IN THE SUPREME COURT OF FLORIDA

Case No. SC13-1768

On Review from the Second District Court of Appeal
LT Case Nos. 2D11-6229, 2D12-1246 (Consolidated); 2009-CA-12996 NC

JOHN JOERG, JR.,
Plaintiff/Petitioner,
v.
STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,
Defendant/Respondent.

AMICUS CURIAE BRIEF OF THE FLORIDA JUSTICE REFORM INSTITUTE, IN SUPPORT OF RESPONDENT STATE FARM.

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STATEMENT OF INTEREST

The Florida Justice Reform Institute (the "Institute") is Florida's leading organization of concerned citizens, small business owners, business leaders, doctors, and lawyers who are working towards the common goal of promoting predictability and personal responsibility in the civil justice system in Florida through the elimination of wasteful civil litigation and the promotion of fair and equitable legal practices. Many of the Institute's members are employers that create jobs in Florida. These employers must purchase liability insurance as a cost of doing business. The Institute is working to ensure that liability insurance premiums are not driven up by inflated future medical damage awards.

SUMMARY OF THE ARGUMENT

This case presents the question of what evidence a jury should be allowed to consider when determining the future health care expenses of a disabled Medicare beneficiary. The trial court below excluded from the jury all evidence about future health care expenses except for the projected "sticker price" (the full amount billed) for the services. The District Court of Appeal reversed, finding that it was error to exclude from evidence the cost of the services at the Medicare rate.

As a disabled adult, Petitioner is entitled to Medicare benefits. Health care providers that participate in the Medicare program must accept what Medicare allows as "payment in full" for services provided to Medicare beneficiaries. It is

unlawful for participating health care providers to seek payment beyond what Medicare allows.

The charges that health care providers bill is often two or three times the amount that Medicare pays. Limiting the jury to evidence of the amount billed by providers would violate settled principles of compensatory damages. This Court has consistently found that a plaintiff is not entitled to damages in excess of the loss actually inflicted by the defendant. In this case, the loss actually inflicted is the cost of future health care services at the Medicare rate, not the amount billed.

The approach outlined by this Court in *Florida Physician's Insurance Reciprocal v. Stanley*, 452 So. 2d 514, 516 (Fla. 1984) allows the jury to consider both the amount billed as well as the amount accepted by the provider as payment in full. This can be accomplished without ever informing the jury that the Petitioner is a Medicare beneficiary. For example, the jury could be informed that future medical bills are estimated to total $60,000, but that the health care providers will accept $20,000 as payment in full for the services.

Petitioner has taken the position that past and future Medicare benefits are specifically excluded from the statutory definition of a "collateral source." (Initial Brief, 23.) ("Therefore, the definitions part of [768.76(2)(a)] expressly excepts 'any payments' (past or future) made pursuant to Medicare from the definition of 'collateral source.'") (emphasis added). This admission, coupled with the fact that

the collateral source rule only prohibits the introduction of payments from collateral sources, leaves Petitioner with no legal basis for excluding the Medicare cost information from evidence. If Medicare is not a collateral source, then the expected cost of future services at the Medicare rate cannot be excluded from evidence based on the collateral source rule.

Other state supreme courts have concluded that when determining the reasonable value of health care services, evidence of both the amount billed and the amount accepted as payment in full should be given to the jury. This is the approach contemplated in *Walker*, followed by the Second District Court of Appeal below, and that should be affirmed by this Court.

ARGUMENT

I. MEDICARE COST INFORMATION SHOULD NOT BE KEPT FROM A JURY THAT MUST DECIDE THE FUTURE HEALTH CARE COSTS OF A MEDICARE-ELIGIBLE PLAINTIFF

This case will determine whether Florida juries will be allowed to hear evidence of Medicare rates when awarding damages for future health care services to a Medicare-eligible plaintiff. The Second District Court of Appeal properly concluded that it was error to exclude evidence of the cost of future medical expenses at the Medicare rate.

A. Mr. Joerg is entitled to receive future medical services through the Medicare program.

In 1965 the Federal Government established the Medicare program.

