FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: CS/HB 947	**COMPANION BILL:** SB 1520 (Grall)
TITLE: Evidence of Damages to Prove Medical Expenses in Personal Injury or Wrongful Death Actions	**LINKED BILLS:** None
SPONSOR(S): Blanco	**RELATED BILLS:** None

Committee References

Civil Justice & Claims 15 Y, 0 N, As CS	➤	Judiciary 19 Y, 3 N

SUMMARY

Effect of the Bill:

CS/HB 947 amends s. 768.0427, F.S., removing certain current requirements of admissible evidence that must be presented at trial to determine the values of past unpaid medical treatments or services, and future medical treatments or services in a personal injury or wrongful death action. As such, the bill allows plaintiff and defense attorneys the opportunity to present what they determine to be the best evidence of damages, letting the judge or jury weigh all admitted evidence, without prescribing specified evidence that must be presented. The bill maintains current admissibility provisions related to evidence of past paid medical treatment. As such, only evidence of the amount actually paid may be admissible.

Specifically, under the bill, with respect to past unpaid medical treatment, any evidence allowed by the court that tends to demonstrate the actual value of such medical treatments and services rendered may be admissible. Similarly, any evidence that demonstrates the actual value of future medical treatments and services that may be received at a later date may be admissible.

The provisions of the bill apply to all causes of action which accrued after March 24, 2023, and for which a final judgment has not yet been entered at the time the bill becomes a law. The bill has an effective date of July 1, 2025.

Fiscal or Economic Impact:

The bill may have a positive fiscal impact on plaintiffs seeking damages arising out of a personal injury or wrongful death action. The bill may have a negative fiscal impact on defendants in such personal injury and wrongful death suits.

JUMP TO SUMMARY ANALYSIS RELEVANT INFORMATION BILL HISTORY

ANALYSIS

EFFECT OF THE BILL:

CS/HB 947 amends s. 768.0427, F.S., relating to the admissibility of evidence to prove damages of medical expenses in certain civil tort actions. With respect to unpaid medical bills for past treatment, the bill eliminates the following requirements of evidence of damages that must be admitted during trial:

- The amount equal to 120% of the Medicare reimbursement rate or 170% of the Medicaid reimbursement rate (if there is no comparable Medicare rate) for medical treatment or services rendered to a plaintiff who does not have health insurance, or has coverage under Medicare or Medicaid;
- The amount the plaintiff's insurance is obligated to pay the provider under the plaintiff's contract for the service or treatment provided plus the plaintiff's portion of those costs, for a plaintiff who has private health insurance;

- The amount a plaintiff's health insurance would pay under the plaintiff's contract for services or treatment rendered to a plaintiff plus the plaintiff's portion of medical expenses that would have been incurred, for a plaintiff who has health insurance but opts to obtain treatment under a letter of protection; and
- The amount a third party has paid for the right to receive payment under a letter of protection, if applicable.

As such, the bill makes all potential admissible evidence permissive, rather than requiring that certain types of evidence must be admitted. Thus, the bill permits any evidence allowed by the court that demonstrates the actual value of unpaid medical treatment and services rendered to be presented before the factfinder. The bill entrusts the judge, or jury in a jury trial, in a personal injury or wrongful death action, to hear and evaluate all evidence of medical services rendered and weigh that evidence when calculating medical damages. The bill lists various types of evidence that may be admitted by the court, including:

- The amount the claimant's health care coverage is, or otherwise would be, obligated to pay to satisfy the charges for the medical treatment or services.
- The reasonable and customary rates for such treatment or services rendered by a qualified provider.
- If the claimant obtains medical treatment or services under a letter of protection and the letter of protection is subsequently transferred to a third party, evidence of the amount the third party agreed to pay the health care provider in exchange for the right to receive payment pursuant to the letter of protection.
- Reasonable amounts billed to the claimant for medically necessary treatment or services provided to the claimant. (Section 1).

