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

REPLY BRIEF OF PLAINTIFF/PETITIONER

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ARGUMENT

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

A. The Certified Question Is One of Great Public Importance.

When Defendant argues that the question certified by the Second District is not of great public importance, he apparently means it is only unimportant because the Second District agreed with his position (AB 9).[1] Yet Defendant later contends that, contrary to this Court's prior decisions, this Court must construe the collateral source statute liberally because of the interrelation between the availability and affordability of liability insurance and tort law and the liability system (AB 19).

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[1] Plaintiff relies on the same designations as in his Initial Brief. In addition, Plaintiff designates references to Defendant's Answer Brief by the prefix "AB." Plaintiff refers to the Florida Defense Lawyers' Association as "FDLA" and designates references to the Amicus Brief filed by the Florida Defense Lawyer's Association by the prefix "FDLA" followed by the page number.

Defendant also claims the Second District's interpretation of the collateral source statute will make personal injury cases easier to settle because it will drastically lower the amounts demanded (AB 10-11). There is no basis for this statement, and common sense refutes it. The "extra" money (*i.e.*, the amount of the discounted or written-off medical expenses) a defendant faces makes it easier to settle cases, because there is more money to pay the bills, pay the attorneys and still net something for the injured plaintiff. The Second District's interpretation leaves no room for compromise.

B. Allowing the Tortfeasor a Collateral Source Reduction for the Discounted Amounts of the Medical Bills Fails to Give Plaintiff the Offset to Which He Is Statutorily Entitled.

One of the express intentions of the Legislature in enacting the collateral source statute was to fully compensate the injured party. *See Goble v. Frohman*, 848 So. 2d 406, 410 (Fla. 2d DCA 2003). The collateral source 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), Florida Statutes (2000) (emphasis added).

Plaintiff has made the point -- both in the Second District and in this Court -- that he did more than just contribute his premiums to obtain the contractual discounts or write-offs that are the subject of this appeal. He forfeited his freedom to select his own healthcare providers. Anyone who has faced the dilemma of either paying for the medical services of a trusted physician who is not an HMO provider, or switching to another physician simply because that physician is on the list of providers selected by the HMO, knows how valuable the freedom of choice actually is. If Plaintiff had not forfeited his freedom of choice, there would have been no discounts. That is reality.

The collateral source statute mandates that the claimant be compensated for the amounts he or she has contributed or forfeited to obtain the collateral source benefits. The Second District's interpretation, however, undermines that mandate by allocating all of the benefits of Plaintiff's participation in the HMO -- discounts and lower premiums -- to the tortfeasor.

No one has been able to formulate any meaningful response to this clear statutory mandate. The Second District ignored it completely. The Defendant responds only with a question: "How can one 'offset' collateral source reductions by amounts 'contributed, or forfeited by . . . the claimant' when those amounts are not susceptible to empirical ascertainment?" (AB 26).

The answer to Defendant's question, however, is simple, and it is provided by the FDLA: If Plaintiff had not worked and had sought medical care from a provider outside the HMO, "then Plaintiff would incur the provider's usual charge, and Defendant would face potential liability for that unreduced sum in accordance with normal tort principles" (FDLA 13). That is precisely the point. The amount represented by Plaintiff's non-monetary contributions or forfeitures is the difference between the amount Plaintiff would have paid if he had selected his own healthcare providers (unreduced sum) and the discounted amounts accepted by the HMO's preselected healthcare providers (reduced sum). Not only is this amount susceptible to "empirical ascertainment," it is a mathematical certainty.

Apparently having no substantive response, the FDLA contends it has no need to respond because Plaintiff did not relinquish his freedom of choice -- he had the freedom to choose not to stay within the HMO plan (FDLA 13). This

is not a meaningful response. While Plaintiff could have sought treatment from a provider outside the HMO, he could not have done so and still obtained the valuable benefit that is the subject of this appeal -- the contractual discount. The **only** way to receive that benefit was for Plaintiff to forfeit his right to choose other medical care when an injury occurred. Because he did so, the statute gives him the express right to retain the amounts represented thereby. § 768.76(1).[2]

If these amounts are allocated to the tortfeasor, Plaintiff will have forfeited his right to choose his own healthcare providers without receiving any benefit. Even the most liberal construction of this statute does not permit rewarding the tortfeasor by penalizing the insured.

