Restoring Transparency in Damages Awards HB 837

I. Introduction

"The fundamental principle of the law of damages is that the person injured . . . by wrongful or negligent act or omission shall have fair and just compensation commensurate with the loss sustained in consequence of the defendant's act which g[a]ve rise to the action."[1] In other words, the damages awarded to a plaintiff should be equal to and commensurate with the actual injury the plaintiff sustained—no more, no less.

In tort actions, the plaintiff's damages often include their expenses for medical care, both in the past and in the future. The cost of medical care—and thus the value of the damages required to compensate a plaintiff for medical care—should be relatively easy to determine. There have been numerous initiatives over the years to ensure consumers have readily available information on the price of health care. For instance, under the Transparency in Coverage Final Rule issued by the Centers for Medicare and Medicaid Services ("CMS"), health insurers must now disclose pricing for covered services and items, including the rates they have negotiated with participating providers for all covered services and items, as well as the allowed and billed amounts for out-of-network providers.[2] Moreover, in virtually every medical procedure, there is an associated American Medical Association ("AMA") Current Procedural Terminology ("CPT") code or Healthcare Common Procedure Coding System ("HCPCS") code. CPT and HCPCS codes are intended to serve as a uniform language for medical providers and insurers for coding medical services and procedures. With a CPT code, one should be able to compare the cost of a particular medical service or procedure across providers by comparing the provider's cost per CPT code. Yet, for a number of reasons, such basic information about the true cost of medical care is excluded from the courtroom and the true valuation of medical expense damages.

When it comes to medical damages, a plaintiff "has the burden to prove the *reasonableness* and necessity of medical expenses."[3] Indeed, Florida's standard jury instruction directs Florida juries to award damages only for the "reasonable" value or expense of hospitalization and medical care and treatment.[4] Although some jurisdictions consider evidence of the amount of a medical

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[1] *Hanna v. Martin*, 49 So. 2d 585, 587 (Fla. 1950).
[2] *See* CMS.gov, Transparency in Coverage, https://www.cms.gov/healthplan-price-transparency.
[3] *Albertson's Inc. v. Brady*, 475 So. 2d 986, 988 (Fla. 2d DCA 1985) (emphasis added; internal citations omitted).
[4] Fla. Std. Jury Instr. (Civ.) 501.2(b).

bill to be sufficient proof of reasonableness, many, including Florida, require "something more."[5] The amount charged is not instructive on what is a "reasonable amount"; rather, a "reasonable amount" for medical services is what the provider is "*willing to accept*" as payment for those services.[6] The evidentiary common-law collateral source rule, however, significantly limits a defendant's ability to challenge the reasonableness of a plaintiff's claimed medical expenses. Further, testimony and other evidence concerning the reasonableness of medical care vis-à-vis the relevant CPT or HCPCS codes are often excluded from the courtroom.

Letters of protection ("LOPs") also present special challenges to the determination of "reasonable" medical damages. LOPs are contracts wherein a plaintiff's medical provider agrees to suspend efforts to collect past medical bills in exchange for a right to payment from any recovery made by the plaintiff in litigation. Thus, LOPs represent an amount for a past medical expense that remains unpaid. LOPs typically bear an artificial value that greatly exceeds the true cost of medical treatment and often fails to include the correct coding for the relevant medical treatment or procedure. LOPs often arise as a result of symbiotic relationships between medical providers, plaintiffs' law firms, and factoring companies, the latter of which purchases LOPs at a discount for a right to collect each LOP's full sticker price.[7] And unfortunately, at the center of all this is often an injured plaintiff encouraged by his or her attorney to seek sometimes unnecessary and substandard treatment under an LOP with the attorney's preferred provider, saddling the plaintiff with medical debt that exceeds what would be customarily paid for that treatment.[8] Regardless of what the plaintiff's medical provider will ultimately accept as full satisfaction of the outstanding bill, an LOP with an artificial sticker price may be admitted at trial as the plaintiff's evidence for the value of his medical treatment. Consideration of such inflated amounts misleads juries into awarding excessive amounts for unpaid bills, future damages for anticipated medical expenses, and pain and suffering. While the existence of an LOP may be used to suggest bias on the part of the plaintiff's treating physicians and to question the reasonableness of a plaintiff's medical damages claims, the collateral source rule still restricts what a defendant may introduce into evidence to challenge the claimed medical damages.

It is time to restore transparency to medical damages, including by bringing to light the problematic referral relationships that have arisen between plaintiffs' attorneys, medical providers, and factoring companies using LOPs. Thus, the Florida Justice Reform Institute supports HB 837 which would expressly define what evidence is admissible to establish such damages and ensure all parties have access to the information necessary to challenge the reasonableness of claimed medical damages.

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[5] *Albertson's*, 475 So. 2d at 988; *see also, e.g.*, *Coop. Leasing, Inc. v. Johnson*, 872 So. 2d 956, 958 (Fla. 2d DCA 2004) ("[T]he 'reasonable value' of medical services is limited to the amount accepted as payment in full for medical services.").

[6] *See Columbia Hosp. (Palm Beaches) Ltd. P'ship v. Hasson*, 33 So. 3d 148, 150 & n.3 (Fla. 4th DCA 2010) (emphasis added).

[7] Indeed often, the factoring company is an interested medical provider or plaintiff law firm, not an independent third party.

[8] *See* Fred Schulte, *Crash Course: Injured Patients Who Sign 'Letters of Protection' May Face Huge Medical Bills and Risks*, Kaiser Health News (Dec. 21, 2021), https://khn.org/news/article/letters-of-protection-personal-injury-cases-surprise-bills/.

II. The Valuation of Medical Expenses

As noted above, a plaintiff bears the burden to prove the reasonableness of medical expenses sought as damages. No single factor determines whether a particular medical expense is reasonable. There are several non-exclusive factors relevant to that inquiry, including but not limited to: (1) an analysis of the relevant market for medical services (including the rates charged by other similarly situated providers for similar services); (2) the usual and customary rate the particular medical provider charges and receives for that service or procedure; and (3) the provider's internal cost structure.[9] The price or value of a particular medical service or procedure is not necessarily the same for each of these categories, for numerous reasons.

Indeed, often a medical provider's "list price" or "sticker price" for a particular service or procedure is very different from what they would ultimately accept in payment, from either the patient or the amount previously negotiated with an insurer. Determining the true value of medical services, then, is often complicated. As background, the generally accepted practice is for a medical provider to set a fee for each service or treatment, typically represented by a CPT code.[10] That billing fee is recorded in the billing system or charge master and generates a charge on the provider's bill for medical services known as the "billed charges." The billed charges are then compared to a contractually determined payment amount—for example, the contractually-set amount for a CPT code agreed to between a medical provider and health insurer—and the lesser of the two is generally the amount paid. Thus, billed charges generally reflect the "charge master" or "price list," which reflect the provider's list price and is not directly related to either the reasonable value of those services or what the provider will actually accept as payment in full for the services. Given the widespread application of negotiated rates between health insurers and providers, fee schedules set by Medicare or Medicaid, and other discounts and write-offs, it is not uncommon for billed charges to be at least three or four times (and often much more) the actual price paid. Indeed, hospital list prices, for example, are often very high, sometimes running 10 times the amount a hospital routinely accepts as full payment from insurers.[11] This growing gulf

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[9] *See, e.g.*, *Colomar v. Mercy Hosp., Inc.*, 461 F. Supp. 2d 1265, 1269 (S.D. Fla. 2006).

[10] The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. These health care professionals use the CPT to identify services and procedures for which they bill public or private health insurers. Decisions regarding the addition, deletion, or revision of CPT codes are made by the AMA. The CPT codes are republished and updated annually by the AMA CPT Editorial Panel. *See* https://www.ama-assn.org/about/cpt-editorial-panel/cpt-purpose-mission. HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items. The development and use of level II of the HCPCS began in the 1980s. CMS's HCPCS Workgroup maintains the HCPCS coe set.

[11] George A. Nation III, *Hospital Chargemaster Insanity: Heeling the Healers*, 43 PEPP. L. REV. 745, 748 (2016). A 2016 Florida Bar Journal article concluded similarly. *See* Steven I. Weissman, *Remedies for an Epidemic of Medical Provider Price Gouging*, 90 FLA. B.J. 22 (2016) ("Average charge master pricing at Florida hospitals is a minimum of 500 percent of Medicare allowable amounts (which amounts to roughly three to four times more than hospitals negotiate as reasonable rates with commercial health insurers).").

between the "billed" amount for a service and what is actually accepted as payment for that service is not found in any other industry.

Letters of protection add an additional wrinkle, as they often include an artificial "sticker" price that has little if any relation to what the provider includes on its charge master or price list or what the provider typically bills and accepts for that procedure. Further, LOPs often do not correctly code services or treatments, reducing a defendant's ability to compare the sticker price for medical treatment reflected in the LOP to the usual and customary charges for such treatment in the relevant geographic area.

Yet, under current Florida law, much of the evidence relevant to the determination of reasonable medical damages is hidden from the jury by operation of the so-called collateral source rule and related doctrines.