Additionally, the bill refines the types of evidence that may be presented to a jury to establish future medical expenses and damages. Thus, any evidence allowed by the court that tends to demonstrate the actual value of medical treatment or services to be rendered in the future may be admissible. As such, the bill removes the compulsory evidence that must be admitted, including:

- Evidence of the amount future charges for services and treatments could be satisfied by the plaintiff's private health care coverage plus the plaintiff's portion of medical expenses, if the plaintiff has private health insurance or is eligible for such health insurance; and
- The amount equal to 120% of the Medicare reimbursement rate or 170% of the Medicaid reimbursement rate (if there is no comparable Medicare rate) for medical treatment or services to be rendered to a plaintiff who does not have health insurance, has coverage under Medicare or Medicaid, or is eligible for such coverage.

Therefore, the bill shifts the evidence to be presented at trial from a list of required evidence, to a wholly permissive evidentiary structure, allowing the factfinder to weigh any and all relevant evidence that the court deems to be admissible. The bill lists as examples of potentially admissible evidence:

- If the claimant has health insurance other than Medicare or Medicaid, any evidence of the amount for which the future charges of health care providers could be satisfied if submitted to the claimant's health care coverage, plus the claimant's share of medical expenses under the insurance contract.
- If the claimant is uninsured or has Medicare of Medicaid coverage, or is eligible for such coverage, the reasonable and customary rates for such treatments or services rendered by a qualified provider.
- Any evidence of reasonable future amounts to be billed to the claimant for medically necessary treatment or services. (Section 1).

The amendments to s. 768.0427, F.S., made by the bill apply to all causes of action which accrued after March 24, 2023, and for which a final judgment has not yet been entered at the time the bill becomes law. (Section 2).

The bill will become effective on July 1, 2025. (Section 3).

FISCAL OR ECONOMIC IMPACT:

PRIVATE SECTOR:

The bill may increase the recovery of a plaintiff in certain cases where the value of medical treatment is at issue. The bill may have a negative fiscal impact on defendants in such cases.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

The Civil Justice System in General

The main purpose of Florida's civil justice system is to properly and fairly redress the civil wrongs caused throughout the state, whether such wrongs be in the form of tortious conduct, breaches of contract, or other non-criminal harm for which the law provides a remedy. The civil justice system accomplishes this goal by providing a neutral court system empowered to decide the amount of monetary damages required to make each wronged person whole again. A functioning civil justice system, when it operates justly:

- Provides a fair and equitable forum to resolve disputes;
- Discourages persons from resorting to self-help methods to redress wrongs;
- Appropriately compensates legitimately harmed persons;
- Shifts losses to responsible parties;
- Provides incentives to prevent future harm; and
- Deters undesirable behavior.[1]

Tort Law

One of the goals of the civil justice system is to redress tortious conduct, or "torts." A tort is a wrong for which the law provides a remedy. Torts are generally divided into two categories, as follows:

- An intentional tort, examples of which include an assault, a battery, or a false imprisonment.
- Negligence, which is a tort that is unintentionally committed. To prevail in a negligence lawsuit, the party seeking the remedy, the "plaintiff," must demonstrate that the:
  - Defendant had a legal duty of care requiring the defendant to conform to a certain standard of conduct for the protection of others, including the plaintiff, against unreasonable risks;
  - Defendant breached his or her duty of care by failing to conform to the required standard;
  - Defendant's breach caused the plaintiff to suffer an injury; and
  - Plaintiff suffered actual damage or loss resulting from such injury.[2]

Negligence

Duty of Care

The first of the four elements a plaintiff must show to prevail in a negligence action is that the defendant owed the plaintiff a "duty of care" to do something or refrain from doing something. The existence of a legal duty is a threshold requirement that, if satisfied, "merely opens the courthouse doors."[3] Whether a duty sufficient to support

[1] *Cf.* Am. Jur. 2d Torts s. 2.
[2] 6 *Florida Practice Series* s. 1.1; *see Barnett v. Dept. of Fin. Serv.*, 303 So. 3d 508 (Fla. 2020).
[3] *Kohl v. Kohl*, 149 So. 3d 127 (Fla. 4th DCA 2014).

a negligence claim exists is a matter of law[4] determined by the court.[5] A duty may arise from various sources, including:

- Legislative enactments or administrative regulations;
- Judicial interpretations of such enactments or regulations;
- Other judicial precedent; and
- The general facts of the case.[6]

In determining whether a duty arises from the general facts of the case, courts look to whether the defendant's conduct foreseeably created a "zone of risk" that posed a general threat of harm to others—that is, whether there was a likelihood that the defendant's conduct would result in the type of injury suffered by the plaintiff.[7] Such zone of risk defines the scope of the defendant's legal duty, which is typically to either lessen the risk or ensure that sufficient precautions are taken to protect others from the harm the risk poses.[8] However, it is not enough that a risk merely exists or that a particular risk is foreseeable; rather, the defendant's conduct must create or control the risk before liability may be imposed.[9]

Breach of the Duty of Care

The second element a plaintiff must prove is that the defendant "breached," or failed to discharge, the duty of care. Whether a breach occurred is generally a matter of fact for the jury to determine.[10]

Causation

The third element a plaintiff must prove is that the defendant's breach of the duty of care "proximately caused" the plaintiff's injury. Whether or not proximate causation exists is generally a matter of fact for the jury to determine.[11] Florida follows the "more likely than not" standard in proving causation; thus, the inquiry for the factfinder is whether the defendant's negligence probably caused the plaintiff's injury.[12] In making such a determination, the factfinder must analyze whether the injury was a foreseeable consequence of the danger created by the defendant's negligent act or omission.[13] It is not required that the defendant's conduct must be the exclusive cause, or even the primary cause, of the plaintiff's injury suffered; instead, the plaintiff must only show that the defendant's conduct substantially caused the injury.[14]

Damages

The final element a plaintiff must show to prevail in a negligence action is that the plaintiff suffered some harm, or "damages." Actual damages, also called compensatory damages, are damages the plaintiff actually suffered as the

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[4] A matter of law is a matter determined by the court, unlike a matter of fact, which must be determined by the jury. Matters of law include issues regarding a law's application or interpretation, issues regarding what the relevant law is, and issues of fact reserved for judges to resolve. Legal Information Institute, *Question of Law*, https://www.law.cornell.edu/wex/question_of_law (last visited March 12, 2025); Legal Information Institute, *Question of Fact*, https://www.law.cornell.edu/wex/Question_of_fact (last visited March 12, 2025).

[5] *Kohl*, 149 So. 3d at 135; *Goldberg v. Fla. Power & Light Co.*, 899 So. 2d 1110 (Fla. 2005).

[6] *Goldberg,* 899 So. 2d at 1105 (citing *Clay Elec. Co-op., Inc. v. Johnson*, 873 So. 2d 1182 (Fla. 2003)).

[7] *Kohl*, 149 So. 3d at 135 (citing *McCain v. Fla. Power Corp.*, 593 So. 2d 500 (Fla. 1992); *Whitt v. Silverman*, 788 So. 2d 210 (Fla. 2001)).

[8] *Kohl*, 149 So. 3d at 135; *Whitt*, 788 So. 2d at 217.

[9] *Bongiorno v. Americorp, Inc.*, 159 So. 3d 1027 (Fla. 5th DCA 2015) (citing *Demelus v. King Motor Co. of Fort Lauderdale*, 24 So. 3d 759 (Fla. 4th DCA 2009)).

[10] *Wallace v. Dean*, 3 So. 3d 1035 (Fla. 2009).

[11] *Sanders v. ERP Operating Ltd. P'ship*, 157 So. 3d 273 (Fla. 2015).

[12] *Ruiz v. Tenent Hialeah Healthsystem, Inc.*, 260 So. 3d 977 (Fla. 2018).

[13] *Id.* at 981-982.

