The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Judiciary

BILL: SB 1668

INTRODUCER: Judiciary Committee and Senator Simmons

SUBJECT: Damages

DATE: January 28, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Elsesser	Cibula	JU	**Fav/CS**
2.			HP	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1668 requires evidence of medical expenses in personal injury claims to be based on the usual and customary charges in the community where the expenses are incurred. The bill bars the use of expenses that have been increased based on the outcome of litigation.

The bill states that the amounts paid or to be paid through any public or private health insurance coverage on behalf of the claimant are presumed to be usual and customary medical charges. The bill permits parties to introduce evidence of the availability of insurance to prove future medical expenses.

II. Present Situation:

"Florida law permits the recovery of 'the reasonable value or expense of hospitalization and medical and nursing care and treatment necessarily or reasonably obtained by [a] (claimant) in the past or to be so obtained in the future.'"[1]

"'In proving special [past] medical damages for personal injuries, proof should be offered (1) that the medical services were rendered, (2) what the reasonable charges are therefor, (3) that

[1] *Auto Club Ins. Co. of Florida v. Babin*, 204 So. 3d 561, 562 (Fla. 5th DCA 2016) (quoting *Volusia Cty. v. Joynt,* 179 So.3d 448, 452 (Fla. 5th DCA 2015) (internal alterations removed)).

the services for which they were rendered were necessary, and (4) that they were related to the trauma suffered in the accident.'"[2]

"Awards [of medical expenses] exceeding … a definite and ascertainable amount [in evidence] are readily vacated and remanded."[3] Jury awards for medical expenses can be reversed if they are "excessive and not supported by the undisputed evidence,"[4] or "contrary to the manifest weight of the evidence."[5]

"[T]he plaintiff has the burden at trial to prove the reasonableness and necessity of medical expenses and … Florida requires more than just evidence of the amount of the bill to establish that reasonableness."[6] "[E]xpert medical testimony is not required in order to admit medical bills into evidence."[7] "When a plaintiff testifies as to the amount of his or her medical bills and introduces them into evidence, it becomes 'a question for the jury to decide, under proper instructions, whether these bills represented reasonable and necessary medical expenses.'"[8]

Florida law restricts recovery of future medical expenses to those expenses "reasonably certain" to be incurred.9 Therefore, "it follows that a recovery of future medical expenses cannot be grounded on the mere 'possibility' that certain treatment 'might' be obtained in the future."10 Further, there must also be an evidentiary basis upon which the jury can, with reasonable certainty, determine the amount of those expenses.11 It is a plaintiff's burden to establish, through competent, substantial evidence, that future medical expenses will more probably than not be incurred.[12]

The Collateral Source Rule

Trial courts must reduce jury awards for medical damages "by the total of all amounts which have been paid for the benefit of the claimant, or which are otherwise available to the claimant, from all collateral sources...."[13] That is, if a claimant's medical expenses were covered by insurance, an award for medical damages must be reduced by the amount paid by the insurer. "This statutory modification was intended to reduce insurance costs and prevent plaintiffs from receiving windfalls."[14] While awards must be set off by the amount the claimant received from insurance, "[a]s an evidentiary rule, payments from collateral source benefits are not admissible

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[2] *Crowe v. Overland Hauling, Inc.*, 245 So. 2d 654, 656 (Fla. 4th DCA 1971) (quoting *Ratay v. Yu Chen Liu*, 260 A.2d 484, 486 (Pa. Superior 1969).
[3] *Aircraft Service Intern., Inc. v. Jackson*, 768 So. 2d 1094, 1096 (Fla. 3d. DCA 1995).
[4] *Burger King Corp. v. Lastre-Torres*, 202 So. 3d 872, 873 (Fla. 3d DCA 2016).
[5] *Ludwig v. Ladner*, 637 So. 2d 308, 310 (Fla. 2d DCA 1994).
[6] *East West Karate Ass'n, Inc. v. Riquelme*, 638 So. 2d 604, 605 (Fla. 4th DCA 1994).
[7] *Albertson's, Inc. v. Brady*, 475 So. 2d 986, 988 (Fla. 2d DCA 1985) (citing *Garrett v. Morris Kirschman & Co.,* 336 So. 2d 566 (Fla.1976)).
[8] *Irwin v. Blake,* 589 So. 2d 973 (Fla. 4th DCA 1992) (quoting *Garrett v. Morris Kirschman & Co., Inc.,* 336 So. 2d 566 (Fla.1976).
[9] *Loftin v. Wilson,* 67 So. 2d 185, 188 (Fla.1953).
[10] *White v. Westlund,* 624 So.2d 1148, 1150 (Fla. 4th DCA 1993) (citing 2 Damages in Tort Actions § 9.55(1), at 9–45 (1986)).
[11] *Joynt,* 179 So.3d at 452.
[12] *See Fasani v. Kowalski,* 43 So. 3d 805, 812 (Fla. 3d DCA 2010).
[13] Section 768.76(1), F.S.
[14] *Joerg v. State Farm Mut. Auto Ins. Co.*, 176 So. 3d 1247, 1249 (Fla. 2015).

