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

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ALBERT GOBLE

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PRELIMINARY STATEMENT

Plaintiff/Petitioner, Albert Goble, refers to himself as "Plaintiff," his capacity in the trial court.

Plaintiff refers to Defendant/Respondent, Mark E. Frohman, as "Defendant," his capacity in the trial court.

Plaintiff designates references to the record on appeal by the prefix "R" followed by volume and page number. References to the trial transcript contain the additional prefix "T" prior to the page number.

Plaintiff designates references to Defendant's Answer Brief in the Second District by the prefix "AB."

STATEMENT OF THE CASE AND FACTS

Plaintiff sued Defendant for serious injuries sustained in a motor vehicle accident (R V1/29-32). As a result of the accident, Plaintiff required 13 surgeries and incurred $574,554.31 in medical bills (R V1/163; V6/T26). Evidence was presented that the amount of these bills was reasonable (R V5/903, 936-941).

Plaintiff's medical bills were submitted for payment to Aetna U.S. Healthcare ("Aetna"), a health maintenance organization ("HMO") of which Plaintiff was a member. The amounts actually paid by Aetna were determined by contractual agreements between Aetna and Plaintiff's healthcare providers (R V2/374). These healthcare providers accepted $145,970.76 in payment from Aetna in full satisfaction of all services rendered to Plaintiff -- a $428,583.55 reduction from the amounts billed (R V2/373). Pursuant to their contracts with Aetna, the healthcare providers agreed they would have no recourse against Plaintiff or other third party for the difference between the total amount charged and the actual payments made by Aetna (R V2/374). Aetna's right of subrogation, however, remains (R V2/373-374).

At trial, the jury returned a verdict in Plaintiff's favor, which included an award for past medical expenses in the amount of $574,554.31 (R V1/163).[1] Defendant moved to reduce this award to reflect the amount actually paid by Aetna, plus the $15,000.00 Plaintiff paid in co-payments and the $7,012.95 Plaintiff paid in insurance premiums from the date of the accident until the date of trial (R V2/218-220). The trial court granted Defendant's motion and entered an order reducing the jury's award for past medical expenses to $167,983.71, a reduction of $406,550.60 (R V2/221-222).

The trial court entered Final Judgment against Defendant in the reduced amount (R V2/223). Plaintiff appealed that Final Judgment to the Second District Court of Appeal.

In its opinion, the Second District affirmed the trial court's reduction of the jury's award for past medical expenses from the full amount billed for these expenses to the amount actually paid by Aetna. *Goble v. Frohman*, 848 So. 2d 406 (Fla. 2d DCA 2003). The court acknowledged Supreme Court precedent mandates a narrow construction of § 768.76, as a statute that is in derogation of the common law; however, it suggested the statute should be liberally construed because it is also

[1] Defendant's Motion to Set Off Jury Award of Past Medical Expenses incorrectly stated the jury had awarded Plaintiff past medical expenses of $574,768.00 (R V2/218).

remedial in nature. *Id.*, at 408. On the merits, the court reasoned that because the remittance of the discounted amount discharged Plaintiff's obligation to his medical providers, the discount itself constitutes a "payment made" on Plaintiff's behalf and is, therefore, a collateral source subject to setoff. *Id.*, at 409.

The court recognized this case presents an issue of great public importance and certified the following question to this Court:

> 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 410.

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 amount of write-offs to Plaintiff's healthcare providers' customary charges for services rendered to Plaintiff pursuant to the healthcare providers' contracts with Plaintiff's HMO are not within the statutory definition of "collateral sources" and, therefore, may not be used to offset a plaintiff's damage award under the collateral source statute.

The collateral source statute defines "collateral sources" as "any **payments made**" to or on behalf of the claimant pursuant to "any contract or agreement of any group, organization, partnership, or corporation **to provide, pay for, or reimburse the costs** of hospital, medical dental or other health care services." The plain meaning of the "collateral sources" definition cannot encompass the amounts Plaintiff's healthcare providers discounted from their medical bills.

First, these discounts or write-offs are not "payments made." At most, they are payments that are not required to be made. Second, the plain language of the statutory definition requires that "collateral sources" must be payments made **to** the healthcare provider, not **by** the healthcare provider. Because Plaintiff's healthcare

providers are the ones who provided the discounts or write-offs, those discounts or write-offs do not meet the statutory definition.

The statute has defined "collateral sources" in clear, unambiguous terms, and that definition says nothing about discounted or written-off charges. This Court has made it clear that Florida courts do not have the authority to rewrite statutes to mirror what a court presumes the Legislature actually intended, rather than what it actually said. Should the Legislature decide it wants to include discounts or write-offs within the definition of "collateral sources," the Legislature -- not the courts -- must amend the statute.

