IN THE SUPREME COURT OF FLORIDA
TALLAHASSEE, FLORIDA

ALBERT GOBLE,

Plaintiff/Petitioner,

vs. CASE NO. SC03-1245

MARK E. FROHMAN,

Defendant/Respondent.
_____/

ON A CERTIFIED QUESTION FROM
THE SECOND DISTRICT COURT OF APPEAL

ANSWER BRIEF OF DEFENDANT/RESPONDENT

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PRELIMINARY STATEMENT

Defendant/Respondent, Mark E. Frohman, will refer to himself as "Defendant," the capacity that he occupied in the trial court. He will refer to Plaintiff/Petitioner, Albert Goble, as "Plaintiff," his capacity in the trial court. References to Goble's Initial Brief in this Court will be designated as "Petitioner's Brief" and the page number.

STATEMENT OF THE CASE AND FACTS

Defendant accepts Plaintiff's Statement of the Case and Facts (Petitioner's Brief at 2-4) as accurate. Defendant would emphasize, however, that it is undisputed that the contracts with Aetna, Plaintiff's HMO carrier, were in effect before Plaintiff received any treatment for his accident-related injuries, and that those contracts required Plaintiff's health care providers to accept discounted rates in satisfaction of their claims for services. Further, Aetna's subrogation right was limited to the $145,970.76 billed by the providers under the contracts.

CERTIFIED 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?

SUMMARY OF ARGUMENT

The contractual adjustments made by Plaintiff's health care providers pursuant to their agreements with Aetna, Plaintiff's HMO, are as much "payments," within the meaning of Section 768.76, *Florida Statutes*, as if there had been an actual transfer of cash. Cases from common-law collateral source rule jurisdictions that do not have statutes similar to Section 768.76 recognize such adjustments, write-downs, or write-offs as forms of compensation, benefits, or indemnity from collateral sources of recovery. Personal injury claimants were never liable for these adjustments, nor were the third-party payors ever subrogated as to the written-down amounts. Therefore, under a statutory scheme like Florida's, a tort defendant should be entitled to a credit for them against the amount a plaintiff's tort recovery.

Section 768.76 was a part of the 1986 Tort Reform and Insurance Act, which was clearly intended by the Legislature as a remedial measure. As such, even though it is in derogation of the common law, it should still be liberally construed to give effect to the Legislature's express intent, which was to enhance the availability and affordability of liability insurance, and to reform the tort system. The Second District's construction of the statute so as to include the adjustments as forms of payment by collateral sources gave effect to that clear legislative intent.

Either the adjustments were payments by collateral sources or they were not. If they were, then Defendant ought to get a credit for them against Plaintiff's tort recovery under the statute, because there was no right of subrogation or reimbursement on Aetna's behalf. If they were not, then Plaintiff should have no right to recover for them, because as he was never responsible for them, they were not damages incurred by Plaintiff as the result of Defendant's negligence.

The adjustments did not spring from any legally cognizable non-monetary contribution by Plaintiff. The amorphous concept of "loss of freedom of choice" by participation in an HMO lacks sufficient concreteness to allow for an offset against the collateral source payments. Although it is probably widely assumed that HMO premiums are less than premiums for other forms of insurance coverage, plaintiff elected not to adduce evidence of any premium difference before the trial court. It cannot be known whether there was in fact a premium difference, and if so, how much it may have been, so as to permit it to be claimed as an offset against the collateral source payments. The argument that allowing Plaintiff to recover the $428,583 in adjustments would help to make him whole by offsetting his contingent attorney fee is simply an attempt to disguise the unquestioned windfall to him as well as to his attorney in the sheep's clothing of full compensation. Further, it is tantamount to awarding him attorneys' fees in an action where fees are not recoverable.

STANDARD OF REVIEW

Defendant agrees with Plaintiff that the appropriate standard of review is *de novo*.

ARGUMENT

REDUCTIONS IN CHARGES MADE BY PLAINTIFF'S HEALTHCARE PROVIDERS PURSUANT TO THE PROVIDERS' CONTRACTUAL OBLIGATIONS TO PLAINTIFF'S HEALTH MAINTENANCE ORGANIZATION MEET THE STATUTORY DEFINITION OF COLLATERAL SOURCES AND MAY BE USED TO OFFSET A PLAINTIFF'S DAMAGE AWARD.