because such evidence may confuse the jury with respect to both liability and damages."[15] Section 768.76, F.S., "does not allow reductions for *future* medical expenses."[16] Benefits received under Medicare or other federal programs providing for a Federal Government lien on or right of reimbursement from a plaintiff's recovery are not considered collateral sources.[17]

"[C]ontractual discounts fit within the statutory definition of collateral sources."[18] Thus, in cases in which a medical provider bills for services at one amount but negotiates with an insurer for the payment of a decreased amount, the negotiated decreased amount is the amount used for setoff.[19] In *Goble*, the hospital billed the claimant $574,554.31 for medical treatment, but due to preexisting fees schedules in contracts between the medical providers and Aetna U.S., the claimant's insurer, Aetna paid and the medical providers accepted $145,970.76 for the services rendered.[20] The differences in the amount billed and the amounts accepted in *Goble,* also demonstrate that medical bills are not always related to the amount a healthcare provider typically expects to receive in payment or accepts for payment in full for medical care.[21]

Letters of Protection

> A letter of protection is a document sent by an attorney on a client's behalf to a health-care provider when the client needs medical treatment[ ] but does not have insurance. Generally, the letter states that the client is involved in a court case and seeks an agreement from the medical provider to treat the client in exchange for deferred payment of the provider's bill from the proceeds of [a] settlement or award[,] and typically if the client does not obtain a favorable recovery, the client is still liable to pay the providers' bills.[22]

Section 768.76(2)(a), F.S., defines collateral sources as "payments made to the claimant," and therefore under letters of protection, which defer payment until after a judgment, the amount negotiated in a letter of protection is not a "collateral source."

"[T]he question of whether a plaintiff's attorney referred him or her to a doctor for treatment is protected by the attorney-client privilege," and thus evidence of letters of protection are inadmissible to prove bias.[23] "Even in cases where a plaintiff's medical bills appear to be inflated for the purposes of litigation," the Supreme Court stated that "we do not believe that engaging in

[15] *Id*. (citing *Sheffield v. Superior Ins. Co.,* 800 So.2d 197, 203 (Fla.2001)).
[16] *Id.*
[17] Section 768.76(2)(b), F.S.
[18] *Goble v. Frohman*, 901 So. 2d 830, 833 (Fla. 2005).
[19] *Id*.
[20] *Id*.
[21] For more discussion on how billing practices may differ significantly from the reasonable value of medical services, see George A. Nation III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients,* 65 BAYLOR L. REV. 425 (Spring 2013).
[22] Caroline C. Pace, *Tort Recovery for Medicare Beneficiaries: Procedures, Pitfalls and Potential Values,* 49 Hous. Law. 24, 27 (2012).
[23] *Worley v. Central Florida Young Men's Christian Ass'n, Inc.*, 228 So. 3d 18, 25 (Fla. 2017).

costly and time-consuming discovery to uncover a 'cozy agreement' between the law firm and a treating physician is the appropriate response."[24]

PIP and the Florida Motor Vehicle No-fault Law

The Florida Statutes limit, in certain circumstances, what amounts may be considered "reasonable medical expenses." Section 627.736(1)(a), F.S., "requires automobile insurers to provide PIP ["Personal-Injury Protection"] coverage for eighty percent of all 'reasonable expenses' for medically necessary services …."[25] The Florida Motor Vehicle No–Fault Law provides two ways of determining whether expenses are "reasonable" for purposes of insurer reimbursements. The first is a fact-dependent methodology that takes into account the service provider's usual and customary charges, community-specific reimbursement levels, and other relevant information.[26] This is the default methodology for calculating PIP reimbursements, which also apparently results in higher reimbursements than the second methodology.[27] The second methodology, introduced by the Legislature in 2008, allows reimbursements for medical services to be limited via the use of fee schedules identified in s. 627.736(5)(a)2., F.S.[28]

HMOs

"Usual and customary" charges also factor into reimbursements to hospitals by health maintenance organizations (HMOs).