There is an independent reason why the healthcare providers' discounts or write-offs cannot be setoff under the collateral source statute. The statute provides that reduction for collateral sources "shall be offset to the extent of any amount which has been paid, **contributed, or forfeited by, or on behalf of, the claimant . . . to secure his right to any collateral source benefit** which the claimant is receiving as a result of his or her injury."

Plaintiff contributed more than his premium payments and co-payments. In order to obtain discounted care through his HMO, he agreed to restrict his freedom to select his own healthcare providers and potentially his treatment options as well. The Second District's interpretation of the collateral source statute fails to implement

express legislative intent by failing to compensate the Plaintiff for his significant non-monetary contribution to securing the discounts or write-offs. Ironically, this creates the windfall the Second District sought to avoid, but for the Defendant, not the Plaintiff.

STANDARD OF REVIEW

The issue before this Court is the proper interpretation of § 768.76(1), Florida Statutes (1999). A question of statutory construction, like other questions of law, is reviewed *de novo* by this Court. *See City of Gainesville v. State*, 28 Fla. L. Weekly S665 (Fla. September 4, 2003); *Armstrong v. Harris*, 773 So. 2d 7 (Fla. 2000). *See also Jackson County Hospital Corporation v. Aldrich*, 835 So. 2d 318 (Fla. 1st DCA 2002), *review granted by Bay Anesthesia, Inc. v. Aldrich*, 847 So. 2d 975 (Fla. 2003) (appellate court reviews trial court's interpretation of statute under *de novo* standard).

ARGUMENT

REDUCTIONS IN THE CHARGES MADE BY PLAINTIFF'S HEALTHCARE PROVIDERS PURSUANT TO THE PROVIDERS' CONTRACTUAL OBLIGATIONS TO PLAINTIFF'S HEALTH MAINTENANCE ORGANIZATION DO NOT MEET THE STATUTORY DEFINITION OF COLLATERAL SOURCES AND MAY NOT BE USED TO OFFSET A PLAINTIFF'S DAMAGE AWARD.

The certified question presented in this appeal arises from the trial court's reduction of the jury's award of past medical expenses to Plaintiff by the amount of write-offs to Plaintiff's healthcare providers' customary charges for the services rendered to Plaintiff pursuant to the healthcare providers' contracts with Plaintiff's HMO. Plaintiff appealed from the final judgment, arguing that such contractual write-offs are not within the statutory definition of "collateral sources" and, therefore, may not be used to offset a plaintiff's damage award under the collateral source statute. *See* § 768.76, Florida Statutes (1999). The Second District Court of Appeal affirmed

the final judgment, but certified the question to this Court as one of great public importance.[2]

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[2] In relevant part, § 768.76, Florida Statutes (1999), provides as follows:

> **768.76 Collateral sources of indemnity. --**
>
> (1) In any action to which this part applies in which liability is admitted or is determined by the trier of fact and in which damages are awarded to compensate the claimant for losses sustained, the court shall reduce the amount of such award by the total of all amounts which have been paid for the benefit of the claimant, or which are otherwise available to the claimant, from all collateral sources; however, there shall be no reduction for collateral sources for which a subrogation or reimbursement right exists. Such reduction shall be offset to the extent of any amount which has been paid, contributed, or forfeited by, or on behalf of, the claimant or members of the claimant's immediate family to secure her or his right to any collateral source benefit which the claimant is receiving as a result of her or his injury.
>
> (2) For purposes of this section:
>
> (a) "Collateral sources" means any payments made to the claimant, or made on the claimant's behalf, by or pursuant to:
>
> * * *
>
> (3) Any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical, dental or other health care services.

§ 768.76(1), 2(a)(3).

A. The Certified Question Presented in this Appeal is One of Great Public Importance.

The Second District's certified question is a question of statutory construction that will affect a significant number of pending and future personal injury cases in this state. Because of the popularity of HMO's, a large percentage of personal injury cases involve or will involve plaintiffs insured under this type of health insurance.

A determination by this Court that an injured but insured plaintiff is no longer entitled to recover the reasonable value of his past medical expenses, but only the amount actually paid by the HMO for these services, will affect the amount of recovery in virtually every personal injury case involving a plaintiff insured under an HMO. It will also negatively impact the settlement process in these cases by encouraging liability insurers to delay settlement as long as possible, thereby enabling more of an injured plaintiff's medical bills to fall into the category of past medical expenses, which the defendant would be permitted to pay only on a discounted basis, rather than future expenses which must be paid at full present value.[3]

[3] The importance of this issue is further evidenced by the requests to file amicus briefs by the Florida Defense Lawyers' Association and the Academy of Florida Trial Lawyers.

B. A Healthcare Provider's Contractual Write-Offs or Discounts Do Not Fit Within the Plain Meaning of the Statutory Definition of "Collateral Sources."

