Accuracy in Damages: Florida Juries Should Base Personal Injury Awards on Actual Costs of Treatment, Not Inflated Medical Bills

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Executive Summary

In our day-to-day lives, Americans recognize that the "list" or "sticker" price for products or services do not always reflect their actual cost. For instance, more than three-quarters of Americans have "club cards" that they routinely use at the supermarket.[1] When the customer presents the card and the store applies applicable discounts at the checkout counter, the total bill can easily come down 20% from the "regular" prices. Another common example is the sticker price of a car. Car buyers recognize that the amount on the dashboard is a starting point for negotiation and they expect to ultimately pay less.

Now, if an unfortunate person who purchased a new car got into an accident as he drove out of the dealership's lot, resulting in a total loss, would he expect his insurance company to pay him the list price of the car or the actual price paid? Likewise, if an individual purchased supplies for a work event at the supermarket, and submitted a request to her employer for reimbursement, would she expect the check to reflect the prices on the receipt prior to the deduction of discounts or the amount she paid? Obviously, in both cases, consumers would expect to be reimbursed for the amount that they actually paid, not based on a list price that has little meaning. They recognize that the sticker price may simply reflect the pricing practices of that industry, not the true costs.

In the topsy-turvy world of the legal system, however, lawyers who represent clients in personal injury cases seek damages for medical expenses, such as hospital bills, diagnostic tests, rehabilitation therapy, and doctor visits, based on amounts originally billed by healthcare providers. This practice occurs even when neither the patient, nor his or her insurer, paid these rates.

Given the widespread application of negotiated rates between managed care plans and providers, fee schedules set by Medicare or Medicaid, and other discounts and write offs, it is not uncommon for list prices of medical services reflected on the original invoice to be three or four times the actual price paid. In fact, evidence suggests that in recent years, the gap between the list prices and actual payments for medical care is further expanding. This difference, the amount that no one ever paid but is sought in personal injury litigation, is sometimes referred to as "phantom damages." These illusory amounts serve no compensatory purpose for those who are injured, but drive up the costs of products and services for consumers.

Phantom damages are an exceptional problem in Florida, where hospitals charge among the highest rates in the country. To its credit, Florida law restricts recovery of phantom damages, but it does so in an inconsistent manner that continues to allow windfalls to plaintiffs in some circumstances. Juries that are misled to believe that a plaintiff paid the billed amount of medical expenses may arrive at an excessive award for future medical expenses or for pain and suffering, even if a judge ultimately reduces the verdict by the amount of the phantom damages after trial. In addition, some personal injury lawyers circumvent Florida's prohibition of phantom damages through use of "Letters of Protection" (LOPs), which, by deferring payment of medical bills until the conclusion of litigation, hide the actual amount that a patient would actually pay.

The Florida Legislature can require accuracy in damages in personal injury litigation by following the simple approach of states such as California, North Carolina, Oklahoma, and Texas. These and other states preclude introduction of evidence of amounts billed at trial when billed amounts do not reflect the actual amount paid in full satisfaction of the bill or the plaintiff's true legal obligation to pay. H.B. 1199 and S.B. 1240, introduced in the 2015 session, provide a solution.

Phantom Damages – Amounts Billed vs. Paid

The goal of tort law is to make the plaintiff whole by reimbursing the plaintiff for all of his or her reasonable and necessary expenses. In many states, defendants pay more, often multiple times what the plaintiff or his or her insurer pay, for medical care. This overpayment is what we call "phantom damages."

Phantom damages are the difference between the amount of medical expenses *billed* by a health care provider, such as a doctor, clinic, or hospital (the "sticker price") and the amount that the plaintiff and his or her insurer *actually paid* for those services. In recent years, healthcare providers have rapidly increased their billed rates, while the practice of discounting these costs has become widespread. For example, U.S. hospital charges grew from 174% of costs in 1994 to 254% of costs in 2004,[2] and have continued to rise over the last decade. Florida hospitals bill amounts that among the highest in the country. For example, a recent study found that charge-to-cost ratio of Florida hospitals is 555.36%, compared to an average of 331% nationwide, placing Florida second only to rates in New Jersey.[3] Nearly a third of the top 100 hospitals with the highest charge-to-cost ratio, the study found, are located in Florida.[4] The billed rate at these hospitals, according to the study, ranged from between eight and eleven times the actual cost.[5] There is no federal or state regulation of billed changes, and each Florida healthcare provider is free to set its charges at any level it pleases.[6]