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[2] Defendant's concern with the lack of record evidence about the difference in premiums demonstrates his lack of understanding of the issues involved (AB 27). It is not Plaintiff who benefits under the statute from the HMO's lower premiums, it is Defendant. Because Plaintiff participated in an HMO, the amount that Defendant must offset from the collateral source reduction to compensate Plaintiff for those premiums is less than it otherwise would have been. § 768.76(1). Defendant keeps more of his money. But even if Plaintiff participated in a very expensive HMO whose premiums were the same as those for a fee-for-service plan, Plaintiff would still have been called upon to forfeit his freedom of choice in order to obtain the contractual discounts that distinguish HMOs from some other types of insurance plans.

C. A Healthcare Provider's Contractual Write-offs Do Not Fit Within Plain Meaning of the Statutory Definition of "Collateral Sources."

Defendant misstates Plaintiff's position as being that a "payment" may encompass only a transfer of cash (AB 8). This is incorrect. While one of the dictionary definitions of the word "payment," standing alone, is the "discharge of a debt or an obligation," the statute does not use the term in this isolated context. Rather, the statute says "payments **made**," and the dictionary definition relied on by the Second District does not fit within this term. § 768.76(2) (emphasis added). It makes no sense to say "the discharge of a debt or an obligation **made**." The inclusion of the word "made" in the statutory definition necessarily limits the meaning of "payments" to monetary transfers.

Defendant also misstates the statutory definition itself by saying, "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) (AB 8)." In fact, it is not the contracts or agreements that are considered "collateral sources," but the "payments made to the claimant or on the claimant's behalf." § 768.76(2)(a)(3).

Defendant questions why the Legislature used so much "excess verbiage" -- "provide, pay for, or reimburse" -- if all the Legislature meant was "pay for." This is another misreading of the statute. These terms clearly modify

“contract or agreement,” not “payments made.” *Id.* By using these terms, the Legislature included within the scope of the definition of “collateral sources” a contract or agreement to “provide” the healthcare directly (such as at an HMO clinic); a contract or agreement to “pay for” healthcare by paying the healthcare provider for these services, or a contract or agreement to “reimburse” the insured for payments he or she made to the healthcare provider. There is no “excess verbiage” in this statute. Each term has a definite purpose, and that purpose is not to amplify the meaning of “payments made.”

The FDLA likewise misreads the statute. It argues that because the statute requires a set-off for 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,” the amount of the debt discharged in excess of the “payment” is “a benefit ‘otherwise available’” (FDLA 8). Although this argument was advanced in the Second District, that court did not adopt it, presumably because the plain language of the statute does not support it. First, the statute does not refer to a “benefit” otherwise available, but to an “amount” otherwise available.

Second, interpreting the statute to permit a set-off only in the amount of a monetary payment does not render the phrase “otherwise available” without any effect. This Court has already construed the phrase “otherwise available to the claimant” in this statute simply to mean currently due and owing. See *Allstate Insurance Company v. Rudnick*, 761 So. 2d 289, 293 (Fla. 2000). Moreover, if the FDLA’s interpretation were correct, it would lead to the absurd result of the tortfeasor being entitled to a collateral source reduction if the plaintiff had a “benefit” available for his or her use, even if the plaintiff did not actually use it.[3]

Both Defendant and the FDLA point to case law from jurisdictions outside Florida that do not have collateral source statutes to support their contention that a contractual write-off or discount is a “payment.” They argue “Plaintiff cannot have it both ways,” but they miss the point (FDLA 10).

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[3] This would mean that Plaintiff would have only been entitled to recover the amounts his HMO would have paid for his care even if he had exercised his freedom of choice and received full-priced care from non-HMO doctors. Even the FDLA does not suggest such an absurd interpretation of the statute (FDLA 13).

