The Florida Justice Reform Institute Opposes HB 947 and Reducing Transparency in Damages

Before 2023, determining a claimant's medical damages was complicated, and damages awards often failed to reflect the true value of medical expenses that a claimant had incurred in the past and would likely incur in the future. This was because juries often heard only the "billed" amounts or "sticker prices" of a claimant's medical treatment, which typically reflected much higher dollar amounts than what an insurer would have otherwise paid for the treatment or what the claimant would have even paid their medical provider out of pocket for the treatment. Consideration of such inflated amounts often misled juries into awarding excessive amounts for unpaid bills, future damages for anticipated medical expenses, and pain and suffering.

That changed with the passage of 2023 HB 837, which restored transparency in damages by specifying the evidence admissible to prove such damages in section 768.0427, Florida Statutes. Now, the 2025 Legislature is considering HB 947, which would amend section 768.0427 to state generally that the evidence admissible to prove both past incurred-but-not-yet-paid medical damages and future damages would be evidence presented under a nebulous, imprecise standard of what represents the "reasonable and customary" rates for medical treatment or services.

Section 768.0427 as enacted through 2023 HB 837 was a significant step forward in ensuring that damages awards for medical expenses reflect reality. Now is not the time to take a step backward. The Legislature should not pass HB 947.

Section 768.0427, Florida Statutes, Created Transparency in Medical Damages Awards

Before enactment of section 768.0427, the standard for what evidence may be admitted to prove medical expenses was often a complicated affair. A claimant bears the burden to prove the reasonableness of medical expenses sought as damages. Under the prior standard, no single factor determined whether a particular medical expense is reasonable. There were 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.[1] 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. Letters of protection ("LOPs") added an additional wrinkle. An LOP is an agreement typically negotiated by a personal injury lawyer

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

wherein a claimant's medical provider agrees to suspend efforts to collect medical bills from the claimant while litigation is pending. LOPs often included 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 or treatment. 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.

The Legislature created certainty and transparency in calculating these damages by enacting section 768.0427 in 2023 through HB 837. In relevant part, section 768.0427 provides that the following evidence is admissible to prove medical expenses:

- For past ***unpaid*** medical expenses—i.e., services or treatment often provided under an LOP—evidence offered to prove the usual and customary amount necessary to satisfy unpaid charges is as follows:
    - If the claimant has health care coverage other than Medicare or Medicaid, 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.
    - If the claimant has health care coverage but obtains treatment under an LOP or otherwise does not submit charges for the treatment to that health care coverage, 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.
    - If the claimant does not have health care coverage, evidence of 120 percent of the Medicare reimbursement rate in effect at the time of trial for the claimant's incurred medical treatment or services, or—if there is no applicable Medicare rate—170 percent of the applicable state Medicaid rate.
    - 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.
    - Any evidence that does not otherwise meet the requirements above may be admitted into evidence, however, if otherwise admissible.
- For future medical expenses, evidence offered to prove the usual and customary amount necessary to satisfy future charges is as follows:
    - 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 healthcare coverage, plus the claimant's share of medical expenses.

- If the claimant does not have 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, or, if there is no applicable Medicare rate for a service, 170 percent of the applicable state Medicaid rate.

- Any evidence that does not otherwise meet the requirements above may be admitted into evidence, however, if otherwise admissible.

§ 768.0427(2), Fla. Stat.

Thus, the statute ensures that juries consider evidence of the actual cost of medical care, often represented by what the claimant's health insurer would have paid. In instances where a claimant lacks health care coverage, the statute looks to a known, acceptable measure of the cost of medical care, Medicare. Medicare rates are based upon classifying healthcare services into clinically similar resource-based units. The purpose of these classifications is to ensure that Medicare payments are based on objective measures such as the provider's costs and allow for geographic adjustments. Regardless of the provider type, all Medicare fees are based upon publicly available and well-known factors that are reliable, reproducible, and independent of personal bias. Thus, Medicare rates can and do readily serve as a convenient and readily recognizable standard or "yardstick" for the value or cost of medical services.

What HB 947 Proposes to Do

HB 947 proposes to delete section 768.0427's provisions which require consideration of common methods of valuing medical care, like Medicare and Medicaid, and require juries to ignore evidence that a plaintiff used an LOP instead of accessing health care coverage.

More specifically, HB 947 would amend section 768.0427's provisions regarding what evidence is admissible to prove past, unpaid medical expenses and future medical expenses to state that the evidence "may" include "[e]vidence of the reasonable and customary rates for such treatment or services rendered by a qualified provider," an amorphous standard that destroys the certainty provided by section 768.0427.

HB 947 would also delete section 768.0427's requirement that, when a claimant has health care coverage but obtains treatment through an LOP or otherwise does not submit his or her charges through their health care coverage, the evidence admissible to demonstrate those medical expenses includes what the claimant's health care coverage would have paid for that treatment, plus the claimant's share of medical charges under the insurance policy, had the claimant obtained medical treatment pursuant to that health care coverage. Again, instead of looking at this highly relevant information in the event a claimant ignores their health care coverage in favor of using an LOP with an inflated value to obtain a treatment or service, HB 947 would provide that the jury would instead consider the imprecise standard of what rate is "reasonable and customary" for that treatment or service.

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Section 768.0427 as currently enacted ensures juries base damages awards on the true cost of medical treatment, and not inflated medical bills, by defining the evidence admitted to prove medical expenses. HB 947, however, proposes to eliminate that certainty and to introduce a highly subjective standard that will destroy that transparency. For all these reasons, the Florida Justice Reform Institute asks the Legislature to reject HB 947.