PLAINTIFF'S RESPONSE TO DEFENDANT'S MOTION IN LIMINE REGARDING PLAINTIFF'S TOTAL MEDICAL BILLS BEING PRESENTED TO THE JURY

COMES NOW, Plaintiff, by and through her undersigned counsel, and hereby requests this Court to uphold Florida law and deny Defendant's Motion in Limine regarding damages to be presented to the jury at trial, and in support thereof states as follows:

1. As a result of Defendant's negligence, Plaintiff sustained severe injuries.
2. The Plaintiff is seeking, inter alia, past and future medical expenses as part of her claim for damages.
3. As further explained in the Memorandum of Law, below, the Florida Supreme Court and Florida Statues provide that a plaintiff should present its full medical bills to a jury and then have those medical bills become subject to a post-trial setoff if there exists a collateral source.
4. A very narrow and limited exception applies to this tenant of Florida law and that limited exception does not apply in this case.
5. In addition, the defense makes certain assertions in their Motion-In-Limine that are factually incorrect – mainly that the Plaintiff did not pay premiums for her United Healthcare Medicare Complete Plus HMO Plan (incorrect) and that the Plaintiff's United Healthcare Medicare Advantage HMO is the equivalent of original or traditional Medicare (also incorrect).

MEMORANDUM OF LAW

Plaintiff should be permitted to introduce, the total amount of medical bills, to the jury.

The Collateral Source Rule, in pertinent part states:

> *In any action… 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…from all collateral sources; however there shall be no reduction for collateral sources for which a subrogation or reimbursement right exists.*
>
> Fla. Stat. 768.76(1) (emphasis added).

Fla. Stat. 786.76(2)(b) excludes Medicare as a collateral source, but Fla. Stat. 786.76(2)(a)(3), specifically includes, "any contract or agreement or any group, organization,

partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical…or other health care services. *Id.*

In *Goble v. Frohman*, 901 So. 2d 830 (Fla. 2005), Goble was severely injured and his lawyer boarded past-medical expenses of approximately $575,000 reflecting what his medical providers had billed. The jury awarded this amount for past-medical bills. However, pursuant to Goble's Aetna HMO, the doctors accepted approximately $146,000 for all those medical services. Aetna asserted their subrogation right and the trial court granted this setoff as Aetna is a collateral source as defined in F.S. 768.76 (2)(a)(3). *Id.* at 832-33.

The Supreme Court in *Goble* agreed that, permitting a setoff for contractual discounts is consistent with the legislature's intent to reduce, "the litigation costs that arise when insurers are required to pay damages beyond what the injured party actually incurred." *Id.* at 832.

In *Thyssenkrupp Elevator Corp. v. Lasky,* 868 So. 2d 547 (Fla 4th DCA 2003) the plaintiff was injured on an elevator and incurred medical bills that were satisfied by Medicare (which paid a significantly reduced rate). The fourth DCA **narrowly** abrogated the collateral-source rule only when dealing with Medicare, as a government benefit, available to all citizens, regardless of wealth and obtained at no cost to the plaintiff. *Id*. at 550-51. (emphasis added).

The fourth DCA confirmed this very narrow holding in *Durse v. Henn*, 68, So. 3d 271 (Fla 4th DCA 2011). Durse was a passenger in a car struck by Henn's vehicle and the fourth DCA agreed that he should have been able to present the full amount of his past medical bills to the jury as opposed to the negotiated reduction in medical bills. *Id.* at 273. The court agreed and indicated that when the trial court (relying on *Thyssenkrupp*) only allowed Durse to present the reduced bills, it prejudiced his ability to establish the value of future medical expenses and non-economic damages; instead the trial court should have resolved the discrepancy in past-medical bills (gross vs. negotiated reduction) with a post-verdict setoff. In addition the *Durse* court emphasised that *Thyssenkrupp* differs because Medicare, as opposed to a private insurance provider, is not an earned benefit and the collateral-source rule should be limited to those benefits earned or paid for in some way by the plaintiff. *Durse* at 275-76 (agreeing with the reasoning in *Nationwide*, 53, So. 3d 1084 (Fla. 1st DCA 2010)).