[14] *Id.* at 982.

result of the injury.[15] Juries award compensatory damages to compensate an injured person for a defendant's negligent acts.[16] Compensatory damages consist of both:

- "Economic damages," which typically consist of financial losses that can be easily quantified, such as lost wages, the cost to replace damaged property, or the cost of medical treatment; and
- "Non-economic damages," which typically consist of nonfinancial losses that cannot be easily quantified, such as pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, and loss of the capacity to enjoy life.[17]

In certain limited situations, a court may also award "punitive damages," the purpose of which is to punish a defendant for bad behavior and deter future bad conduct, rather than to compensate the plaintiff for a loss.[18]

Admissibility of Evidence in General

"Admissible evidence" is evidence that may be presented to the factfinder (the judge or jury) for consideration in deciding the case.[19] Generally, for evidence to be admissible, it must be relevant and not outweighed by countervailing considerations (e.g. the evidence is unfairly prejudicial, confusing, a waste of time, privileged based on hearsay, etc.).[20]

In Florida, the admissibility of evidence is provided for under ch. 90, Florida Statutes, in the Florida Evidence Code. It is up to the judge to determine whether evidence presented is admissible under the Florida Evidence Code. In a case that is tried before a jury, the court must conduct the proceedings in such a manner as to prevent inadmissible evidence from being suggested to the jury by any means.[21] Thus, a judge may hear arguments from both sides in a case outside the presence of the jury to determine whether a piece of evidence is admissible or not.

Calculating Medical Damages

In a typical negligence action, the jury is responsible for determining the amount of damages to award to the plaintiff. In such action, the plaintiff may seek to inform the jury of the plaintiff's medical bills so that the jury can accurately calculate the amount of damages. This process of accurately computing damages can become difficult, however, in light of the lack of a set standard of the cost of a medical procedure or treatment.

A plaintiff may recover compensatory damages for past and future medical expenses, as well as for pain and suffering. A policy question that often arises is how a court should calculate medical damages and what evidence is admissible for the jury to hear in order to make such calculations.

Collateral Source Rule

Under Florida law, a "collateral source" is any payment made to a claimant or on a claimant's behalf by or pursuant to:

- The United States Social Security Act, except Title XVIII and Title XIX; any federal, state, or local income disability act; or any other public programs providing medical expenses, disability payments, or other similar benefits, except those prohibited by federal law and those expressly excluded by law as collateral sources.

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[15] *Birdsall v. Coolidge*, 93 U.S. 64 (1876).
[16] *St. Regis Paper Co. v. Watson*, 428 So. 2d 243 (Fla. 1983).
[17] *Cf.* s. 766.202(8), F.S.
[18] *See* ss. 768.72, 768.725, and 768.73, F.S. (providing standards and requirements for awarding punitive damages).
[19] Cornell Law School, Legal Information Institute, *Admissible Evidence*, https://www.law.cornell.edu/wex/admissible_evidence (last visited March 8, 2025).
[20] *Id*.
[21] S. 90.104(2), F.S.

- Any health, sickness, or income disability insurance; automobile accident insurance that provides health benefits or income disability coverage; and any other similar insurance benefits, except life insurance benefits available to the claimant, whether purchased by her or him or provided by others.
- Any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health care services.
- Any contractual or voluntary wage continuation plan provided by employers or by any other system intended to provide wages during a period of disability.[22]

At common law,[23] the collateral source rule did two things:

- First, the rule ensured that a plaintiff could recover the full amount of damages suffered in a personal injury tort case. Under the rule, a court was prohibited from reducing the damages a plaintiff received by the benefits of collateral sources. As such, a plaintiff could recover the full value of the medical services billed, regardless of the amount that was actually paid for the services.
- Second, the rule prohibited a defendant from introducing evidence of collateral sources at trial for fear that introduction of such evidence would confuse and mislead the jury.[24]

Legislative Modification of the Collateral Source Rule

In 1986, the Legislature enacted the Tort Reform and Insurance Act ("Act") which modified the first prong of the collateral source rule.[25] Specifically, the Act created s. 768.76, F.S., which required a court to reduce the amount of damages awarded to a plaintiff from all collateral sources, except where a subrogation or reimbursement right exists.[26] For example, if a jury awards damages for past medical costs that were paid in full by the plaintiff's health insurer, a court must reduce that award after the trial.