Initially, the program was limited to Americans 65 and over. Then, in 1972, it was expanded to provide benefits to people under 65 with certain disabilities.[1] As explained in the Answer Brief, disabled adults, like the Petitioner, who qualify for the Supplemental Security Income (SSI) program automatically qualify for Medicare after 24 months in SSI.[2] In 2013 Medicare covered 52.3 million people. Of this number, 8.8 million people (about 17%) are under 65 and disabled.[3] As a developmentally disabled adult, Mr. Joerg is entitled to receive Medicare benefits both now and in the future.

B. Participating health care providers must accept what Medicare pays as payment in full for services to Medicare beneficiaries.

In contrast to private insurance rates that are generally set through a negotiated contract, Medicare rates are set by the federal government. *Baker County Medical Servs., Inc. v. Aetna Health Mgmt.*, LLC, 31 So. 3d 842, 844 (Fla. 1st DCA 2010) (noting that the reimbursement rates for Medicare patients are "set

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[1] The Henry J. Kaiser Family Foundation, *Medicare at a Glance* (Sept. 2, 2014) available at http://kff.org/medicare/fact-sheet/medicare-at-a-glance-fact-sheet/ (visited 9/17/14).

[2] Social Security Administration, *Understanding Supplemental Security Income SSI Eligibility Requirement -- 2014 Edition*, (setting out the requirements for SSI) *at* http://www.ssa.gov/ssi/text-eligibility-ussi.htm (visited 10/2/14); Social Security Administration, *Disability Planner: Medicare Coverage If You're Disabled*, (noting automatic enrollment in Medicare after two years of SSI disability benefits), at http://www.ssa.gov/dibplan/dapproval4.htm (visited 10/2/14).

[3] 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 7 (July 28, 2014), http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf (visited 9/18/14).

by the government agency administering those programs"). As a condition for participation in the Medicare program, health care providers must agree to accept the reimbursement rate set by the government as payment in full. *Wildermuth v. Staton*, No. CIV.A.01–2418–CM, 2002 WL 922137, *5 n.3 (D. Kan. Apr. 29, 2002) (citing 42 U.S.C. § 1395cc(a)(1)(A); 42 U.S.C. § 1395cc(a)(1)(O); 42 U.S.C. § 1395cc(a)(2)(A); and 42 C.F.R. § 489.21(a).). Mr. Joerg, as a Medicare beneficiary, is entitled to receive his future health care services at the rate that Medicare pays, regardless of the amount billed by his health care providers.

C. The amount billed for health care services (the "sticker price") is often two or three times the amount Medicare allows as payment in full for the services.

Pricing in the private health care industry is complex. *See* Keith T. Peters, *What Have We Here? The Need for Transparent Pricing and Quality Information in Health Care: Creation of an SEC for Health Care*, 10 J. HEALTH CARE L. & POL'Y 363, 366 (2007). For health care services, discounts from the amount billed are almost always applied.[4]

Some commentators have analogized "charges" for health care services to the "sticker price" on the window of a new automobile. Peters, *What have We*

[4] *Id.*; *Haygood v. De Escabedo*, 356 SW 3d 390, 399 (Tex. 2011) (observing that "[f]ew patients today ever pay a hospital's full charges") (citation omitted); George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101, 104 (2005-06) (concluding that less than five percent of uninsured patients pay full charges).

Here? at 366 (cited in *Haygood v. De Escabedo*, 356 SW 3d 390, 393 n.13 (Tex. 2011)). Just as almost no one pays the sticker price for a new car, so almost no one pays the "sticker price" (the amount billed) for private health care services.

