No. SC21-43

In the Supreme Court State of Florida

ELAINE DIAL,

Petitioner,

v.

CALUSA PALMS MASTER ASSOCIATION,

Respondent.

ON DISCRETIONARY REVIEW OF A DECISION OF THE SECOND DISTRICT COURT OF APPEAL
L.T. CASE NO. 2D18-4339

AMICUS CURIAE BRIEF OF FLORIDA TRUCKING ASSOCIATION, FLORIDA CHAMBER OF COMMERCE, AMERICAN PROPERTY CASUALTY INSURANCE ASSOCIATION AND FLORIDA JUSTICE REFORM INSTITUTE IN SUPPORT OF RESPONDENT

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INTRODUCTION

Notwithstanding the Legislature's efforts in enacting the Tort Reform and Insurance Act of 1986, codified at section 768.76, Florida Statutes, the jurisprudence of the past three decades relating to the determination of a plaintiff's medical damages in tort claims has resulted in a morass. Litigants face a patchwork quilt of appellate decisions, as courts struggle to find a unifying principle that ensures fairness while thwarting efforts to game the system.

The inflation of medical damages through the submission of medical bills that the healthcare provider has no reasonable expectation of having paid has far-reaching consequences just within the average trial. At times, the calculation of future medical damages is dependent on past medical charges; and under section 768.73(1), Florida Statutes, the rare award of punitive damages is linked to the amount of compensatory damages.

The Second District's decision below and the Fourth District's decision in *Gulfstream Park Racing Ass'n, Inc. v. Volin*, --- So. 3d ---, 2021 WL 1997278 (Fla. 4th DCA May 19, 2021), represent the latest efforts to restore transparency to medical billing practices and control jury consideration of relevant damages evidence. This Court should endorse the effort to achieve maximum transparency in medical billing in tort litigation, answer the certified question in the negative, and approve the Second District's decision.

STATEMENT OF IDENTITY AND INTEREST OF AMICI

The Florida Trucking Association ("FTA") has been the trusted voice of Florida's trucking and transportation industry for almost 90 years. The FTA consists of both carrier members (trucking companies) and supplier members (trucking industry partners and associated vendors). It advocates on behalf of its members' interests in key litigation.

The Florida Chamber of Commerce ("Chamber") and its members have been fighting for greater economic opportunity and job creation since 1916. The Chamber espouses, among other values, fair and predictable laws and regulations that promote economic development and do not impose unreasonable costs on businesses or their customers, and a unified and responsible business community that acts in the long-term interest of our state.

The American Property Casualty Insurance Association ("APCIA") is the primary national trade association for insurers. For 150 years, APCIA has promoted and protected the viability of private competition for the benefit of consumers and insurers. On issues of importance to the insurance industry and marketplace, APCIA advocates sound and progressive public policies on behalf of its members in legislative and regulatory forums and submits amicus curiae briefs in significant cases, including before this Court.

The Florida Justice Reform Institute ("Institute") is Florida's leading organization of concerned citizens, business owners, business leaders, doctors, and lawyers who seek the adoption of fair legal practices to promote predictability and personal responsibility in the civil justice system. The Institute advocates practices that build faith in Florida's court system and judiciary. It represents a broad range of participants who share a substantial interest in a balanced litigation environment that treats plaintiffs and defendants evenhandedly.

Many of the Amici's members are frequently named defendants or insure those defendants in plaintiffs' personal injury lawsuits. As a result, those members frequently confront the issue of phantom medical damages proposed by plaintiffs who, in fact, have no obligation ever to pay the medical bills submitted by treating physicians, whether the treatment is provided subject to letters of protection or not. Those phantom damages mislead juries not only as to the past financial harm actually suffered, but also proposed future financial expenses and the determination of reasonable charges for the services rendered.

SUMMARY OF ARGUMENT

The Court should approve the Second District's decision below, as well as the Fourth District's reasoning in *Volin*, because

doing so (i) maximizes transparency in medical billing practices, (ii) comports with longstanding principles as to the purpose of compensatory damages, and (iii) enhances the truth-finding function of trials. Allowing juries to consider evidence of medical bills, which healthcare providers have no plausible expectation of being paid by Medicare, private insurance, or other third-party sources, serves only to provide a windfall to plaintiffs and inflates jury verdicts not only as to past medical expenses, but also future medical expenses and, occasionally, punitive damages.

