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CS/CS/HB 837 – Tort Reform Legislation signed into law on March 24, 2023

The following report is intended to address CS/CS/HB 837 (hereinafter referred to as the "Bill"), which was signed into law on March 24, 2023. Included below is the Legislative Summary included in the Bill, with critical sections addressed thereafter.

This summary is intended to highlight the most relevant changes effectuated by the Bill's passage, with emphasis given to those directly impacting litigation arising out of motor vehicle accidents. Changes limited to non-auto matters may be omitted, which includes discussion of changes regarding premises liability for criminal acts of third parties.

For a complete review, the full text of the Bill is available at https://www.flsenate.gov/Session/Bill/2023/837/BillText/er/PDF.

Critical Changes and Notations

- The legislation modifies §768.81, replacing the pure comparative fault model with a modified comparative fault law that will bar a plaintiff from recovering anything if he/she is found to be greater than 50% at fault for his or her own harm.
- The statute of limitations period for negligence actions is changing from four (4) to two (2) years. The limitations period for causes of actions that accrued (*i.e.* the accident occurred and injuries were suffered) prior to March 24, 2023 is not impacted by the passage of this bill. The two-year SOL will apply to causes of action that occur after March 24, 2023.
- Any rights under an insurance contract if in effect on or before March 24, 2023, are not impaired or affected. To the extent that this act affects rights under an insurance contract, the act applies to an insurance contract that is issued or renewed after the effective date of the Bill.
- Except as mentioned above, the other changes shall apply to causes of action filed after March 24, 2023.
- The Bill is intended to drastically limit the application of fee multipliers.

- **The one-way fee statute applied to insurance cases is repealed.** Recovery of fees by a named insured, omnibus insured, or named beneficiary is preserved only when the aforementioned prevails in a declaratory judgment action under Ch. 86, Florida Statutes, after there has been a total coverage denial.
- For purposes of bad faith, mere negligence on behalf of the carrier is insufficient to maintain a bad faith cause of action.
- A 90-day safe harbor period is created that protects insurance carriers from bad faith claims if, within 90 days of receiving notice of a claim which is accompanied by sufficient evidence to support the amount of the claim, the carrier either tenders the lesser of (1) the policy limits or (2) the amount demanded by the claimant.
- In situations involving multiple claimants where the anticipated value of the claims may collectively exceed the policy limits available, the carrier is provided two options (*i.e.* filing an interpleader action or enter into binding arbitration) for tendering the policy limits, which will insulate the carrier from subsequent bad faith claims.
- The 90-day safe harbor provision and the interpleader option for resolving multi-party claims do not appear to protect the insured from suit or subsequent excess recovery.
- The voluntary binding arbitration option in multi-party claims appears to ensure that the insured will receive a release in their favor from the claimant whose claim(s) are resolved through the binding arbitration period.

Legislative Summary

An act relating to civil remedies; amending s. 57.104, F.S.; creating a rebuttable presumption that a lodestar fee is a sufficient and reasonable attorney fee in most civil actions; providing an exception; creating s. 86.121, F.S.; authorizing a court to award attorney fees in certain declaratory actions; prohibiting the transfer, assignment, or acquisition of the right to such attorney fees except by specified persons; providing applicability; amending s. 95.11, F.S.; reducing the statute of limitations for negligence actions; providing applicability of certain provisions to actions involving servicemembers; amending s. 624.155, F.S.; providing standards for bad faith actions; providing for the distribution of proceeds when two or more third-party claims arising out of a single occurrence exceed policy limits; creating s. 624.1552, F.S.; providing for applicability of specified offer of judgement provisions to civil actions involving insurance contracts; creating s. 768.0427, F.S.; providing

definitions; providing standards for the admissibility of evidence to prove the cost of damages for medical expenses in certain civil actions; requiring certain disclosures with respect to claims for medical expenses for treatment rendered under letters of protection; specifying the damages that may be recovered by a claimant for the reasonable and necessary cost of medical care; creating s. 768.0701, F.S.; requiring the trier of fact to consider the fault of certain persons who contribute to an injury; creating s. 768.0706, F.S.; providing definitions; providing that the owner or principal operator of a multifamily residential property which substantially implements specified security measures on that property has a presumption against liability for negligence in connection with certain criminal acts that occur on the premises; requiring the Florida Crime Prevention Training Institute of the Department of Legal Affairs to develop a proposed curriculum or best practices for owners or principal operators; providing construction; amending s. 768.81, F.S.; providing that a party in a negligence action who is at fault by a specified amount may not recover damages under a comparative negligence action; providing applicability; repealing ss. 626.9373 and 627.428, F.S., relating to attorney fees awarded against surplus lines insurers and insurers, respectively; amending s. 627.756, F.S.; providing for the award of costs and attorney fees in certain actions; amending ss. 475.01, 475.611, 517.191, 624.123, 624.488, 627.062, 627.401, 627.441, 627.727, 627.736, and 628.6016, F.S.; conforming provisions to changes made by the act; repealing ss. 631.70 and 631.926, F.S., relating to attorney fees; amending s. 632.638, F.S.; conforming provisions to changes made by the act; providing a directive to the Division of Law Revision; providing applicability and construction; providing an effective date.