But, there is an important difference. Whereas the sticker price on a car often is only slightly above its likely selling price, the sticker prices on private health care services are much more inflated. And because Medicare is one of the largest third-party payors, it is able to demand deep discounts from the charges that most health care providers bill. The federal government recently released Medicare reimbursement data indicating that Medicare reimburses doctors in Florida just 32.5% of the amount billed on average. *See e.g.*, Meghan Hoyer & Kelly Kennedy, *First Look at Medicare Data in 35 Years*, USA Today, April 10, 2014 (reporting on Medicare reimbursement rates nationally).[5] Thus to settle a $300 bill from a Florida doctor, on average Medicare would pay less than $100. A study that analyzed nationwide hospital bills found that for "every $1 Medicare is billed by American hospitals, Medicare pays only $0.27 – that's a 73% discount."[6] Thus,

[5] This article and interactive map showing reimbursement rates by state is available at http://www.usatoday.com/story/news/nation/2014/04/09/government-releases-medicare-physician-payment/7462923/ (visited 9/17/14).

[6] Christina LaMontagne, *NerdWallet Health Study Finds Medicare Gets a 73% Discount on Hospital Bills* (June 3, 2013), at http://www.nerdwallet.com/blog/health/2013/06/03/nerdwallet-health-study-finds-medicare-73-discount-hospital-bills/ (visited 10/2/14).

the average amount that Medicare would tender as payment in full for a $1,000 hospital bill would be $270.

D. When setting future health care damages, juries should be given all relevant information, including the Medicare rate that participating health care providers must accept as payment in full.

An important part of the Court's holding in *Stanley* is that the jury should hear "all the relevant evidence on future damages." 452 So. 2d at 516 (emphasis added). As the court explained, this does not mean that those with disabilities may "recover only the future cost of the free or low cost governmental or charitable care available to all persons with that disability." *Id*. Instead, this Court clearly trusted the jury to hear all relevant evidence and to award damages for future medical costs as appropriate.

Other states that have addressed the question of what evidence should go to a jury related to the reasonable value of health care services have concluded that the jury should be given both the "amount billed" and the "amount paid." *See e.g.*, *Martinez v. Milburn Enterprises., Inc*., 233 P.3d 205, 208, 229 (Kan. 2010) (holding that both the amount originally billed for medical treatment and the reduced amount actually accepted by the medical provider in full satisfaction of the amount billed "are relevant to prove the reasonable value of the medical treatment, which is a question for the finder of fact."); *Robinson v. Bates*, 857 N.E.2d 1195,

222-223 (Ohio 2006) (same); *Stanley v. Walker*, 906 N.E.2d 852 (Ind. 2009) (same).[7] This is exactly what this Court contemplated in *Stanley*.

Excluding from evidence the Medicare rates as proposed by the Petitioner will tend to produce inflated judgments that will drive up the cost of goods and services and thereby hurt consumers. In addition, as will be explained below, such a framework violates settled principles of compensatory damages.

II. COMPENSATORY DAMAGES MUST BE LIMITED TO THE LOSS ACTUALLY INFLICTED BY THE DEFENDANT

The guiding light for the resolution of this case is found in the settled principles of compensatory damages. This Court articulated those principles in *MCI Worldcom Network Services, Inc. v. Mastec, Inc*., 995 So. 2d 221 (Fla. 2008).[8] There, the Court explained that a person injured by another is entitled

[7] Although these cases involve claims for past medical damages, courts have applied the same principle to future medical damages. *Corenbaum v. Lampkin*, 215 Cal. App. 4th 1308, 1330-31 (Cal. Ct. App. 2013) (finding that the rules applicable to the admissibility of evidence related to past medical damages apply to claims for future medical damages).

[8] These principles have remained constant for many years, *see e.g., Mercury Motors Express, Inc., v. Smith,* 393 So. 2d 545, 547 (Fla. 1981) ("The objective of compensatory damages is to make the injured party whole to the extent that it is possible to measure his injury in terms of money."); *Fisher v. City of Miami,* 172 So. 2d 455 (Fla. 1965) (holding that "the primary basis for an award of damages is *compensation*. That is, the objective is to make the injured party whole to the extent that it is possible to measure his injury in terms of money."); *Hanna v. Martin*, 49 So. 2d 585, 587 (Fla. 1951) (holding that "the damages awarded should be equal to and precisely commensurate with the injury sustained."); *Florida East Coast Ry. Co. v. McRoberts*, 149 So. 631, 632 (1933) (holding that compensatory

compensation "commensurate with the resulting injury or damage." *Id.* at 223 (citations omitted, emphasis added). The Court noted that "[c]ompensatory damages are designed to make the injured party whole to the extent that it is possible to measure such injury in monetary terms." *Id.* (citations omitted). Then, vital to the issues presented here, the Court warned that recovery is not permitted in excess of the loss actually inflicted:

> A plaintiff, however, is not entitled to recover compensatory damages in excess of the amount which represents the loss actually inflicted by the action of the defendant.