Few patients, however, pay the billed rates. For many years, healthcare providers have received payment not based on their list prices, but either based on payment schedules set by Medicare rules[7] or negotiated rates with managed care plans. Likewise, uninsured patients rarely pay list prices, as healthcare providers have established indigent care programs that provide subsidies or discounts to low-income patients and write off an increasing amount of bills.[8]

For example, a hospital may charge $1,500 for an MRI, but accept $500 as full payment for that MRI. The plaintiff may have paid a $25 co-pay and the insurer paid the remaining $475. Yet, in litigation, in states that allow recovery of phantom damages, a defendant must pay the full $1,500 to the plaintiff – $1,000 more than anyone ever paid – simply because that amount was printed on the original bill. As explained in this white paper, in Florida, a jury may learn of the full $1,500 charge, but not the actual rate paid. Although Florida courts may reduce jury verdicts by amounts never paid, consideration of such inflated charges may mislead juries into awarding excessive amounts for unpaid bills, future damages for anticipated medical expenses, and pain and suffering.

Defendants and their insurers evaluate medical expenses based on usual and customary rates. Here is an actual example from a July 2010 settlement comparing invoices for treatment for wrist, knee, neck and lower back injuries with amounts that half, three-quarters, and 90% of healthcare providers would accept as full payment for such services.

		Total % Overages by Percentile		
Provider	**Invoice**	**50th%**	**75th%**	**90th%**
Med. Ctr.	*$2,266*	*$1,169*	*$1,458*	*$1,791*
Imaging Ctr.	*$4,200*	*$4,765*	*$5,878*	*$6,900*
MD	*$296*	*$72*	*$100*	*$153*
Neuro Services	*$2,400*	*$591*	*$871*	*$1,224*
Orthopedics	*$58,888*	*$15,284*	*$18,353*	*$21,674*
Healthcorp.	*$1,605*	*$1,605*	*$1,605*	*$1,605*
MD	*$39*	*$27*	*$36*	*$43*
Hospital	*$29,466*	*$23,933*	*$24,923*	*$26,672*
IM Residency	*$164*	*$136*	*$162*	*$202*
Clinic	*$1,850*	*$1,760*	*$2,022*	*$2,392*
TOTAL	*$101,174*	*$49,342*	*$55,408*	*$62,656*

It is enormously wasteful to over-compensate plaintiffs for their medical bills. These costs are invariably passed on to consumers.

A Response to Phantom Damages Proponents

Personal injury lawyers who support permitting their clients to recovery phantom damages, and the courts that have agreed with them, typically make two arguments – one in public and one in private.

Publicly, they argue that the lower rates for medical services negotiated between insurers and healthcare providers is a benefit that an individual earned through purchasing insurance and paying premiums. Therefore, proponents of phantom damages reason that, under the collateral source rule, a plaintiff is entitled to collect the discounted amount. The California Supreme Court has persuasively rebutted this incorrect view. As the court explained:

> Plaintiff … receives the benefits of the health insurance for which she paid premiums: her medical expenses have been paid per the policy, and those payments are not deducted from tort recovery.
>
> Plaintiff's insurance premiums contractually guaranteed payment of her medical expenses at rates negotiated by the insurer with the providers; they did not guarantee payment of much higher rates the insurer never agreed to pay. Indeed, had her insurer not negotiated discounts from medical providers, plaintiff's premiums presumably would have been higher, not lower. In that sense, plaintiff clearly did not pay premiums for the negotiated rate differential. Recovery of the amount the medical provider agreed to accept from the insurer in full payment of her care, but not more, thus ensures plaintiff receives the benefits of her thrift and the tortfeasor does not garner the benefits of his victim's providence.[9]

"Plaintiff … receives the benefits of the health insurance for which she paid premiums: her medical expenses have been paid per the policy, and those payments are not deducted from tort recovery."

-California Supreme Court

Privately, personal injury lawyers suggest that phantom damages are needed to pad their client's recovery so that after the attorneys take their one-third share plus their expenses from the award, their clients still have sufficient recovery to cover past and anticipated future expenses. Inflating a plaintiff's damages to provide more money to pay attorneys' fees, however, is contrary to principles of American law in which each side is generally responsible for his or her own legal expenses absent a statute to the contrary.