III. Discovery and Admissibility of Evidence Related to the Reasonableness of Medical Expenses

With that background, we turn to what evidence may be admitted at trial—and indeed, what evidence is discoverable in the first place—regarding a plaintiff's claimed medical damages.

Admissibility of Medical Damages Evidence

What evidence is admissible at trial regarding the reasonable value of past and future medical care differs in part based on the application of the collateral source rule. Under this rule, an injured party's damages may not be reduced as the result of payments or benefits received from third sources, like insurance; the rule also prohibits the admission of evidence at trial that the injured party has received or is entitled to receive such payments or benefits. Florida has partially abrogated this common-law rule through section 768.76, Florida Statutes, which provides that, after verdict, a court must reduce a damages award by the total amount of collateral sources paid for the benefit of, or which are otherwise available to, the plaintiff, subject to certain exceptions. Notwithstanding the statutory abrogation of the damages rule, the evidentiary collateral source rule has survived largely unchanged, with a few exceptions.

In *Florida Physician's Insurance Reciprocal v. Stanley*,[12] the Florida Supreme Court held that evidence of governmental or charitable benefits available to all citizens should not be precluded by the evidentiary collateral source rule, reasoning that the "common-law collateral source rule should be limited to those benefits earned in some way by the plaintiff. Governmental or charitable benefits available to all citizens, regardless of wealth or status, should be admissible for the jury to consider in determining the reasonable cost of necessary future care." *Id.* at 515.

The Florida Supreme Court receded from this holding in *Joerg v. State Farm Mutual Automobile Insurance Co.*[13] *Joerg* was a negligence action arising from a car accident where the injured party was developmentally disabled and a lifelong Medicare recipient. The plaintiff, on behalf of the injured party (the plaintiff's son), moved to exclude evidence of any collateral source benefits to which the injured party was entitled. The trial court ultimately granted the motion; in

[12] 452 So. 2d 514 (Fla. 1984).
[13] 176 So. 3d 1247 (Fla. 2015).

relevant part, the court precluded the defendant State Farm from introducing evidence of the injured party's future Medicare or Medicaid benefits.

The Florida Supreme Court accepted review to consider the question of whether the exception to the collateral source rule created in *Stanley* applies to future benefits provided by social legislation like Medicare. The Court held that because "future Medicare benefits are both uncertain and a liability under *Stanley*, due to the right of reimbursement that Medicare retains," the collateral source rule bars admission of these benefits.[14] The Court went on to reason that "it is absolutely speculative to attempt to calculate damage awards based on benefits that a plaintiff has not yet received and may never receive, should either the plaintiff's eligibility or the benefits themselves become insufficient or cease to continue."[15]

Joerg barred the admission of evidence that Medicare or Medicaid benefits are available for *future* medical expenses.[16] A number of Florida courts have limited evidence of *past* medical expenses, however, to those amounts actually paid for by Medicare and Medicaid benefits.[17] For instance, in *Cooperative Leasing, Inc. v. Johnson*, the Second District Court of Appeal reversed a trial court's decision that had allowed the plaintiff to admit into evidence bills for medical expenses the plaintiff never had to pay because the expenses were covered by Medicare, recognizing that to rule otherwise would allow "the plaintiff to receive a windfall by recovering 'phantom damages.'"[18]

Notwithstanding the fact that this rationale would seem to apply equally in the private health insurance context, the gross amount of a medical bill is admissible when a health insurer paid the bill, and a defendant may not introduce evidence that the insurer paid less than the gross amount.[19] Part of the rationale for this appears to be that payments from an insurance company are set off from the verdict under the setoff statute, while past Medicare or Medicaid payments are not.[20] A Florida court has also held that the gross amount of a medical bill was admissible even when the uninsured injured party was simply able to negotiate a lower amount from the provider, because the injured party "earned in some way" the lower final amount of his bill.[21]

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[14] *Id.* at 1253.

[15] *Id.* at 1255.

[16] The Florida Supreme Court has recently confirmed that *Joerg* is limited to future medical expenses and has no application to past medical expenses. *Dial v. Calusa Palms Master Ass'n, Inc.*, 337 So. 3d 1229 (Fla. 2022).

[17] *Coop. Leasing, Inc.*, 872 So. 2d at 960; *Thyssenkrupp Elevator Co. v. Lasky*, 868 So. 2d 547, 549-51 (Fla. 4th DCA 2004) ("When a provider charges for medical service or products and later accepts a lesser sum in full satisfaction by Medicare, the original charge becomes irrelevant because it does not tend to prove that the claimant has suffered any loss by reason of the charge.")

[18] *Coop. Leasing, Inc.*, 872 So. 2d at 959.

[19] *See, e.g.*, *Nw. Mut. Fire Ins. Co. v. Harrell*, 53 So. 3d 1084, 1087 (Fla. 1st DCA 2010) ("[P]ursuant to the evidentiary portion of the collateral source rule as it currently exists in Florida, we hold that the trial court correctly ruled that appellee was entitled to introduce into evidence (and to request from the jury) the gross amount of her medical bills, rather than the lesser amount paid by appellee's private health insurer in full settlement of the medical bills.").

[20] *See Matrisciani v. Garrison Prop. & Cas. Ins. Co.*, 298 So. 3d 53, 58 (Fla. 4th DCA 2020).

[21] *Durse v. Henn*, 68 So. 3d 271, 277 (Fla. 4th DCA 2011).

That said, some courts have allowed admission of evidence that a plaintiff chose not to use health insurance coverage and instead obtained treatment under an LOP, on the rationale that it was not prohibited collateral source evidence as "there have been no payments made" and such evidence was relevant to the question of bias on the part of the treating physician: "the provider has intentionally and voluntarily heightened his interest in the outcome of the litigation by foregoing more certain contractual reimbursement in favor of more risky reimbursement through an LOP."[22]

Evidence from Databases Which Compile Medical Charges Are Often Excluded. One ongoing challenge to ensuring juries have all evidence relevant to the valuation of medical damages is courts' treatment of databases which would indicate the true market value of medical services. What other similarly-situated providers have charged and accepted for a particular medical service or procedure is plainly relevant to the determination whether a particular provider's claimed charge for that same service or procedure is reasonable. Yet providers' specific price lists are typically treated as proprietary information. One must consult larger databases which compile medical charges to determine the usual and customary charges for medical services. Thus, the most reliable means of determining how a provider's charges for a certain CPT code compare to other providers offering the same services is to use independently published compilations based on review of millions of claims submitted by providers. An expert can be used to consult these compilations and then assess whether the charges included in an LOP make sense in light of what those compilations show.

Evidence from such databases should be admissible under the hearsay exemption for "[m]arket quotations, tabulations, lists, directories, or other published compilations, generally used and relied upon by the public or by persons in particular occupations."[23] Yet courts often restrict such testimony on the mistaken belief that reliance on such databases is improper because they are hearsay.[24] Florida courts have also stringently interpreted the hearsay exception for market quotations and directories. For example, in *Hardy v. State*,[25] in a prosecution of a defendant for unlawfully possessing methadone, the trial court admitted information from the Florida Department of Health's Prescription Drug Monitoring Program database. The trial court admitted this information under the hearsay exception for market reports and commercial publications. On appeal, the First DCA reversed. The court held that the database did not qualify as a market report or commercial publication "for several reasons," including that it was not published.[26] But

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[22] *See* Order Granting Defendant's Motion in Limine, *Caraballo v. Athey*, No. 2018-CA-002867-08-K (Fla. 18th Cir. Ct. Nov. 7, 2022).
[23] § 90.803(17), Fla. Stat.
[24] *See, e.g.*, Order on Plaintiff's Motion to Strike Defendant's Expert, *Martinez v. Griffis*, No. 2019-CA-00019-O (Fla. 9th Cir. Ct. Nov. 18, 2022) (excluding expert testimony based on databases of medical charges for the purported reason that such databases were hearsay and did not directly reflect charges of a self-pay patient treated under an LOP); Order on Plaintiff's *Daubert* Motion to Exclude, *White v. Schrum*, No. 05-2020-CA-043021-XXXX-XX (Fla. 18th Cir. Ct. Oct. 21, 2022) (excluding expert testimony which the judge said "regurgitate[ed] what one database says a charge should be" and because the databases used did not contain specific information to cash payors who are treated under an LOP).
[25] 140 So. 3d 1016 (Fla. 1st DCA 2014).
[26] *See id.* at 1020 ("Section 90.803(17) includes 'market quotations, tabulations, lists, directories, or other published compilations.' This language plainly requires that the evidence be published to qualify under the exception."). In dissent, Judge Rowe said she would have admitted the database information under the

excluding such highly relevant evidence forecloses juries from having a full picture of what medical services actually cost or are worth.

The evidentiary and damages collateral source rules are supposed to work together: the evidentiary rule is supposed to render collateral source evidence inadmissible because it may confuse the jury with respect to both liability and damages, while any potential windfalls to the plaintiff are minimized by the court later reducing the damages award by any collateral source outside the presence of a jury.[27] But the reality is, allowing the jury to hear the gross amount of a plaintiff's medical bills—even though the plaintiff will never pay that amount—and foreclosing the defendant from admitting evidence that undermines that gross amount influences the jury to award larger damages amounts for past medical expenses and even other damages, such as for pain and suffering.