Id. (citation omitted). As explained above, participating health care providers must accept as payment in full the amount that Medicare allows for services. Thus, the "loss inflicted" is the cost of the services at the Medicare rate.

The law that limits damages to the "loss actually inflicted by the action of the defendant" conserves consumer resources and protects the integrity of the judicial system. Petitioner invites this Court to adopt a framework for calculating future medical damages that is engineered to exceed the "loss actually inflicted" by the defendant. Such a framework clearly violates the requirement that damages must be limited to the amount required to make the Plaintiff whole. It also has the unintended consequence of driving up the cost of consumer goods and services.

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damages "are recoverable as compensation for the actual loss sustained by such an injured party by reason of the tortfeasor's wrongdoing").

Two Florida cases involving Medicare payments for past health care services provide guidance on the application of the rule that compensatory damages. In *Thyssenkrupp Elevator Corporation v. Lasky*, 868 So. 2d 547 (Fla. 4th DCA 2003), the jury awarded the Plaintiff for past medial expenses based on the "sticker price" billed by the health care providers instead of the amount paid by Medicare as payment in full for the services. The court reversed, finding that "a plaintiff has suffered no damage from the higher charge by the provider when it later accepts Medicare payment in full satisfaction of the charge." *Id.* at 551 (on denial of motion for rehearing) (emphasis added). Similarly, in *Cooperative Leasing, Inc. v. Johnson*, 872 So. 2d 956, 957, 958 (Fla. 2d DCA 2004) (emphasis added), the court analyzed the objective of compensatory damages and concluded that the plaintiff "was not entitled to recover for medical expenses beyond those paid by Medicare because she never had any liability for those expenses and would have been made whole by an award limited to the amount that Medicare paid to her medical providers."

In *Walker*, the court determined that when awarding future damages, the jury should hear "all the relevant evidence on future damages." 452 So. 2d at 516. Here, evidence of the amount that Medicare will pay for the future service is certainly relevant to the question of the Petitioner's expected future damages.

Consistent with *Walker*, a jury that is determining future medical damages should hear all the relevant evidence.

III. PETITIONER'S AUTHORITIES AND ARGUMENTS FALL SHORT

A. Compensatory damages must be limited to the injury sustained.

There is no dispute that Mr. Joerg is entitled to be "made whole" with respect to his future medicals. The question presented here is one of valuation: What monetary award is needed to make the Petitioner whole? Regardless of the amounts reflected in the bills submitted to Medicare, as a matter of law participating providers must accept the amount that Medicare allows as payment in full for the services. Therefore, in order to properly value future medical services, the jury must be given evidence of the Medicare rates for the services. Were the jury to award future health care damages at the Medicare's rate, that would cover the cost of all future health care services and would make the patient whole.

On the issue of valuation, Petitioner fails to explain how the trial judge's ruling that allowed the jury to hear only evidence of the amount billed (as opposed to the amount that Medicare will pay) for all projected future medical services is consistent with the requirement that damages "should be equal to and precisely commensurate with the injury sustained." *Hanna v. Martin*, 49 So. 2d 585, 587 (Fla. 1951). If, for example, the sticker price for the package of future medical services is $300,000, and that is the only information given to the jury, the most

likely award for future medicals would be $300,000. But, such an award would violate settled principles of compensatory damages because it would not be "equal to and precisely commensurate with the injury sustained."[9]

B. Having conceded that Medicare is not a collateral source, there is no legal justification to exclude the Medicare rate from evidence.