The threshold question presented by this appeal is whether a healthcare provider's contractual write-offs or discounts fit within the plain meaning of the statutory definition of "collateral sources" set forth in § 768.76. The statute defines "collateral sources," in relevant part, to mean ". . . **any payments made** to the claimant, or made on the claimant's behalf, by or pursuant to: . . . (3) Any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical, dental or other health care services. . . ." § 768.76(2)(a)(3), Florida Statutes (1999) (emphasis added). Thus, the term "payments made" would have to encompass the amounts discounted or written off by healthcare providers pursuant to their HMO contracts in order for them to be "collateral sources."

"'[W]hen the language of the statute is clear and unambiguous and conveys a clear and definite meaning, there is no occasion for resorting to the rules of statutory interpretation and construction; the statute must be given its plain and obvious meaning.'" *Rollins v. Pizzarelli*, 761 So. 2d 294, 297 (Fla. 2000)(quoting *Holly v. Auld*, 450 So. 2d 217 (Fla. 1984)). A statutory term is ambiguous only if reasonable persons can find different meanings in the same language. *See Id.*, at 297.

The plain meaning of "collateral sources" as defined in § 768.76 cannot encompass the amounts Plaintiff's healthcare providers discounted from their medical bills for two reasons. First, these contractual discounts are not "payments made." At most, they are payments **not** made or, more precisely, payments not required to be made. Because these discounts are not "collateral sources," they cannot reduce the jury's award pursuant to a statute that permits reductions "by the total of all amounts which have been paid for the benefit of the claimant, or which are otherwise available to the claimant, **from all collateral sources** . . . ." § 768.76(1)(emphasis added).[4]

Second, the subsection of the "collateral sources" definition that encompasses HMOs further limited the scope of "payments made" to those "payments made to the claimant or on the claimant's behalf, by or pursuant to: . . . 3. Any contract or agreement of any group, organization, partnership, or corporation **to provide, pay for or reimburse the costs of hospital, medical, dental or other health care services**." § 768.76(2)(a)(3) (emphasis added). In other words, "collateral sources"

[4] Although the Second District determined the statutory definition of "collateral sources" found in § 768.76(2)(a)(3) is the relevant provision for an HMO such as Aetna, the same rationale regarding "payments made" applies to all subsections of the definition, including § 768.76(2)(a)(2), which encompasses other types of healthcare plans.

must be "payments made" **to** the healthcare provider, not **by** the healthcare provider.[5] Because Plaintiff's healthcare providers are the ones who provided the discounts or write-offs, those discounts or write-offs do not satisfy the plain meaning of the statutory definition of "collateral sources."

The statute has defined "collateral sources" in clear, unambiguous terms, and that definition says nothing about discounted or written-off charges. This is the analytical framework utilized by this Court in *Chester v. Doig*, 842 So. 2d 106 (Fla. 2003), to examine the issue of statutory set-offs and collateral source definitions in the context of the arbitration provisions of the Medical Malpractice Act. *Chester* addressed whether an arbitration award made pursuant to § 766.207(7), Florida Statutes (1997), should be set off (reduced) by the amount of a prior settlement. *Id.*, at 107.

The Fifth District had reversed the arbitration panel's decision not to set off the settlement amount from the arbitration award, holding it was error for the panel not to consider Florida's setoff statutes. Specifically, the Fifth District found that by refusing to consider the setoff statutes, the arbitration panel had "ignored the intent of the Legislature to prevent double recovery." *Id.*, at 108. This Court, however,

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[5] Plaintiff's healthcare providers agreed to provide healthcare, not the costs of healthcare.

disagreed that a desire to implement presumed legislative intent gave the Court the authority to read words into otherwise plain statutory language. *Id.*

> The plain language of section 766.207(7)(a) and (c) clearly provides that the only set off available in a medical malpractice arbitration is for collateral sources as defined by section 766.202(2). Because the settlement award in this case does not meet the definition of a collateral source or a collateral source payment, the Fifth District erred in concluding that the settlement award should be set off against the arbitration award. . . . **If the Legislature intended for Florida's setoff statutes to control the elements of damages available in medical malpractice arbitration, it could have specifically provided for the application of those statutes in the Medical Malpractice Act. . . .** Because the Legislature has not done so, we conclude the arbitration award should not be set off by the settlement award in this case.

Id., at 109 (emphasis added, footnotes omitted).

The Second District's misconstruction of § 768.76 evidences similar concern regarding the Legislature's intent to prevent over compensation of the injured party. *Goble*, 848 So. 2d at 410. This Court, however, has made clear that courts do not have authority to rewrite statutes to mirror what a court presumes the Legislature actually intended rather than what it actually said. The definition of "collateral sources" in § 768.76 refers only to "payments made" and makes no reference to contractual discounts or write-offs as "collateral sources." Should the Legislature decide it wants to include these items within that definition, the Legislature -- not the courts -- must amend the statute.

