CS/CS/HB 837 Relating to Civil Remedies

CS/CS/HB 837 ("HB 837") would amend numerous statutes related to civil litigation.

Section 1: Creating Presumption that Lodestar Fee is Sufficient and Reasonable

Section 1 of HB 837 (lines 63-84) would amend section 57.104, Florida Statutes, to add the following subsection (2):

> In any action in which attorney fees are determined or awarded by the court, there is a strong presumption that a lodestar fee is sufficient and reasonable. This presumption may be overcome only in a rare and exceptional circumstance with evidence that competent counsel could not otherwise be retained.

This is meant to address several Florida Supreme Court cases which allow courts to deviate from the traditional method of calculating attorney fees—the lodestar method.

To calculate an attorney's fee award, Florida courts begin with the lodestar method established by the federal courts. *Fla. Patient's Compensation Fund v. Rowe*, 472 So. 2d 1145, 1150-52 (Fla. 1985). Under this method, attorney's fees are calculated using the number of attorney hours reasonably expended on the matter multiplied by the reasonable hourly rate. *Id.* at 1150-51. In determining what is reasonable, however, the *Rowe* Court also outlined a number of factors to be considered, including: the time and labor required, the novelty and difficulty of the question involved, and the skill requisite to perform the legal service properly; the time limitations imposed by the client or by the circumstances; and the experience, reputation, and ability of the lawyer or lawyers performing the services. *Id.* at 1150; *see also id.* at 1152. In some cases, a court may decide that the lodestar figure does not represent a reasonable fee. Under *Rowe*, the Florida Supreme Court instructed trial courts that they may adjust the lodestar amount in contingency fee cases and apply a multiplier from 1.5 to 3 based on the "likelihood of success" at the outset of the case. *Id.* at 1151. In *Joyce v. Federated National Insurance Company*, 228 So. 3d 1122 (Fla. 2017), the Court said that this multiplier could be applied in any case, rejecting the argument that it should apply in only rare and exceptional circumstances. HB 837 would make the lodestar figure, however, the presumptive fee absent rare and exceptional circumstances.

Sections 2, 5, 10, 11, 12, 16, 17, 18, 19, 21, 22, 23, 24, 25, and 26: Repealing One-way Attorney Fees in Insurance Cases Except for Certain Declaratory Judgment Actions

Sections 10 and 11 of HB 837 (lines 740-743) would repeal sections 626.9373 and 627.428, Florida Statutes, which authorize the recovery of one-way attorney fees to insureds in certain cases. Sections 12, 16, 17, 18, 19, 21, 22, 23, 24, 25, and 26 of the bill amend other statutes in light of that repeal.

Section 2 of the bill would create section 86.121, Florida Statutes (lines 85-109), applicable to actions for declaratory relief to determine insurance coverage after an insurer has totally denied coverage for a claim. In those circumstances, a named insured, omnibus insured, or named beneficiary could recover reasonable attorney fees upon obtaining a declaratory judgment in their favor. This provision would not apply, however, to any action arising under a residential or commercial property insurance policy. Section 5 would confirm, however, in creating section 624.1552, Florida Statutes (lines 450-455), that the offer of judgment statute, section 768.79, Florida Statutes, applies to civil actions involving insurance contracts.

This is meant to address the broad interpretation afforded the one-way attorney fee statutes in cases like *State Farm Fire & Casualty Co. v. Palma*, 629 So. 2d 830 (Fla. 1993), and *Ivey v. Allstate Ins. Co.*, 774 So. 2d 679 (Fla. 2000). *See also, e.g.*, *Wollard v. Lloyd's & Cos. of Lloyd's*, 439 So. 2d 217 (Fla. 1983) (holding that although section 627.428 requires the "rendition of a judgment" in favor of the insured, where an insurer pays the policy proceeds after a suit has been filed but before a judgment has been rendered, "the payment of the claim is . . . the functional equivalent of a confession of judgment or a verdict in favor of the insured" entitling the insured to attorney fees); *Allstate Ins. Co. v. Regar*, 942 So. 2d 969 (Fla. 2d DCA 2006) (assignee of insurance claim was entitled to attorney fees under section 627.428); *Mercury Ins. Co. of Fla. v. Cooper*, 919 So. 2d 491 (Fla. 3d DCA 2005) (insurer brought declaratory judgment against insured, but voluntarily dismissed it after settling tort claim against insured; court held that insured was entitled to attorney fees for dismissal, despite insured's arrest for insurance fraud).