As its name suggests, the collateral source rule applies only to collateral sources. Indeed, both Petitioner and the Florida Justice Association (FJA) quote from this Court's plurality opinion in *Gormley v. GTI Products Corporation*, 587 So. 2d 455, 457 (Fla. 1991), stating that, "[a]s a rule of evidence, the collateral source rule prohibits the introduction of payments from collateral sources, upon proper objection." (Initial Brief, 21; FJA Amicus Brief, 5).

Petitioner's Initial Brief analyzes section 768.76(2)(a), Florida Statutes, and takes the position that payments from Medicare—past or future—are excluded from the definition of a "collateral source":

> Therefore, the definitions part of [768.76(2)(a)] expressly excepts "any payments" (past or future) made pursuant to Medicare from the definition of "collateral source."

[9] An award for the amount billed could be four times the Medicare rate. *See, e.g., Burton v. Riverboat Inn Corp.*, 4:12-CV-40-WGH-RLY, 2013 WL 6150309, at *1 (S.D. Ind. Nov. 22, 2013) ("The parties agree that Plaintiff's medical care providers billed her for $237,398.46 in medical expenses but accepted a payment of $56,100.09 from Medicare in complete satisfaction of those charges.").

(Initial Brief, 23.)[10] This admission that Medicare (past or future) is not a collateral source, coupled with the fact that the collateral source rule only bars the introduction of payments collateral sources, leaves Petitioner with no legal grounds to exclude from the jury evidence of future health care costs at the Medicare rate.[11]

C. Qualifying for Medicare is not analogous to affirmatively purchasing a private insurance policy.

As explained in the Answer Brief, Petitioner is already enrolled in Medicare based on his disability. Petitioner is unable to work and does not pay for his Medicare benefits. Yet, Petitioner argues that Petitioner's Medicare benefits are like private health insurance benefits that should be excluded from the jury, apparently as a "collateral source." (Initial Brief, 8, 8-17.) This argument is problematic for at least three reasons. First, Petitioner has taken the position that future Medicare benefits are not a collateral source. (Initial Brief, 23.)

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[10] The Second District Court of Appeal held § 768.76(2)(b), Fla. Stat., does not apply to *future* Medicare benefits. *State Farm Mut. Auto. Ins. Co. v. Jeorg*, Case Nos. 2D11–6229, 2D12–1246, 2013 WL 3107207, at *4 (Fla. 2d DCA June 21, 2013). The extent that a jury award must be reduced based on the receipt of benefits from a collateral source is not at issue in the case at bar.

[11] Were this Court to interpret section 768.76(2)(b) differently that Petitioner, or to find that this statutory definition is not controlling, it would not matter. As will be explained in the next subsection, the collateral source rule only excludes from jury payments received from a collateral source—not the reasonable value of the damage caused by the tortfeasor. Thus, the jury does not need to be told that future medicals will be covered by Medicare. But, the jury must be told the cost of the future medicals at the Medicare rate.

Second, under the collateral source rule only the existence of the collateral source is kept from the jury—not the amount of the loss caused by the tortfeasor. The jury can be given accurate information about the likely cost of future health care services without indicating that a Petitioner is eligible for Medicare benefits. For example, the jury could be told that expected future health care charges are $60,000, but that the health care providers will accept $20,000 as payment in full for the health care services. Other states use this approach.[12]

Third, in contrast to private insurance that has historically been voluntary, Medicare is funded through payroll taxes that are mandatory. Federal law requires employers to collect payroll taxes. And, while the employee is required to pay a portion of the payroll tax, an employer's withholding of a federal tax does not constitute an affirmative decision on the part of the employee to obtain Medicare coverage. *Liberty v. Westwood United Super. Inc*., No. 89,143, 2005 WL 1006363, at *5 (Kan. App. Ct. Apr. 29, 2005) (unpublished). Further, while there is some risk that a private insurer could drop a policy holder, relegating a the claimant to