The Second District Court of Appeal made two holdings. First, it held that Section 768.76, *Florida Statutes* (1999), was remedial in nature, and therefore it ought to be liberally construed to give effect to the legislature's express intent.[1] The legislative intent, as divined by the Second District, was:

> to fully compensate the injured party while simultaneously reducing the litigation costs that arise when insurers are required to pay damages beyond what the injured party actually incurred. . . . The allowance of such a windfall completely undermines the purpose of the Act by requiring insurers to pay damages based on a billing fiction, especially when the insurers will be sure to pass the cost for these phantom damages on to Floridians.

Goble v. Frohman, 848 So.2d 406, 410 (Fla. 2d DCA 2003). Second, the court concluded that regardless of whether a strict or liberal interpretation were employed, the contractual discounts were "payments made to the claimant, or made on the claimant's behalf," within the statute's meaning.[2] The court distinguished *D'Angelo v. Fitzmaurice*, 832 So.2d 135 (Fla. 2d DCA 2002), *review granted*, (Fla.

[1] *Goble v. Frohman*, 848 So.2d 406, 410 (Fla. 2d DCA 2003).
[2] *Id.* at 409.

May 15, 2003), which held that a defendant was not entitled to the setoff of a settlement with a hospital for the forgiveness of an outstanding bill and cash, on the basis that under Section 768.76(2)(a), a settlement with a co-defendant was not a "collateral source" of indemnity.[3] The court went on to observe that because in the instant case, "remittance of the discounted amount [by Aetna] discharged Goble's obligation to his medical providers for treatment,"[4] and because the providers had no further right to reimbursement from Goble or from third parties, the contractual discounts constituted "payments." The court employed definitions of the term "payment" from *Webster's Third New International Dictionary* (1986) and from *Black's Law Dictionary* (7th ed. 1999) in support of its interpretation of the statutory language.

Plaintiff's apparent quarrel with the Second District's holding centers around his view that a "payment" may encompass only a transfer of cash. This interpretation ignores the language of Section 768.76(2)(a)(3), which includes as collateral sources contracts or agreements to "*provide, pay for, or reimburse* the costs of hospital, medical, dental or other health care services (emphasis added)." If a "payment" meant only a cash transfer, then why did the Legislature use all of this excess verbiage? Why didn't it just say "pay for," and leave it at that?

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[3] *Id.*

[4] *Id.*

Plaintiff's argument depends on the adoption of a construction of the term "payment" that goes beyond "strict," and can best be described as "myopic." Plaintiff would have this Court throw out the dictionary definitions of the word, and apply an interpretation that would virtually emasculate the collateral source statute's remedial purpose. These arguments, and the others advanced by Plaintiff, will for this Court's and opposing counsel's convenience, be dealt with below in the order in which they appear in his brief.

A. The Certified Question Presented in This Appeal is Not One of Great Public Importance.

This case does not present an issue of the type sufficient to cause this Court to exercise its "absolute discretion"[5] to review the Second District's decision. The question certified by the lower court is not one of "constitutional magnitude,"[6] nor is the issue "one which is frequently raised but with inconsistent results by lower tribunals."[7] There exists no conflict among the district courts of appeal, as the Second District is the only such court to have addressed the issue.[8]

The lower court's interpretation of Section 768.76, *Florida Statutes* (1999) did not involve "complex or difficult issues."[9] Indeed, the Second District

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[5] *Bradley v. State*, 615 So.2d 854, 855 (Fla. 1st DCA 1993).
[6] *Id.*
[7] *Id.*
[8] *State v. Irizarry*, 698 So.2d 912, 913 (Fla. 4th DCA 1997).
[9] *Star Casualty v. U.S.A. Diagnostics, Inc.*, 855 So.2d 251, 252 (Fla. 4th DCA 2003), citing *Everhart v. State*, 559 So.2d 427 (Fla. 4th DCA 1990).

performed the singularly effortless task of correctly deciding what the word "payment" meant in the statutory context. In *Star Casualty v. U.S.A. Diagnostics, Inc.*, 855 So.2d 251, 252 (Fla. 4th DCA 2003), the court observed that no standard existed to guide a court in certifying a question. It went on to note, however, that:

> one general guide is that a question should be certified where our decision will affect a large segment of the public *and* the extant decisional law may not coalesce around a single answer to the question posed.