ARGUMENT

I. THE QUESTION OF WHAT CONSTITUTES ACTUAL MEDICAL DAMAGES SHOULD BE RESOLVED OUTSIDE THE COLLATERAL SOURCE RULE CONTEXT.

The collateral source rule has concerned itself with ensuring that "an injured party…recover full compensatory damages from a tortfeasor irrespective of the payment of any element of those damages by a source independent of the tortfeasor." *Gormley v. GTE Products Corp.*, 587 So. 2d 455, 457 (Fla. 1991). The common law rule has two components—one addressing the determination of the amount of damages and the other addressing the admissibility of evidence as to the existence of collateral sources. *Joerg v. State Farm Mut. Auto. Ins. Co.*, 176 So. 3d 1247, 1249 (Fla. 2015). As the

Joerg Court acknowledged, the Legislature abrogated the damages component when it enacted section 768.76, and "[t]oday, trial courts must reduce awards '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…." *Id.* (quoting § 768.76(1), Fla. Stat.).

The *Joerg* Court, however, held that the evidentiary component of the collateral source rule remains intact. That portion of the rule precludes the introduction in evidence of "payments from collateral source benefits" because ostensibly "such evidence may confuse the jury with respect to both liability and damages." *Id.* (citing *Sheffield v. Superior Ins. Co.*, 800 So. 2d 197, 203 (Fla. 2001)).

None of the concerns that undergird the rule's evidentiary component, however, is implicated by the adoption of a rule that limits the presentation of evidence of medical damages to those sums a plaintiff is *actually* obligated to pay, based on the amounts the healthcare provider is willing to accept in full payment of the services rendered. As the Court observed in *Allstate Ins. Co. v. Boecher*, 733 So. 2d 993 (Fla. 1999), albeit in the discovery context, "Any limitation on this inquiry [into the ongoing relationship between a party and a witness] has the potential for thwarting the

truth-seeking function of the trial process." *Id.* at 998. So, too, in determining what constitutes proper evidence of medical damages actually incurred, the presentation to a jury of inflated medical bills that no one is obligated to pay, and which the healthcare provider has no legitimate expectation of having fully satisfied, "has the potential for thwarting the truth-seeking function of the trial process."

This is the approach the Second District below and the Fourth District in *Volin* correctly adopted in concluding that medical bills reflecting sums above what the healthcare provider was willing to accept as full payment for services rendered should not be admissible.

A. The *Volin* decision.

Not long after the Second District issued its opinion in this case, the Fourth District issued a similar decision in *Volin*. There, the trial court denied a defense motion in limine and allowed the plaintiff to introduce evidence of the amount *billed* by the healthcare providers, rather than the amount Medicare paid in full satisfaction of the expenses. *Volin*, 2021 WL 1997278, *1. The trial court determined that it "would handle any collateral source setoffs post-verdict." *Id.* The jury awarded the gross amount of medical

bills and the trial court "setoff certain amounts from the verdict," but the Fourth District reversed. *Id.*

The court reasoned: "[w]hen a provider charges for medical services 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." *Id.* (quoting *Thyssenkrupp Elevator Corp. v. Lasky*, 868 So. 2d 547, 551 (Fla. 4th DCA 2003)). The court concluded: "We agree that the amounts a provider billed that Volin will never pay—so called phantom damages—are inadmissible." *Id.*

In response to the plaintiff's argument that *Joerg* "implicitly overruled" *Thyssenkrupp* and *Cooperative Leasing, Inc. v. Johnson*, 872 So. 2d 956, 959 (Fla. 2d DCA 2004), the Fourth District correctly distinguished *Joerg*:

> *Joerg* did not address the issue in this case or in the cases discussed above.[1] In *Joerg*, the issue was "[w]hether the exception to the collateral source rule created in [*Fla. Physician's Ins. Reciprocal v. Stanley*, 452 So. 2d 514 (Fla. 1984)] applies to future benefits provided by social legislation such as Medicare...." *Id.* at 1253. The Florida Supreme Court "conclude[d] that the trial court properly excluded evidence of Luke Joerg's eligibility for future benefits from Medicare, Medicaid, and other social

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1 The "issue in this case" was "the appropriate measure of compensatory damages for past medical expenses." *Volin*, at *2.

legislation as collateral sources." *Id.* at 1257. In comparison, this case addresses past medical bills.