[12] For example, the Kansas Supreme Court suggested this approach in *Martinez v. Milburn Enterprises., Inc*., 233 P.3d 205, 226 (Kan. 2010) (suggesting that the jury would only hear that "the hospital will accept $5,000 to satisfy its bill of $70,000," leaving the jury to "reasonably perceive that the plaintiff will make payment herself"); *see also Haygood v. De Escabedo*, 356 SW 3d 390, 400 (Tex. 2011) (holding that the jury should hear evidence of the amount that will be accepted as payment in full for the services, but noting that the jury should not be told "that a health care provider adjusted its charges because of insurance").

obtain health care services that might be more costly, the risk that Petitioner will lose his Medicare benefits is virtually non-existent.

D. This Court should affirm or extend the holding in *Stanley*, not retreat from it.

The Second District Court of Appeal relied on this Court's decision in *Stanley*, 452 So. 2d at 515, to hold that the jury should have been permitted to consider the governmental and charitable services that were available to the Plaintiff when setting future damages. Tommy Stanley suffered from "retardation and cerebral palsy" as a result of negligent care in conjunction with his birth. In assessing future damages, the trial court permitted the jury to hear evidence of the low-cost charitable and governmental programs available to meet Tommy's needs. The District Court of Appeal reversed, holding that evidence of the low-cost charitable and governmental programs should have been excluded. This Court sided with the trial judge, holding that "the admission in this case of evidence concerning <u>future</u> governmental and charitable services did not violate the common-law collateral source rule." *Id.* (emphasis added). The Court went on to explain that "[k]eeping such evidence from the jury may provide an undeserved and unnecessary windfall to the plaintiff." *Id.*

In *Stanley*, it was Tommy's condition that qualified him for certain governmental programs. Similarly, here it is Mr. Joerg's condition as a developmentally disabled adult that qualifies him for the Medicare program. As

the Answer Brief explains, Mr. Joerg is entitled to Medicare benefits at no cost to him because of his disability.

1. The holding of *Stanley* should be extended to exclude from evidence the amount billed absent a showing that the plaintiff is likely to be liable for the full amount billed.

The rule of compensatory damages provides that damages "should be equal to and precisely commensurate with the injury sustained." *Hanna v. Martin*, 49 So. 2d 585, 587 (Fla. 1951). This principle, calls into question the relevancy of the amount billed. In the context of a Medicare beneficiary, the courts in *Thyssenkrupp* 868 So. 2d at 551, and *Cooperative Leasing* 872 So. 2d at 958-960, properly concluded that the amount accepted as payment in full for the health care service reflects the reasonable value of the service, not the amount billed by the provider.

Courts in the two largest states have concluded that because almost no one pays the full amount billed, the amount billed is generally not relevant and therefore inadmissible. The court in *Howell v. Hamilton Meats & Provisions*, 257 P.3d 1130, 1146 (Cal. 2011), determined that the amount billed for the plaintiffs' medical care was not admissible for purposes of determining a plaintiff's damages for medical expenses where the medical providers had accepted lesser amounts as full payment pursuant to prior agreements with the insurers.[13] Then, in

[13] Although *Howell* involved private insurance, in *Luttrell v. Island Pacific Supermarkets, Inc.*, 215 Cal. App. 4th 196, 205-08 (Cal. App. Ct. 2013), the court concluded that *Howell* applies when the medical payments are paid by Medicare.

Corenbaum v. Lampkin, 215 Cal. App. 4th 1308, 1330-31 (Cal. Ct. App. 2013), the court applied *Howell* to hold that the amount billed by health care providers is not relevant when determining damages for future medical expenses.

Similarly, in *Haygood v. De Escabedo*, 356 SW 3d 390, 398-99 (Tex. 2011), the court held that amounts billed by a medical care provider, but not paid or anticipated to be paid by the patient, cannot be placed in evidence. In that case, the plaintiff was billed over $110,000.00, but the Medicare rate for the services was just $28,000.00. *Id*. at 392. The court held that the Medicare rate was all that the plaintiff was obliged to pay and, therefore, was all he was entitled to recover from the tortfeasor. *Id*. at 398.