Goble v. Froman, a 2005 Florida Supreme Court case,[27] demonstrates how courts apply the Act in a case involving past paid medical damages. In *Goble*, 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 more than $400,000. The plaintiff argued on appeal that the jury award of $574,554 should stand. The Second DCA disagreed, holding that the payments were collateral sources made on the claimant's behalf subject to setoff under s. 768.76, F.S. On appeal, the Florida Supreme Court agreed, finding 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.[28]

Letters of Protection

A "letter of protection" is a written agreement between a plaintiff and a medical provider wherein the provider agrees to defer collection on the medical bill until the plaintiff recovers in a lawsuit; upon recovery from a lawsuit, the provider is then paid from the proceeds of the lawsuit. If there is no favorable recovery, the client may remain liable to pay the medical bills.[29] A person might need to obtain services under a letter of protection if he or she is uninsured and unable to pay out of pocket for necessary medical treatment prior to obtaining a settlement or judgment against the party who was responsible for the injury.

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[22] S. 768.76(2)(a), F.S.
[23] "Common law" refers to laws made by judicial decisions as opposed to laws found in statutes. *See* Black's Law Dictionary (11th ed. 2019).
[24] *Gormley v. GTE Prods. Corp.*, 587 So. 2d 455, 458 (Fla. 1991).
[25] Ch. 86-160, s. 55, L.O.F.
[26] S. 768.76(1), F.S.
[27] *Goble v. Frohman*, 901 So. 2d 830, 834 (Fla. 2005).
[28] *Goble v. Frohman*, 848 So. 2d 406, 409 (Fla. 2d DCA 2003).
[29] *See Smith v. Geico Cas. Co.*, 127 So. 3d 808, 812 n.2 (Fla. 2d DCA 2013) (quoting Caroline C. Pace, *Tort Recovery for Medicare Beneficiaries: Procedures, Pitfalls and Potential Values*, 49 Hous. Law 24, 27 (2012)).