Id. (emphasis added). The issue that confronted the lower court did not affect a large segment of the public; it just affected personal injury litigants. Also, there is no reason to believe that the extant decisional law surrounding Section 768.76 is such as to breed multiple, conflicting answers to the simple issues of whether a health insurance write-off is the equivalent of a "payment" within the statute's meaning, or of whether the statute should receive a strict or a liberal construction.

Plaintiff imagines a sinister cabal of insurers bent on delaying settlement so that personal injury claimants will incur more past medical specials which may be compensated at discounted rates rather than future medicals which must be paid at full value.[10] Not only does this somewhat paranoid apprehension give insurers more credit than they probably deserve, but it also makes very little sense. The Second District's interpretation will drastically reduce the amounts that plaintiffs

[10] Petitioner's brief at 12.

will be able to claim as special damages, thus lowering overall demands in personal injury claims and making them easier to settle.

Of course, these issues are very important to the Academy and to the FDLA,[11] because they are groups whose membership consists largely of attorneys practicing personal injury law. But because the issue is one of "great importance" to the trial bar does not mean that it is one of "great public importance."[12]

B. A Healthcare Provider's Contractual Write-offs or Discounts Fit Within the Plain Meaning of the Statutory Definition of "Collateral Sources."

Although Plaintiff cites *Rollins v. Pizzarelli*, 761 So.2d 294 (Fla. 2000), for the proposition that a statute must be given its plain and obvious meaning, without resort to rules of interpretation and construction,[13] he goes on to ignore the ordinary, dictionary meanings of the word "payment,"[14] as recognized by the Second District.[15] If an intercessor, contractually bound to indemnify a debtor for his obligation to a creditor of $50.00, were to persuade the creditor to accept $49.00 in satisfaction of the indebtedness, would not the tender of the $49.00 by the indemnitor, and the acceptance of that amount by the obligee, constitute "payment" of the obligation? The obligation has been completely satisfied. The

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[11] *Id.*
[12] Fla. R. App. P. 9.130(a)(2)(A)(v).
[13] Petitioner's Brief at 13.
[14] *"[P]ayments* made to the claimant, or on the claimant's behalf, ..." § 768.76(2)(a)(3), *Florida Statutes* (1999) (emphasis added).
[15] 848 So.2d at 409.

obligation no longer exists, and despite the fact that the indemnitor did not remit the full $50.00 owed to the creditor, no one would seriously argue that the debt had not been paid.

Plaintiff suggests[16] that the adjustments contractually negotiated on his behalf by his HMO are not really payments, but instead are "payments not made," or "payments made . . . by the healthcare provider," rather than *to* the healthcare provider. This is just sophistry. However Plaintiff chooses to characterize it, the HMO's discharge of Plaintiff's obligation to his providers in return for a discounted amount is the literal equivalent of payment which, as noted by the Second District, is "more than the act of remitting money."[17]

The cases cited by Plaintiff belie his protestations that payment is restricted to the exchange of currency in satisfaction of a debt. In *Acuar v. Letourneau*, 260 Va. 180, 531 S.E. 2d 316 (2000),[18] the Virginia Supreme Court addressed an analogous fact situation. The plaintiff's health care providers had written off certain amounts from his total costs of medical treatment, pursuant to agreements with his health insurance carriers.[19] Virginia did not have a "collateral source" statute similar to Section 768.76. Therefore, the common-law collateral source

[16] Petitioner's Brief at 14-15.
[17] 848 So.2d at 409.
[18] Petitioner's Brief at 28-29.
[19] *Id.* at ___, 531 S.E. 2d at 183 n. 1.

rule was in effect.[20] In rejecting the argument by the defendant that the write-offs were *not* collateral sources, the court stated:

> Acuar [defendant] cannot deduct from that full compensation any part of the benefits Letourneau [plaintiff] received from his contractual arrangement with his health insurance carrier, whether those benefits took the form of medical expense payments or amounts written off because of agreements between his health insurance carrier and his health care providers. Those amounts written off are as much of a benefit for which Letourneau paid consideration as are the actual cash payments made by his health insurance carrier to the health care providers. The portions of the medical expenses that the health care providers write off *constitute 'compensation or indemnity received by a tort victim from a source collateral to the tortfeasor . . . .'* [citation omitted].