Courts in these common law jurisdictions consider write-offs or discounts to be collateral sources because they are as much of a benefit to the insured as actual cash payments under a traditional common law analysis.[4] However, these courts are not restricted in their interpretation by a statute that defines "collateral sources" to mean "payments made to the claimant, or made on the claimant's behalf . . . ." § 768.76(2)(a). Where the Legislature has used particular words to define a term, courts do not have the authority to redefine it. *See, e.g., Baker v. State*, 636 So. 2d 1342, 1344-1345 (Fla. 1994). Florida courts do not have the authority to redefine "collateral sources" to mean include contractual write-offs or reductions, when the Legislature did not see fit to include those terms within the definition.[5]

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[4] *See, e.g., Rose v. Via Christi Health System, Inc.*, 78 P.3d 798, 806 (Kan. 2003)(under common law rule, contractual write-offs by hospital considered a collateral source).

[5] This Court's recent pronouncements in *Chester v. Doig*, 842 So. 2d 106 (Fla. 2003), are instructive. Contrary to Defendant's assertion, the Legislature did not enunciate "its intent to encompass virtually all satisfactions of the charges of third-party providers, . . . within the ambit 'collateral sources'. . . . (AB 17)" The statute says nothing like this. Just as this Court observed in *Chester* regarding the application of the set-off statutes to the Medical Malpractice Act, if the Legislature had intended contractual discounts or write-offs to be considered "collateral sources," it could have said so. However, because it did not, this Court lacks authority to read words into otherwise plain statutory language. *See Id.*, at 108-109.

The defense fails to distinguish the Connecticut line of cases. Although Plaintiff cited several Connecticut cases, Defendant responded to only one. Defendant distinguishes *Hecht v. Staskiewicz*, ___ A.2d ____, 2002 WL 442319 (Conn. Super. 2002), on the basis that the plaintiff's premium payment exceeded the amount of the write-off (AB 16). This is true, but it played no part in the court's analysis of the statute. *Hecht* also noted that " . . . the intent of the legislature is to be found not in what the legislature meant to say, but in the meaning of what it did say." *Id.*, at *2 (citation omitted). *Hecht* found the statute was unambiguous; consequently, the court had no need to construe the statute at all.

> 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.

Id. *See also Sackman v. Sullivan*, 2002 WL 31374777 (Conn. Super. 2002); *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.").[6]

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[6] "It is a general rule of law that, where a question of statutory construction is one of novel impression, it is (continued...)

The FDLA cites to a solitary 1990 Minnesota decision, arguing it is more persuasive because the Minnesota statute more closely resembles Florida's collateral source statute than does the Connecticut statute (FDLA 10). This is incorrect. The Connecticut collateral source statute was patterned after Florida's statute and defines "collateral sources" using the identical "payments made to the claimant, or on his behalf" language. *See* Conn. Gen. Stat. § 52-225b (2003); *Schroeder v. Triangulum Associates*, 259 Conn. 325, 343-344, 789 A.2d 459, 471 (Conn. 2002).

The FDLA argues the Minnesota statute permits a set-off for amounts "paid or otherwise available," which it contends broadens the scope of the set-off as compared to the Connecticut statute, which does not contained the "or otherwise available" language (FDLA 10-11). As noted above, this language does affect the statutory definition of "collateral sources," and simply refers to amounts that are currently due and owing. *See Rudnick, supra.*

The Minnesota statute also differs from Florida's statute in a way that substantially broadens the category of payments subject to set-off. That statute exempts from set-off collateral sources "for which a subrogation right has

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[6] (...continued)
proper to resort to decisions of courts of other states construing statutory language which is identical or of similar import." *Rolls v. Bliss & Nyitray, Inc.*, 408 So. 2d 229, 235, n. 4 (Fla. 3d DCA 1982)(quoting 73 Am.Jur.2d Statutes § 166 at 370).

been **asserted**. . . ." Minn. Stat. § 548.36(2)(1)(emphasis added). The statute refers to "asserted" subrogation rights to ensure that waived subrogation rights are not excepted from collateral source reduction. *See Buck v. Schneider*, 413 N.W.2d 569, 571 (Minn. App. 1987).