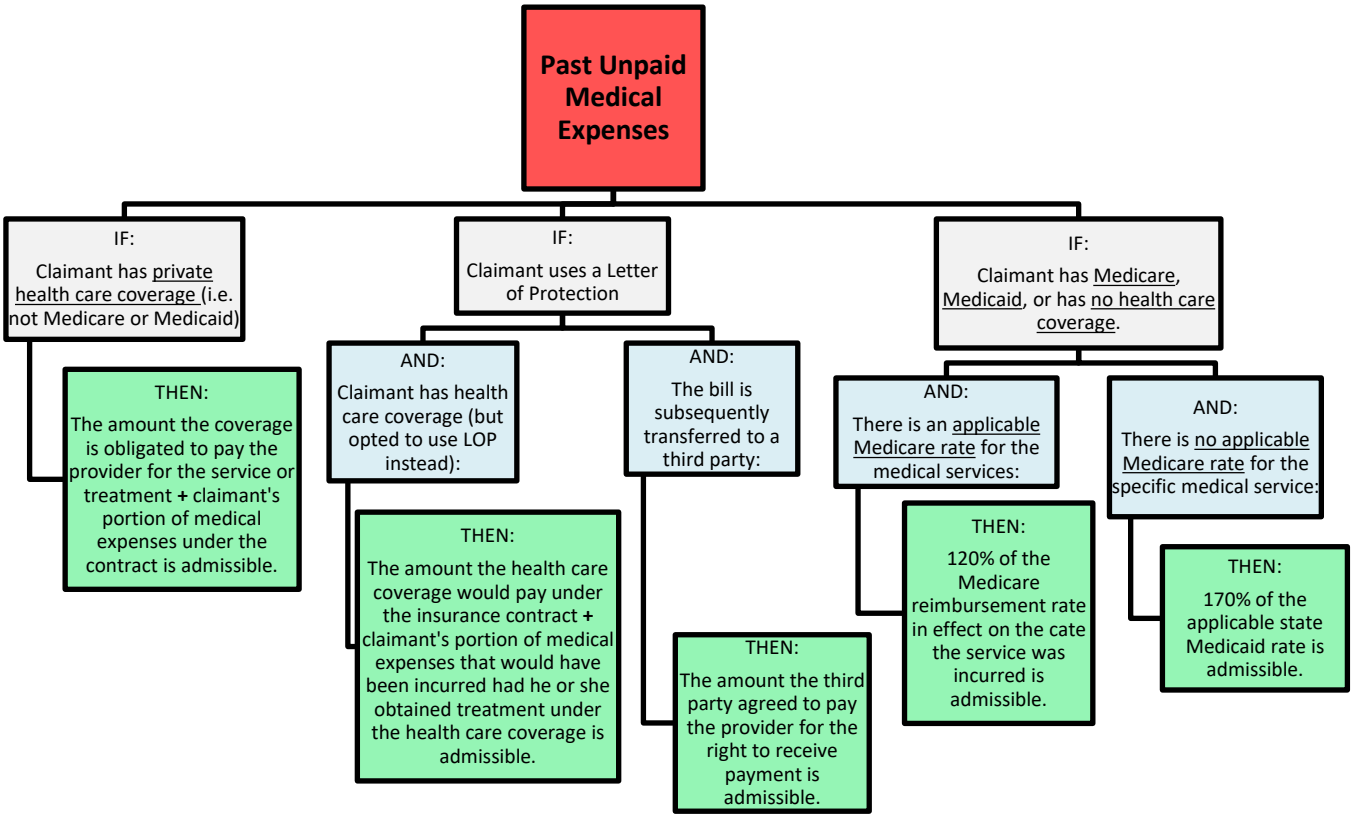
Under Current Law (*Post 2023 HB 837)*

During the 2023 legislative session,[30] the Legislature created s. 768.0427, F.S., and established defined guidelines for the admissibility of evidence and the calculation of damages in personal injury or wrongful death actions. The 2023 legislation created a statutory process for the calculation of damages by defining and limiting the types of evidence the factfinder (judge or jury) could hear.

Under current law, the following restrictions on the admissibility of evidence apply:

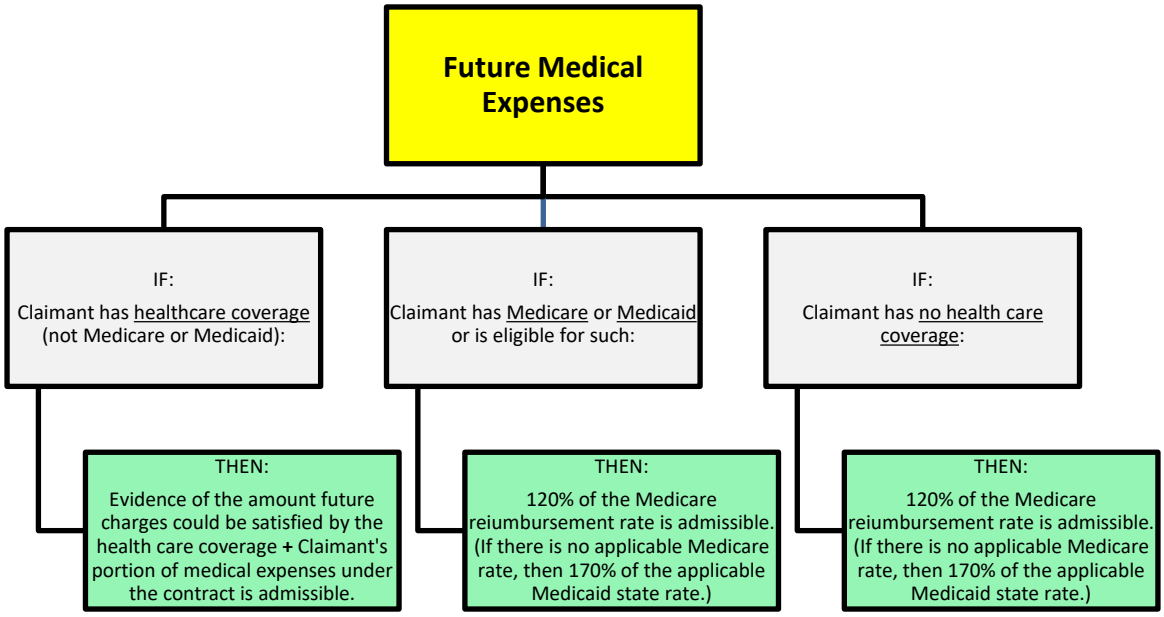
- **Past paid medical bills**. To prove damages for past paid medical bills and services, only the amount actually paid for the service or treatment is admissible, regardless of the course of such payment. Thus, evidence of the initial billed amount or of the usual and customary amount for a similar treatment is inadmissible; only evidence of the amount actually paid is admissible.[31]
- **Past unpaid medical bills**. With respect to medical treatments or services that have already been rendered but have not yet been paid, admissible evidence shall include, but is not limited to, any evidence of reasonable amounts billed to the claimant for medically necessary treatment or services provided to the claimant. The evidence offered must also include, but is not limited to, the following amounts depending on whether the claimant has health care coverage:[32]
    - *Claimant has health care coverage other than Medicare or Medicaid*: If the claimant has health care coverage other than Medicare or Medicaid, evidence of the amount the coverage is obligated to pay the provider for satisfaction of the medical services rendered plus the claimant's portion of medical expenses under the contract.
    - *Claimant has health care coverage but opts to use a letter of protection*: If the claimant has health care coverage but forgoes the coverage and obtains medical treatment under a letter of protection (or otherwise does not submit charges to his or her insurer), evidence of the amount the health care coverage would pay under the contract plus the claimant's portion of medical expenses, had he or she obtained treatment pursuant to the health care coverage.
    - *Claimant has Medicare or Medicaid or does not have health care coverage*: If the claimant has Medicare or Medicaid or does not have health care coverage, 120% of the Medicare reimbursement rate in effect on the date the claimant incurred the medical services; or, if there is no applicable Medicare rate for the services in question, 170% of the applicable state Medicaid rate.
    - *Claimant receives services under a letter of protection, and the bill is then transferred to a third party*: If the claimant receives services pursuant to a letter of protection and the provider subsequently transfers the right to receive payment of the bill to a third party, evidence of the amount the third party agreed to pay the provider for the right to receive payment.