Volin, at *3. Indeed, *Joerg* never addresses the evidentiary question of what is the proper amount of past medical damages that a jury should be permitted to consider.

Finally, the Fourth District further justified reversing the trial court because section 768.76 does not allow for post-trial setoffs of Medicare payments, which the statute expressly excludes from the definition of "collateral sources." *Id.* at *3 (citing § 768.76(2)(b), Fla. Stat. ("Medicare…shall not be considered a collateral source.")).[2,3] The *Volin* Court concluded by noting its agreement with the Second

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[2] Amici do not dispute this distinction under section 768.76. However, private insurance is functionally indistinguishable from Medicare in terms of determining the proper *amount* of healthcare expenses to be presented to a jury. As elaborated below, Amici believe there is no principled reason for treating Medicare and private insurance differently, from an evidentiary perspective, when compensatory damages are considered *outside* the context of section 768.76 and the collateral source rule. *See infra* at 13-18.

[3] *Joerg* commented that excluding Medicare from "collateral sources" does not result in a windfall to the plaintiff because of Medicare's right of reimbursement. 176 So. 3d at 1249. But plainly, that observation relates only to the *discounted* Medicare rates. Medicare would not seek reimbursement of amounts it never paid. *Joerg*, however, did *not* address how Medicare "discounts" would be accounted for post-trial if a jury included the *undiscounted* amounts in a verdict.

District's decision here and certifying the same question of great public importance. *Volin*, at *3.

The Amici urge the Court to endorse the Fourth District's conclusion. However, while the Fourth District concluded that medical bills are inadmissible "when Medicare satisfies the plaintiff's medical expenses for a lesser amount," the evidentiary ruling should be broader. What matters in terms of transparency is not whether Medicare or a private insurer has *actually* satisfied the plaintiff's medical bills, but rather what the healthcare provider was either prepared or required to accept from a third-party as full payment for services rendered.

B. The Second District's decision below should be approved.

Citing *Cooperative Leasing*, the Second District below correctly concluded "that the appropriate measure of compensatory damages for past medical expenses when a plaintiff has received Medicare benefits does not include the difference between the amount that the Medicare providers agreed to accept and the total amount of the plaintiff's medical bills." 308 So. 3d 690, 691 (Fla. 2d DCA 2020). The court also distinguished *Joerg* and correctly limited its evidentiary holding to evidence concerning the availability of *future* Medicare benefits. *Id.* at 691-92 (citing *Joerg*, 176 So. 3d at 1253).

Clearly, the concerns expressed in *Joerg* about the potential unavailability of future Medicare benefits, 176 So. 3d at 1253, 1254, are inapplicable to medical expenses already incurred. Similarly, the *Joerg* Court's concern about potential prejudice arising from a jury learning that a plaintiff has private insurance or is eligible for Medicare is not implicated by a rule that requires the plaintiff to present evidence reflecting only medical charges for which the provider plausibly expects to be paid.

Petitioner here conflates the exclusion of evidence of collateral source payments under the common law rule and limiting evidence to amounts that are actually due and payable. The false premise underlying Petitioner's argument is that in order for a jury to learn what a healthcare provider is prepared to accept as full payment, it *must* also learn that the plaintiff is a Medicare recipient or has private insurance. What matters, though, is the amount, not the source. Under a newly announced rule limiting the presentation of evidence of medical damages, litigants could conform their discovery and trial practices to ensure that potentially prejudicial information relating to the *source* is excluded and only the correct *amounts* are used.