Discovery Related to Medical Damages

Putting aside the collateral source rule and what is ultimately admissible at trial, numerous cases confirm that parties may inquire in discovery about evidence tending to show whether claimed medical damages are reasonable or unreasonable. For instance, in *Giacalone v. Helen Ellis Memorial Hospital*,[28] a patient challenged the reasonableness of a hospital's charges for treatment. The appellate court held that the patient's discovery requests were proper as the requests sought evidence relevant to a determination of the reasonableness of the medical charges, including evidence necessary to a comparative analysis of the relevant market, the usual and customary rates the hospital charged and received for the services at issue, and the hospital's internal cost structure.[29] Numerous courts have extended the rationale of *Giacalone* to discovery requests for information concerning LOPs, including, for example, what amounts a provider charges patients with LOPs versus others.[30]

The Problem of *Worley*. The ability to discover critical evidence necessary to challenge the reasonableness of LOPs has been hampered, however, by the Florida Supreme Court's 2017 decision *Worley v. Central Florida Young Men's Christian Association*,[31] where the Court restricted the ability of defendants to inquire through discovery about the referral relationships that

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hearsay exception for market reports and publications, finding that "published" for purposes of the exemption did not require wide dissemination. *Id.* at 1022 (Rowe, J., dissenting).

[27] *See Joerg*, 176 So. 3d at 1255.

[28] 8 So. 3d 1232 (Fla. 2d DCA 2009).

[29] *Id.* at 1236.

[30] *See, e.g.*, *Columbia Hosp. (Palm Beaches) Ltd. P'ship v. Hasson*, 33 So. 3d 148 (Fla. 4th DCA 2010); *see also, e.g.*, *Osceola Cnty. Bd of Cnty. Comm'rs v. Sand Lake Surgery Ctr. LLC*, 320 So. 3d 950 (Fla. 5th DCA 2021) (documents sought through discovery—including LOPs—were clearly relevant in personal injury action as the reasonableness of medical charges are at issue in such cases); *Katzman v. Rediron Fabrication, Inc.*, 76 So. 3d 1060 (Fla. 4th DCA 2011) (Discovery regarding billing information for a particular procedure is "permitted as it is calculated to lead to the discovery of admissible evidence regarding the reasonableness of medical expenses, that is, whether the health care provider charges non-litigation patients a lower fee for the same medical services" (internal quotation marks omitted)); *Gulfcoast Surgery Ctr., Inc. v. Fisher*, 107 So. 3d 493 (Fla. 2d DCA 2013) (agreeing similar discovery was permitted but requiring trial court to impose protective measures to prevent dissemination of trade secrets).

[31] 228 So. 3d 18 (Fla. 2017).

might exist between plaintiffs' counsel and treating physicians and factoring companies—the relationships which give rise to LOPs. In *Worley*, the Florida Supreme Court held that a defendant is not permitted to inquire through discovery about any referral relationship that might exist between a plaintiff's attorney and the plaintiff's treating physician because it is protected by the attorney-client privilege. What the Court did not assail, however, was the right to inquire about, and to present evidence regarding, the use of an LOP. Indeed, the Court expressly stated that if the hope of such discovery was to uncover bias, "bias on the part of a treating physician can be established by *providing evidence of a letter of protection* . . . , which may demonstrate that the physician has an interest in the outcome of the litigation."[32] The Court also suggested that bias may be demonstrated where the "physician's practice was based entirely on patients treated pursuant to LOPs," and where the LOPs appear to demonstrate expenses that are "higher than normal."[33] Notwithstanding this, *Worley* unreasonably protects much of the LOP relationship under the shield of the attorney-client privilege.

IV. Setoff

Putting aside for a moment what evidence is discoverable and admissible concerning medical damages, we turn to the principles of setoff. As noted above, Florida has partially abrogated the common-law collateral source rule through section 768.76, Florida Statutes, which provides that, after a jury verdict, a court must reduce (or set off) a damages award by the total amount of collateral sources paid for the benefit of, or which are otherwise available to, the plaintiff, subject to certain exceptions. Specifically, section 768.76 states in relevant part as follows:

> 768.76 Collateral sources of indemnity.—
>
> (1) In any action to which this part applies in which liability is admitted or is determined by the trier of fact and in which damages are awarded to compensate the claimant for losses sustained, the court shall reduce the amount of such award 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 . . . .

§ 768.76(1), Fla. Stat. The statute further defines the term "collateral source" to mean "any payments made to the claimant, or made on the claimant's behalf" pursuant to an insurance policy or the like. *Id.* § 768.76(2)(a). Collateral sources thus include, for example, private health insurance, auto insurance that provides medical or disability coverage, Social Security payments, and employee salary continuation plans. *See id.* Collateral sources do not include payments or benefits for which a right of subrogation or reimbursement exists, *id.* § 768.72(1), or Medicare, Medicaid, workers' compensation, or life insurance benefits.

As the statute suggests, however, it applies only to *paid* amounts or amounts which are otherwise available to the claimant, such as through insurance. For instance, a discount on a medical bill negotiated by a claimant's insurance carrier is a collateral source subject to setoff

[32] *Id.* at 23 (emphasis added).
[33] *Id.* at 24.

under section 768.76.[34] The setoff statute, however, does not reach *unpaid* medical bills, including LOPs, as they would not constitute a collateral source within the meaning of the statute. In other words, even though an LOP reflects a past medical treatment, since no one has paid it on the claimant's behalf yet, it is still deemed a "future" expense and not yet a past paid amount subject to the setoff statute.[35]

The following examples illustrate how setoff under section 768.76 generally works.

Scenario 1 – Health Insurance with a Right of Subrogation and Deductible/Co-Pay.[36] Assume that a jury awarded the plaintiff $100 in damages due to a past medical expense. The basics of that medical expense are as follows:

Bill (Retail Doctor's Visit)	$100
Health Insurance Payment	$50
Adjustment/Contractual Discount	$40
Co-Pay/Balance owed by patient	$10

Because the plaintiff paid or owes the $10 co-pay/balance, it is not set off. Because the claimant owes the $50 paid by the insurer back to the insurer under a right of subrogation, it is also not set off. Because the claimant does not owe the $40 contractual adjustment negotiated by the insurer, however, it is set off from the ultimate verdict. The ultimate result is that, post-verdict, the $100 awarded by the jury would be reduced by $40 and the net recovery to the plaintiff is $60.

Scenario 2 – Medicare (No Co-Pay). Assume that the jury again awarded the plaintiff $100 in damages for a past medical expense, but that the specifics of that expense were as follows:

Bill (Retail Doctor's Visit)	$100
Medicare allowable amount	$20
Adjustment	$80

Because Medicare has a right of subrogation, the $20 is not set off. The result is that, post-verdict, the plaintiff would receive a net award of $20, as the $80 adjustment is setoff.

Scenario 3 – Health Insurance with No Right of Subrogation. Again assume that the jury awarded the plaintiff $100 for a past medical expense, but the specifics of that expense were instead as follows:

Bill (Retail Doctor's Visit)	$100
Health Insurance Payment	$50
Adjustment/Contractual Discount	$50

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[34] *Goble v. Frohman*, 901 So. 2d 830, 833 (Fla. 2005).
[35] *See, e.g.*, *Joerg*, 176 So. 3d at 1249 ("section 768.76 does not allow reductions for *future* medical expenses").
[36] The sample verdict form and illustrations come from those used by Judge Donald Myers of the Ninth Judicial Circuit Court of Florida in a presentation entitled "Damages in Florida Tort Actions" given to the Florida House of Representatives Judiciary Committee on November 2, 2021.

The ultimate result is that, post-verdict, because the health insurer has no right to be repaid and the claimant does not owe the adjusted amount, the entire bill is setoff and the net recovery is zero.

The following example goes further to illustrate how the issue of medical damages and setoff are handled at trial and post-trial.

The Trial and Verdict. Attached as **Exhibit A** is a sample completed jury verdict form in the hypothetical case of *Paul Plaintiff v. XYZ Company and 123 Company*. In the underlying case, Plaintiff has sued XYZ Company ("XYZ") and 123 Company ("123") for negligence due to Plaintiff's slip and fall. At trial, Plaintiff was permitted to introduce as evidence the full billed amount or "sticker price" of his past paid medical bills, $90,000.

Defendants XYZ and 123 were barred by the collateral source rule from introducing evidence that: (1) Plaintiff's health insurer, Florida Purple, has already paid those medical bills on Plaintiff's behalf; and (2) due to prior contractual arrangements between Florida Purple and Plaintiff's medical providers, Florida Purple paid only $50,000 in full satisfaction of those bills due to contractual adjustments and write-offs.

At trial and as reflected in Exhibit A, the jury concluded that XYZ and 123 were both negligent and that their negligence was the legal cause of Plaintiff's injury. The jury also determined the amount of damages owed Plaintiff, including the specific amount of **$90,000** for past medical expenses, which represented the exact "sticker" price of Plaintiff's past medical bills. That the jury found that Plaintiff suffered $90,000 in past medical expenses may have influenced their other damages awards, including for future medical expenses ($110,000) and pain and suffering ($90,000).