Nationwide Mut. Fire. Ins. Co. v. Harrell, 53 So. 3d 1084 (Fla. 1st DCA 2010), *review denied*, 67 So. 3d 1050 (Fla. 2011) upheld *Goble* and distinguished the *Thyssenkrupp* line of cases, concluding that the gross amount of medical bills should be allowed into evidence (as opposed to the lesser amount paid by the plaintiff's private health insurance company) because the abrogation of the collateral source rule is limited to cases where the benefits were not earned or paid for in some way by the plaintiff. *Id.* at 1085-86.

The second DCA, in *State Farm v. Joerg*, 38 Fla. L. Weekly D 1378 (2013) noted that evidence of past medical expenses had to reflect the lower Medicare reimbursement only because Joerg's benefits were not earned or purchased, rather they were provided under the Medicare program due to his disability (the disability predated the subject injury). The Court further concludes that, had Joerg in some way paid for or earned the benefits (e.g. via deductions from his monthly paychecks) the collateral source rule would apply. *Id*. at 16 (referencing *Winston Towers 100 Ass'n v. De Carlo,* 481 So. 2d 1261, 1262 (Fla. 3d DCA 1986)).

HOW MEDICARE WORKS

According to www.medicare.gov:

There are two main ways to get Medicare: (i) one can choose Original Medicare (sometimes called Traditional Medicare), which includes Part A and Part B, which is provided by the federal government and available to everyone; or (ii) one can choose a Medicare Advantage plan, Part C, which is offered through private insurance companies and are not available to everyone.

- You do not pay a premium for Medicare Part A (Hospital Insurance) if you paid Medicare taxes while working.
- You do pay a premium for Medicare Part B (Medical Insurance),
- You do pay a premium for Medicare Part D (Prescription Drug Coverage)
- Medicare Advantage Plans (Part C): this is a type of Medicare health plan offered by private companies that contracts with Medicare to provide Part A and Part B benefits. Some Medicare Advantage Plans offer prescription drug coverage as well (Part D) including Plaintiff's AARP Medicare Complete Plus Plan 1 (HMO-POS).

Original Medicare is the same across the United States. Medicare Part C and Part D plans are offered by private insurance companies and are only available in certain counties, states or regions called "service areas" and you have to live in a plan's service area in order to join it. Original Medicare does not cover things like: dental, routine eye or foot care, long-term care, chiropractic services and acupuncture that may be covered by a Part C Medicare Advantage Plan.

Medicare Advantage Plans, as opposed to traditional Medicare, can charge different out-of pocket costs, premiums, deductibles, copays and have different rules for how you get services (i.e. whether you need a referral to see a specialist or if you have to go to remain in-network for non-emergency care) and even what services are offered. A citizen only chooses a Medicare Advantage Plan after weighing the benefits gained or lost compared with the static and uniform

benefits provided by traditional Medicare. As such, a Medicare Advantage plan, such as that utilized by plaintiff clearly differs from Traditional Medicare as it is not a government benefit, available to all citizens, regardless of wealth and obtained at no cost to the plaintiff, as is described in *Thyssenkrupp*, 868 So. 2d 547 at 550.

CONCLUSION

Understanding that:

1. Medicare Advantage Part C plans are run by private insurance companies, which are specifically defined as collateral sources in Fla. Stat. 786.76(2)(a)(3) (in this case United Healthcare HMO);

2. Plaintiff paid for or earned the benefits provided by her United Healthcare HMO (both in premiums paid and in the medical benefits that differ from those offered by Traditional Medicare – i.e. access to certain benefits and not others; paying more for some services, less for others),

3. That Medicare Advantage plans are not offered to everyone equally (some people cannot afford these plans or are otherwise unable to enroll); and

4. That Plaintiff agrees that the Defense is entitled to a post-verdict setoff, taking the subrogation right asserted by United Healthcare into consideration, thereby avoiding a windfall for the Plaintiff;

Plaintiff's case is clearly distinguishable and unaffected by the narrow abrogation of the Collateral Source Rule as proffered by the *Thyssenkrupp* line of cases.