Modification of F.S. 57.104 - Computation of Attorney's Fees

Section 57.104, Florida Statutes, provides the itemized list of factors that courts were to consider when computing the amount of attorney's fees to be awarded by the courts. The Bill amends §57.104 to include language that imposes a "a strong presumption that the lodestar fee is sufficient and reasonable." The presumption is rebuttable, but "only in a rare and exceptional circumstance with evidence that competent counsel could not otherwise be retained."

The "lodestar method" refers to a method of computing attorney's fees by multiplying the numbers of hours reasonably spent by trial counsel by a reasonable hourly rate. Historically, courts have taken the lodestar amount and applied multipliers, leading to exponentially large fee awards. The language of the Bill is intended to prevent multipliers being applied, absent exceptional circumstances.

Creation of §86.121 – Attorney's Fees for Declaratory Judgment Actions Under Certain Circumstances

The Bill creates §86.121, which provides that attorney fees are recoverable by an insured that successfully prevails in an action for declaratory relief to determine insurance coverage after a total coverage denial of a claim. This portion of the Bill was not included in the original draft, but added through amendment in an apparent attempt to pacify challengers to the original bill, purportedly ensuring that carriers are not able to systemically deny coverage incorrectly without consequence.

As discussed in greater detail below, the Bill eliminates the one-way fee statute that has historically enabled insureds as prevailing parties to recover attorney fees from their carrier(s). The creation of §86.121 serves to carve out an exception when a named insured, omnibus insured, or named beneficiary under a policy of insurance prevails in a declaratory judgment action after the carrier has made a total coverage denial of the claim.

The carve-out is expressly limited in its applicability. First, recovery of fees is limited to those instances when there has been a complete denial of coverage. If a carrier provides a defense to an insured under a reservation of rights, it does not constitute a coverage denial. Additionally, the recovery is limited to the fees incurred in the declaratory judgment action to determine coverage of insurance issued under the Florida Insurance Code. And finally, the legislature expressly stated that §86.121 does not apply to any actions arising under a residential or commercial property insurance policy.

Modification of §95.11 – Statute of Limitations

Historically, the limitations period applicable to an action founded on negligence was four (4) years. The Bill modifies that period to two (2) years.

Notably, the language of the Bill states that the modification of this statutory section does not apply to causes of action that have already accrued. This means that if someone was in a car accident prior to the Bill's passage, the limitations period applicable to that claim remains four (4) years from the date the claim accrued (i.e. the date of the accident when the injury was suffered). The two (2) year limitation period will only apply to new causes of action that occur after March 24, 2023.

The Bill does not modify or alter the limitations period applicable to breach of contract cases.

Finally, there is a carve-out for military personnel. If you encounter a cause of action involving servicemembers, including members of the United States Armed Forces, United States Reserve Forces, or the National Guard, please refer to the text of the amended statute for clarification.

Modification of § 624.155 – Affecting the Standard Applied in Bad Faith

The Bill substantially modifies the civil remedy statute by: (1) adding a safe-harbor period for carriers; (2) clarifying that mere negligence is insufficient on its own to support a bad faith claim; (3) imposing a "good-faith" duty on insureds, claimants, and representatives of the insured or claimant; and (4) creating protection and a framework for carriers to utilize when presented with competing claims arising out of a single occurrence, which in total may exceed the available policy limits of one or more of the insured parties who may be liable.

First, the Bill provides that "an action for bad faith involving a liability insurance claim, including any such action brought under common law, shall not lie if the insurer tenders the lesser of the policy limits or the amount demanded by the claimant within 90 days after receiving actual notice of a claim which is accompanies by sufficient evidence to support the amount of the claim." In effect, carriers will now have a 90-day safe harbor period in which to tender the available limits, if they wish to avoid bad faith exposure. However, the safe-harbor period does not bar a claimant from filing suit against an insured and seeking recovery from the individual in an amount in excess of the policy limits. Carriers should not view the safe harbor period as insulating or protecting their insureds in any manner.

