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 Banking and Insurance

BILL:	CS/CS/SB 1668
INTRODUCER:	Health Policy Committee; Judiciary Committee; and Senator Simmons
SUBJECT:	Damages
DATE:	February 18, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Elsesser	Cibula	JU	**Fav/CS**
2.	Kibbey	Brown	HP	**Fav/CS**
3.	Arnold	Knudson	BI	**Pre-meeting**
4.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/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. Under the bill, these usual and customary charges may not include increased or additional charges based on the outcome of litigation. The bill establishes that the charges from an independent, nonprofit, statistically reliable benchmarking database that has been in existence for the last 5 years and that qualifies for nonprofit status under s. 501(c)(3) of the U.S. Internal Revenue Code are admissible as evidence of the usual and customary medical charges in the consideration of past and present medical expenses.

Evidence of the reasonableness of future medical expenses may be considered along with other relevant evidence.

The bill provides an effective date of July 1, 2020.

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 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]

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[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)).
[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 s. 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).

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 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, such a 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. Typically if the client does not obtain a favorable recovery, the client is still liable to pay the providers' bills.[22]

[13] Section 768.76(1), F.S.
[14] *Joerg v. State Farm Mut. Auto Ins. Co.*, 176 So. 3d 1247, 1249 (Fla. 2015).
[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).

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

Insurance Reimbursement of Usual and Customary Charges

Usual and customary charges are used to determine reimbursement of medical providers under Personal Injury Protection (PIP) motor vehicle insurance, out-of-network hospitals pursuant to health maintenance organization (HMO) contracts, and various health care providers under the Workers' Compensation Law. In the context of provider reimbursement under PIP and Workers' Compensation, a health care provider's usual and customary charges are considered in conjunction with other facts to reach a determination regarding the proper reimbursement of the medical provider. Usual and customary charges are used differently to determine reimbursement of out-of-network hospitals under an HMO contract, as reimbursement will be the lowest of usual and customary charges, the provider's charges, or the in-network rate.

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 a motor vehicle insurer writing PIP coverage to reimburse the medical services provider 80 percent of all reasonable expenses for medically necessary[25] medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices and medically necessary ambulance, hospital, and nursing services if the individual receives initial services and care with 14 days after the motor vehicle accident.

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, federal and state medical fee schedules, and other relevant information. This is the default methodology for calculating PIP reimbursements, which also apparently results in higher reimbursements than the second methodology.[26] 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.[27]

[23] *Worley v. Central Florida Young Men's Christian Ass'n, Inc.*, 228 So. 3d 18, 25 (Fla. 2017).
[24] *Id*.
[25] Section 627.732(2), F.S., defines "medically necessary" as referring to a medical service or supply that a prudent physician would provide for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or symptom in a manner that is in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; and not primarily for the convenience of the patient, physician, or other health care provider.
[26] *Stand-UP MRI*, 188 So 3d at 2.
[27] *See Geico Gen Ins. Co. v. Virtual Imaging Servs. Inc*, 141 So. 3d 147,156 (Fla. 2013).

Health Maintenance Organizations

"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 s. 641.513(5), F.S., which provides that reimbursement for emergency services and care provided by a provider that does not have a contract with the health maintenance organization must be the lesser of:

- The provider's charges;
- The usual and customary provider charges for similar services in the community where the services were provided; or
- The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.

The First District Court of Appeals determined that in the context of this section of statute, it is clear that paragraph (b) refers to 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.[28]

Workers' Compensation Maximum Reimbursement Allowances

The Department of Financial Services (DFS), Division of Workers' Compensation, provides regulatory oversight of Florida's workers' compensation system. Florida's Workers' Compensation Law provides medically necessary treatment and care for injured employees, including medications. The law provides reimbursement formulas and methodologies to compensate providers of health services, subject to maximum reimbursement allowances (MRAs).

A three-member panel (panel) consisting of the CFO or CFO's designee and two Governor's appointees sets the MRAs.[29] The DFS incorporates the statewide schedules of the MRAs by rule in reimbursement manuals. In establishing the MRA manuals, the panel considers the usual and customary levels of reimbursement for treatment, services, and care;[30] the cost impact to employers for providing reimbursement that ensures that injured workers have access to necessary medical care;[31] the financial impact of the MRAs on healthcare providers and facilities;[32] and the Health Care Board's most recent maximum allowable rate of increase for hospitals.[33] Florida law requires the panel to develop MRA manuals that are reasonable, promote the workers' compensation system's healthcare cost containment and efficiency, and are sufficient to ensure that medically necessary treatment is available for injured workers.[34]

[28] *Baker Cty. Med. Servs., Inc. v. Aetna Health Mgmt, LLC*, 31 So. 3d 842, 844 (Fla. 1st DCA 2010).
[29] Section 440.13(12)(a), F.S.
[30] Section 440.13(12)(d)1., F.S.
[31] Section 440.13(12)(d)2., F.S.
[32] Section 440.13(12)(d)3., F.S.
[33] Section 440.13(12)(d)4., F.S.
[34] Section 440.13(12)(d)3., F.S.

