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 846
INTRODUCER:	Senator Brandes
SUBJECT:	Medical Expenses
DATE:	March 8, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Davis	Cibula	JU	**Pre-meeting**
2.			HP	
3.			RC	

I. Summary:

SB 846 significantly alters the current method of proving medical cost damages at trial. The bill limits the scope of evidence that is admitted to prove past paid and unpaid medical charges in a personal injury or wrongful death lawsuit. To prove past *paid* medical expenses that have been satisfied, evidence is limited to the amount paid, regardless of the source of the payment.

For a plaintiff to prove the amount necessary to satisfy an *unpaid* charge for medical expenses, evidence is limited to the amount necessary to satisfy the charge.

- If the plaintiff has health care coverage, evidence of the amount needed to satisfy an unpaid medical charge may not exceed the amount needed to satisfy the charge under his or her health care coverage, plus the plaintiff's share of medical expenses under the insurance contract or regulation. It is irrelevant whether the claimant has used or will be using his or her health care coverage to satisfy the charge.

- If the plaintiff does not have health care coverage, evidence of the amount necessary to satisfy an unpaid charge may not exceed the usual and customary amount or the amount customarily accepted for those services by the plaintiff's medical providers and by providers in the same geographic area.

The damages that may be recovered by a plaintiff for the cost or value of medical services provided may not exceed the sum of the amounts paid to the health care provider and any amounts necessary to satisfy charges that have been incurred but remain to be paid.

The bill abrogates the collateral source rule by permitting the introduction of collateral source payments to satisfy past medical costs.

The bill takes effect July 1, 2021.

II. Present Situation:

Background

A tort lawsuit is a civil legal action filed by a plaintiff to recover damages for a loss, injury, or death caused by the negligent conduct of a defendant. In essence, the plaintiff is seeking to be compensated, made whole, or returned to a pre-accident condition from the defendant's financial resources. The purpose is not to punish the defendant. In order to establish liability, the plaintiff bears the legal burden of proving four elements:

- Duty – That the defendant owed a duty, or obligation, of care to the plaintiff;
- Breach – That the defendant breached that duty by not conforming to the standard required;
- Causation – That the breach of the duty was the legal cause of the plaintiff's injury; and
- Damages – That the plaintiff suffered actual harm or loss.

Damages

While these four elements seem relatively straightforward, the issue of computing damages for medical costs has become very complex. Much of the complexity is driven by the application of the common law collateral source rule as it has been partially abrogated and modern medical billing practices. Modern medical billing practices are known to result in medical bills that have little relationship to amounts usually accepted as payment in full. Due to the collateral source rule and its partial abrogation, juries may receive evidence of the plaintiff's medical bills instead of evidence of much lower actual medical expenses. This evidentiary practice, in violation of the tort law principle to make the plaintiff whole, seems to permit excessive awards for medical expenses which then may result in greater damages for pain and suffering.[1] On the other hand, the collateral source rule as partially abrogated may prevent a defendant from reduced liability and receiving the full benefit of a plaintiff's insurance coverage or other collateral source benefits.[2]

Collateral Source Rule or Doctrine

Background

The collateral source rule was an established legal doctrine in English common law[3] as early as 1838.[4] The doctrine traveled across the Atlantic and was embraced by the United States Supreme Court before the Civil War. In an 1854 decision, *The Monticello*,[5] a steamboat collided with a schooner, causing the schooner and its cargo to sink. The schooner was insured and its owner was fully compensated for the loss by his insurance company. The owner of the steamboat, who was at fault, argued that, because the schooner's owner was compensated by the insurance company and made whole for the loss of the schooner and its cargo, the schooner's owner could not seek additional compensation from him. The U.S. Supreme Court disagreed and held that the steamboat owner was bound to pay for the entire injury he had caused. The payment by the insurance company was irrelevant and did not provide the steamboat owner with a defense.

[1] *Higgs v. Costa Crociere, S.P.A. Co.*, 969 F.3d 1295, 1313 (11th Cir. 2020).
[2] *Id.* at 1311.
[3] "Common law" refers to laws made by judicial decisions as opposed to laws found in statutes. It also refers to old rules found in English law. BLACK'S LAW DICTIONARY (11th ed. 2019).
[4] *Yates v. Whyte*, 4 Bing NC 272, (1838).
[5] *The Propeller Monticello v. Mollison*, 58 U.S. 152 (1854).

The collateral source rule has since been construed to mean that a plaintiff's award of damages may not be reduced by benefits received or payments made by "collateral sources."[6] In other words, a defendant must pay the full cost of a plaintiff's injury, even if the plaintiff receives compensation from an independent or collateral source. A collateral source generally means any source of compensation that provides a benefit to a plaintiff as compensation for the injury he or she has sustained and the compensation is also wholly independent of the defendant.[7] The most common collateral source payments to plaintiffs are insurance proceeds.[8]

Evidence and Damages

Historically, the common law collateral source rule functioned as both a rule of evidence and a rule of damages. With respect to evidence, the rule prevented the introduction of evidence of collateral source benefits available to a plaintiff. A long line of cases reasoned that the introduction of collateral source evidence could mislead the jury on the issue of liability and subvert the jury process. The cases also reasoned that the evidence could lead a jury to conclude that the plaintiff was trying to obtain double or triple payments for a single injury or that compensation already obtained was sufficient.[9] With respect to damages, the rule prevented the reduction of a plaintiff's damages based on collateral source benefits.[10]

Reform Efforts

Although most states have retained some form of the collateral source rule, where it has been partially or completely abrogated by statute, the rule's impact has been reduced.[11] The logic used to abrogate the rule is simple: If a plaintiff has been compensated for his or her injuries and damages, it is unfair and a duplication of resources to require the defendant to pay again for the damages.