Post-Verdict Motion for Setoff. Attached as **Exhibit B** is a sample motion by Defendants XYZ and 123 seeking a post-verdict setoff.

Specifically, the motion outlines the facts that Plaintiff's health insurer, Florida Purple, has paid Plaintiff's past medical bills, and due to contractual agreements with Plaintiff's medical providers, Florida Purple had to pay only $50,000 of the total $90,000 "sticker price." Consequently, XYZ and 123 are entitled under Florida law to have the trial court setoff the jury's $90,000 award for past medical expenses by $40,000—the amount of write-offs and adjustments—such that, when judgment is entered, only **$50,000** should be included in the judgment for past medical expenses.

This of course does not account for any past but *unpaid* medical expenses, such as those reflected in an LOP which defers payment until after settlement or judgment. Thus, notwithstanding the fact that an LOP might similarly bear a face value of $90,000, and the expenses reflected therein might have been satisfied for much less than that amount—say for $50,000—the jury will hear that the past unpaid medical expenses reflected on the LOP are $90,000, and the trial court will not adjust any damages award related to the LOP.

V. Florida's Current Law Forecloses Transparency in Damages

We next turn to several real examples of how Florida's existing law concerning what evidence is admissible at trial hampers the jury's ability to assess a plaintiff's claimed medical treatments.

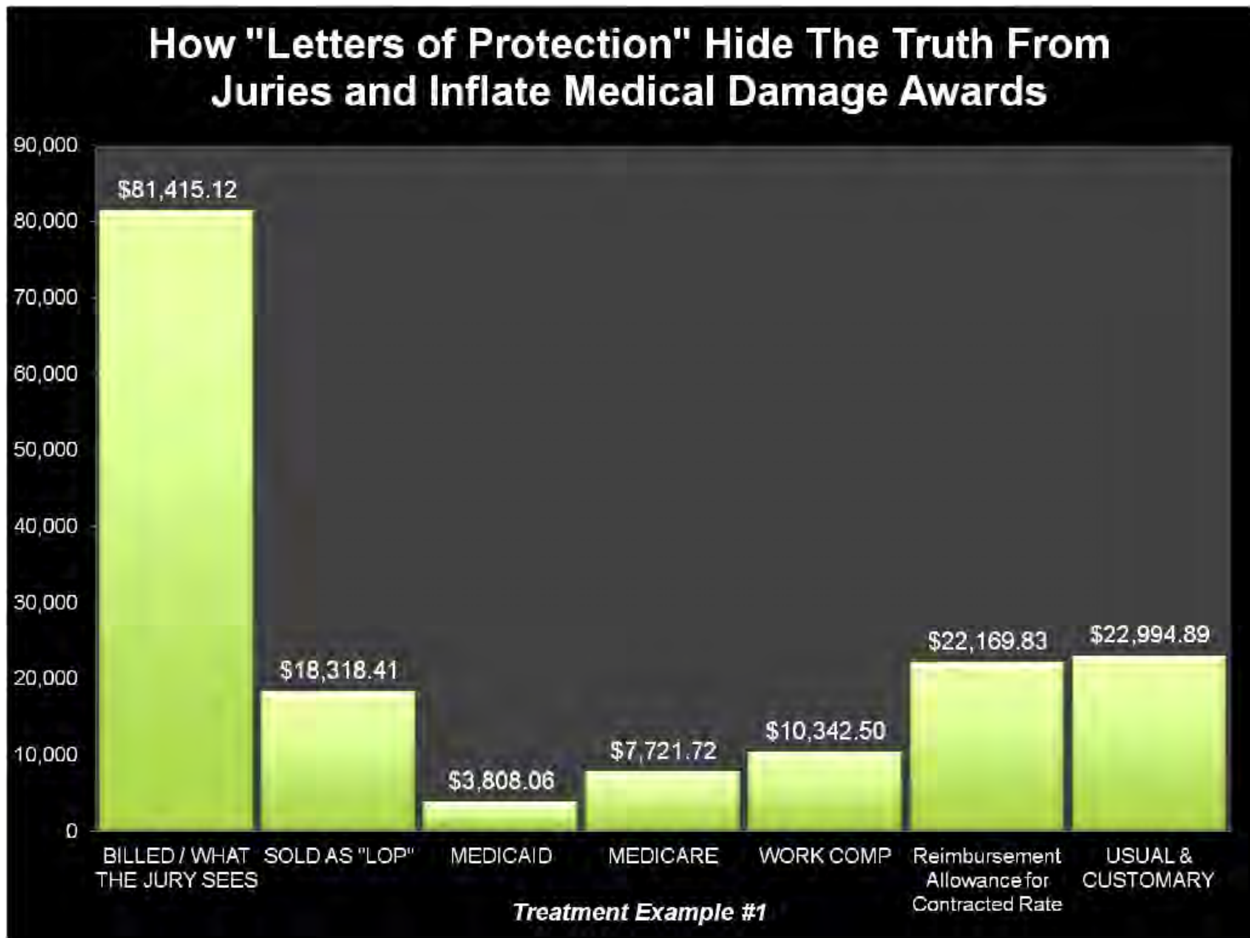
As noted above, for numerous reasons, the "sticker price" or billed charge for a medical procedure or service often has little if any relationship to the true cost or value of that procedure or service. LOPs add an additional wrinkle. Again, an LOP is an agreement typically negotiated by a personal injury lawyer wherein a plaintiff's medical provider agrees to suspend efforts to collect medical bills from the plaintiff while litigation is pending. In exchange, the provider receives a right to payment of their bills from any recovery by the plaintiff. Often, the plaintiff is foregoing use of their own health insurance in order to receive treatment under an LOP. The LOP often provides that the plaintiff remains responsible for paying his medical bills if the litigation is unsuccessful. LOPs once served a legitimate function: they provided a means for those who are uninsured or have exhausted insurance coverage, and who do not have Medicaid or Medicare, to promptly receive and continue medical care during litigation regardless of financial resources.

Unfortunately, however, LOPs are also used to inflate damages awards. Physicians providing care under LOPs often charge many times more than the typical cost of service and later accept a fraction of their billed amounts as part of an ongoing relationship with plaintiffs' attorneys. Further, because the LOP is essentially a note receivable, physicians often sell these "notes" to medical lien purchasing or "factoring" companies to get compensation sooner than the end of litigation and often in amounts in excess of what physicians would receive otherwise through sources like insurance.

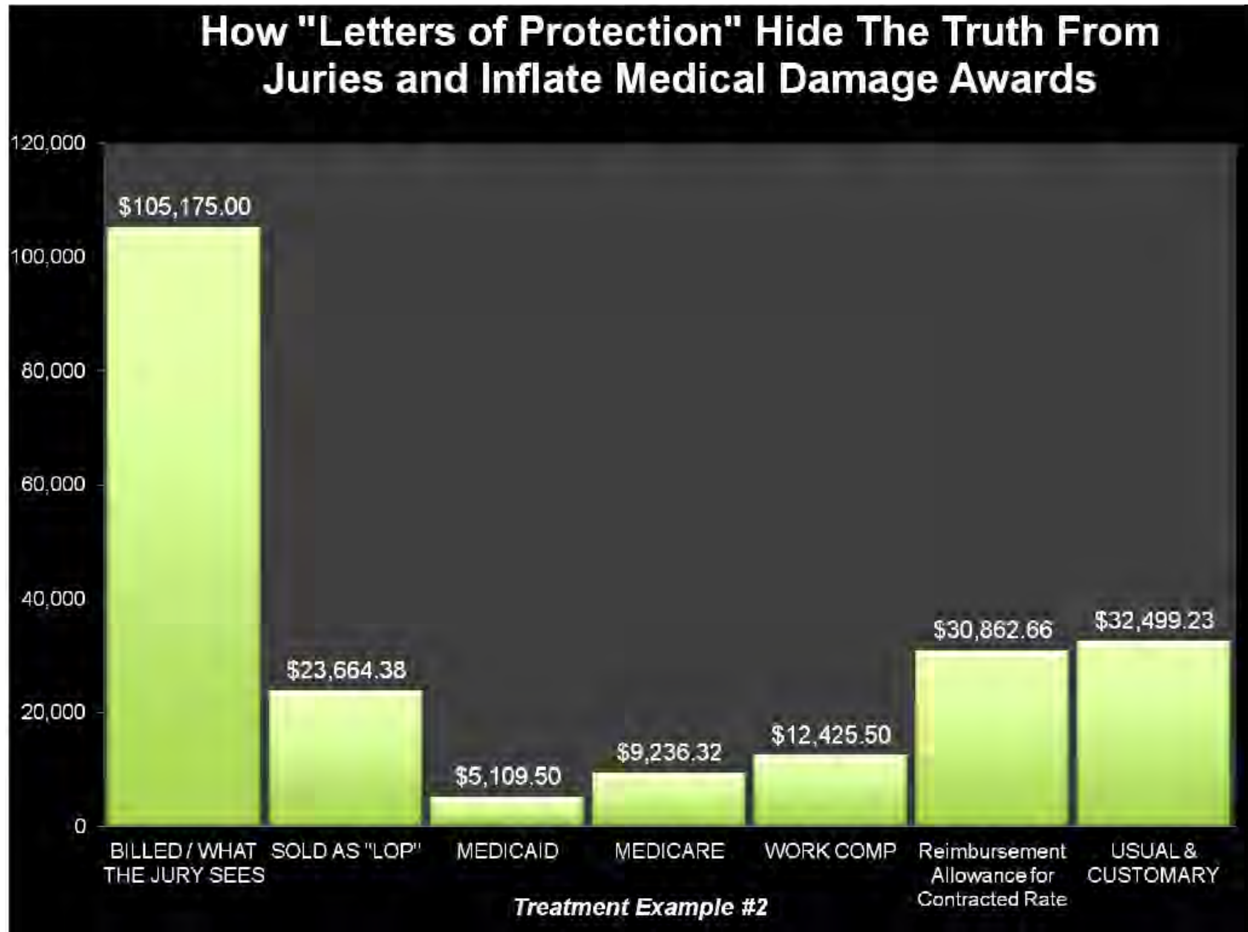
The sticker price of an LOP has no connection with the true cost or value of the medical service or procedure in question, as demonstrated by what other similarly-situated providers would accept for such treatment or other common methods of valuing medical care such as Medicare and Medicaid—yet the LOP's sticker price is all the jury knows.