Phantom Damages in Florida

To its credit, Florida is among the growing number of states that limit the ability of plaintiffs to recover damages for amounts of medical bills reflecting list prices that no one paid or is legally obligated to pay. Of the states that limit phantom damages, however, Florida does so in an awkward and inconsistent manner that misleads the jury and results in excessive damage awards in some cases.

Applicable Florida Law

In enacting the Tort Reform and Insurance Act, the Florida Legislature sought to reduce escalating damage awards, curb increasing insurance costs, and end a crisis in the liability insurance industry. Among these reforms was Fla. Stat. § 786.76, which abrogated the "collateral source rule." The collateral source rule is a court-made doctrine that had permitted plaintiffs to recover damages, such as medical expenses, irrespective of whether the plaintiff had already received compensation for those expenses through insurance or other sources. This rule allowed double recovery on the basis that a defendant should not be relieved of wrongdoing based on the plaintiff's foresight in purchasing insurance. The Florida Legislature found that such recovery, which did not serve a truly compensatory purpose, contributed to spiraling liability insurance costs. For that reason, it enacted Section 786.76, which requires Florida courts to "set-off" (deduct) collateral sources from jury awards unless a right of subrogation or reimbursement exists.

In *Goble v. Frohman*, the Florida Supreme Court found that contractual discounts off medical bills are collateral sources subject to set off under Section 786.76.[10] The court reasoned that a "payment" is "not limited to the actual remitting of cash but includes any act that discharges a debt or obligation." Thus, amounts discounted or written off pursuant to preexisting fee schedules negotiated between an insurer and a healthcare provider constituted "payments made" on the plaintiff's behalf. The Court recognized that "[t]he alternative, forcing an insurer to pay for damages that have not been incurred, would result in a windfall to the injured party. The allowance of a windfall would undermine the legislative purpose of controlling liability insurance rates because insurers will be sure to pass the cost for these phantom damages on to Floridians."

"[F]orcing an insurer to pay for damages that have not been incurred, would result in a windfall to the injured party. The allowance of a windfall would undermine the legislative purpose of controlling liability insurance rates because insurers will be sure to pass the cost for these phantom damages on to Floridians."

-Goble v. Frohman (Fla. 2005)

Three justices, in an opinion authored by Justice Bell, recognized an additional, commonsense reason to preclude recovery of phantom damages: they do not fulfill the purpose of compensatory damages – to make the plaintiff whole. As Justice Bell recognized, "The reason is simple: Goble has not paid, nor is he obligated to pay, the prediscount amount of his medical bills."[11] Common law principles of compensatory damages, therefore, allow him to only recover the portion that he actually was obligated to pay. The concurring justices recognized the practical reality of the healthcare environment in which "[m]anaged-care plans routinely negotiate discounted fees with medical providers. In these cases, it makes little sense to allow a plaintiff to recover damages based on the providers' billed amounts when those billed amounts tell us nothing about the actual costs incurred by the plaintiff."[12]

Goble v. Frohman	
Injury:	Motorcycle Accident
Payment:	HMO
Billed Medical Expenses:	$574,554.31
HMO Paid:	$145,970.76
Co-Payment:	$15,000.00
Phantom Damages:	$413,883.55
Amount Introduced at Trial:	$574,554.31
Jury Award for Medical Expenses:	$574,554.31
Judgment (after set off):	$160,670.76
Result of Appeal:	Affirmed

The end result of the *Goble* case dramatically illustrates the profound effect of phantom damages on the tort system. Mr. Goble sought recovery for nearly $600,000 in medical bills. His HMO paid, and his providers accepted, less than $150,000 as full payment. The Florida Supreme Court ruled that the First District Court of Appeal correctly instructed the trial court to deduct $413,883.55 in phantom damages from the jury verdict for the full amount of the billed medical expenses since neither Mr. Goble, nor his insurer, had paid this amount.

Admissibility of Phantom Damages Depends on Method of Payment

While the Florida Supreme Court in *Goble* remanded with instructions that the trial court amend the judgment to set off phantom damages, the Court did not specifically consider whether billed amounts that were never paid should be admissible in the first place. The concurring opinion suggests that at least three members of the court believed phantom damages are "irrelevant," since they do not reflect an amount that the plaintiff was legally obligated to pay, and therefore are inadmissible.[13]

Several of Florida's District Courts of Appeal have considered this issue. Their rulings on the admissibility of phantom damages vary based on whether the plaintiff paid medical expenses through private insurance, Medicare or Medicaid, or was uninsured. The law remains unclear and Florida judges may reach inconsistent decisions. The general approach followed by appellate courts that have ruled on the issue is discussed below.