This Court's decision in *Goble v. Frohman*, 901 So. 2d 830 (Fla. 2005) ("*Goble II*"), is both illustrative and in need of

clarification.[4] In *Goble II*, the trial court allowed the plaintiff to present the medical bills submitted by her providers, without adjustment for HMO contractual discounts. Those bills totaled $574,554.31, when in reality, the HMO paid and the providers accepted $145,970.76 as complete payment for the services rendered. *Id.* at 831. The jury awarded an amount roughly $430,000 higher than the amount the providers had agreed to accept. *Id.* at 832.

This Court observed, "[T]he providers have no right to seek reimbursement from Goble or from any third party for the contractual 'discount' of over $400,000, the difference between the amounts billed and the amounts paid." *Id.* at 831-32. The Court noted that Aetna had a right of subrogation for the lower amount accepted by the providers. *Id.* at 832. Faced with the reality of the inflated jury award, the defendant sought and was granted a post-trial reduction of the verdict under section 768.76. *Id.*

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[4] While Petitioner focuses solely on the district court of appeal decision, even that decision referred to the inflated medical bills in that case as "a billing fiction" and "phantom damages." *Goble v. Frohman*, 848 So. 2d 406, 410 (Fla. 2d DCA 2003) ("*Goble I*"). The Second District in this case did not discuss either *Goble* decision.

The Second District affirmed, reasoning that "forcing an insurer to pay for damages that have not been incurred, would result in a windfall to the injured party. The allowance of a windfall would undermine the legislative purpose of controlling liability insurance rates because 'insurers will be sure to pass the cost for these phantom damages on to Floridians.'"[5] *Id.* (quoting *Goble I*, 848 So. 2d at 409). This Court agreed with the Second District's conclusion. *Id.*

Given the question certified by the Second District and the reality that the trial court had admitted in evidence *only* the providers' undiscounted charges (resulting in the inflated damages verdict), the Court agreed with the Second District that the damages award had been properly reduced, pursuant to section 768.76, to account for the unconsidered contractual discounts. *Id.* at 833. The Court concluded that the contractual discounts "fit" within the meaning of "collateral source" under section 768.76 and observed,

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[5] The Second District also certified the following question: "UNDER SECTION 768.76, FLORIDA STATUTES (1999), IS IT APPROPRIATE TO SETOFF AGAINST THE DAMAGES PORTION OF AN AWARD THE AMOUNTS OF REASONABLE AND NECESSARY MEDICAL BILLS THAT WERE WRITTEN OFF BY MEDICAL PROVIDERS PURSUANT TO THEIR CONTRACTS WITH A HEALTH MAINTENANCE ORGANIZATION?" *Id.* at 813 (citing *Goble I*, 848 So. 2d at 410).

"Because of the medical providers' contract with Goble's HMO, Goble was obligated to pay … $145,970.76, rather than the billed charges of $574,554.31." *Id.* The Court did *not* discuss the trial court's original decision to admit only the undiscounted medical bills or the Second District's affirmance of that ruling.

Justice Bell's concurrence, joined by Justices Wells and Cantero, suggested an alternative basis for affirming that "Goble is not entitled to recover, as compensatory damages, the full (prediscount) amount of his medical bills." *Id.* Significantly, this alternative basis "lies outside the question of 'collateral sources' either as defined by statute or at common law." *Id.* Justice Bell reasoned:

> Under common-law principles of compensatory damages, Goble can recover only the discounted portion of his medical bills—the only portion that he actually was obligated to pay. The amount of the full (prediscount) bill that was written off pursuant to the contractual agreement between Goble's HMO and Goble's medical-services provider was an amount that Goble never was obligated to pay. This amount, therefore, does not represent Goble's actual damages. To allow for the recovery of this full amount, under the guise of "compensatory damages," would allow for the recovery of what the district court aptly described as "phantom damages."

Id. at 833-34 (citing *Goble I*, 848 So. 2d at 410). Citing both *Thyssenkrupp* and *Cooperative Leasing*, the concurrence anchored

its reasoning in the "fundamental principle of Florida law that the measure of compensatory damages in a tort case is limited to the actual damages sustained by the aggrieved party." *Id.* at 834 (citing *Hanna v. Martin*, 49 So. 2d 585, 587 (Fla. 1950)).

