HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1199 Damages in Personal Injury Actions
SPONSOR(S): Civil Justice Subcommittee; Metz and others
TIED BILLS: None **IDEN./SIM. BILLS:** SB 1240

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Civil Justice Subcommittee	8 Y, 5 N, As CS	Malcolm	Bond
2) Judiciary Committee			

SUMMARY ANALYSIS

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

Most providers of medical services offer (or are required) to discount their standard billing rates to a negotiated rate with the insurance company. Generally under current law, a jury may hear and base its award only on the standard billing rate, rather than the negotiated discount rate. To arrive at the final damages award, the trial judge reduces the award by applying the appropriate negotiated rate, if any. This reduction is based on the theory that the plaintiff would otherwise receive a windfall.

In general, this bill moves the determination of damages for past 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 paid and the jury may not award a higher amount. Where the balance for such services is outstanding, the bill provides that the following evidence may be admitted at trial and considered by the jury in determining damages:

- The amounts the provider routinely accepts as payment from governmental or private insurers for the same or similar services;
- Amounts billed by the provider for services provided to the plaintiff; and
- Amounts the provider received in compensation for the sale of an agreement between the provider and the plaintiff.

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 the wrongful acts of another. Damages may, in appropriate circumstances, be awarded to the injured person for past and future medical expenses, lost wages, property damage, and pain and suffering.[1] This bill modifies the calculation and award of past medical expenses in personal injury lawsuits.

History of the Collateral Source Rule

At common law, the collateral source rule barred the reduction in damages in a personal injury verdict for benefits received or payments made by collateral sources of indemnity, such as insurance payments. [2] Further, the existence of such collateral sources was considered inadmissible at trial based on the rationale that such evidence may mislead the jury on the issue of liability and may lead the jury to believe that the plaintiff is trying to obtain multiple payments for the same injury.[3] At common law, an injured person in a personal injury action was entitled to recover the full value of the medical services incurred regardless of whether the injured person ever paid the court-awarded sum to the medical provider.

Section 768.76, F.S., created by the Tort Reform and Insurance Act of 1986,[4] modified Florida's common law collateral source rule.[5] 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.”[6] Although a verdict for both past and future damages may be reduced by the court under the Act, the common law collateral source rule still bars the admission of the existence of collateral sources of indemnity at trial.[7]

Medical Billing

In a typical personal injury case, a plaintiff may see a health care provider within the plaintiff’s Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) plan for any injuries he or she may have sustained. 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 health care industry it is often a third-party, such as an insurance company, rather than the patient that negotiates down the price of the procedure. The difference between the amount billed (the list price) and the amount paid (the negotiated price), if awarded to a plaintiff, is sometimes referred to as “phantom damages”.[8]

Current Practice

Appellate court rulings have created confusion among the courts involving the interpretation and application of s. 768.76, F.S., and the admissibility of evidence related to payments for past and future

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[1] 17 Fla. Jur 2d Damages § 7.
[2] Robert E. Gordon and Justin Linn, *Goble, Thyssenkrupp, and the Collateral Source Rule: Resolving The Ongoing Conflict*, 84 FLA. B.J. 18 (Dec. 2010).
[3] *Gormley v. GTE Prods. Corp.*, 587 So. 2d 455, 458 (Fla. 1991).
[4] Chapter 86-160, L.O.F.
[5] Gordon, *supra* note 2 at 18.
[6] Section 768.76(1), F.S.
[7] Gordon, *supra* note 2 at 18 (citing *Gormley*, 587 So.2d at 458).
[8] *Goble v. Frohman*, 901 So. 2d 830, 832 (Fla. 2005).

medical care from collateral sources. The Florida Supreme Court has ruled that the collateral source rule does not prohibit the admission of evidence of the value of unearned governmental or charitable medical services for the purpose of determining the reasonable cost of *future* medical care.[9] However, a court may not reduce the jury verdict award by the amount of such future medical services.[10] The Fourth District Court of Appeal has held that if payments for past medical care were made by Medicare or other governmental plan, the amounts actually paid by the plan must be allowed into evidence for the jury to consider and any jury verdict for past medical expenses should be reduced by the difference between the amount charged by the provider and amount actually paid to the provider by Medicare.[11] However, the Fourth District has also held that evidence that a plaintiff is entitled to future Medicaid benefits is inadmissible, where such evidence is not relevant to the issue of the plaintiff's future medical care.[12]

In cases where a plaintiff's healthcare payments were made by an HMO or other private health insurer, the Florida Supreme Court has held that the full amount of the medical bills may be admitted as evidence, but the jury award must be reduced to the amount of the contractual rate by the court post-verdict.[13] Similarly, the Fourth District Court of Appeal has allowed the jury to hear evidence of the full amount of a plaintiff's medical bills where the plaintiff did not have health insurance even though the plaintiff paid a lower, individually negotiated rate, reasoning that the lower price the plaintiff actually paid was negotiated rather than received from a gratuitous source.[14]

Effect of the Bill

This bill creates s. 768.755, F.S., to modify both the limitation on recovery for medical expenses and 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 portion of the common law collateral source rule.