Private Insurance. When a plaintiff's private insurance paid all or a part of his or her medical expenses, Florida courts generally permit the plaintiff to "board" the gross amount of the medical bills at trial, even when the amounts do not reflect the true amount of the plaintiff's expenses.[14] The jury is misled into believing that these list prices are the amounts actually paid by the plaintiff. In 2010, the First District Court of Appeal ruled that, in cases involving private insurance, the jury is to learn only of the "gross amount" of the plaintiff's medical bills and is not to be told of the lower negotiated rates that were paid.[15] After the jury enters a verdict for damages based on the list prices, the judge then reduces ("sets off") the damage award by the amount of the medical expenses that the plaintiff, or his or her insurer, did not actually pay.[16]

Medicare or Medicaid. Florida courts have taken a different approach when a plaintiff's medical expenses are paid by Medicare or Medicaid, rather than through private insurance. In such instances, the Second, Third, and Fourth District Courts of Appeals have each ruled that the jury should learn only of the amounts actually paid for medical expenses, not the fictitious list prices that no one actually paid.[17] In Medicare cases, courts grant pre-trial motions by defense lawyers to preclude introduction of evidence of the gross amounts of medical bills at trial. A trial court errs in allowing a plaintiff "to admit into evidence bills for medical expenses for which she never incurred liability and in allowing her to recover an amount in excess of benefits paid by Medicare as an element of compensatory damages."[18]

Cooperative Leasing v. Johnson

Injury:	Car Accident
Payment:	Medicare/PIP
Billed Medical Expenses:	$56,950.70
PIP Coverage Paid:	$15,000,00
Medicare Paid:	$13,461.00
Phantom Damages:	$28,489.00
Amount Introduced at Trial:	$56,950.70
Jury Award for Medical Expenses:	$56,950.70
Judgment:	$56,950.70

Result of Appeal: *Reversed* - trial court should not have permitted introduction of the full amount of medical bills. Required trial court to recalculate damages to subtract amounts never paid.

Uninsured. The Fourth District Court of Appeal addressed the admissibility of phantom damages in a car accident case involving a plaintiff who lacked health insurance.[19] In *Durse v. Henn*, the healthcare provider that treated the plaintiff accepted an amount in full satisfaction of his account that was less than that which it initially billed him. The trial court followed the path of the Medicare/Medicaid cases, finding that evidence of amounts billed, but not paid, were inadmissible at trial. The Fourth DCA reversed. Although the plaintiff had not paid insurance premiums, it presumed that the plaintiff had negotiated the lower amount and therefore had "earned in some way" a discount from the healthcare provider. Therefore, the court found that when a hospital reduces its list rates for an uninsured patient, the patient is entitled to present the full billed amount to the jury subject to a post-verdict set off of amounts never paid.

Florida courts based the distinction between private insurance and Medicare/Medicaid on the interaction between Fla. Stat. § 768.76 and their interpretation of the "collateral source rule." The collateral source rule, where applicable, allows plaintiffs to collect in litigation amounts already paid by others, such as insurers, when such payments resulted from their own efforts. The Florida courts have ruled that the jury may learn of the full sticker price when the case involves a private insurer because the plaintiff (or his or her employer) purchased that insurance and therefore earned the benefits (including discounts it negotiated with healthcare providers). Some Florida courts have interpreted Section 768.76 to abrogate the collateral source rule as a matter of *substance*, but not as a matter of *evidentiary* law. In plain English, these courts have said that when a plaintiff paid medical bills with private insurance, he or she is entitled to tell the jury of the full amounts, even if not permitted to collect the full amounts under the statute. With respect to Medicare, however, Florida courts bar admission of evidence of the gross amount of medical expenses entirely because, unlike private insurance, the plaintiff did not earn or pay for the benefits.

Circumventing the Rule Against Phantom Damages Through "Letters of Protection"

Typically, it takes several years for a personal injury lawsuit to go to trial. By that time, in most cases, the plaintiff or his or her insurer has paid all of the medical bills related to the injury. In relatively few cases does a plaintiff have outstanding medical bills if and when the case is submitted for a jury's consideration. In such situations, since there is no amount actually paid by which to judge the true value of care, plaintiffs' lawyers can seek recovery based on the gross amount of the medical bills. Some personal injury lawyers in Florida have taken advantage of this loophole by abusing Letters of Protection ("LOP") to delay payment of medical bills during litigation.