The concurrence's reasoning also jibes with a long line of cases holding that the purpose of compensatory damages is to make the plaintiff whole, and not to award a windfall or punish the defendant. *See, e.g., MCI Worldcom Network Servs., Inc. v. Mastec, Inc.*, 995 So. 2d 221, 224 (Fla. 2008) ("[T]he purpose of compensatory damages is to compensate, not to punish defendants or bestow a windfall on plaintiffs.") (quoting *Cooperative Leasing*, 872 So. 2d at 958); *Mercury Motors Exp., Inc. v. Smith*, 393 So. 2d 545, 547 (Fla. 1981) ("The objective of compensatory damages is to make the injured party whole….").

In *MCI Worldcom*, this Court expressly endorsed the principle underlying the concurrence in *Goble II*:

> 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 give[s] rise to the action. In other words, *the damages should be equal to and precisely commensurate with the injury sustained*.

995 So. 2d at 224 (quoting *Hanna*, 49 So. 2d at 587) (emphasis added). *See also Deaville Hotel Mgm't, LLC v. Ward*, 219 So. 3d 949,

954 (Fla. 3d DCA 2017) ("A plaintiff 'is not entitled to recover compensatory damages in excess of the amount which represents the loss actually inflicted by the action of the defendant.'") (quoting *MCI Worldcom*, 995 So. 2d at 223).

Underlying the *Goble II* concurrence's reasoning is a simple premise: *before* applying the collateral source rule and section 768.76, one must *first* determine what constitutes compensatory damages and the amount thereof. To do otherwise puts the proverbial cart before the horse.

Any suggestion that a post-trial reduction of medical damages pursuant to section 768.76 constitutes an adequate remedy for windfall medical damages awards should be rejected for two reasons. First, it should not be necessary to require "adjustments" to errant verdicts that can be avoided in the first instance by abiding by longstanding principles governing the purpose of compensatory damages. Concerns of jury confusion or prejudice arising from a jury learning that a plaintiff has insurance or is eligible for Medicare can be readily addressed by informing jurors solely of the *amounts* the providers would accept, rather than the manner by which those amounts were determined (*e.g.,* by applying insurance discounts or referencing Medicare schedules). Once litigants understand that the only evidence admissible on the

question of medical damages is the amount the provider was prepared to accept as full payment, there should be no need to mention insurance or Medicare to the jury. These are matters readily addressed through discovery and pre-trial motion practice.

Second, relying on section 768.76 to correct damage award errors that should have been avoided in the first place creates additional problems with respect to awards of future damages or punitive damages. Petitioner acknowledges that future medical damages awards are frequently affected by the amount award for past medical damages. IB at 27. Had the jury in *Goble* awarded damages for future medical care based on the grossly inflated verdict of $574,554.31 for past medical damages, how would that defect have been remedied post-trial? Existing precedent prohibits the invocation of section 768.76 to reduce awards for future medical damages. *Allstate Ins. Co. v. Rudnick*, 761 So. 2d 289, 292-93 (Fla. 2000). And a trial court would be hard-pressed to grant a remittitur if the inflated medical bills lent support to the future award. *See Owens-Corning Fiberglass Corp. v. McKenna*, 726 So. 2d 361, 363-64 (Fla. 3d DCA 1999) ("The trial court properly denied [the] motions for a new trial or a remittitur. There is competent substantial evidence to support the jury's award of damages.");

§ 768.74(5)(e), Fla. Stat. (identifying as relevant to remittitur "[w]hether the amount awarded is supported by the evidence…").

The Court should endorse the principle of maximum transparency in medical billing practices and adopt the reasoning of the *Goble II* concurrence as the governing evidentiary rule: admissible evidence of medical damages must be limited to the *amounts* healthcare providers were willing, prepared or required to accept in full compensation for services rendered to a plaintiff, regardless of whether those amounts are determined by Medicare, private insurance contract or other third-party arrangement. Adopting this standard furthers the truth-seeking function of trials and discourages what is, at best, the questionable practice of healthcare providers billing patients grossly varying amounts depending on whether or not they are involved in litigation.