260 Va. at ___, 531 S.E. 2d at 322 (emphasis added). What is the difference between "payment" and "benefit?" Between "payment" and "compensation?" Between "payment" and "indemnity?" No matter how narrowly one chooses to define the term, it is inescapable that "payment," under the Virginia court's logic, encompasses adjustments, and that if Virginia had a statute like Section 768.76, an adjustment would have to be considered a "payment" by a "collateral source."

A similar interpretation is apparent in the Wisconsin Supreme Court's treatment of provider write-offs in *Koffman v. Leichtfuss*, 246 Wis. 2d 31, 630 N.W. 2d 201 (2001).[21] Like Virginia, Wisconsin does not have a statute similar to Section 768.76, and the state adheres to the common-law collateral source rule. As

[20] *Id.* at ___, 531 S.E. 2d at 189.
[21] Petitioner's Brief at 29-30.

in *Acuar*, the plaintiff's medical bills were adjusted by his providers pursuant to agreements with his insurers. Citing *Acuar* with approval,[22] the Wisconsin court concluded that the collateral source rule required that the plaintiff be allowed to recover the full amount of the reasonable and necessary medical bills, saying:

> the collateral source rule allows the plaintiff to seek recovery of the reasonable value of medical services without consideration . . . *or payments made by outside sources on the plaintiff's behalf, including insurance payments.* [citations omitted] Where the plaintiff's health care providers settle the plaintiff's medical bills with the plaintiff's insurers at reduced rates, the collateral source rule dictates that the defendant-tortfeasor not receive the benefit of the written-off amounts.

Id. at ___, 630 N.W. 2d at 210 (emphasis added). Neither *Koffman* nor the instant case deals with medical services rendered gratuitously, without consideration. Instead, these are situations in which "health care providers settle[d] plaintiff's medical bills with the plaintiff's insurers at reduced rates, ..." *Id.* The foregoing language makes it clear that the Wisconsin court considered such settlements to be a species of payment by a collateral source. Therefore, had Wisconsin enacted a statutory provision similar to Section 768.76, a result similar to that reached by the Second District would have accrued. *See also Hardi v. Mezzanotte*, 818 A. 2d 974, 984 (D.C. App. 2003) (citing *Acuar* with approval, in another common-law collateral source rule jurisdiction).

[22] 246 Wis. at ___, 630 N.W. 2d at 210 n. 9.

Mississippi, still another collateral source rule adherent, appears to equate write-offs to payments. In *Wal-Mart Stores, Inc. v. Frierson*, 818 So.2d 1135 (Miss. 2002), the court considered Medicare and Medicaid write-offs in the context of the collateral source rule. The court opined that:

> Wal-Mart argues that the trial court erred by allowing the jury to consider evidence of medical expenses which were later written off by Frierson's medical providers pursuant to Medicare and Medicaid regulations.
>
> . . .
>
> In *Brandon HMA* [*Inc. v. Bradshaw*, 809 So.2d 611 (Miss. 2001)], we found that Medicaid payments are subject to the collateral source rule, which states that a tortfeasor cannot mitigate its damages by factoring in compensation the plaintiff received from a collateral source other than the tortfeasor, such as insurance.
>
> . . .
>
> There is no reason why *Medicaid benefits should be treated any differently than insurance payments*, and they should be subject to the collateral source rule.

818 So.2d at 1139-40 (emphasis added). The court clearly equated Medicaid write-offs (benefits) to insurance "compensation," which is logically indistinguishable from payments.

A similar interpretation has been adopted in a simpler and more direct manner by Georgia, another common-law collateral source rule state. In *Olariu v. Marrero*, 248 Ga. App. 824, 825, 549 S.E. 2d 121, 123 (2001), the court asserted

that "*Candler Hosp.* [*v. Dent,* 228 Ga. App. 421, 491 S.E. 2d 868 (1997)] establishes that a write-off of medical expenses is a collateral source of payment." A more plain equation of a write-off to a payment could not be imagined.

Plaintiff places great emphasis on the Connecticut rule,[23] which appears to slavishly adhere to a breathtakingly narrow interpretation of that state's enactment of a statutory provision that is similar to Section 768.76.[24] *Hecht v. Staskiewicz*, ___ A.2d ___, 2002 WL 442319 (Conn. Super. 2002), went off on the fact that the premiums paid for Plaintiff's medical insurance *exceeded* the amount of the write-off, a circumstance that does not exist here. The court also noted that the intent of the legislature, as revealed by the statute's legislative history, was an important consideration in interpreting the statute. No reference, however, was made by the court to any remedial purpose on the legislature's part in enacting the statute. Finally, the court focused on the legislature's enumeration of payments that were considered "collateral sources," rather than construing what the legislature considered to be "payments." *Hecht* is therefore distinguishable, and has no precedential value.