LOPs are agreements negotiated between personal injury lawyers and healthcare providers. Through LOPs, medical facilities and physicians agree to suspend efforts to collect medical bills from the plaintiff while litigation is pending. In exchange, healthcare providers receive a right to payment of their bills from any recovery. The contract typically provides that the patient remains fully responsible for paying the medical bills if the litigation is unsuccessful. LOPs serve a legitimate function. Traditionally, LOPs provided a means for those who are uninsured or exhausted Personal Injury Protection (PIP) benefits or insurance coverage, and did not have Medicare, to promptly receive and continue medical care during litigation regardless of financial resources.

In Florida, however, some personal injury lawyers have used LOPs to circumvent restrictions on phantom damages. Since the LOP agreement defers payment of any bills until after the conclusion of the litigation, the lower amounts that a healthcare provider would have accepted as full payment are not available at trial. If the plaintiff recovers, then the medical provider receives payment at the excessive billed rate (and the personal injury lawyer receives his or her typical one-third share). If the litigation does not lead to a successful result for the plaintiff, then the medical provider discounts or writes off the patient's bills. The phantom damages are hidden from the court.

This practice is no secret. Personal injury lawyers in Florida openly tout their use of LOPs to recover non-discounted rates. For example, a Tampa personal injury law firm explains on its website that medical providers often agree to delay their collection efforts during litigation through an LOP because, if the litigation is successful, they can collect greater amounts than they typically receive from insurers. The firm also notes that if the lawsuit is not successful, the healthcare provider "often writes off the bill" because the injured person "probably cannot afford to pay" the list price for the medical care.[20]

Use of LOPs are no longer limited to those who lack insurance or exceed their policy limits. Lawyers also refer clients who have insurance to clinics under LOPs so as to avoid damage awards at the lower rates negotiated between insurers and healthcare providers. Thus, some accident victims in Florida, under the direction of their attorneys, turn down submitting claims to their own insurance companies or seeing in-network doctors who accept insurance in favor of the potential for a larger verdict or settlement. Since the plaintiff does not expect to pay the bill, he or she may be unconcerned about excessive charges accumulating under an LOP.

Other States Require Accuracy in Damages

The list below provides a general assessment of where states fall today with respect to requiring accuracy in damages.

Allows Phantom Damages	Limits or Prohibits Phantom Damages	Law is Uncertain
Arizona	Alabama	Alaska
Colorado	California	Arkansas[21]
Delaware	Connecticut	Michigan
District of Columbia	Florida	Montana
Georgia	Idaho	Nevada
Hawaii	Indiana	New Jersey
Illinois	Maryland	New Mexico
Iowa	Massachusetts	North Dakota
Kansas[22]	Minnesota[23]	Rhode Island
Kentucky	Missouri	Tennessee
Louisiana	New Hampshire	Utah
Maine	New York	Vermont
Mississippi	North Carolina	Wyoming
Nebraska	Ohio	
Oregon	Oklahoma	
South Carolina	Pennsylvania	
South Dakota	Texas	
Virginia		
Washington		
West Virginia		
Wisconsin		

It is important to note that this area of the law is continually developing. In addition, some states may draw distinctions between private insurance, for which a plaintiff independently paid, Medicare, which is supported by taxes on employers and employees, and Medicaid, which is funded by taxpayers in general. Some states have fully eliminated the collateral source rule in medical malpractice cases, but not other personal injury actions.

While in many states, introduction and recovery of billed medical expenses is an issue decided by the courts, several states have required accuracy in damages by explicitly eliminating phantom damages from litigation awards through legislation. Oklahoma[24] and North Carolina[25] enacted legislation in 2011 providing that amounts paid for medical expenses, not amounts billed for expenses incurred, are admissible at trial. They follow the Texas legislature, which in 2003, enacted a provision stating that "recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant."[26] The Texas Supreme Court resolved a split among its appellate courts in 2011 by interpreting this statute to find that evidence of billed amounts of medical expenses that cannot actually be recovered by the plaintiff are irrelevant and therefore admissible evidence is limited to amounts actually paid or are payable by or on behalf of the plaintiff after any contractually or statutorily required reductions, write-offs or write-downs.[27]

