committee substitute and reported the bill favorably as a committee substitute. The committee substitute differs from the bill as filed by providing that the jury does not consider the amount that has already been billed and paid when determining the reasonableness of the amount billed and provides that a jury may not see individual contracts between providers and insurers and that such contracts are not subject to discovery. This analysis is drafted to the committee substitute as passed by the Civil Justice Subcommittee.

[19] *Id.* at 368.
[20] *Lower Florida Keys Hospital Dist. v. Skelton*, 404 So.2d 832 (Fla. 3rd DCA 1981).