If the carrier does not tender the lesser of the policy limits or amount demanded within 90 days of receiving the requisite notice, the existence of the safe harbor period and its protections being available, but not secured, is inadmissible in

any action seeking to establish bad faith. In short, the claimant cannot use the statute against the carrier to establish or bolster a bad faith claim.

Interestingly, the statute provides that "if the insurer fails to tender pursuant to [the safe harbor provision], any applicable statute of limitations is extended for an additional 90 days." The application of this provision is likely to cause some confusion and the extension period should not be relied upon by claimants until such time as additional guidance is provided.

Next, in any bad faith action, regardless of whether it is brought under the statute or based on common law, the Bill provides that "mere negligence alone is insufficient to constitute bad faith."

Further, the Bill imposes a duty of good faith on the insured, claimant, and representatives of the insured or claimant. The duty to act in food faith applies to furnishing information regarding the claim, in making demands of the insurer, in setting deadlines, and in attempting to settle the claim. In any case for bad faith against an insurer, the trier of fact may consider whether the aforementioned individuals did not act in good faith, in which case the trier of fact may reasonably reduce the amount of damages awarded against the insurer. In effect, the actions of the claimant in a bad faith case are admissible and can serve as a basis for reducing the claimant's recovery.

In situations where multiple third-party claimants have competing claims arising out of a single occurrence, where the total recovery *may* exceed the available policy limits of one or more of the insured parties who *may* be liable to the third-party claimants, the Bill provides that the insurer "is not liable beyond the available policy limits for failure to pay all or any portion of the available policy limits to one or more of the third-party claimants if, within 90 days after receiving notice of the competing claims in excess of the available policy limits, the insurer" complies with one of the following:

> (a) The insurer files an interpleader action under the Florida Rules of Civil Procedure; or
>
> (b) pursuant to binding arbitration that has been agreed to by the insurer and the third-party claimants the insurer makes the entire amount of the policy limits available for payment to the competing third-party claimants before a qualified arbitrator agreed to by the insurer and the third-party claimants at the expense of the insurer.

Under option (a), if the claims of the competing third-party claimants are found to be in excess of the policy limits, the claimants are entitled to a prorated share of the policy limits as determined by the trier of fact. Notably, the insurer's interpleader action does not alter or amend the insurer's obligation to defend its insured.

If option (b) is pursued, the claimants are entitled to a pro rata share of the policy limits, as established by the arbitrator. Interestingly, this option also requires that "[a] third-party claimant whose claim is resolved by the arbitrator must execute and deliver a general release to the insured party whose claim is resolved by the proceeding."

The majority of the original text of § 624.155 remains in place and unaffected by the modifications.

Creation of § 624.1552 – Applicability of § 768.79 to Any Civil Action Involving an Insurance Contract

The addition of this statute serves to confirm that Proposals for Settlement are applicable to any civil action involving an insurance contract.

Creation of § 768.0427 – Admissibility of Evidence to Prove Medical Expenses; disclosure requirements of LOP's; and recovery of past and future medical expenses.

The Bill modifies and clarifies what information is admissible at trial to prove past and future medical expenses. The summary below is intended to summarize the various scenarios contemplated in the Bill:

1) **Past Medical Expenses**
   a) If evidence is offered to prove the amount of past-medical damages that have already been paid, the evidence is limited to the amount actually paid, regardless of the source of payment.
   b) If the evidence is offered to prove the amount necessary to satisfy outstanding bills for medical services previously rendered, then:
      1. If the claimant has health insurance other than Medicare or Medicaid, evidence of what the health insurance company is obligated to pay is admissible, including any amounts payable by the plaintiff as a co-pay.
      2. If the claimant has health insurance, but seeks treatment under an LOP or otherwise does not submit his/her medical bills for payment

to the health insurance provider, evidence of what the claimant's health insurer would pay the provider to satisfy the past unpaid medical charges is admissible. The amount of the plaintiff's co-pay is also admissible.

c) If the claimant does not have health insurance or has coverage through Medicare or Medicaid, evidence of 120% of Medicare's reimbursement rate is admissible.
    1. If there is no applicable Medicare rate for the service(s) rendered, then it's admissible to present 170% of the state Medicaid rate.
d) If the claimant obtains treatment through an LOP, which the provider subsequently transfers/sells to a third-party, evidence of the amount the third party paid or agreed to pay the provider for the right to recover under the LOP is admissible.