> Reimbursement to hospitals providing emergency medical services to patients who subscribe to an HMO that does not have a contract with the hospital is determined according to section 641.513(5), Florida Statutes (2006)[29], which provides:
>
> > Reimbursement for services pursuant to this section by a provider who does not have a contract with the health maintenance organization shall be the lesser of:
> > (a) The provider's charges;
> > (b) The usual and customary provider charges for similar services in the community where the services were provided; or
> > (c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.
>
> > In the context of the statute, it is clear what is called for [by subsection (5)(b)] is the fair market value of the services provided. Fair market value is the price that a willing buyer will pay and a willing seller will accept in an arm's-length transaction.[30]

[24] *Id.*
[25] *Allstate Fire and Cas. Ins. v. Stand-Up MRI of Tallahassee, P.A.*, 188 So. 3d 1, 1 (Fla. 1st DCA 2015).
[26] *See* s. 627.736(5)(a)1., F.S.
[27] *Stand-UP MRI*, 188 So 3d at 2.
[28] *See Geico Gen Ins. Co. v. Virtual Imaging Servs. Inc*, 141 So. 3d 147,156 (Fla. 2013).
[29] Section 641.513(5), F.S., as it reads today, contains the same provision for usual and customary charges as it did in 2006.
[30] *Baker Cty. Med. Servs., Inc. v. Aetna Health Mgmt, LLC*, 31 So. 3d 842, 844 (Fla. 1st DCA 2010).

III. Effect of Proposed Changes:

The bill states that, in any claim for damages if personal injury to a claimant, evidence of past, present, or future medical expenses must be based on the usual and customary charges in the community where medical expenses are incurred.

This may significantly alter the current methods for proving damages, which involves presenting medical bills as evidence of past expenses and testimony of reasonably certain needed procedures as evidence of future expenses. Notably, the amount of an award of past medical damages would be determined without consideration of evidence of the billed costs of any medical services actually rendered for a claimant.

This new methodology is consistent with the current methodology for calculating PIP reimbursements under existing s. 627.736(5)(a)1, F.S., which also requires a determination of costs based on usual and customary charges in a community. As the methodology in the bill is still a "fact-dependent methodology"[31] it requires evidence of a service provider's typical charges and the amounts charged to others in the community. Moreover, because the bill contains similar language to the method described in existing s. 627.736(5)(a)1, F.S., courts will likely interpret the bill as requiring the same type of evidence. Similarly, courts would presumably also construe the "usual and customary" community standard to mean the fair market value that a willing buyer would likely pay in an arm's-length transaction.[32]

The bill states that evidence of usual and customary charges may not include evidence of increased or additional charges based on the outcome of litigation. This provision would prevent using evidence of costs that have been "inflated" in anticipation of a jury award that may be larger than the amount insurers are typically willing to pay and larger than amounts healthcare providers typically accept. The requirement in the bill that evidence of medical costs be based on usual and customary charges in the community will decrease the opportunity for claimants to present evidence of "inflated" costs through the use of letters of protection.

The bill states that evidence of the availability of insurance may be used to prove future damages. This provision undoes the rule announced in *Joerg v. State Farm*, in which the Supreme Court held that evidence of the availability of Medicare could not be used to establish future damages in which it receded from prior precedent allowing the practice.[33]

The bill also states that the amounts paid or payable to claimants under insurance coverage are presumed to be the usual and customary medical charges, unless a claimant shows that the amounts are inadequate under the circumstances.

[31] *Stand-UP MRI*, 188 So. 3d at 2.

[32] *Baker*, 31 So. 3d at 844.

[33] The majority in *Joerg* found the use of the availability of Medicare to establish future damages was prejudicial to the claimant and speculative. The *Joerg Court* receded from the Supreme Court's opinion in *Florida Physician's Ins. Reciprocal v. Stanley*, 452 So. 2d 514, 515 (Fla. 1984), in which it stated, "Petitioners claim that evidence of free or low cost services from governmental or charitable agencies available to anyone with specific disabilities is admissible on the issue of future damages. We agree." The *Stanley* Court further explained that "[k]eeping such evidence [of governmental or charitable benefits available to all citizens] from the jury may provide an undeserved and unnecessary windfall to the plaintiff." *Id.* 616.

The bill takes effect July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill requires evidence of medical expenses in personal injury claims to be based on the usual and customary charges in the community. This change may make awards of damages for medical costs more predictable.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends s. 768.042, F.S.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Judiciary on January 28, 2020:
The committee substitute differs from the underlying bill by:

- Stating that parties to a personal injury lawsuit may introduce evidence of the availability of insurance to establish future medical expenses.
- Clarifying that payments paid or payable by insurers are presumed to be the usual and customary charges in the community.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.