The problems described above are highlighted by a few real-world examples.

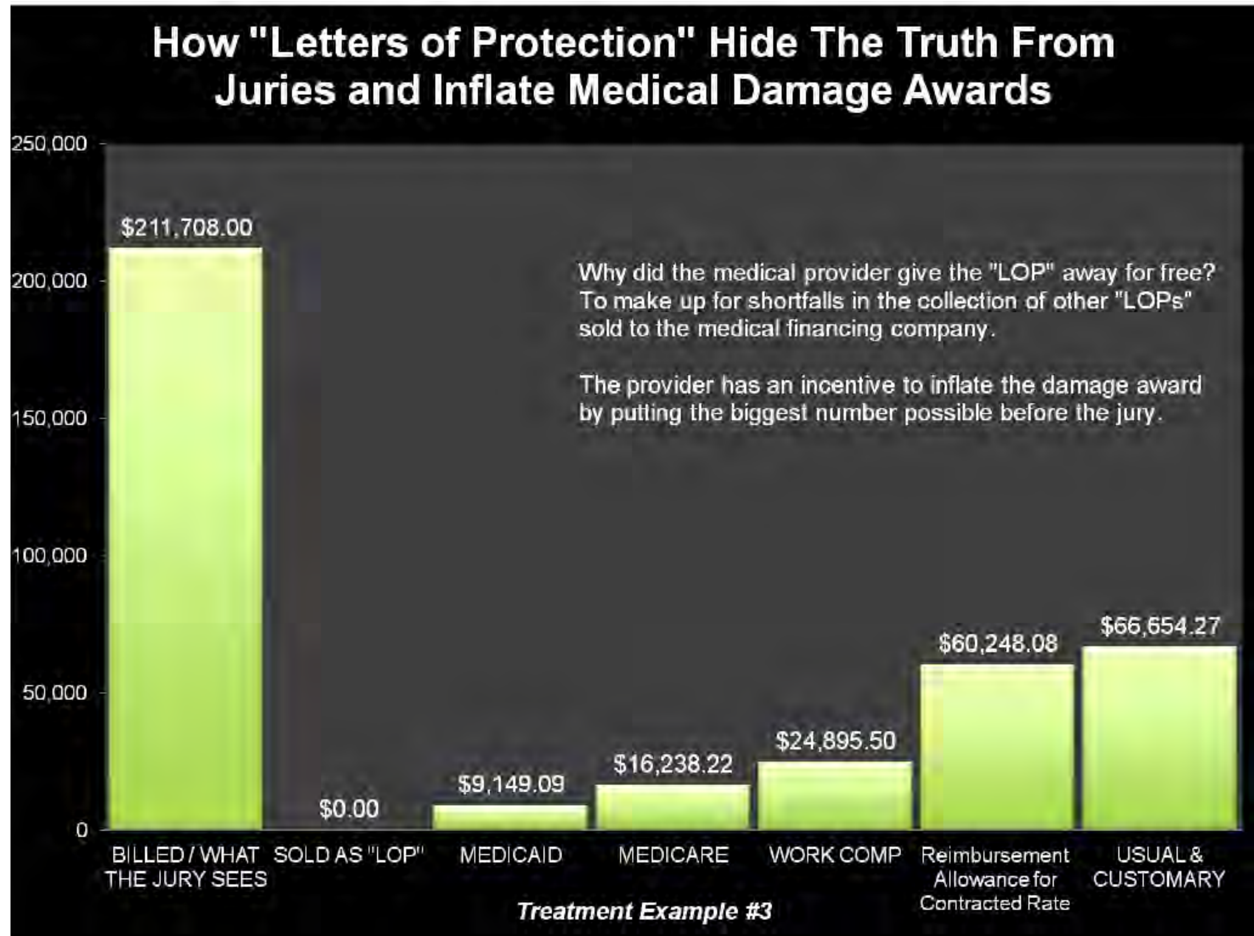
EXAMPLE 1. In the below example, the plaintiff received medical treatment under an LOP. The sticker price of the LOP, as negotiated by the plaintiff's counsel and the treatment provider, was **$81,415.12** (as represented by the "Billed/What the Jury Sees" bar). The defendant learned through discovery that a factoring company purchased the LOP from the provider for a fraction of that amount—$18,318.41. A coding expert would opine that the same treatment would have cost only $3,808.06 if covered by Medicaid and $7,721.72 if covered by Medicare, and that the "usual and customary" cost for the treatment in the relevant area is $22,994.89. Even though these other amounts all better represent the true value of the plaintiff's medical treatment, the jury only hears about the inflated "billed" amount represented by the LOP, which is more than **3.5 times** the usual and customary rate charged for the treatment.



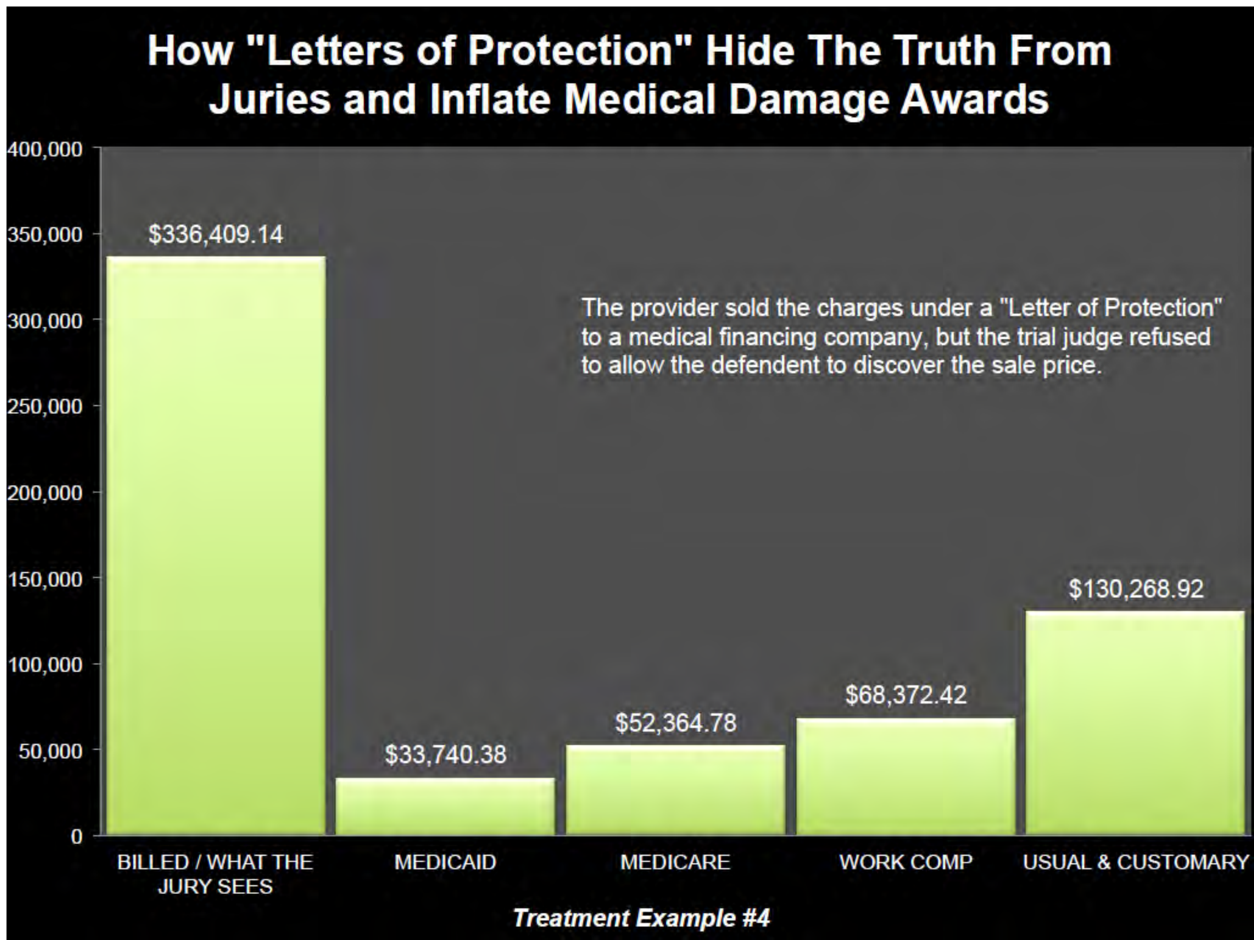
EXAMPLE 2: In this second example, the plaintiff received medical treatment under an LOP with a sticker price of **$105,175.00.** The LOP was "sold" to a factoring company for only $23,664.38. Medicaid would have covered the same medical treatment for $5,109.50; Medicare would have covered it for $9,236.32; and the reimbursement allowance for insurer contracted rate is only $30,862.66. The "usual and customary" cost for the treatment is only $32,499.23. Yet the jury hears that the "cost" of the plaintiff's medical treatment is $105,175 as represented by the LOP.