This is also the conclusion recently reached by Connecticut courts in interpreting that state's collateral source statute -- a statute patterned after Florida's statute that defines "collateral sources" using the identical "payments made" language.[6] *See* Conn. Gen. Stat. § 52.225b (2003); *Schroeder v. Triangulum Associates*, 259 Conn. 325, 343-344; 789 A.2d 459, 471 (Conn. Super. 2002)(§ 52.225b enacted as part of Connecticut's tort reform legislation and modeled after Florida's statutory definition of collateral sources; comparison of the two statutes shows Connecticut's statute is taken nearly verbatim from its Florida counterpart).

Hecht v. Staskiewicz, 2002 WL 442319 (Conn. Super. 2002), addresses whether amounts written off by medical providers constitute collateral source payments, as defined in § 52-225b, which would entitle the defendant to a reduction in the amount of economic damages awarded to the plaintiff. After examining the precise language that is before the Court in this case, the Connecticut court held:

> The legislative [sic] has defined in clear unambiguous language those payments that it considers a collateral source. The statute does not define a decision by a medical provider to "write-off" any balance due from the plaintiff as a collateral source payment.

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[6] The Connecticut statute defines "collateral sources" to mean "any **payments made** to the claimant, or on his behalf, by or pursuant to" a list of sources set out in the statute, including "any health or sickness insurance." Conn. Gen. Stat. § 52.225b (emphasis added).

Id., at *2.

Sackman v. Sullivan, 2002 WL 31374777 (Conn.Super. 2002), reaches the same conclusion, even though the patient was not responsible for paying the difference. The healthcare provider (a hospital) in that case submitted a full bill to Medicare but was required to accept a lower payment as full satisfaction of the entire amount of the patient's bill. Citing *Hecht*, the court held:

> Fundamental principles of statutory construction preclude Medicare write offs as falling within the collateral source payment statute. In the absence of an applicable statute specifically addressing Medicare write offs, the common law applies. Our common-law principle is that a tortfeasor may not benefit, and an injured plaintiff's tort recovery may not be diminished because of benefits received by the plaintiff from independent sources.

Id. See also Garbatini v. Allstate Insurance Company, 34 Conn. L. Rptr. 346, 2003 WL 1874707 (Conn. Super. 2003)("By statutory definition collateral sources do not include the forgiveness or writing off of charges for medical care by their providers.")

C. This Court has Mandated a Narrow Construction of the Collateral Source Statute.

Plaintiff submits that healthcare provider discounts and write-offs plainly and unambiguously are not "payments made." However, to the extent the language of the collateral source statute may be considered ambiguous, this Court has specifically mandated a narrow construction of this act:

> The common-law rule prohibited both the introduction of evidence of collateral insurance benefits received, and the setoff of any collateral source benefits from the damage award. *See Gormley v. GTE Prods. Corp.*, 587 So. 2d 455, 457-59 (Fla. 1991). **As an alteration of the common law, the statutory provisions that allow the introduction into evidence and setoff of collateral insurance benefits must be narrowly construed.**

Rollins v. Pizzarelli, 761 So. 2d 294, 300 (Fla. 2000) (emphasis added).

In *Allstate Insurance Company v. Rudnick*, 761 So. 2d 289, 293 (Fla. 2000), citing to *Rollins*, this Court reiterated that the collateral source statute is subject to the canon of statutory construction providing that courts must narrowly construe statutes altering common law principles. *Rudnick* narrowly construed the phrase "or which are otherwise available" to mean only those amounts which have been paid or which are presently due and owing. *Id.*

Although the Second District conceded it was bound by this Court's multiple pronouncements specifying a strict construction of the collateral source statute, it "suggested" a liberal construction should be required because § 768.76 is also remedial in nature.[7] *Goble*, at 408. However, a liberal construction does not permit a court to re-write a statute under the guise of satisfying legislative intent. Where the legislature has used particular words to define a term, courts do not have the authority

[7] The Second District cited *Irven v. Department of Health & Rehabilitative Services*, 790 So. 2d 403, 406 (Fla. 2001), for this proposition.

to redefine it. *See Racetrac Petroleum, Inc. v. Delco Oil, Inc.*, 721 So. 2d 376, 377-78 (Fla. 5th DCA 1998).

D. Under any Construction, a Discount by the Healthcare Provider is Not a Payment Made by the HMO.

The Second District erroneously concluded that, even under a strict construction of the statutory language, a contractual discount constituted a "'payment made' on Goble's behalf because remittance of the discounted amount discharged Goble's obligation to his medical providers." *Goble*, 848 So. 2d at 409. Such a strained interpretation of the word "payment" cannot be reached under any reasonable interpretation of the statutory language, much less under the strict construction of the statute mandated by this Court's decisions.