This is not the law in Florida. Florida's statute does not permit a "reduction for collateral sources for which a subrogation or reimbursement right **exists**." § 768.76(1). Florida courts interpret this language to mean there can be no collateral source reduction even though the providers of those sources have waived or relinquished that right. *See, e.g., 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 (Fla. 5th DCA 1996).

The difference between the Minnesota and Florida statutes is particularly important in analyzing the issue before this Court, because the contractual discounts or write-offs in this case are essentially **advance** waivers of the healthcare providers' subrogation rights. No one has offered any cogent or fair reason to explain why the timing of the waiver should lead to such disparate results.

D. Plaintiff Is Entitled to the Reasonable Value of His Medical Services.

The opposition does not dispute that if Plaintiff had gone outside the HMO network for his medical treatment, Defendant would have been responsible for the entire (unreduced) amount of the healthcare provider's usual and customary charges (AB 21; FDLA 13). Plaintiff presented evidence that the amount of his medical bills was reasonable (R V5/903, 936-941).

The jury was instructed that the measure of Plaintiff's damages for medical expenses is "[t]he reasonable expense of hospitalization and medical care and treatment necessarily and reasonably obtained by [the plaintiff] in the past, or to be so obtained in the future." Fla. Std. Jury Instr. (Civil) 6.2c. The collateral source statute does not change this measure of damage.

Defendant contends the "'[r]easonable and necessary' charges are nothing more than a fantasy," and to allow Plaintiff to recover any amount above that which was ultimately accepted by the healthcare providers in full compensation would be a windfall (AB 21). This is wrong. As noted above, failing to award Plaintiff the reasonable value of the medical treatment he received is a windfall to the Defendant because it does not compensate Plaintiff for

the non-monetary contributions or forfeitures he made in order to secure the contractual discounts or write-offs, and violates the statutory language.

The cases cited by the FDLA for the proposition that a plaintiff may not recover past medical expenses in an amount exceeding what anyone was obligated to pay for the medical care are inapposite (FDLA 14). In *Hanna v. Martin*, 49 So. 2d 585 (Fla. 1950), for example, the Court found that the plaintiffs were not entitled to the costs of constructing a bulkhead to prevent future encroachment by debris from the defendants' property, because this would have compensated the plaintiffs for an injury they had not sustained. *Id.*, at 587. There is no question that Plaintiff actually sustained the injury for which the jury found he was entitled to compensation.

Hollins v. Perry, 582 So. 2d 786 (Fla. 5th DCA 1991), adds nothing to the discussion because the opinion does not indicate why the hospital reduced its bill. It may have done so because the hospital found a mistake in its charges, not because it was giving a volume discount.

Aircraft Service International, Inc. v. Jackson, 768 So. 2d 1094 (Fla. 3d DCA 1995), is factually distinguishable. There, it was undisputed the amount of the plaintiff's medical bills was $143,000, but the jury awarded $150,000 when there was no evidentiary support to do so. The court correctly held the award was $7,000 too much.

Horton v. Channing, 698 So. 2d 865 (Fla. 1st DCA 1997), and *Dourado v. Ford Motor Company*, 843 So. 2d 913 (Fla. 4th DCA 2003), both involved application of the wrongful death statute, which provides that a personal representative may recover for the estate the medical expenses "that have become a charge against her or his estate or that were paid by or on behalf of the decedent." § 768.21(6)(b), Florida Statutes. The results of those cases are readily explainable because the estates were not ultimately responsible for the amounts written off by the medical providers; consequently, the personal representatives were not entitled to recover those amounts. That is not the situation here, where Plaintiff is entitled to the reasonable value of his past medical care and treatment, regardless of whether part of his contractual obligation to pay those amounts was discounted because he was a member of an HMO and used an HMO doctor's services.

CONCLUSION

Plaintiff respectfully requests this Court to answer no to the certified question 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

I HEREBY CERTIFY that this brief has been prepared using 14-point Times New Roman type, a font that is proportionately spaced.

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