[30] Ch. 2023-15, L.O.F.
[31] S. 768.0427(2)(a), F.S.
[32] S. 768.0427(2)(b), F.S.



- **Future medical bills**. With respect to evidence to prove damages for future medical services or treatments, admissible evidence must include any evidence of reasonable future amounts to be billed to the claimant for medically necessary services. Evidence offered must also include, but is not limited to, the following amounts, depending on whether the claimant has health care coverage:[33]
    - *Claimant has health care coverage other than Medicare or Medicaid or is eligible for such health care coverage*: In this situation, evidence of the amount for which the future charges could be satisfied by the coverage plus the petitioner's portion of medical expenses under the contract.
    - *Claimant has Medicare or Medicaid, is eligible for such coverage, or does not have health care coverage*: In this situation, 120% of the Medicare reimbursement rate in effect at the time of the trial for such future services; or, if there is no applicable Medicare rate for the future services in question, 170% of the applicable state Medicaid rate.

[33] S. 768.0427(2)(c), F.S.



Additionally, under current law, disclosure for individual contracts between providers and authorized commercial insurers or authorized health maintenance organizations (HMOs) are privileged and not subject to discovery or disclosure and are not admissible into evidence. [34]

RECENT LEGISLATION:

YEAR	BILL #	HOUSE SPONSOR(S)	SENATE SPONSOR	OTHER INFORMATION
2023	CS/CS/HB 837	Gregory, Fabricio	Hutson	The bill became law on March 24, 2023.

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Civil Justice & Claims Subcommittee	15 Y, 0 N, As CS	3/20/2025	Jones	Mathews
THE CHANGES ADOPTED BY THE COMMITTEE:	Clarify that the provisions of the bill apply to all causes of action which accrued after March 23, 2023, and for which a final judgment has not yet been entered.			
Judiciary Committee	19 Y, 3 N	3/26/2025	Kramer	Mathews

THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.

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[34] S. 768.0427(2)(e), F.S.