If this Court is inclined to revisit *Stanley*, it should extend its holding to provide that the amount billed by health care providers may only be admitted into evidence where the Plaintiff shows he or she may be liable for full amount billed.

2. The arguments of the Florida Justice Association fail to articulate grounds for the Court to retreat from *Stanley*.

The FJA amicus brief quotes at length from *Cates v. Wilson*, 361 S.E.2d 734 (N.C. 1987), and argues that this Court should look to this decision for guidance. In *Cates*, the court quoted from the defendant's closing argument show how the defendant improperly urged the jury not to award any damages to the plaintiff because of all the public services the plaintiff was entitled to receive at no cost. *Id.* at 740. Those are not the facts here. This case involves a separate and distinct

question of valuation. In this case there is no dispute that Petitioner is entitled to recover damages for his future medical costs. The question is what evidence the jury will be allowed to consider in order to value the future services.

Notably, as explained above, other courts have found ways to inform the jury of the expected cost of future medical services without indicating that the petitioner is a Medicare beneficiary, or is otherwise entitled to services without cost. Telling the jury that total charges for future health care services are expected to be $30,000, but that the provider will accept $10,000 as payment in full gives the jury relevant information about the likely cost of future health care damages without suggesting the existence of a collateral source.

As for the argument in *Cates* that there is no guarantee that current government programs will continue, or that existing benefits will not be reduced, those risk factors do not provide a basis for excluding relevant evidence from a jury on the expected cost of health care services. Instead, those issues are examples of arguments that can be made to the jury. Life is uncertain. The future is unknown. As with any disputed fact, each side must take its best hold. Then, when all the evidence is in, the jury must decide what amount of money is needed to make the plaintiff whole.

CONCLUSION

When a person's negligence causes injury to another, the injured party is entitled to go into court and to recover damages sufficient to make the injured party whole. Compensatory damages must be limited to the amount needed to make the plaintiff whole. As a Medicare beneficiary, evidence of the cost of Petitioner's future medicals at the Medicare rate is highly relevant and must go to the jury. To limit the jury to the amount billed would establish a system that requires defendants to pay future medical damages that are likely two to four times the actual cost of the services at the Medicare rate. Such a system is inconsistent with the law of compensatory damages and should be rejected by this Court.

Admitting only the "sticker price" on the issue of future medicals will result in inflated damage awards. To fund these awards that far exceed the cost of the needed health care services, Floridians will be saddled with higher insurance premiums. To cover the cost of increased premiums small businesses that provide essential goods and services will be forced to raise their prices, which will hurt consumers and slow economic growth.

The jury system is the foundation of our system of justice. A jury can only render a verdict that is just, fair, and equitable when it is given all the relevant evidence. In *Walker* this Court correctly trusted the jury, holding that the jury should be given all the relevant evidence on future damages. To retreat from that

holding would undermine the integrity of the judicial process. Therefore, the Second District Court of Appeal should be affirmed.

Respectfully submitted this 6th day of October, 2014.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that the foregoing has been electronically filed through the eFiling Portal; and that a copy has been served by e-mail to: Tracy Raffles Gunn, Esquire, Counsel for Joerg, at tgunn@gunnappeals.com and tbishoff@gunnappeals.com; Damian B. Mallard, Esquire, Co-Counsel for Joerg, at Damian@mallardlawfirm.com and Hannah@mallardlawfirm.com; Lee D. Gunn, IV, Esquire, Co-Counsel for Joerg, at lgunn@gunnlawgroup.com; Mark D. Tinker, Esquire and Charles W. Hall, Esquire, Counsel for State Farm, at mtinker@bankerlopez.com and service-mtinker@bankerlopez.com; and James H. Burgess, Jr., Esquire., Co-Counsel for State Farm, at jburgess@burgessharrell.com all on this 6th day of October, 2014.

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CERTIFICATE OF RULE 9.210 COMPLIANCE

I HEREBY CERTIFY that this brief complies with the font requirements of Rule 9.210(a)(2), Florida Rules of Appellate Procedure.

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