Also that year, the California Supreme Court, which is not generally viewed as particularly favorable to defendants in civil cases, ruled 6-1 in a closely-watched case that a plaintiff may not recover undiscounted sums stated in a healthcare provider's bill but never paid "for the simple reason that the injured plaintiff did not suffer any economic loss in that amount."[28] The court held that "a personal injury plaintiff may recover *the lesser* of (a) the amount actually paid or incurred for medical services, and (b) the reasonable value of the services."[29] The court concluded that where a healthcare provider has accepted less than a billed amount as full payment, evidence of the full billed amount is not relevant and is inadmissible to determine past medical expenses.[30] The stakes on this issue were high in California, as they are in other states. California insurers estimated that requiring compensation based on the amount billed, rather than the amount paid based on negotiated rates and discounts, could cost them *$3 billion annually*.[31]

A Potential Solution: Accuracy in Damages

Inconsistency in Florida's treatment of phantom damages based on the source of payment is wholly unnecessary, creates confusion in the courts, and is contrary to sound public policy. Both approaches (inadmissibility of billed amounts vs. post-verdict set-off) ultimately eliminate recovery of phantom damages, but consistently excluding from evidence amounts of medical bills that exist only on paper is clearly a more straightforward method. The "set off" approach used in some cases by Florida courts blindfolds the jury to the plaintiff's actual losses in favor of an amount that no one paid or ever will pay. Irrespective of whether Medicare, Medicaid, or private insurance settled the plaintiff's bill, or the healthcare provider gave a discount to an uninsured patient, the plaintiff owes no more than the amount actually paid in settlement of the bills.

While the "set off" approach ultimately eliminates the phantom damages, this practice is likely to lead a jury to inappropriately inflate other aspects of damages. For instance, if a plaintiff is expected to incur future medical expenses, then the jury may base such damages on its inflated award for the past medical expenses. In addition, juries often consider the amount of the plaintiff's medical expenses when making the difficult, inherently subjective determination of an appropriate amount to award for his or her pain and suffering. Some jurors use a multiple of the medical expenses to compute a pain and suffering award.[32]

Many states avoid these problems by simply providing that evidence of billed medical expenses is inadmissible when it does not reflect the amount that the plaintiff actually paid, the amount that was paid on the plaintiff's behalf, or that the plaintiff is legally obligated to pay. As noted earlier, the Oklahoma and North Carolina legislatures, as well as the California and Texas Supreme Courts, all have adopted this sound approach within the last four years.

In sum, the Florida Legislature can address the issue of inflated awards by enacting accuracy-in-damages legislation that allows juries to consider the following elements in determining past unpaid medical expenses:

- Amounts the provider routinely accepts as payment from governmental or commercial insurance payors for identical or substantially similar medical or health care services;
- Amounts billed by the provider for the services provided by the claimant, including those amounts billed under an agreement between the provider and the claimant or the claimant's representative;

- Amounts the provider received in compensation, if any, for the sale of the agreement between the provider and the claimant or the claimant's representative under which the medical or health care services were provided to the claimant.

For past paid medical expenses, the jury should simply consider the actual amount paid to the provider by the plaintiff or his or her insurer.

H.B. 1199, introduced by Representative Metz, and S.B. 1240, introduced by Senator Richter, accomplish these goals. These bills provide a new section of law that reads:

> 768.755 Damages recoverable for cost of medical or health care services; evidence of amount of damages; applicability.—
>
> (1)(a) In a personal injury or wrongful death action to which this part applies, damages for the cost of medical or health care services provided to a claimant shall be calculated as follows:
>
> For such medical or health care services provided by a particular health care provider to the claimant which are paid for by the claimant and for which an outstanding balance is not due the provider, the actual amount remitted to the provider is the maximum amount recoverable.
>
> 2. For such medical or health care services provided by a particular health care provider to the claimant which are paid for by a governmental or commercial insurance payor and for which an outstanding balance is not due the provider, other than a copay or deductible owed by the claimant, the actual amount remitted to the provider by the governmental or commercial insurance payor and a copay or deductible owed by the claimant is the maximum amount recoverable.
>
> 3. For such medical or health care services provided to the claimant for which an outstanding balance is claimed to be due the provider, the parties may introduce into evidence:
>
> a. Amounts the provider routinely accepts as payment from governmental or commercial insurance payors for identical or substantially similar medical or health care services.
>
> b. Amounts billed by the provider for the services provided to the claimant, including those amounts billed under an agreement between the provider and the claimant or the claimant's representative.
>
> c. Amounts the provider received in compensation, if any, for the sale of the agreement between the provider and the claimant or the claimant's representative under which the medical or health care services were provided to the claimant.
>
> (b) In an action in which there is more than one health care provider who has provided medical or health care services to the claimant, the evidence admissible under this subsection as to a provider with no outstanding balance due may not

be used as evidence regarding the reasonableness of the amounts billed by any of the other health care providers who have an outstanding balance due.