The Second District's reliance on the dictionary definitions of "payment" demonstrates that it confused the concept of whether there was a "payment made" with the **amount of the payment**. In this case, it is undisputed Aetna made a payment to Plaintiff's healthcare providers in the amount of $145,970. However, it is a total disconnect in logic to then conclude this $145,970 payment became a $574,554 payment simply because the healthcare providers discounted their services by $428,583.

The Second District assumes that because a "payment" can be in the form of something other than money, a discount or write-off must also be a "payment." This is wrong. The court's error in logic is easily demonstrated by example. Assume the healthcare provider has discounted a $1,000 bill to the insured patient by 100 percent or, in other words, written it off entirely. No one would contend in that situation that the insurer made a $1,000 "payment." That the insurer has made a $100 partial payment and the healthcare provider has forgiven the $900 balance does not change the analysis: the amount of the "payment made" is still only $100. Nothing in the dictionary definitions referenced by the Second District even suggests the $900 forgiven by the healthcare provider in this example is also a "payment."

E. The Common Law Collateral Source Rule Applies.

In interpreting a statute that is in derogation of the common law, the Court must presume the statute was not intended to alter the common law, other than by what was clearly and plainly specified in the statute. *Ady v. American Honda Finance Corporation*, 675 So. 2d 577, 581 (Fla. 1996); *see also Carlile v. Game and Fresh Water Fish Commission*, 354 So. 2d 362 (Fla. 1977). At common law, the tortfeasor was not entitled to **any** setoff of collateral source benefits from the damage award. *See Sheffield v. Superior Insurance Company*, 800 So. 2d 197, 200, n. 3 (Fla. 2001);

Rollins v. Pizzarelli, 761 So. 2d 294, 300 (Fla. 2000). Nothing in the statute clearly and plainly entitles the tortfeasor to a collateral source reduction in these circumstances. Consequently, the common law still applies.

At common law, "total or partial compensation for an injury received by the injured party from a collateral source wholly independent of the wrongdoer will not operate to lessen the damages recoverable from the person causing the injury." *Paradis v. Thomas*, 150 So. 2d 457, 458 (Fla. 2d DCA 1963)(citation omitted). The principle underlying this common law rule is that:

> a wrongdoer should not be permitted to benefit from a policy of insurance where there is no privity between him and the plaintiff's insurer, and the policy was written for the benefit of the insured and not the wrongdoer; if there must be a windfall, it is more just that the injured party profit, rather than the wrongdoer be relieved of full responsibility for his wrongdoing.

Janes v. Baptist Hospital of Miami, Inc., 349 So. 2d 672, 673 (Fla. 3d DCA 1977), *cert. denied*, 355 So. 2d 512 (Fla. 1978).

Under the common law, a plaintiff is able to recover for the reasonable value of medical treatment made necessary by a tortfeasor's negligence **even if the services are rendered free of charge** to the plaintiff. The defendant-tortfeasor in *Paradis* sought to demonstrate to the jury that the plaintiff, a member of the armed services, was not "obligated" to pay for his hospitalization in a governmental facility and,

therefore, was not entitled to compensation for this treatment. The court quoted from *Burke v. Byrd*, 188 F. Supp. 384 (N.D.Fla. 1960), as follows:

> "Where services are rendered gratuitously to the plaintiff, it does not seem reasonable that defendant, who is a wrong-doer, should be permitted to profit by any gratuity extended to his victim, and consequently the reasonable value of said services should be recoverable."

Paradis, at 458 (citations omitted). The court concluded that a plaintiff "may be able to recover for the reasonable value of medical treatment or other services made necessary by the injury although these have been donated to him." *Id.*, at 459 (quoting from the Restatement of the Law, Torts, Ch. 47, § 920, comment (e)).

Similarly, in *Weaver v. Wilson*, 532 So. 2d 67 (Fla. 1st DCA 1988), the plaintiff, who had been working for her father, was injured and could not work for three months. She lived at home with her parents during her convalescence, and her father paid her $2,000 a month "'because she needed the money.'" *Id.*, at 68. The amount of her lost earnings during this period of time was $6,000, but the trial court's award excluded any consideration of this element of damage based on her father's monthly $2,000 payments. The plaintiff appealed what she contended was a grossly inadequate damage award because it did not include an amount for lost earnings. The defendant argued the lost earnings were properly excluded under the collateral source rule. *Id.*

The appellate court agreed with the plaintiff and reversed. After discussing the Supreme Court's decision in *Florida Physician's Insurance Reciprocal v. Stanley*, 452 So. 2d 514 (Fla. 1984), which limited the common law collateral source rule to those benefits earned in some way by the plaintiff (as opposed to governmental or charitable benefits available to all citizens regardless of wealth or status), *Weaver* held:

> The *Stanley* limitation on the collateral source rule was not intended to apply to benefits paid by the employer and/or parent as a result of appellant's injuries. These relationships create mutual obligations and liabilities, and the benefits paid to an employee or to a child cannot be characterized as "unearned" in the sense used in *Stanley*, or as benefits available to all citizens. Therefore, plaintiff was not precluded from receiving damages for lost earnings.