Collateral Source Statute

In 1986, the Legislature adopted a collateral source statute which modified the general rule the courts had followed for longer than a century.[12] The statute is contained in s. 768.76, F.S. In the preamble to the bill, the Legislature noted that "the current tort system has contributed to the insurance availability and affordability crisis" and named the legislation the "Tort Reform and Insurance Act of 1986." Under the statute, the collateral source rule continues to prohibit the introduction of evidence at trial of collateral source benefits. Accordingly, a plaintiff may introduce into evidence the full amount of his or her medical bills, but a defendant is generally not allowed to introduce the amounts paid and accepted in full satisfaction of those bills.[13] As

[6] Robert E. Gordon and Justin Linn, *Goble, Thyssenkrupp, and the Colateral Source Rule: Resolving the Ongoing Conflict*, 84 FLA. B.J., Dec. 2010, at 18, 18.
[7] Jacob A. Stein, 3 Stein on Personal Injury Damages Treatise s. 19:31 (3d ed. (Oct. 2020).
[8] BLACK'S LAW DICTIONARY (11th ed. 2019).
[9] *Gormley v. GTE Products Corp.,* 587 So. 2d 455, 457 - 458 (Fla. 1991).
[10] *Joerg v. State Farm Mut. Auto. Ins. Co.,* 176 So. 3d 1247, 1248 (2015).
[11] Stein, *supra* note 7.
[12] Chapter 86-160, s. 55, Laws of Fla.
[13] Lance B. Stephan, *Sticker Shock: Florida Juries Still Awarding Phantom Damages*, 33 TRIAL ADVOC. Q. 23 (Fall 2014).

such, juries are not told the actual amounts that were paid and accepted for a plaintiff's medical care.[14]

With respect to damages, the statute requires a court, after trial, to reduce the amount of damages awarded to a plaintiff from all collateral sources, except where a subrogation or reimbursement right exists.[15] For example, if a jury awards damages for past medical costs that were paid in full by the plaintiff's health insurer, the court will reduce that award after the trial to prevent the plaintiff from receiving a windfall.

Calculating Damages for Medical Expenses

When a plaintiff is injured, he or she generally receives treatment from a medical professional and is billed for those services. When presenting those medical expenses at trial, a plaintiff prefers that the "original face value of the bills" be presented to the jury rather than the amounts that the plaintiff *actually paid* or the amount the medical provider has negotiated with the plaintiff's insurance company. One reason is that amounts billed and presented to the jury, rather than the actual amounts paid or written off, are believed to have a positive influence on increasing a jury's award for future medical costs and non-economic damages such as pain and suffering.[16]

<u>"Phantom Damages"</u>
It is well known that the original face value of a medical bill often bears little relationship to the amount actually paid by the patient and accepted by the provider as payment in full. Providers may also have significantly different rates for the identical procedure based on their contracts with an insurer. In the *Goble v. Frohman* decision rendered by the Florida Supreme Court in 2005, the Court referred to the difference between the amounts billed and amounts accepted as payment as "phantom damages," repeating a phrase used earlier by the Second District Court of Appeal.[17] In the *Goble* case, the plaintiff's medical providers billed him $574,554 for treatment. However, because his insurer had a preexisting fee schedule with the medical providers, the providers accepted $145,970, writing-off of more than $400,000. The plaintiff argued on appeal that the jury award of $574,554 should stand. The courts disagreed and held that the payments were collateral sources made on the claimant's behalf subject to setoff under s. 768.76, F.S. The Second District Court of Appeal determined, and the Florida Supreme Court agreed, that permitting a setoff for contractual discounts was consistent with the Legislature's intent to reduce litigation costs when insurers are required to pay damages in excess of what an injured party actually incurred.[18]

<u>Hospital Chargemasters</u>
Chargemasters have come under attack for contributing to artificially high medical bills. A chargemaster is a hospital's price list of goods and services. The chargemaster prices are reported to run as much as ten times the amount that a hospital often accepts as full payment

[14] Instead of providing evidence of the amounts paid and accepted for the plaintiff's care, the defense will need to introduce evidence of the reasonable value of the medical care. See Instruction 501.2b., Fla. Std. Jury Instr. (Civ.).
[15] Section 768.76(1), F.S.
[16] *Durse v. Henn*, 68 So. 3d 271, 275 (Fla. 4th DCA 2011).
[17] *Goble v. Frohman*, 901 So. 2d 830, 834 (Fla. 2005).
[18] *Goble v. Frohman*, 848 So. 2d 406, 409 (Fla. 2d DCA 2003).