Plaintiff's reliance[25] on *Chester v. Doig*, 842 So.2d 106 (Fla. 2003), is misplaced. *Chester* involved the issue of a set-off against an arbitration award

[23] Petitioner's Brief at 17-18.
[24] Conn. Gen. Stat., § 52.225b.
[25] Petitioner's Brief at 15-16.

under Section 766.207, *Florida Statutes*, by the amount of a settlement with another tortfeasor. The case did not involve Section 768.76, or a reduction by virtue of health care provider adjustments necessitated by contracts with the plaintiff's health insurers. Presumably, Plaintiff cites the case for the proposition that the legislature must clearly delineate its intent to apply any set-off against a plaintiff's tort recovery. Defendant agrees that the Legislature ought to say what it means and mean what it says. However, it is readily apparent that in the case of Section 768.76, the Legislature amply enunciated its intent to encompass virtually all satisfactions of the charges of third-party providers, as to which a plaintiff's indemnitors were not subrogated, within the ambit of "collateral sources," for which the plaintiff cannot recover. *See Sheffield v. Superior Ins. Co.*, 800 So.2d 197, 200 n. 3 (Fla. 2001).

C. This Court May Have Incorrectly Mandated a Narrow Construction of the Collateral Source Statute.

It goes without saying that Defendant does not take lightly the earlier pronouncements of this Court regarding the strict or broad interpretations of statutory provisions such as Section 768.76, and Defendant recognizes that in *Allstate Ins. Co. v. Rudnick*, 761 So.2d 289 (Fla. 2000), this court stated that Section 768.76 was to be narrowly construed, as in derogation of common law. However, it is respectfully submitted that in *Rudnick*, the statute's legislative

history may not have been brought to the attention of this Court, and therefore, this Court may not have been given an opportunity to fully consider it.

The Second District, below, noted that Ch. 86-160, Fla. Laws, clearly enunciated the Legislature's intent that the Tort Reform and Insurance Act, of which Section 768.76 was a part, be remedial in nature.[26] Thus, despite its alteration of the common law, because of its remedial nature, it should be liberally construed to give effect to the Legislature's express intent. *Irven v. Dep't of Health and Rehab. Services*, 790 So.2d 403 (Fla. 2001).

In 1986, the Legislature, after recognizing the existence of "a financial crisis in the liability insurance industry,"[27] stated that:

> [t]he Legislature finds and declares that a solution to the current crisis in liability insurance has created an overpowering public necessity for a comprehensive combination of reforms to both the tort system and the insurance regulatory system. *This act is a remedial measure and is intended to cure the current crisis and to prevent the recurrence of such a crisis.*[28]

If Section 768.76 is remedial in nature, and therefore to be liberally construed, then it makes sense that an interpretation should be adopted that will give effect to the Legislature's intent in enacting the statute. The 1986 Tort Reform and Insurance Act's legislative history is replete with allusions to the lack

[26] 848 So.2d at 408.
[27] Fla. Laws, Ch. 86-160, Preamble.
[28] *Id.* at § 2 (emphasis added).

of availability and affordability of liability insurance, and the interrelation of tort law and the liability system.[29] The legislative intent is clear.

In the instant case, Plaintiff's medical bills, in the amount of $574,554.31, were reduced by virtue of the providers' contracts with Aetna to $145,970.76 -- a reduction of $428,583.55.[30] Plaintiff was not obligated to pay the $428,583.55 balance. In fact, no one was obligated to pay the balance. The amount was simply adjusted, as a result of the reality of managed care. *Mitchell v. Hayes*, 72 F. Supp. 2d 635, 636 n. 2 (W.D. Va. 1999).

If Plaintiff were allowed to recover from Defendant the illusory amount of $428,583.55, then the burden of that non-existent charge may be shifted to Defendant or to his liability insurance carrier, either in the form of a judgment or a claim for extra-contractual damages against the insurer. In either event, the net result would be to allow Plaintiff, whose personal liability for the written-off medical bills is nothing, and whose HMO insurer has no right of subrogation, to recover a truly substantial amount of money from Defendant, or more likely, from his liability carrier. The net effect would be precisely the evil that the Legislature sought to prevent by its enactment of Ch. 86-160: an adverse consequence to the availability and affordability of liability insurance, and a tort system that is out of

[29] *Id.*, Preamble.
[30] Petitioner's Brief at 2.

control. The remedial nature of Ch. 86-160 cries out for a liberal interpretation on this court's part to give effect to the Legislature's intent.