EXAMPLE 3: The plaintiff received treatment under an LOP with a face value of **$211,708.00**. In this instance, the provider sold the LOP to a factoring company for nothing. Medicaid would have covered the same treatment at a cost of $9,149.09, and Medicare would have paid $16,238.22. An expert would opine that the usual and customary cost for the same treatment is $66,654.27—less than a third of the face value of the LOP. As noted below, in this example the LOP was given away for "free" to a factoring company—likely to make up for shortfalls in the collection of other LOPs.

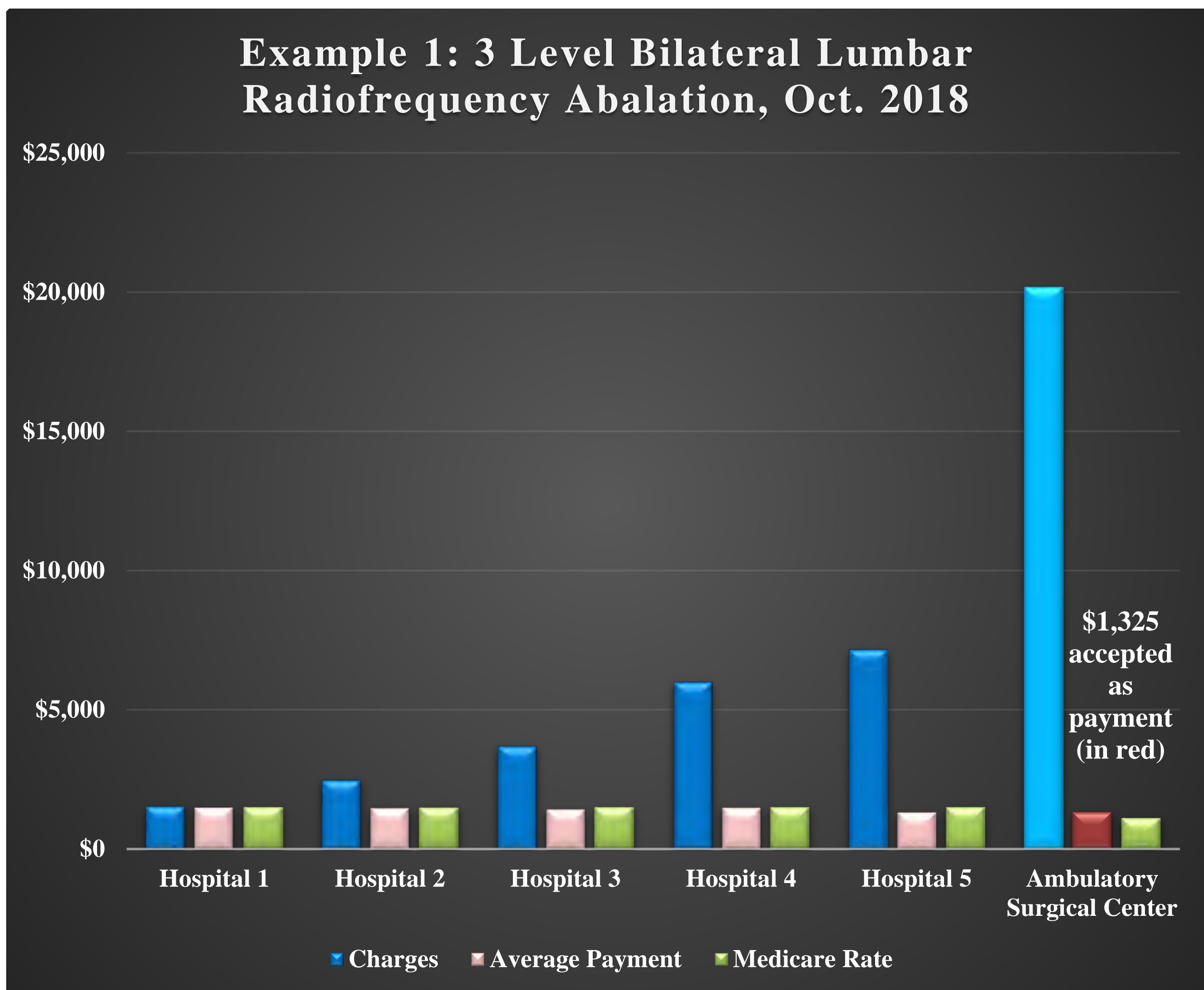


EXAMPLE 4: The plaintiff received treatment under an LOP with a face value of **$336,409.14**. The provider sold the LOP to a factoring company, but the trial judge refused to allow the defendant to discover the sale price. If covered by Medicaid, the treatment would have cost only $33,740.38, and Medicare would have covered the same treatment for $52,364.78. The usual and customary cost for the treatment in the relevant community is only $130,268.92. Yet the jury cannot hear any of these facts; they only know the sticker price of the LOP.

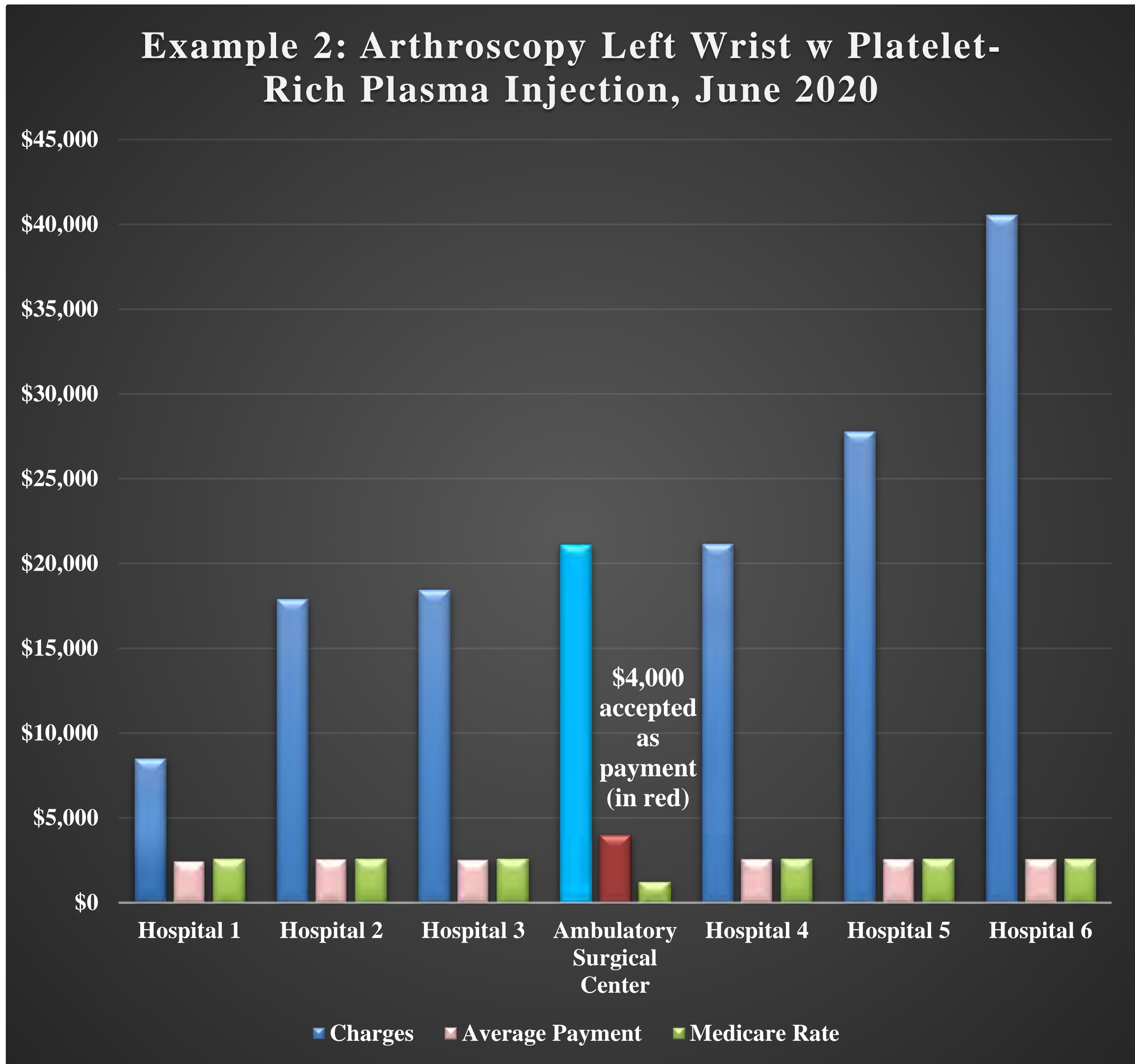


The above examples provide in one bar the "usual and customary" charges for a particular procedure. However, the following examples from real cases illustrate the stark difference between what the jury hears regarding the purported "value" of medical treatment—often as represented by an LOP's sticker price—versus what other, similarly-situated providers would charge and accept in full payment for that same procedure in the same geographic area.