Section 3: Amending the Statute of Limitations for Negligence Claims

Under current law, a four-year statute of limitations applies to negligence actions. In other words, a party has to bring "[a]n action founded on negligence" within four years of the time that the cause of action accrues (i.e., when the last element of the cause of action occurs). § 95.11(3)(a), Fla. Stat. Section 3 of HB 837 would make the statute of limitations period applicable to negligence actions two years (lines 113-249).

Section 4: Revising Bad Faith

HB 837 would revise section 624.155, Florida Statutes, in numerous respects to address bad faith claims.

Subsection 4 (lines 335-352): **No Bad Faith Liability in Certain Circumstances**. Proposed new subsection (4) would provide a safe harbor from bad faith liability where a liability insurer tenders the lesser of the policy limits or the amount demanded by the claimant within 90 days after receiving actual notice of a claim which is accompanied by sufficient evidence to support the amount of the claim. Further, if the insurer does not tender payment under this section, the existence of the 90-day period and that no bad faith action could lie had the insurer tendered is inadmissible in any action seeking to establish bad faith. If the insurer fails to tender pursuant to this paragraph within the 90-day period, any applicable statute of limitations is extended for an additional 90 days.

This is meant to address decisions in which courts have held that an insurer may be liable for bad faith regardless of when the insurer tenders policy limits. *See, e.g.*, *Harvey v. GEICO*

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General Ins. Co., 259 So. 3d 1 (Fla. 2018); *Berges v. Infinity Ins. Co.*, 896 So. 2d 665 (Fla. 2005). For instance, in *United Automobile Insurance Co. v. Levine*, 87 So. 3d 782 (Fla. 3d DCA 2011), the insurer tendered the policy limits to an injured third party's estate prior to receiving any demand or claim, along with a general release in favor of the insured. Acceptance of the policy limits, however, was not conditioned on signing the release. Two months later, without explanation, the estate returned the check. On appeal, the Third DCA upheld the $5.2 million bad faith damages award against the insurer, stating that the jury could find the insurer acted in bad faith.

HB 837 would define a time period by which an insurer may act to avoid bad faith liability. *See, e.g.*, *Snowden v. Lumbermens Mutual Cas. Co.*, 358 F. Supp. 2d 1125 (N.D. Fla. 2003) (rejecting insurer's "attempt to impose a mechanical standard for the span of time which must pass before a failure to initiate settlement can be deemed bad faith"); *Powell v. Prudential Prop. & Cas. Ins. Co.*, 584 So. 2d 12, 14 (Fla. 3d DCA 1991) (finding that the tender of policy limits did not automatically insulate an insurer from liability for bad faith as the jury could consider whether the insurer's delay in responding to claimant's attorney's requests was bad faith).

Subsection 5 (lines 353-369): **Negligence Is Not Bad Faith and Duties of Claimant and Insured**. New paragraph (5)(a) would confirm that negligence alone is insufficient to constitute bad faith. New paragraph (5)(b) would ensure that the insured, claimant, and any representative of the claimant or insured have their own duty to act in good faith in furnishing information regarding the claim, making demands of an insurer, in setting deadlines, and in attempting to settle a claim. In an action for bad faith, the trier of fact would be able to consider any bad faith conduct of the insured, claimant, and representative in assessing damages.