D. An Adjustment Made by a Provider, Which Was Required by an HMO Contract That Pre-existed the Service Dates, Is As Much a "Payment" by the HMO As If the HMO Had Written A Check.

Here, the HMO agreed in advance with Plaintiff's providers that all billings submitted by the providers for the HMO's members would be paid at the contract rate, and not at the providers regular billing rates. The providers did not submit the entire $574,544 to Aetna, only to have Aetna haggle until the providers threw up their hands and agreed to accept the $145,970. The providers knew that in order to be included on Aetna's approved provider list, they would have to go along with the HMO's rates. It was either that, or forego treating patients who happened to be Aetna insureds. Welcome to the world of managed care.

Aetna, by negotiating the provider contracts, arranged for the payment of Plaintiff's medical bills at much reduced rates. This notwithstanding, Aetna still gave value in return for the satisfaction of Plaintiff's medical bills in full. To insist otherwise is to be totally unrealistic. Suppose Aetna went over and bartered with its approved providers for satisfaction of its insureds' bills in return for free or discounted malpractice insurance premiums for a year. Aetna has given the providers something of value in return for stamping "paid" to the insureds' accounts. By paying at the reduced contract rates, Aetna has also given the

providers something of value – some money, as well as the privilege to be on Aetna's approved list, and treat patients from the ranks of Aetna's insureds. How much is that privilege worth? Obviously, enough to induce the providers to accept about 20¢ on every dollar of their medical bills, judging by the amounts written off in the instant case.

The previously negotiated HMO contract billing rates are the true "reasonable and necessary" medical expenses incurred by Plaintiff, not the standard charges that the providers would make in a non-managed care dream world. Those standard charges were never billed to Plaintiff, and he was not at any time liable for their payment. When the providers get up on the witness stand and testify that their wished-for customary fees are reasonable and necessary, what they are really saying is that "this is what I would've charged for procedure 'X' but for managed care." "Reasonable and necessary" charges are nothing more than a fantasy. Managed care is the reality. The lower court's decision recognizes this, and so should this Court.

E. There Is Authority for the Proposition That the Collateral Source Rule Does Not Apply to Amounts Adjusted By Providers, for Which a Plaintiff Was Never Liable.

Defendant recognizes that, prior to the enactment of Section 768.76, *Florida Statutes*, Florida followed the common-law collateral source rule. The collateral source rule still applies to benefits received by a plaintiff, which are not "collateral

sources" within the meaning of the statute. The main issue involved in the instant case is whether the contractual adjustments made by Plaintiff's health care providers are "collateral sources" under Section 768.76, applying either a strict or liberal construction of that remedial provision.

As has been seen, several courts have held that such contractual adjustments are collateral sources under the common-law rule.[31] None of these courts were located in jurisdictions had statutes like Section 768.76. If they had enacted similar statutes, then under the reasoning expressed in the decisions, the write-downs would be considered "payments" by collateral sources, which had no subrogation rights. Therefore, the defendants would have been entitled to set-offs for the amounts written off.

Plaintiff in the instant case cannot have it both ways. Either the contractual adjustments were payments by collateral sources, or they weren't. If they were payments by collateral sources, then because no subrogation right in the HMO *ever* existed, Defendant is entitled to a set-off under Section 768.76 for them. If they were not payments by collateral sources, then Plaintiff would not be entitled to recover for them, even in the absence of the statute.

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[31] See, e.g., *Hardi v. Mezzanotte*, 818 A. 2d 974 (D.C. App. 2003)*; Wal-Mart Stores, Inc. v. Frierson*, 818 So.2d 1135 (Miss. 2002); *Koffman v. Leichtfuss*, 246 Wis. 2d 31, 630 N.W. 2d 201 (2001); *Olariu v. Marrero*, 248 Ga. App. 824, 549 S.E. 2d 121 (2001); *Acuar v. Letourneau*, 260 Va. 180, 531 S.E. 2d 316 (2000).