<u>Limitations on Recovery</u>

Where the cost of past medical services has been paid in full at the time of the suit, the bill, in ss. 768.755(1)(a)1. and 2., F.S., limits the recovery of damages for such medical expenses to the actual amount paid regardless of the source of the payment plus any copay or deductible paid by the claimant. Additionally, where the cost of medical services has been paid in full at the time of the suit, any difference between the amount originally billed for medical services and the amount actually paid for such services is not recoverable.

<u>Admissibility of Evidence</u>

In cases where a plaintiff's medical provider has an outstanding balance due at the time of the suit, s. 768.755(1)(a)3., F.S., created by the bill allows the parties to introduce the following into evidence for the purpose of calculating damages for the cost of past medical care:

- The amounts the provider routinely accepts as payment from governmental or commercial insurance providers for the same or similar services;
- Amounts billed by the provider for services, including amounts billed under an agreement between the provider and the plaintiff; and
- Amounts the provider received in compensation for the sale of an agreement between the provider and the plaintiff.

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[9] *Florida Physician's Ins. Reciprocal v. Stanley*, 452 So. 2d 514, 515 (Fla. 1984); *see also State Farm Mut. Auto. Ins. Co. v. Joerg*, 2013 WL 3107207 (Fla. 2d DCA 2013).
[10] *Stanley*, 452 So. 2d at 515.
[11] *Thyssenkrupp Elevator Corp. v. Lasky*, 868 So. 2d 547 (Fla. 4th DCA 2003).
[12] *Velilla v. VIP Care Pavilion, Ltd.*, 861 So. 2d 69, 71-72 (Fla. 4th DCA 2003).
[13] *Goble v. Frohman*, 901 So. 2d 830, 832 (Fla. 2005); *see also Nationwide Mut. Fire Ins. Co. v. Harrell*, 53 So. 3d 1084 (Fla. 1st DCA 2010).
[14] *Durse v. Henn*, 68 So. 3d 271, 277 (Fla. 4th DCA 2011).

However, the bill, in s. 768.755(2), F.S., prohibits discovery or disclosure of any contracts between health care providers and insurers or HMOs and provides that such contracts are inadmissible at trial.

If multiple providers have provided medical services to the plaintiff, 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 whose outstanding balance is still due.

Additionally, in cases where there is a difference between the amount originally billed for medical services and the amount actually paid for such services, evidence of such difference is inadmissible.

Evidence and Recovery for Certain Lienors and Subrogees

If Medicaid, Medicare, or an insurance company regulated under the Florida Insurance Code[15] has covered the plaintiff's medical services and has given notice of a lien or subrogation claim for past medical expenses in the action, the bill, in s. 768.755(3), F.S., limits the amount recoverable and admissible into evidence to the amount of the lien or subrogation claim plus any copayments or deductibles paid by the plaintiff.

Applicability

Section 768.755(4), F.S., created by the bill, provides that the bill 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; evidence of the amount of damages; and applicability.

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.

[15] Chapter 624, F.S.

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 medical and health care services in personal injury or wrongful death cases. The Florida Supreme Court upheld an earlier statute partially abrogating the collateral source rule against a challenge on equal protection grounds.[16] 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.[17] The Supreme Court also addressed challenges based on access to courts, separation of power, and the Court's exclusive rulemaking authority and dismissed them as being "without merit."[18] The Third District Court of Appeal has similarly denied a due process challenge to the reduction of damages for medical expenses by the amount received from collateral sources.[19]

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 rulemaking or rulemaking authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill appears to only apply to a jury's determination of damages for *past* medical care; consequently, it appears that the bill does not apply to a jury's determination of damages for *future* medical care or to the admissibility of evidence for such purpose.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 24, 2015, the Civil Justice Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The amendment specifies that the prohibition on recovering damages for the difference between the amount originally billed for past medical services and the amount actually paid for such services

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[16] *Pinillos v. Cedars of Lebanon Hospital Corp.*, 403 So. 2d 365, 367 (Fla. 1981).
[17] *See id.*
[18] *Id.* at 368.
[19] *Lower Florida Keys Hospital Dist. v. Skelton*, 404 So. 2d 832 (Fla. 3d DCA 1981).

only applies when there is no outstanding balance due to the medical provider. This analysis is drafted to the committee substitute as passed by the Civil Justice Subcommittee.