The panel develops four different reimbursement manuals to determine statewide schedules of maximum reimbursement allowances. The healthcare provider manual limits the maximum reimbursement for licensed physicians to 110 percent of Medicare reimbursement,[35] while reimbursement for surgical procedures is limited to 140 percent of Medicare.[36] The hospital manual sets maximum reimbursement for outpatient scheduled surgeries at 60 percent of usual and customary charges,[37] while other outpatient services are limited to 75 percent of usual and customary charges.[38] Reimbursement of inpatient hospital care is limited based on a schedule of per diem rates approved by the panel.[39] The ambulatory surgical centers manual limits reimbursement to 60 percent of usual and customary as such services are generally scheduled outpatient surgeries.

III. Effect of Proposed Changes:

Section 1 amends s. 768.042, F.S., to require in any claim for damages of personal injury to a claimant, that evidence of past, present, or future medical expenses be based on the usual and customary charges in the community where medical expenses are incurred or are reasonably probable to be incurred. As the methodology in the bill is still a "fact-dependent methodology" it requires evidence of typical charges in the community.[40] Similarly, current court precedent indicates that the courts would presumably 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. [41]

This alters the current methodology 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, under this bill, the amount of an award of past medical damages would be determined with no consideration of evidence of the billed costs of any medical services actually rendered for a claimant.

The methodology proposed in the bill is consistent with the current methodology for calculating PIP reimbursements. Section 627.736(5)(a)1, F.S., relating to PIP reimbursements, also requires a determination of costs based on usual and customary charges in a community.

The bill establishes that the charges from an independent, nonprofit, statistically reliable benchmarking database that has been in existence for the last 5 years and that qualifies for nonprofit status under s. 501(c)(3) of the U.S. Internal Revenue Code are admissible as evidence of the usual and customary medical charges in the consideration of past and present medical expenses.

The bill prohibits evidence of usual and customary charges from including evidence of increased or additional charges based on the outcome of litigation. This prevents the evidence of "inflated"

[35] Section 440.13(12)(b)4., F.S.
[36] Section 440.13(12)(b)5., F.S.
[37] Section 440.13(12)(b)3., F.S.
[38] Section 440.13(12)(a), F.S.
[39] *Id*.
[40] Section 627.736(5)(a), F.S.
[41] *See Baker* at fn. 29.

costs from being used in hopes of securing a jury award that is larger than the amount insurers typically pay and larger than the amount healthcare providers typically accept. By requiring evidence of medical costs to be based on usual and customary charges in the community claimants should not be able to present evidence of "inflated" costs through the use of letters of protection.

The bill provides that evidence of the reasonableness of future medical expenses may be considered along with other relevant evidence.

Section 2 provides an effective date of 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.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/CS/SB 1668 requires evidence of medical expenses in personal injury claims to be based on the usual and customary charges in the community. This requirement may make awards of damages for medical costs more predictable, resulting in an interminable effect on the private sector.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

Regarding the bill's provision relating to a statistically reliable benchmarking database, the bill does not specify that the charges are to be held, cataloged, or stored in a database that is maintained by a nonprofit organization. Rather the bill suggests that the database must be nonprofit and independent in nature and must qualify for nonprofit status under s. 501(c)(3) of the U.S. Internal Revenue Code. If the intent is for charges to be held, cataloged, or stored in a database that is maintained by a nonprofit organization that meets the bill's criteria, the bill's language in this regard should be rewritten to provide clarity.

Further, under the bill, the database must have been in existence for "the last 5 years," but the bill does not specify if the database must have been in existence for the last 5 years from the time that evidence is introduced, from the time that damages are alleged to have occurred, or from the date that the bill takes effect as law. The bill's intent for this provision is unclear.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 768.042 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS/CS by Health Policy on February 11, 2020:
The committee substitute:

- Establishes that that the charges from an independent, nonprofit, statistically reliable benchmarking database that has been in existence for the last 5 years and that qualifies for nonprofit status under s. 501(c)(3) of the U.S. Internal Revenue Code are admissible as evidence of the usual and customary medical charges in the consideration of past and present medical expenses.
- Removes a provision from the underlying bill that allowed evidence of the availability of private or public health insurance to be used to prove damages for future medical expenses.
- Removes a provision from the underlying bill that established that amounts paid to or made payable to claimants under private or public health insurance coverage are presumed to be the usual and customary charges, unless a claimant shows that the amounts were inadequate.
- Provides that evidence of the reasonableness of future medical expenses may be considered along with other relevant evidence.

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

- Establishing that parties to a personal injury lawsuit may introduce evidence of the availability of public or private health insurance, with respect to damages for future medical expenses.
- Rebutting the presumption that the amounts paid or payable under the insurance or governmental health coverage are the usual and customary medical charges if the claimant shows that such amounts are inadequate under the circumstances.

B. Amendments:

None.