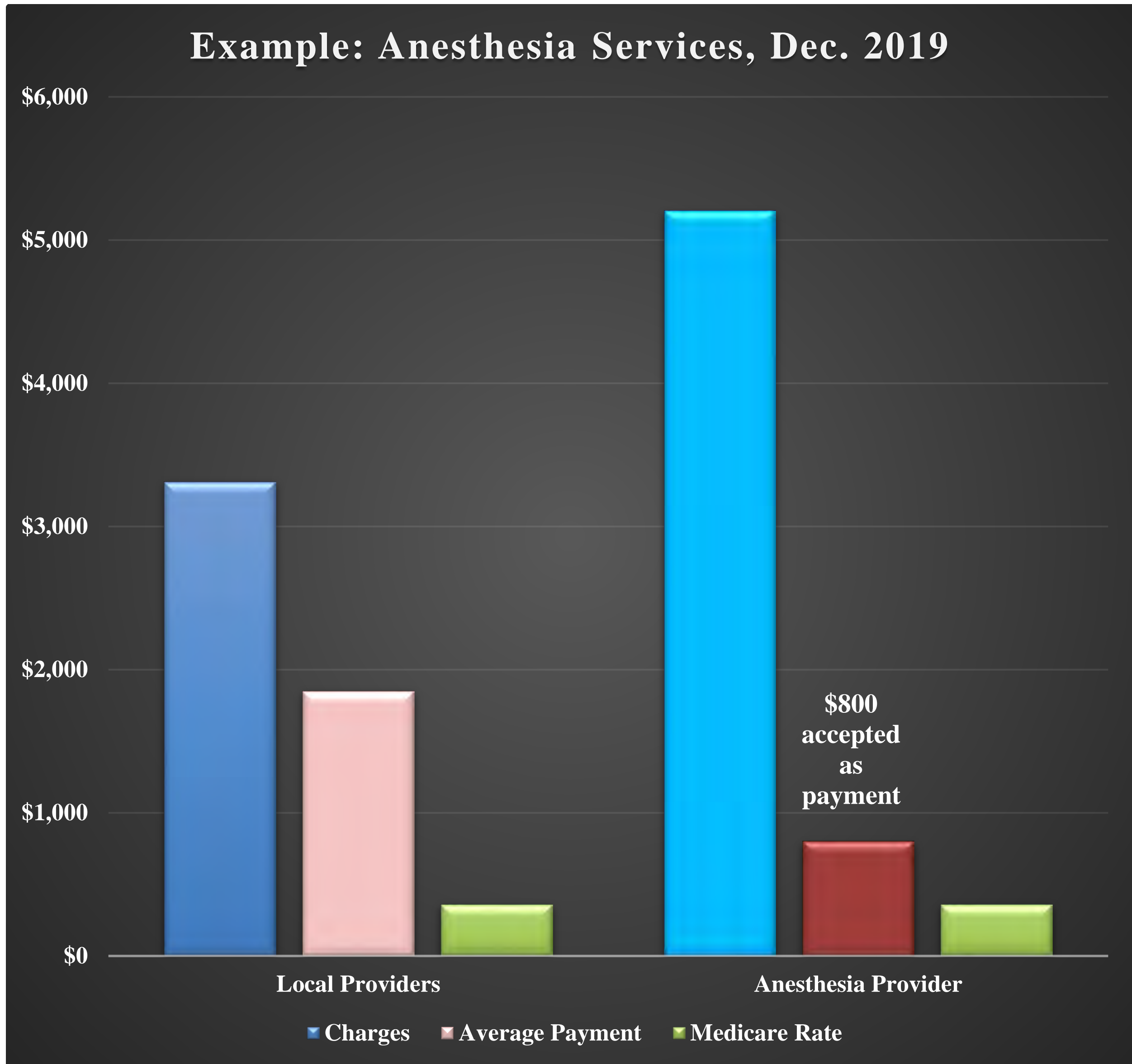
EXAMPLE 1: In the below example, an ambulatory surgical center's "billed" charge for a 3 level bilateral lumbar radiofrequency ablation in October 2018 was **$20,188**. Ultimately, however, the surgical center accepted only **$1,325** as payment on that bill. As shown by examining readily available public information on pricing of the same procedure at a number of local hospitals, the sticker price for the ***same*** procedure at five hospitals in the same geographic area of the ambulatory surgical center typically runs between $1,539 and $7,169, and even then on average those hospitals accept a fraction of that as payment—similar to the amount that the surgical center actually accepted in payment for the procedure. In short, the plaintiff was able to present the "sticker" price of this procedure by the ambulatory surgical center as evidence of his medical damages, even though that sticker price is many times more the rate charged by local hospitals and is 15 times more than what the facility actually accepted in payment.



EXAMPLE 2: In the next example, an ambulatory surgical center billed **$21,136** for an arthroscopy in June 2020. That billed amount was in line with what several local hospitals charged for that outpatient surgery. But ultimately the surgical center accepted **$4,000** for payment, while the local hospitals on average accepted much less. Regardless, $21,136 was presented at trial as the real medical expenses for which the plaintiff was responsible—despite the fact that this amount is five times what the surgical center actually accepted in payment (and even that amount is above what other local hospitals would have accepted).



EXAMPLE 3: In the final example, an aesthesia provider's billed charge for services in December 2019 was **$5,204**. Similar, local providers would have charged only $3,312 for the same services. Notably too, the Medicare rate for the same services is only $361. Ultimately, the provider accepted **$800** from the plaintiff's attorney prior to trial, much less than what local providers would have accepted for the same services. Despite all this, the inflated billed charge was presented as trial as the real medical expenses for which the plaintiff was responsible.



* * *

As these examples show, under current Florida law the jury is not given a full picture of a plaintiff's medical damages. While plaintiffs must still prove the reasonableness of their medical damages, the evidentiary collateral source rule in many ways precludes defendants from effectively challenging that reasonableness as the collateral source rule asks the jury to ignore the practical reality of the modern health care industry and instead evaluate a plaintiff's injuries based on the inflated sticker price reflected on past and future medical bills (including through LOPs). Consideration of such inflated charges misleads juries into awarding excessive amounts, including for pain and suffering. Moreover, while the mere fact a plaintiff received treatment under an LOP may be used to show bias and challenge the reasonableness of a claimed medical expense, the fact remains that a jury still gets to hear and consider the often-inflated value of an LOP as evidence of the cost of the plaintiff's medical treatment, and further evidence that would undermine the stated value of an LOP is kept from the courtroom. At the center of this problematic practice is often a plaintiff patient taken advantage of by a treating provider, a plaintiff's attorney, and a factoring company, all encouraging that plaintiff patient to use an LOP and treatment via the attorney's preferred provider in order to drive up the ultimate damages award earned in litigation.

VI. The Legislature Must Take Action to Restore Transparency in Damages

Juries must know the true cost of medical treatment in order to accurately assess the damages that should be awarded injured plaintiffs. Accordingly, the Institute supports HB 837 that would do the following:

- Amend section 90.502, Florida Statutes, concerning the lawyer-client privilege, to overrule *Worley* and state that the privilege does not apply if "[a] communication is relevant to the lawyer's act of referring the client for treatment by a health care provider." (Section 2, lines 64-65.)

- Define and outline the evidence admissible to show both past and future medical expenses (Section 4), including that:

    - For past paid medical expenses, evidence is limited to the amount actually paid, regardless of the source of payment. (Lines 287-290.)

    - For past unpaid medical expenses:

        - If the claimant has health care coverage, evidence of the amount which such health care coverage is obligated to pay the medical provider to satisfy the charges for the claimant's incurred medical treatment or services, plus the claimant's share of medical expenses under the insurance contract or regulation. (Lines 294-299.)

        - If the claimant has health care coverage but obtains treatment under an LOP, evidence of the amount that the claimant's health care coverage would pay the medical provider to satisfy the past unpaid medical charges under the insurance contract or regulation, plus the claimant's share of medical

expenses, had the claimant obtained medical services or treatment pursuant to health care coverage. (Lines 300-309.)

        - If the claimant does not have health care coverage, evidence of the Medicare reimbursement rate in effect at the time of trial for the claimant's incurred medical treatment or services. (Lines 310-314.)