This is meant to address courts' use of the totality of the circumstances standard under *State Farm Mutual Automobile Insurance Co. v. Laforet*, 658 So. 2d 55 (Fla. 1995), to find that bad faith may be shown from insurer negligence alone and even when the insured or his or her representative hinders settlement of the claim. *See, e.g.*, *Goheagan v. Am. Vehicle Ins. Co.*, 107 So. 3d 433 (Fla. 4th DCA 2011) (bad faith claim survived summary judgment under the totality of the circumstances standard even though insurer immediately tried to contact injured party's next of kin and was rebuffed).

Subsection 6 (lines 370-400): **Authorizing Use of Interpleader and Arbitration in Multiple Claimant Situations**. New subsection (6) would provide an insurer with options to avoid bad faith liability in the event it faces competing claims from multiple third parties arising from a single occurrence which in total exceed policy limits. In such circumstances, an insurer would not be liable beyond the available policy limits for failure to pay all or any portion of the available policy limits to one or more of the claimants if, within 90 days after receiving notice of the competing claims, the insurer either (a) uses interpleader or (b) uses arbitration.

Under proposed new subsection (6)(a), the insurer may file an interpleader action. If the claims of the competing third-party claimants are found to be in excess of the policy limits, the third-party claimants are entitled to a prorated share of the policy limits as determined by the trier of fact. An insurer's interpleader action would not alter or amend their duty to defend.

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Under proposed new subsection (6)(b), the insurer may use binding arbitration if agreed to by the insurer and the third-party claimants. Under this procedure, the insurer would make the entire amount of the policy limits available for payment to the competing third-party claimants before a qualified arbitrator agreed to by the insurer and third-party claimants at the expense of the insurer. The third-party claimants are entitled to a prorated share of the policy limits as determined by the arbitrator, who must consider the comparative fault, if any, of each third-party claimant, and the total likely outcome at trial based upon the total of the economic and noneconomic damages submitted to the arbitration for consideration. A third-party claimant whose claim is resolved by the arbitrator must execute and deliver a general release to the insured party whose claims is resolved by the proceeding.

These provisions are meant to address cases like *Farinas v. Florida Farm Bureau General Insurance Co.*, 850 So. 2d 555 (Fla. 4th DCA 2003), where a Florida appellate court held that a jury was entitled to decide whether an insurer acted in bad faith when it settled some but not all claims made by multiple third parties arising from the same car accident and which in total exceeded policy limits.

Section 6: Creating Section 768.0427, Florida Statutes, Concerning Medical Damages

Section 4 would create new Florida statute section 768.0427, which would describe what evidence is admissible to prove damages for medical expenses, both future and past.

Subsection 1 (lines 462-498): **Definitions**. The statute would define several relevant terms, including "letter of protection," "factoring company," "health care coverage," and "health care provider." For example, the legislation defines a "letter of protection" ("LOP") as "any arrangement by which a health care provider renders treatment in exchange for a promise of payment for the claimant's medical expenses from any judgment or settlement of a personal injury or wrongful death action. The term includes any such arrangement, regardless of whether referred to as a letter of protection."

Subsection 2 (lines 499-570): **Defining Admissible Evidence**. Subsection 2 of proposed section 768.0427 would define the evidence admissible to prove both past and future medical expenses.

Paragraph (2)(a): Past paid medical expenses. This provision would state that the evidence offered to prove the amount of damages for past medical treatment or services that have been satisfied would be limited to evidence of the amount actually paid, regardless of the source of payment.

Paragraph (2)(b): Past unpaid medical expenses—e.g., LOPs. This provision would address the evidence admissible to prove damages for outstanding, unpaid medical bills for past treatment. This situation most commonly arises because the claimant has used an LOP.

- Subparagraph (2)(b)1. and 2.: If the clamant has health care coverage other than Medicare or Medicaid, evidence of the amount which such health care coverage is obligated to pay to satisfy the claimant's incurred medical treatment or services, plus the claimant's share of medical expenses, is admissible.

