Accuracy in Damages
Ensuring Fairness in Awards of Medical Expenses

The Present Situation: Phantom Damages

In personal injury cases, the greatest element of economic damages is often medical expenses. Plaintiffs are generally entitled to recover the costs of past medical care already incurred, as well as the estimated costs of future medical care reasonably likely to be incurred, as a result of defendants' negligence. However, awards of medical expenses are often significantly inflated, resulting in what have come to be known as "phantom damages". In Florida, there are currently two main causes of phantom damages.

The Difference Between Billed Charges and Paid Charges

The first cause of phantom damages arises from the difference between the amount billed by health care providers for medical services and the amount normally accepted as payment in full for those health care services. In Florida, generally only the amount billed is admissible as evidence at trial. This is because section 768.76, Florida Statutes, prohibits introduction of evidence regarding payments for medical expenses made on behalf of plaintiffs by collateral sources such as private health insurers. The statute has also been interpreted to prohibit introduction of evidence regarding medical bills that have been discounted or written off by health care providers.[1] Only when the bill is paid by a non-collateral source – such as Medicare or Medicaid – is evidence of the actual amount paid admissible.[2]

After trial, judges are responsible for adjusting the plaintiff's award based on the plaintiff's receipt of collateral source benefits. For example, suppose a physician charges $100,000 for the plaintiff's medical treatment. The plaintiff's private insurer negotiates a discounted rate and pays $30,000 in full satisfaction of the bill. In Florida, the jury is only allowed to see the original $100,000 bill; thus, if it finds the defendant liable, the jury will award $100,000 to the plaintiff for past medical expenses. Post-trial, the judge will reduce the award by $70,000, the amount of the discount given by the physician. However, because the insurer usually has a right of subrogation – that is, a right to recover amount it paid to the provider on behalf of the plaintiff[3] – the total award will still be $30,000.

The goal of section 768.76 is fairness. The plaintiff is able to recover for the actual costs of his or her medical care – subject to the insurer's right of subrogation – while the defendant is required to pay for the damage caused by his or her negligence. Yet there are two fundamental flaws that make the statute inherently unfair. First, the introduction of the "billed" charges misleads the jury about how much the plaintiff has actually been damaged. Most people – and most jurors – would face economic ruin if they had to pay $100,000 out of their own pockets for medical care. Further, most people – and most jurors – know that car owners, medical professionals, homeowners, and businesses generally have insurance which covers negligence awards.[4] It is no surprise, then, that in cases of dubious liability, the jury is more sympathetic to the perceived plight of the plaintiff and thus more likely to find against the defendant. In other words, even though the statute requires the plaintiff's award for past medical expenses to be reduced post-verdict, there would be no award but for the statute's prohibition against introducing anything other than the inflated, misleading medical bills.

The second fundamental flaw of section 768.76 is that because judges are not allowed to reduce awards for which payment has yet to be made, all awards for future medical expenses are based on the inflated bills for past treatment. In the above example, suppose the physician testifies that the plaintiff will need another round of future medical treatment identical to the past treatment. As far as the jury knows, the cost of plaintiff's past

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[1] *Goble v. Frohman*, 901 So.2d 830, 833 (Fla.2005).
[2] *Thyssenkrupp Elevator Corp. v. Lasky*, 868 So. 2d 547 (Fla. 4th DCA 2003).
[3] *Blue Cross & Blue Shield of Florida, Inc. v. Matthews*, 498 So.2d 421, 422 (Fla. 1986).
[4] See *Martinez v. Milburn Enterprises,* Inc., 233 P.3d 205 (Kan. 2010)

medical treatment was $100,000. Thus – again, as far as the jury knows – the plaintiff's future medical treatment will likewise cost $100,000. While the defendant could argue that the future treatment will really only cost $30,000, who will the jury believe: the plaintiff and the plaintiff's physician – who introduced into evidence actual bills totaling $100,000 – or the defendant and the defendant's paid expert? The answer is clear. However, unlike the $100,000 award for past medical expenses, the $100,000 award for future medical expenses will not be reduced post-verdict because – even though the actual costs of future treatment will only be $30,000 – payment for such future treatment has yet to be made. This $70,000 difference, then, constitutes phantom damages.

Medically Unnecessary Treatment

The third cause of phantom damages is the provision of care that is not medically necessary. Florida law requires plaintiffs to prove that their medical treatment was reasonable and medically necessary.[5] For this reason, the necessity of medical treatment is always an issue in personal injury cases. However, treatment that is not medically necessary may also constitute medical malpractice. Under Florida law, a defendant is liable for a physician's malpractice in treating injuries caused by the defendant's negligence.[6] Thus, if a defendant presents evidence that the plaintiff's treatment was not medically necessary, Florida courts have held that such arguments are tantamount to accusing the plaintiff's treating physician of medical malpractice, entitling plaintiff to a so-called "*Stuart* instruction." A *Stuart* instruction directs the jury that if negligence if found, the defendant is liable for all of plaintiff's medical treatment, including any treatment necessitated by the negligence, mistake or lack of skill of the treating physician.[7]

As a result of *Stuart* and its progeny, health care providers are able to perform – and bill for – treatment that is not medically necessary. Defendants are forced to pay for medical treatment that was not caused by the defendants' negligence, while plaintiffs are allowed to collect a windfall in phantom damages.

Solution

These two causes are addressed by HB 587. To address the first cause, the bill requires that if medical expenses have already been paid, only evidence of the amount paid – not the amount billed – is admissible at trial. And to address the second cause, the bill limits recovery of medical expenses to the costs incurred for medically necessary services resulting from the defendant's negligence.

[5] *Nason v. Shafranski*, 33 So.3d 117 (Fla. 4th DCA 2010).
[6] *Stuart v. Hertz Corp.*, 351 So.2d 703 (Fla. 1977).
[7] *Dungan v. Ford*, 632 So.2d 159 (Fla. 1st DCA 1994); *Emory v. Florida Freedom Newspapers*, 687 So.2d 846 (Fla. 4th DCA 1997); *Pedro v. Baber*, 83 So.3d 912 (Fla. 2d DCA 2012).