Id., at 68.

Thus, as the case law makes clear, even if Plaintiff had received free medical care from his healthcare provider, he would still be able to claim the reasonable value of those services. *Paradis; Weaver*.

Application of the common law collateral source rule in this case, *i.e.*, reinstatement of the jury's award, is also consistent with the result reached under well-established case authority pursuant to § 768.76(1) when there are "collateral sources" for which a subrogation or reimbursement right exists, but the providers of those sources have waived or relinquished that right. Indeed, this is analogous to what has happened here. But for their contractual arrangements with Aetna, these healthcare

providers would have the right to obtain payment from the Plaintiff for the entire amounts of their medical bills; however, they have contractually waived or relinquished in advance their right to payment for any amounts above the $145,970.76 paid by Aetna. Under the collateral source statute, such a waiver or relinquishment has no effect on the tortfeasor's entitlement (or lack thereof) to a collateral source reduction. *See Bruner v. Caterpillar, Inc.*, 627 So. 2d 46 (Fla. 1st DCA 1993); *Centex-Rodgers Construction Company v. Herrera*, 816 So. 2d 1206 (Fla. 4th DCA 2002); *Sutton v. Ashcraft*, 671 So. 2d 301, 303 (Fla. 5th DCA 1996).

For example, this case is analogous to the situation in *Bruner*, where the court held the tortfeasor was not entitled to a collateral source reduction based on the plaintiff's receipt of worker's compensation benefits, even though the worker's compensation carrier claimed no subrogation interest in accordance with a negotiated agreement for settlement of the worker's compensation claim. Noting that the tortfeasor was not a party to and had no interest in the worker's compensation action, the court held the collateral source statute "does not imbue a wrongful tortfeasor with the benefit of a plaintiff's settlement of a third party claim with a negotiated subrogation waiver." *Id.*, at 47. In a concurring opinion, Judge Booth observed, "Under section 440.39(2), Florida Statutes, an employer or workers' compensation insurer has a right of subrogation to an injured employee's rights against a third-party

tortfeasor. It is the existence of this right of subrogation, not the exercise of such right, which prevents appellee from being entitled to a collateral source offset." *Id*.

Centex-Rodgers Construction Company reached the same conclusion with respect to payments made to an injured plaintiff by a disability insurance carrier. There, the jury awarded the injured plaintiff over $750,000 in compensatory damages. The plaintiff had settled the disability carrier's common law equitable subrogation lien for $1,000. The court found that the tortfeasor was not entitled to a collateral source reduction because of the disability carrier's right of equitable subrogation. Citing *Bruner*, the court noted that even though the carrier had waived that right, the character of the right was unaffected for purposes of the collateral source statute. *Centex-Rodgers Construction Company*, 816 So. 2d at 1207.

Also following *Bruner*'s lead, *Sutton* rejected a tortfeasor's attempt to obtain a collateral source reduction where the tortfeasor had paid the plaintiff's insurer to relinquish its rights to subrogation and reimbursement. The court agreed with *Bruner* that it is the existence of the rights of subrogation and/or reimbursement, not their exercise, which prevents a tortfeasor from enjoying a collateral source offset. *Id.*, 671 So. 2d at 303.

No meaningful distinction exists between a waiver or relinquishment of a subrogation or reimbursement right pursuant to a third-party settlement agreement and

a waiver or relinquishment of the right to obtain payment from the insured pursuant to a contract between an HMO and healthcare providers. In both situations, the waiving parties have agreed to accept less than the full amounts owed to them. In neither situation did the waiving parties intend to benefit the tortfeasor. Under the Second District's holding, the tortfeasor is the only party to benefit from the reduction of the jury's award by the amounts Plaintiff's healthcare providers agreed not to collect -- a result that violates both the statutory and the common law collateral source rules. The Second District failed to provide any reason, much less one that was logical or fair, to justify different results based solely on the timing of the waiver.

High courts across the country agree the common law collateral source rule does not permit a defendant tortfeasor to reap the benefit of contractual discounts or write-offs made by an insured plaintiff's healthcare providers. For example, in *Acuar v. Letourneau*, 531 S.E.2d 316, 321 (Va. 2000), the Virginia Supreme Court held:

> [W]e conclude that Acuar cannot deduct from that full compensation any part of the benefits Letourneau 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 medical expenses that health care providers write off constitute "compensation or indemnity received by a tort victim from a source collateral to the tortfeasor . . . ."