        - If the claimant obtains medical treatment or services under an LOP and the medical provider subsequently transfers the right to receive payment under the LOP to a third party, evidence of the amount the third party paid or agreed to pay the provider in exchange for the right to collect under the LOP. (Lines 315-321.)

    - For future medical expenses:

        - If the claimant has health care coverage or is eligible for any health care coverage, evidence of the amount for which the future charges of health care providers could be satisfied if submitted to such healthcare coverage, plus the claimant's share of medical expenses. (Lines 327-332.)

        - If the claimant does not have health care coverage, evidence of the Medicare reimbursement rate in effect at the time of trial for the medical treatment or services the claimant will receive, or, if there is no applicable Medicare rate for a 336 service, 140 percent of the applicable state Medicaid rate. (Lines 333-337.)

- Require the disclosure of certain information about LOPs, including: all billings for the claimant's medical expenses, which must be itemized and to the extent applicable, coded according to CPT or HCPS; if the health care provider sells the accounts receivable for the claimant's medical expenses to a factoring company or other third party, the name of the factoring company or third party and the dollar amount for which the factoring company or other third party purchased the account; whether the claimant, at the time medical treatment was rendered, had health care coverage and, if so, the identity of such coverage; and whether the claimant was referred for treatment under an LOP and, if so, the identity of who made such referral. (Section 4, lines 345-372.)

- Confirm that the damages recoverable for medical treatment or services is limited to the amounts actually paid by or on behalf of the claimant to a health care provider, the amounts necessary to satisfy charges for medical treatment or services that are due and owing but at the time of trial are not yet satisfied, and amounts necessary to provide for any reasonable and necessary medical treatment or services the claimant will receive in the future. (Section 4, lines 373-388.)

EXHIBIT A

IN THE CIRCUIT FOR THE xxTH JUDICIAL CIRCUIT IN
AND FOR ANY COUNTY, FLORIDA

CASE NO: ABCD12-34567

PAUL PLAINTIFF,

Plaintiff,

v.

XYZ COMPANY; and
123 COMPANY

Defendant

____

VERDICT

We, the jury, return the following verdict:

1. **Was there negligence on the part of XYZ Company which was legal cause of injury or damage to Paul Plaintiff?**

   YES___x____ NO_________

2. **Was there negligence on the part of 123 Company which was legal cause of injury or damage to Paul Plaintiff?**

   YES___x____ NO_________

If your answer to Question **1 and 2** are NO, your verdict is for defendants, and you should not proceed further except to date and sign this verdict form and return it to the courtroom. If you answer to questions **1 and 2** is YES, please answer question **3.**

3. **Was there negligence on the part of Paul Plaintiff which was a legal cause of her injury or damage?**

   YES_______ NO____x_____

If your answer to question **3** is YES, please answer question **4.** If you answer to question **3** is NO, skip question **4** and answer questions **5, 6, 7, and 8.**

4. **State the percentage of negligence or fault, which was a legal cause of injury or damage to Paul Plaintiff that you charge to:**

XYZ Company	**___50_____%**
123 Company	**___50____%**
Paul Plaintiff	**____0____%**

Total must be 100%

By answering the following questions, you will determine the damages, if any, that Paul Plaintiff sustained as a result of the incident in question. In determining the amount of damages, do not make any reduction because of the negligence, if any, of Paul Plaintiff. If you find that Paul Plaintiff was negligent or at fault, the court in entering judgment will make an appropriate reduction in the damages awarded.

5. **What is the amount of damages sustained in the past for medical expenses?** **$_____90,000______**

6. **What is the present money value of any damages to be sustained in the future for medical expenses?** **$_____110,000______**

7. **What is the amount of any damages for pain and suffering, disability, physical impairment, disfigurement, mental anguish, inconvenience, and loss of capacity for the enjoyment of life?**

   a. **In the past?** **$______30,000_________**

   b. **In the future?** **$______60,000_________**

8. **What is the total amount of Paul Plaintiff's damages, if any, for lost earnings?**

   a. **In the past?** **$_______15,000_______**

   b. **In the future?** **$_______55,000_______**

TOTAL DAMAGES OF PAUL PLAINTIFF: **$_______360,000________**
(ADD LINES 5, 6, 7a, 7b, 8a, and 8b)

SO SAY WE ALL, this ___4th___ day of _____March_______, 2014___

____
FOREPERSON

EXHIBIT B

IN THE CIRCUIT FOR THE
xxTH JUDICIAL CIRCUIT IN
AND FOR ANY COUNTY,
FLORIDA

CASE NO: ABCD12-34567

PAUL PLAINTIFF,

Plaintiff,

v.

XYZ COMPANY; and
123 COMPANY

Defendant

____

MOTION FOR POST-TRIAL SET-OFF IN ACCORDANCE WITH COLLATERAL SOURCE WRITE-OFFS AND ADJUSTMENTS

Defendants, XYZ Company and 123 Company, by and through the undersigned attorney, respectfully move for a post-trial set-off in the amount of collateral source write-offs and adjustments made to Plaintiff's past medical bills in this case, and as grounds in support thereof state:

1. This is a personal injury slip-and-fall case. At the conclusion of a four (4) day jury trial, a verdict was entered in favor of the Plaintiff on March 4, 2014, in the total amount of $360,000.

2. Of that total award, $90,000 was for past medical expenses. Those past medical expenses were paid though Plaintiff's health insurer, Florida Purple. In connection with Florida Purple's payments to Plaintiff's health care providers, which those providers accepted as payment in full for all medical care and treatment they rendered to

the Plaintiff, Plaintiff's medical providers made write-offs and adjustments to their bills in the amount of $40,000, in accordance with their contractual agreements with Florida Purple.

3. Under Florida Statute 768.76(2)(a), health insurance is a collateral source.

4. "Upon proper objection, the collateral source rule prohibits the introduction of any evidence of payments from collateral sources." *Sheffield v. Superior Ins. Co.*, 800 So. 2d 197, 200 (Fla. 2001); *See*, *also*, *Gormley v. GTE Products Corp.*, 587 So. 2d 455 (Fla. 1991).

5. In the instant case, Plaintiff filed a motion *in limine* seeking to preclude the introduction into evidence of any collateral source payments, which was granted by this Court prior to trial.

6. Under the Florida Supreme Court's decision in *Goble v. Frohman*, 901 So.2d 830 (Fla. 2005) and the First District Court of Appeal's decision in *Nationwide v. Harrell*, 53 So.3d 1084 (Fla. 1st DCA 2011), plaintiffs whose past medical bills have been paid by health insurance are entitled to blackboard to the jury and recover their entire past medical bills at trial, including the portions of those bills which have already been written-off or adjusted by Plaintiff's medical providers, and defendants must later seek a post-trial set-off in the amount of the adjustments or write-offs made to those past medical bills by Plaintiff's medical providers.

7. In overruling a trial court's decision to allow a Plaintiff to blackboard and recover at trial **only** those amounts actually accepted by Plaintiff's health care providers as payment in full for their past medical care and treatment of the Plaintiff, Florida's Fourth District Court of Appeal noted, "…[Plaintiff] argues that the trial court's ruling prejudices

his ability to establish the value of future medical expenses and non-economic damages and contends that this is an issue that should be resolved post-verdict…" *See*, *Durse v. Henn*, 68 So.3d 261 (Fla. 4th DCA 2011). The Fourth DCA agreed with the plaintiff's position in *Durse*, reversed the trial judge, and remanded the case for a new trial. *Id.*

8. In the instant case, this Court followed current Florida law and refused to allow these defendants to introduce evidence at trial of Plaintiff's health insurance, Florida Purple, and the Court also refused to allow these defendants to introduce evidence as to the write-offs and adjustments made to Plaintiff's past medical bills by Plaintiff's medical providers pursuant to their contractual agreements with Florida Purple.

9. Under current Florida law, as the jury's award in this case of $90,000 for Plaintiff's past medical bills included $40,000 in write-offs and adjustments which neither the Plaintiff nor Florida Blue will ever have to pay to Plaintiff's medical providers since those providers have accepted the remaining $50,000 as payment in full for all medical care and treatment provided to the Plaintiff prior to trial, this Court should set-off the jury's $90,000 award for past medical expenses by $40,000, such that, when judgment is entered, only $50,000 should be included in that judgment for past medical expenses, rather than the full $90,000 awarded by the jury.

WHEREFORE, Defendants, Defendants, XYZ Company and 123 Company, request the Court to enter an order granting this motion and further entering a post-trial set-off to Plaintiff's past medical bills in the amount of $40,000, and therefore reducing Plaintiff's past medical expenses from $90,000 to $50,000 prior to the entry of judgment in this case, together will all other relief deemed just and proper by the Court.

CERTIFICATE OF SERVICE

WE HEREBY CERTIFY that a true and correct copy of the foregoing was sent via email this 14th day of March, 2014, to: John Smith, Esq., *Counsel for Paul Plaintiff*, 100 Main Street, Any Town, FL 33301.

SMITH JONES LLP
1 Main Street, Suite 600
Any Town, Florida 33334
(111) 112-3000 - Office
(111) 112-3001 - Facsimile

By:____________________________
Ralph Jones, Esquire
Fla. Bar No. 000000