Several courts have held that because the plaintiffs were never liable for the written-off amounts, they were not damages incurred by the plaintiffs, and therefore the plaintiffs could not recover for them. In *Boutte v. Kelly*, ___ So.2d ___, 2003 WL 22244932 (La. App. 4th Cir. 9/17/03), the court dealt with a Medicare adjustment. The court stated:

> the situation at bar concerns not what was paid by Medicare, but what was discounted by Medicare, an amount for which the plaintiffs were never liable.
>
> . . .
>
> In *Terrell v. Nanda*, 33,242 (La. App. 2 Cir. 5/10/00), 759 So.2d 1026, the second circuit concluded that the collateral source rule does not allow recovery of expenses in excess of Medicaid payments. The court's decision was based on its finding that the plaintiff had no liability to the provider for expenses above those paid by Medicaid; thus no natural obligation existed, and if allowed to recover all of the claimed expenses, the plaintiff would receive a windfall.

2003 WL 22244932 at 17-18. *See also Suhor v. Lagasse*, 770 So.2d 422 (La. App. 4th Cir. 2000); *Terrell v. Nanda*, 759 So.2d 1026 (La. App. 2d Cir. 2000).[32]

In *Terrell, supra*, the court observed that "[a] plaintiff may ordinarily recover reasonable medical expenses, past and future, which he incurs as a result of injury . . . . The term 'incur' is defined as 'to become liable for.'" *Id.* at 1030-31. If a claimant is never liable for a medical bill, then how can he or she be said to

[32] There is a split of authority on the issue in Louisiana. Compare *Brannon v. Shelter Mutual Ins. Co.*, 520 So.2d 984 (La. App. 3d Cir. 1987) and *Kozina v. Zeagler*, 646 So.2d 1217 (La. App. 5th Cir. 1994).

have sustained it as an element of damage? If the claimant has never sustained the element of damage, then why should he or she be allowed to recover for it?

The collateral source rule is a fiction. Tort plaintiffs' providers may come to court and testify that their bills are reasonable and necessary, irrespective of whether they ever expect them to be paid. In point of fact, after the patient has settled the suit, or received a verdict, the providers' claims are often resolved for pennies on the dollar. The providers, therefore, have every incentive to aggrandize and expand the amounts of their charges. The excess over what the provider is willing to accept in resolution of its bill is a windfall to the plaintiff.

The fiction is even more transparent where there is absolutely no way that the providers could ever recover the charges that they testify are reasonable and necessary because they were contractually bound to accept, and have accepted, discounted amounts from the patients' health insurers. The instant case is a perfect example of this artifice. Plaintiff's providers were paid, and had accepted, $145,970 for their services. Nevertheless, they were allowed to come to court and testify that Plaintiff owed them an additional $428,583, when in fact, he owed them nothing. Had Plaintiff been allowed to recover the "reasonable and necessary" medical expenses claimed, the $428,583, which was owed to no one, and which was not really a legitimate element of damage to him, would have gone in Plaintiff's pocket.

Plaintiff goes on to rely on a line of Florida cases which hold that where a subrogated third party, for one reason or another, waived its right of subrogation or reimbursement after the fact, the payments made by the third party did not constitute collateral sources for which a set off was available to the defendant under Section 768.76.[33] *Centex-Rogers Construction Co. v. Herrera*, 816 So.2d 1206 (Fla. 4th DCA 2002), *Sutton v. Ashcraft*, 671 So.2d 301 (Fla. 5th DCA 1996), and *Bruner v. Caterpillar, Inc.*, 627 So.2d 46 (Fla. 1st DCA 1993), exemplify this line of cases. Each involves the waiver of an *existing* subrogation or reimbursement right, and on that ground, they are all distinguishable from the instant case. Judge Booth, concurring in *Bruner*, correctly pointed out that "it is the *existence* of this right of subrogation, not the exercise of such right, which prevents [the defendant] from being entitled to a collateral source offset." 627 So.2d at 47. Defendant has no quarrel with the proposition that where a right of subrogation or reimbursement comes into existence at the outset, it makes no difference what the subrogated third party later does with that right. Its mere existence prevents benefits paid by the subrogated third party from being collateral sources under Section 768.76. The distinction, of course, is that Aetna never became subrogated to the amounts contractually adjusted. Because the subrogation right never came into existence, no impediment to the classification of the

[33] Petitioner's Brief at 25-28.

adjustments as Section 768.76 collateral sources arises. *Bruner* and its progeny are not analogous to the instant case, and Plaintiff's reliance upon them is disingenuous.