In addition to the above, "any evidence of reasonable amounts billed to the claimant for medically necessary treatment or medically necessary services provided to the claimant[]" are admissible.

2) Future Medical Expenses

a) If the claimant has health coverage other than Medicare or Medicaid, or is eligible for any such health care coverage, evidence of the amount for which future charges could be satisfied if submitted to the health insurance carrier for payment. Evidence of the claimant's anticipated co-pay is also admissible.
b) If the claimant does not have health insurance or is covered under Medicare or Medicaid, or is eligible for such coverage, evidence of 120 percent of Medicare's reimbursement rate in effect at the time of trial for the medical treatment/service anticipated are admissible.
    a. If there is not an assigned Medicare rate for the treatment, then 170% of the state Medicaid rate is admissible.

In addition to the above, "any evidence of reasonable future amounts to be billed to the claimant for medically necessary treatment or medically necessary services" are admissible.

The Bill prohibits discovery and the admission into evidence of any individual contracts between providers and authorized commercial insurers or authorized health maintenance organizations.

3) Letters of Protection (LOP's)

In personal injury and Wrongful Death actions, the Bill creates the following requirements as a condition precedent to asserting any claim for medical expenses for treatment rendered under a letter of protection. The claimant must disclose:

a) A copy of the letter of protection.

b) All billing for the claimant's medical expenses, which must be itemized and, to the extent applicable, coded according to:
    a. For health care providers billing at the provider level, the American Medical Associate's Current CPT, or the HCPCS, in effect when service were rendered.
    b. For health care providers billing at the facility level for expense incurred in a clinical or *outpatient* setting, the ICD diagnosis code and, if applicable, the AMA's CPT codes, in effect on the date the service were rendered.
    c. For health care providers billing at the facility level for expense incurred in an *inpatient* setting, the ICD diagnosis and procedure codes in effect on the date the service were rendered.
c) If the provider sells the accounts receivable for the medical expenses to a factoring company or other third party, the following must be disclosed:
    a. The name of the purchasing company.
    b. The dollar amount paid, as well as any discount provided to the invoice.
d) Whether the claimant, at the time of the medical treatment was rendered, had health care coverage and, if so, the identity of such coverage.
e) Whether the claimant was referred for treatment under the LOP and, if so, the identity of the person who made the referral, which includes the claimant's attorney.

In addition to the above disclosure requirements, the Bill makes the evidence of a referral from an attorney of their client to a LOP provider admissible at trial. The Bill expressly states that evidence of the financial relationship between a law firm and a medical provider, including the number of referrals, frequency, and financial benefit obtained, is relevant to the issue of the bias of the testifying medical expert.

4) Damages Recoverable for Medical Treatment or Service

The Bill is intended to cap the recovery of damages for medical treatment/services in both personal injury and wrongful death actions, by prohibiting the inclusion of any amounts in excess of the amounts discussed above, and also may not exceed the following:

a. Amounts actually paid to the health care provider who rendered the services;
b. Amounts necessary to satisfy charges for medical treatment or services that are due and owing but at the time of trial are not yet satisfied; and
c. Amounts necessary to provide for any reasonable and necessary medical treatment or services the claimant will receive in the future.

Modification of § 768.81 – Replaces Pure Comparative Negligence System with Modified Comparative Negligence System

Prior to the recent amendments, Florida operated under a pure comparative negligence system, which allowed a claimant to recover proportionately based on the degree of fault assigned to the defendant(s). Under the historical model, a plaintiff that was ultimately found to be 90% at fault for the accident could still recover 10% of the damages from a defendant.

Under the modified statutory language contained in the Bill, a plaintiff will be barred from recovering anything if he/she is found to be greater than 50% at fault for his or her own harm.

Repeal of § 627.428 – Repeal of One-Way Fee Statute

The Bill eliminates the one-way fee statute traditionally utilized by plaintiffs in claims against insurers in first-party actions. Amendments were proposed throughout the legislative session to simply modify the statute's applicability; however, the final version of the Bill serves to repeal the fee statute.

It is anticipated that this will have the most immediate impact on PIP litigation, as the only avenue for recovery of attorney fees above a pure contingency arrangement will be through the issuance of a valid Proposal for Settlement.

CONCLUSION

We trust that this report will assist you and your teams in applying the new laws to matters moving forward. Please do not hesitate to reach out to our office with any questions.

Sincerely,

Stephen A. Spaid, Esq.