> This conclusion is consistent with the purpose of compensatory damages, which is to make a tort victim whole. However, the injured party should be made whole by the tortfeasor, not by a combination of compensation from the tortfeasor and collateral sources. The wrongdoer cannot reap the benefit of a contract for which the wrongdoer paid no compensation.

Id., at 322-23 (citations omitted).

The Supreme Court of Wisconsin also analyzed the common law collateral source rule in the context of reduced fee schedules pursuant to contracts between an insurer and various healthcare providers and reached a similar result to *Acuar* -- namely that the plaintiff was entitled to seek recovery of the reasonable value of the medical services, without limitation to the amounts paid. *See Koffman v. Leichtfuss*, 630 N.W.2d 201, 205 (Wis. 2001). That court reasoned:

> In the context of medical expense damages, the collateral source rule allows the plaintiff to seek recovery of the reasonable value of medical services without consideration of gratuitous medical services rendered or payments made by outside sources on the plaintiff's behalf, including insurance payments. 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. The benefit of the reduced payments inures solely to the plaintiff.
>
> Applying the collateral source rule to payments that have been reduced by contractual arrangements between insurers and health care providers assures that the liability of similarly situated defendants is not dependent on the relative fortuity of the manner in which each plaintiff's medical expenses are financed. One plaintiff may be uninsured and receive the benefit of Medical Assistance, another's insurer may have

> paid full value for the treatment, and yet another's insurer may have received the benefit of reduced contractual rates. Despite the various insurance arrangements that exist in each case, the factor controlling a defendant's liability for medical expenses is the reasonable value of the treatment rendered.

Id., at 210 (citations omitted). *See Montgomery Ward & Company, Inc. v. Anderson*, 976 S.W.2d 382 (Ark. 1998)(gratuitous or discounted medical services are common law collateral sources not to be considered in assessing damages due personal injury plaintiff); *see also Hardi, M.D. v. Mezzanotte*, 818 A.2d 974 (D.C. App. 2003)(under common law collateral source rule, plaintiff entitled to include in her damages all benefits resulting from her contract of insurance, including any write-offs negotiated by her private insurance company); *Griffin v. Louisiana Sheriff's Auto Risk Association*, 802 So. 2d 691 (La.App. 1 Cir. 2001).

F. The Second District's Interpretation Fails to Compensate Plaintiff for His Non-Monetary Contribution to Securing the Discounts or Write-Offs.

There is a second independent reason why these contractual discounts or write-offs cannot be setoff under the collateral source statute -- one which the Second District's opinion ignored. Even if this Court were to agree with the Second District that the amounts written off by Plaintiff's healthcare providers could somehow be

characterized as "payments made" and, therefore, constitute "collateral sources" as defined in the statute, Defendant is still not entitled to a reduction.

As the Second District recognized, one of the express intentions of the Legislature in enacting the collateral source statute was to fully compensate the injured party. *Goble*, at 410. To that end, the statute provides that reduction for collateral sources "shall be offset to the extent of any amount which has been paid, **contributed, or forfeited by, or on behalf of, the claimant . . . to secure her or his right to any collateral source benefit** which the claimant is receiving as a result of her or his injury." § 768.76(1) (emphasis added).

No one disputes that this provision entitles Plaintiff to offset the premium payments he made to obtain these contractual discounts or write-offs. However, Plaintiff contributed more than just his premium payments; in order to obtain discounted care through his HMO, he agreed to restrict his freedom to select his own healthcare providers and potentially his treatment options as well. Allowing the tortfeasor a collateral source reduction for the amounts Plaintiff's healthcare providers discounted their medical bills fails to give Plaintiff the offset to which he is statutorily entitled, negating this important component of the statute, and conflicting with the Legislature's expressly stated intent.

HMO insureds agree to limit themselves to providers who have contracted with the HMO, and generally to the specific doctors to whom the primary care or "gatekeeper" physicians refer them.[8] In return, healthcare providers who participate in HMOs agree to substantial discounts for HMO members off their usual and customary fees, because the HMO provides them with a pool of patients who **must** use their services or pay their medical bills out of their own pockets. Thus, restriction on the insured's freedom of choice of medical providers is the very foundation of the provider discounts or write-offs that are the subject of this appeal.

In contrast, a traditional fee for service health insurance plan does not generate these provider discounts precisely because there are no prior contractual arrangements between the doctor and the insurer. Since Plaintiff, and other HMO members, made these discounts or write-offs possible by forfeiting their freedom of choice, the collateral source statute expressly requires that these discounts be allocated to them, not to the tortfeasor.