from an insurer. The chargemaster prices are alleged to serve as a starting point for negotiations with third-party payers for the amount they will ultimately pay the hospital for the goods and services. According to one law professor, these chargemaster prices place a particularly difficult burden on patients who self-pay the expenses.[19]

Letters of Protection

Letters of protection are often characterized as a mechanism used by plaintiff attorneys to place excessive medical bills before a jury. Letters of protection have been criticized as being inflated and not reflective of the usual and customary billing practices in the medical community. A letter of protection is a document sent by a plaintiff's attorney to a health care provider on behalf of the client who needs medical treatment but might not have insurance. The letter is an agreement that entitles the physician to deferred payment from the proceeds of the plaintiff's recovery. If there is no favorable recovery, the client may remain liable to pay the medical bills.[20]

Because a letter of protection gives the plaintiff's physician a financial interest in the outcome of the litigation, it is admissible to show bias. However, the potential bias a medical provider has developed from a longstanding referral relationship with a law firm is not discoverable based upon a 2017 Florida Supreme Court opinion.[21]

Unpaid and Future Medical Costs

Although the collateral source rule has been partially abrogated by statute, it has no mechanism to reduce to actual costs the amounts a jury may award for unpaid medical costs, including future medical costs. Therefore, the rule, in some instances, allows a plaintiff to recover amounts that exceed his or her actual medical costs.

III. Effect of Proposed Changes:

The bill specifies the evidence that is admissible at trial to prove past medical expenses in a personal injury or wrongful death lawsuit. By providing jurors with information reflecting what a medical provider actually received for past services, rather than what the provider billed for past services, jurors may be able to more accurately determine the plaintiff's damages for medical expenses. The bill does not address future medical expenses.

Past Paid Medical Expenses

For a plaintiff to prove the amount of a past medical expense that has been satisfied, evidence is limited to the amount paid, regardless of the source of the payment. This provision prohibits a plaintiff from placing medical bills that have no relationship to amounts accepted as payment, before jurors that might cause them to believe the plaintiff's medical injuries are more extensive than they actually are.

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[19] George A. Nation III, *Hospital Chargemaster Insanity: Heeling the Healers*, 43 PEPP. L .REV. 745 (2016).
[20] *Worley v. Central Florida Young Men's Christian Ass'n, Inc*., 228 So. 3d 18 (Fla. 2017), at footnote 4, quoting Caroline C. Pace, *Tort Recovery for Medicare Beneficiaries: Procedures, Pitfalls and Potential Values*, 49 HOUS. LAW. 24, 27 (2012).
[21] *Worley*, 228 So. 3d at 28. It is worth noting that two cases are pending before the Florida Supreme Court which may result in *Worley* being overruled. See *Younkin v. Blackwelder*, 2019 WL 847548 (Fla. 5th DCA 2019), *rev. granted*, 2019 WL 2180625 (Fla. 2019); *Dodgen v. Grijalva*, 281 So. 3d 490 (2019), *rev. granted*, 2019 WL 4805833 (Fla. 2019).

Past Unpaid Medical Expenses

For a plaintiff to prove the amount necessary to satisfy an unpaid charge for a medical expense, evidence is limited to the amount necessary to satisfy the charge.

With Health Care Coverage

If the plaintiff has health care coverage, evidence of the amount needed to satisfy an unpaid medical charge may not exceed:

- The amount by which the charge may be satisfied by the claimant's health care coverage, *plus*
- The claimant's share of medical expenses[22] under the insurance contract or regulation, regardless of whether the health care coverage is used or will be used to satisfy the charge.

Without Health Care Coverage

If the claimant does not have health care coverage, evidence of the amount necessary to satisfy an unpaid medical charge may not exceed the usual and customary amount or the amount customarily accepted as payment for the services by the claimant's medical providers and by other providers in the same geographic area. For purposes of determining the amount customarily accepted, the trier of fact must consider amounts accepted by providers in the same geographic area for identical or substantially similar medical or health care services:

- On a cash basis;
- Under Medicare;
- Under the Workers' Compensation Law; and
- By Payors regulated under the Florida Insurance Code.

Limit on Damages Recoverable

The bill places a limit on 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 medical care. The amount may not exceed the sum of:

- The amounts paid by or on behalf of the injured person to a health care provider who treated the claimant; and
- Any amounts necessary to satisfy the medical care charges that have been incurred but not yet satisfied.

Health Care Coverage

Health care coverage is defined in the bill to mean any form of third-party coverage of applicable medical expenses, including, but not limited to:

- Commercial health insurance;
- Medicare;
- Medicare supplemental health insurance;
- Medicaid;
- Tricare;

[22] The claimant's share of medical expenses would likely be deductibles or insurance premiums.

- Workers' compensation; and
- Personal Injury Protection.

Effective Date

The bill takes effect July 1, 2021.

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:

If SB 846 results in reduced jury awards, then insurance companies might experience more financial stability that could ultimately reduce insurance costs.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 768.0427, Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.