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Further, if the claimant has health care coverage but obtains treatment under an LOP or otherwise does not submit charges for medical treatment or services to health care coverage, evidence of the amount the claimant's health care coverage would pay the health care provider to satisfy the past unpaid medical charges under the insurance contract or regulation, plus the claimant's share of medical expenses under the insurance contract or regulation, had the claimant obtained medical services or treatment pursuant to the health care coverage, is admissible.

- Subparagraph (2)(b)3.: If the claimant does not have health care coverage or has health care coverage through Medicare or Medicaid, the evidence admissible to prove past medical expenses is evidence of 120 percent of the Medicare reimbursement rate in effect at the trial of trial for the claimant's incurred medical treatment or services, or, if there is no applicable Medicare rate for a service, 170 percent of the applicable state Medicaid rate.

- Subparagraph (2)(b)4.: If the claimant obtains medical treatment or services under an LOP, and the health care 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 health care provider in exchange for the right to receive payment pursuant to the LOP is admissible.

- Subparagraph (2)(b)5.: This provision states that any evidence of reasonable amounts billed to the claimant for medically necessary treatment or medically necessary services provided to the claimant is admissible.

Paragraph (2)(c): Future medical expenses. This provision would address the evidence admissible to prove damages for future medical treatment and care.

- Subparagraph (2)(c)1.: If the claimant has health care coverage other than Medicare or Medicaid, or is eligible for any such health care coverage, evidence of the amount for which the future charges of health care providers could be satisfied if submitted to such health care coverage, plus the claimant's share of medical expenses under the insurance contract or regulation, is admissible.

- Subparagraph (2)(c)2.: If the claimant does not have health care coverage or has health care coverage through Medicare or Medicaid, or is eligible for such health care coverage, evidence of 120 percent of the Medicare reimbursement rate in effect at the time of trial for the medical treatment or services the claimant will receive is admissible, or, if there is no applicable Medicare rate for a service, 170 percent of the applicable state Medicaid rate.

- Subparagraph (2)(c)3.: Any evidence of reasonable future amounts to be billed to the claimant for medically necessary treatment or medically necessary services is also admissible.

One effect of this portion of the legislation would be to overturn the Florida Supreme Court's ruling in *Joerg v. State Farm Mutual Automobile Insurance Co*., 176 So. 3d 1247

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(Fla. 2015), that evidence of eligibility for future benefits like Medicare is inadmissible as collateral sources, and to further abrogate the common-law collateral source rule.

Paragraph (2)(d): No duty to negotiate charges. This provision would confirm that nothing above requires a party to seek a reduction in billed charges to which the party is not contractually entitled.

Paragraph (2)(e): **Insurance contracts not affected**. This provision ensures that individual contracts between providers and licensed commercial insurers or licensed health maintenance organizations are not subject to discovery or disclosure and are not admissible into evidence.

***Subsection (3) (lines 571-619)*: Required Disclosures Concerning LOPs**. Subsection (3) states that certain items relating to LOPs are subject to disclosure; specifically, the claimant must disclose:

- A copy of the LOP.

- All billings for the claimant's medical expenses, which must be itemized and, to the extent applicable, coded according to the American Medical Association's Current Procedural Terminology ("CPT"), or the Healthcare Common Procedure Coding System ("HCPCS"), in effect on the date in which services are rendered. CPT and HCPCS coding would be required for providers billing at the provider level. Similar coding information would be required for health care providers billing at the facility level, depending upon the setting (clinical, outpatient, or inpatient).

- 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 other third party who purchased such accounts; and

    - The dollar amount for which the factoring company or other third party purchased such accounts, including any discount provided below the invoice amount.

- Whether the claimant, at the time medical treatment was rendered, had health care coverage and, if so, the identity of such coverage.