The Court should also, respectfully, either limit or clarify the *Goble II* majority opinion. The majority concluded that the contractual HMO discounts at issue in that case constituted a collateral source that could be discounted from the damages award post-trial. 901 So. 2d at 833. That determination was necessitated by the reality that the trial court had already allowed in evidence only the inflated medical bills, resulting in a windfall verdict for the plaintiff based on phantom damages. Once a new evidentiary rule

governing medical damages is established, there will be no need to correct errant medical damages verdicts by making adjustments pursuant to section 768.76. The majority opinion in *Goble II*, therefore, should be clarified or restricted to its specific factual circumstances.

II. THE COURT'S RULING HERE SHOULD CONSIDER THE IMPLICATIONS OF POTENTIAL MISUSES OF LETTERS OF PROTECTION.

Plaintiffs' lawyers in tort cases frequently enter into arrangements known as "letters of protection." A letter of protection is

> a document sent by an attorney on a client's behalf to a health-care provider when the client needs medical treatment, but does not have insurance. Generally, the letter states that the client is involved in a court case and seeks an agreement from the medical provider to treat the client in exchange for deferred payment of the provider's bill from the proceeds of [a] settlement or award; and typically, if the client does not obtain a favorable recovery, the client is still liable to pay the provider's bills.

Worley v. Central Fla. Young Men's Christian Ass'n, Inc., 228 So. 3d 18, 23 (Fla. 2017) (quoting Caroline C. Pace, *Tort Recovery for Medicare Beneficiaries: Procedures, Pitfalls and Potential Values*, 49 Hous. Law. 24, 27 (2012) (hereafter, "*Pace*")).

The same article the Court cited in support of its definition suggests a troubling scenario intended to avoid transparency in medical billing and circumvent the salubrious results of *Volin* and the decision under review here. The author begins by considering a Texas Supreme Court decision that reached the outcome sought by Respondent and Amici here: *Haygood v. De Escobado*, 356 S.W. 3d 390 (Tex. 2011). *Pace* at 26.

In *Haygood*, the Texas Supreme Court considered the question of recoverable medical damages in a tort claim:

> Damages for wrongful personal injury include the reasonable expenses for necessary medical care, *but it has become increasingly difficult to determine what expenses are reasonable*. Health care providers set charges they maintain are reasonable *while agreeing to reimbursement at much lower rates determined by insurers to be reasonable, resulting in great disparities between amounts billed and payments accepted*. Section 41.0105 of the Texas Civil Practice and Remedies Code, enacted in 2003 as part of a wide-ranging package of tort-reform measures, provides that "recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant." *We agree with the court of appeals that this statute limits recovery, **and** consequently the evidence at trial, to expenses that the provider has a legal right to be paid*.

Id. at 391 (footnotes omitted; emphasis added). The Texas Supreme Court further noted the reality underlying today's medical billing practices:

> A two-tiered structure has evolved: "list" or "full" rates sometimes charged to uninsured patients, but frequently uncollected, and reimbursement rates for patients covered by government and private insurance. We recently observed that "[f]ew patients today ever pay a hospital's full charges, due to the prevalence of Medicare, Medicaid, HMOs, and private insurers who pay discounted rates." Hospitals, like health care providers in general, "feel financial pressure to set their 'full charges' ... as high as possible, because the higher the 'full charge' the greater the reimbursement amount the hospital receives since reimbursement rates are often set as a percentage of the hospital's 'full charge.'"
>
> * * *
>
> Portions of bills showing only list charges are admitted in evidence, with proof of reasonableness coming from testimony by the provider....

Id. at 394 (footnotes and citations omitted).