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[8] Aetna's representative testified in deposition that an HMO insured has the right to obtain medical services at a reduced rate from healthcare providers with whom Aetna has a provider contract, as long as he follows the terms of his plan and the certificate of coverage, including obtaining referrals from the primary care physician for any specialist follow-up treatment (R V4/748-749). *See also* § 641.19(13), Florida Statutes (2002).

Had Plaintiff sought treatment from healthcare providers having no contractual arrangements with Aetna, he would have been charged the full amount for their services. Plaintiff had the right to elect such undiscounted treatment and recover his full costs from Defendant in this action. However, in this case, Plaintiff chose to stay within his HMO plan and trade freedom of choice of healthcare providers for discounted healthcare, thereby contributing or forfeiting the difference in cost compared to the undiscounted healthcare he could have chosen. The collateral source statute does not entitle the tortfeasor to reap the benefit of Plaintiff's contribution or forfeiture, but expressly requires that it be allocated to the injured party.

The Second District's assessment that an "injured party is fully compensated by an award that equals the amounts the injured party paid to the medical provider plus the amounts paid by his insurer," is simply wrong, because it ignores what is arguably the most valuable contribution HMO insureds make in order to secure their collateral source benefits -- namely, the loss of their freedom of choice.[9] *Goble*, at 410.

Contrary to the Second District's assessment, Defendant's lack of entitlement to a collateral source reduction based on the discounted amounts of the medical bills

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[9] The Second District's method of statutory construction -- whether liberal or strict -- that enables it to view discounts or write-offs as "payments made" must, by the same logic, also require compensation for Plaintiff's non-monetary contributions that helped to secure those discounts or write-offs.

does not mean Plaintiff receives a windfall. In fact, it is only possible even to argue a jury award that includes the amount of these contractual discounts or write-offs as a windfall if one ignores the value of Plaintiff's non-monetary contribution. By participating in an HMO, Plaintiff significantly limited his ability to choose his own medical providers. That limitation of choice has a value – namely, the difference between the amount the HMO healthcare providers agreed to accept and the amount that same healthcare would have cost had Plaintiff not participated in the HMO and compensated his healthcare providers on an undiscounted fee-for-service basis. If the value of Plaintiff's limitation on his choice of healthcare providers is allocated to Defendant, Plaintiff will have forfeited his right to choose without receiving the benefit of that contribution. Ironically, this creates the windfall the Second District claimed it sought to avoid, but for the Defendant, not the Plaintiff.

Even without reducing jury awards by the amount of discounts or write-offs, a defendant still benefits from a plaintiff's participation in an HMO. As the defense recognized below, the premiums for an HMO policy are lower than those of a traditional health insurance plan; consequently, the amount of offset from the collateral source reduction to compensate a plaintiff for premiums paid is less than it otherwise would have been (AB 17). § 768.76(1). Under the Second District's interpretation of the statute, however, Plaintiff receives neither the benefit of the reduced premium nor

the value of his contribution in the form of the limitation of his choice of healthcare providers. Again, the windfall goes to Defendant.[10]

Awarding injured parties the reasonable value of their medical expenses, without limitation to the amount of those expenses that were actually paid, will not result in a windfall to plaintiffs. Failing to do so, however, does result in a windfall, not only to tortfeasors, but also to liability insurers who collect premiums without knowing whether the ultimate claimants will be members of HMOs, insureds under traditional health insurance policies or not insured at all.

If the Legislature is confident the insurance industry will rebate its windfall to the citizens of Florida in the form of lower premiums, as the Second District seems to assume, the Legislature can amend the statute. Short of such an amendment, however, neither the collateral source statute nor the common law permits defendant tortfeasors

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[10] The Second District's concern about plaintiffs receiving windfalls also ignores the reality of personal injury litigation: most plaintiffs pay their own attorneys' fees. If the plaintiff's attorney is being compensated under a contingent fee agreement, the amount of the jury award the plaintiff must pay to his attorney is usually 40%. *See* R. R. Fla. Bar 4-1.5(f)(4)(B). The percentage may be more in the event of an appeal. In addition to fees, a plaintiff must also pay the often substantial costs of litigation from the award. The difference between the amounts paid by a plaintiff's HMO and the amount of the original medical bills -- *i.e.*, the amount of the write-offs -- can help to make the plaintiff whole in light of his or her attorneys' fee and cost obligations. Any "windfall" is illusory.

and their liability insurers to benefit from these contractual write-offs at the expense of injured but insured plaintiffs.

CONCLUSION

Plaintiff respectfully requests this Court to answer the certified question in the negative and quash the opinion of the Second District Court of Appeal, with instructions to remand the case to the trial court for reinstatement of the jury's verdict.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief uses 14 point Times New Roman type, a font that is proportionately spaced.

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