- Whether the claimant was referred for treatment under the LOP and, if so, the identity of who made such referral. If the referral is made by the claimant's attorney, disclosure of the referral is permitted, and evidence of such referral is admissible notwithstanding any provision of the Evidence Code concerning the attorney-client privilege, specifically section 90.502, Florida Statutes. Moreover, the financial relationship between a law firm and a medical provider—including the number of referrals, frequency, and financial benefit obtained—is relevant to the issue of the bias of a testifying medical provider.

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This is meant to address the Florida Supreme Court's ruling in *Worley v. Central Florida Young Men's Christian Association*, 228 So. 3d 18 (Fla. 2017), in which the 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—the type of relationship that might give rise to an LOP—because it is protected by the attorney-client privilege.

***Subsection (4) (lines 620-635)*: Damages Recoverable for Medical Care**. Proposed subsection (4) of section 768.0427 states that the medical expense damages that a claimant may ultimately recover in a personal injury or wrongful death action "may not include any amount in excess of the evidence of medical treatment and services expenses admitted pursuant to subsection (2), and also may not exceed the sum of the following:

(a) Amounts actually paid by or on behalf of the claimant to a health care provider who rendered medical treatment or services;

(b) 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

(c) Amounts necessary to provide for any reasonable and necessary medical treatment or services the claim will receive in the future."

Sections 7 and 8: Applying Comparative Fault Principles to Negligent Security Premises Liability and Providing for Presumption Against Liability in Certain Circumstances

Section 7 of HB 837 (lines 636-644) would create new section 768.0706, Florida Statutes, to state:

> Premises liability for criminal acts of third parties.—Notwithstanding s. 768.81(4), in an action for damages against the owner, lessor, operator, or manager of commercial or real property brought by a person lawfully on the property who was injured by the criminal act of a third party, the trier of fact must consider the fault of all persons who contributed to the injury.

This is meant to address *Merrill Crossings Associates v. McDonald*, 705 So. 2d 560, 561 (Fla. 1997), in which the Florida Supreme Court held that in negligent security actions, comparative negligence does not apply and joint and several liability does.

Additionally, Section 8 (lines 645-723) of the proposed legislation would create new section 768.0706, Florida Statutes, which would provide a "presumption against liability" for negligent security claims against owners and operators of "multifamily residential property," such as an apartment or condominium community, where the owner or operator has implemented certain security measures on its property. Those security measures include:

- the placement and specified usage of security cameras;

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- lighted parking lots, walkways, laundry rooms, common areas, and porches meeting specified visibility standards;
- a locking device on windows, sliding doors, and other common area doors;
- locked gates with key or fob access for community pool fences;
- a peep hole or other door viewer on each dwelling unit door;
- by January 1, 2025, the owner or operator has a crime prevention through environmental design assessment that is no more than 5 years old completed for the property, and the property remains in substantial compliance with the assessment; and
- by January 1, 2025, the owner or operator provides proper crime deterrence and safety training to employees within 60 days of their hire date.

This presumption would not apply to claims committed by employees or agents of the owner or operator of the multifamily residential property.

Section 9: Modified Comparative Fault

Section 9 of the legislation (lines 724-739) would amend section 768.81, Florida Statutes, to apply modified comparative negligence rather than pure comparative negligence, in all but medical negligence cases. Specifically, the legislation would amend section 768.81 as follows:

> (2) EFFECT OF CONTRIBUTORY FAULT.—In a negligence action, contributory fault chargeable to the claimant diminishes proportionately the amount awarded as economic and noneconomic damages for an injury attributable to the claimant's contributory fault, but does not bar recovery, subject to subsection (6).
>
> (6) GREATER PERCENTAGE OF FAULT.—In a negligence action to which this section applies, any party found to be greater than 50 percent at fault for his or her own harm may not recover any damages. This subsection does not apply to an action for damages for personal injury or wrongful death arising out of medical negligence pursuant to chapter 766.

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