The *Haygood* Court began its analysis by focusing on the same basic principle the concurrence in *Goble II* did: "As a general principle, compensatory damages, like medical expenses, 'are intended to make the plaintiff 'whole' for any losses resulting from the defendant's interference with the plaintiff's rights.'" *Id.* (quoting *Transp. Ins. Co. v. Moriel*, 879 S.W. 2d 10, 16 (Tex. 1994)). However, contrary to the majority in *Goble II*, the Texas Supreme Court avoided the implications of the collateral source rule by concluding

that the discount or adjustment required by insurance is *not* a collateral benefit.[6] *Id.* at 395.

In addressing the implications of the collateral source rule, the Texas Supreme Court explained, "The collateral source rule reflects 'the position of the law that a benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor.'" *Id.* (citing Restatement (Second) of Torts § 920A cmt. b). However, the court promptly and correctly observed that "impos[ing] liability for medical expenses that a health care provider is not entitled to charge does not prevent a windfall to a tortfeasor; it creates one for a claimant…." *Id.* The same reasoning applies here and explains why the *Goble II* concurrence considered its alternative reasoning as "outside" the collateral source rule.

The *Pace* article, though, posits a "hypothetical" seemingly encouraging circumvention of the Texas Supreme Court's reasoning in *Haygood* through the use of letters of protection. *Pace* at 27. The author states:

> Additionally, the Court held that because a claimant can only recover medical expenses paid or to be paid by or for the plaintiff, only evidence of recoverable medical

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[6] Hence the reason Amici believe *Goble II* should be clarified or limited, because the majority there reached its contrary conclusion only *after* a jury had already awarded a windfall verdict to the plaintiff based on undiscounted medical bills.

> expenses is admissible at trial. Thus, juries are not provided evidence of the amount discounted or written off due to the lower rates charged to government or private insurers. …
>
> *To avoid the risk of a reduced recovery* created by *Haygood, Ms. C seeks to persuade her medical providers not to submit their charges to Medicare. She prefers for the jury to determine her medical damages and non-economic damages based on some amount greater than Medicare's conditional payments*. Because she is indigent, she cannot personally pay the medical damages. *However, as discussed below, she may be able to obtain letters of protection … for amounts greater than Medicare's discounted rate*.

Id. (emphasis added)

> The author then makes the worrisome recommendation:
>
> *Ms. C's recovery may be increased if she enters into letters of protection with her medical providers in lieu of the medical providers submitting their bills to Medicare for payment*.
>
> * * *
>
> Through letters of protection, the medical providers and Ms. C's attorney can negotiate the amount of the medical expenses. Pursuant to *Haygood*, Ms. C's attorney understands that her potential recovery likely depends on the amount of admissible medical expenses and that to be admissible, the expenses must have been paid or must be paid by or for Ms. C. … At minimum, [Ms. C and her providers] prefer to recover an amount greater than Medicare's discounted rate.

Id. (emphasis added).

The foregoing scheme—which is intended to game the system and maximize recovery for plaintiffs, healthcare providers and lawyers, at the expense of defendants or their insurers (who will logically pass on increased coverage expenses to policyholders in conformity with actuarial imperatives)—should not be countenanced. For this reason, the Fourth District's articulation of the issue in *Volin* as focused on what Medicare has *actually* paid, rather than on what Medicare *would have* paid, should be avoided.

The proper inquiry should be what the healthcare provider was *prepared* to accept as full payment from third-party payors (whether Medicare, Medicaid, private insurance or some other third-party), rather than a "negotiated" inflated charge. This approach maximizes transparency in medical billing practices, furthers the truth-finding function of the trial process, and reduces the actual and societal costs of tort litigation.

CONCLUSION

The Amici respectfully request that the Court approve the Second District's decision below and announce a rule that limits evidence of medical damages to the amounts healthcare providers were prepared to accept as full payment from third-parties for the services rendered.

Respectfully submitted,

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By: /s/ *Edward G. Guedes*
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CERTIFICATE OF SERVICE

I certify that a copy of this amicus curiae brief was filed and served via E-Portal this 21st day of September, 2021, on all counsel of record identified therein.

/s/ *Edward G. Guedes*
Edward G. Guedes

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief was prepared in Bookman Old Style, 14-point font, in compliance with Florida Rules of Appellate Procedure 9.045 and 9.210, and consists of 4,927 words.

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