F. Plaintiff Made No Legally Cognizable Non-monetary Contributions to Securing the Discounts or Write-offs.

Plaintiff asserts that the lower court failed to recognize the "non-monetary contributions" made by him in the form of (1) sacrificing his freedom of choice by agreeing to treat with HMO-approved providers, (2) allowing Defendant to benefit through Plaintiff's lower premiums paid to the HMO, and (3) incurring higher attorneys' fees on a higher damage award.[34] In doing so, Plaintiff descends from the sublime to the ridiculous.

Medical special damages are hard economic losses. "Loss of freedom of choice" is a non-economic concept that cannot be quantified. How can one place a value on loss of freedom of choice? What is loss of freedom of choice worth? How can one "offset" collateral source reductions by amounts "contributed, or forfeited by . . . the claimant"[35] when those amounts are not susceptible to empirical ascertainment?

The hypothetical difference between HMO premiums and premiums for other forms of health insurance, on the other hand, is presumably subject to

[34] *Id* at 30-35.
[35] Section 768.76(1), *Florida Statutes* (1999).

quantification. The problem is that the record in the instant case is devoid of any evidence that there is such a difference, and if so, what that difference might be. If Plaintiff wanted to urge an offset for such a difference in premiums, then he should have done it in the trial court. Moreover, the suggested difference in premiums is inextricably tied to the "freedom of choice" claim. What is paying higher premiums in order to obtain freedom of choice worth? Shouldn't the higher premiums be diminished by the freedom of choice gained?

Plaintiff seems to be arguing that if he were awarded a higher amount of damages, then he would have more money available to pay his attorneys' fees.[36] If the higher award helped to offset his attorneys' fees, then he would come closer to being made whole for his damages. This is all well and good, except for the fact that in a straight tort action, attorneys' fees are not a recoverable element of damage. Plaintiff claims that this factor renders the windfall occasioned by the award of fictitious damages "illusory."[37] This is simply untrue. The award of damages that are not in any way compensatory merely gives Plaintiff a 60% windfall, and the attorneys a 40% windfall, according to Plaintiff's logic.

[36] Petitioner's Brief at 35 n. 10.
[37] *Id.*

CONCLUSION

In no way is this case one of "great public importance." The contractual adjustments are, indeed, "payments" by collateral sources, whether one adopts a strict or liberal construction of Section 768.76. A liberal construction is indicated because the statute is remedial in nature, despite the fact that it is in derogation of the common law. Even if the common law collateral source rule were to govern, it is still possible to view the adjustments as outside the ambit of compensatory damages. Plaintiff made no non-monetary contributions that were sufficient to reduce the collateral source set offs that were mandated by Section 768.76. Therefore, the decision of the Second District was correct, and if this court decides to exercise jurisdiction, it ought to be affirmed.

Respectfully Submitted,

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I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by U. S. Mail to: Theodore E. Karatinos, Esq. and Timothy F. Prugh, Esq., Prugh, Holliday, Deem & Karatinos, P.L., 1009 W. Platt Street, Tampa, Florida 33606, Attorneys for Plaintiff/Petitioner; Amy S. Farrior, Esq., Raymond T. Elligett, Jr., Esq., and Charles P. Schropp, Esq., Schropp, Buell & Elligett, P.A., 3003 W. Azeele Street, Suite 100, Tampa, Florida 33609, Attorneys for Plaintiff/Petitioner; Roy D. Wasson, Esq., Suite 450, Gables One Tower, 1320 S. Dixie Highway, Miami, Florida 33146, Attorney for Amicus Curiae Florida Academy of Trial Lawyers; Warren Kwavnick, Esq., **Cooney, Mattson**, Lance, Blackburn, Richards & O'Conner, P.A., 2312 Wilton Drive, Ft. Lauderdale, Florida 33305, Attorney for Amicus Curiae Florida Defense Lawyers Association; and Charles W. Hall, Esq., Fowler, White, Boggs, Banker, P.A., 501 1st Avenue North, Suite 900, St. Petersburg, Florida 33701, Attorneys for Amicus Curiae Allstate, this _____ day of November, 2003.

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CERTIFICATE OF COMPLIANCE

I hereby certify that this Answer Brief satisfies the requirement of Florida Rule of Appellate Procedure 9.210. This brief is submitted in Times New Roman 14-point font.

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