(c) Any difference between the amount originally billed by a health care provider who has provided medical or health care services to the claimant and the actual amount remitted to the provider is not recoverable or admissible into evidence.

(2) Individual contracts between providers and licensed commercial insurers or licensed health maintenance organizations are not subject to discovery or disclosure in an action under this part, and such information is not admissible into evidence in an action to which this section applies.

(3) Notwithstanding any provision of this section, if Medicaid, Medicare, or a payor regulated under the Florida Insurance Code has covered or is covering the cost of a claimant's medical or health care services and has given notice of assertion of a lien or subrogation claim for past medical expenses in the action, the amount of the lien or subrogation claim, in addition to the amount of any copayments or deductibles paid or payable by the claimant, is the maximum amount recoverable and admissible into evidence with respect to the covered services.

(4) This section applies only to those actions for personal injury or wrongful death to which this part applies arising on or after the effective date of this act and has no other application or effect regarding compensation paid to providers of medical or health care services.

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Endnotes

[1] *See, e.g.,* Katy McLaughlin , *The Discount Grocery Cards That Don't Save You Money*, Wall St. J., Jan. 21, 2003, *at* http://online.wsj.com/news/articles/SB1043006872628231744 (finding that although supermarkets were increasing adopting discount card programs, stores that had such programs typically adjusted their pricing to result in the same or greater revenue).

[2] Glenn A. Melnick & Katya Fonkych, *Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices?*, 27 Health Affairs 116, 116 (2008) (citing Medicare Payment Advisory Comn'n, A Data Book: Healthcare Spending and the Medicare Program (Wash.: MedPAC, June 2006). The study found that the charge-to-cost ratio at California hospitals increased from 3.1 to 3.8 between 2001 and 2005, indicating that hospitals routinely charge, on average, four times what they actually collect. *See id.* at 118-19.

[3] *See* Press Release, *National Nurses United and Institute for Health and Socio-Economic Policy, New Data – Some Hospitals Set Charges at 10 Times their Costs*, Jan. 6, 2014, *at* http://www.nationalnursesunited.org/press/entry/new-data-some-hospitals-set-charges-at-10-times-their-costs/ and chart of average cost-to-charge ratio by state *at* http://nurses.3cdn.net/966a1174efbe3f9ad1_39m6bntzv.pdf (last visited Mar. 12, 2015).

[4] *See id*., chart of top 100 most expensive hospitals by state *at* http://nurses.3cdn.net/e2086b18382cb8e96d_0dm6b5ad3.pdf.

[5] *See id.*

[6] The list price for a treatment often varies tremendously among healthcare providers. As a *Washington Post* investigation found, "even on the same street, hospitals can vary by upwards of 300 percent in price for the same service." *See* Wilson Andrews et al., *Disparity in Medical Billing*, Wash. Post, May 8, 2013, *at* http://www.washingtonpost.com/wp-srv/special/national/actual-cost-of-medical-care/; *see also* Sarah Kliff & Dan Keating, *One Hospital Charges $8,000 — Another, $38,000*, Wash. Post, May 8, 2013, *at* http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/08/one-hospital-charges-8000-another-38000/.

[7] *See* Department of Health & Human Services, Centers for Medicare & Medicaid Services, *Fee Schedule - General Information*, *at* https://www.cms.gov/feeschedulegeninfo/.

[8] Researchers have found that, in 2001, patients at California hospitals with private insurance paid 41% of charges, patients with Medicare and Medicaid paid 35% and 30% of billed rates, respectively, and uninsured patients paid 39% of billed charges. Melnick & Fonkych, *supra*, at 118. The study found that, over time, the ratios declined for all payers in part due to the rapid increase in billed charges. *See id.* In 2005, uninsured patients as a group continued to pay less than those with private insurance, but a higher percentage of charges, on average, than patients with Medicare or Medicaid coverage. *See id.* at 119.

[9] *Howell v. Hamilton Meats & Provisions, Inc.,* 257 P.3d 1130, 1144 (Cal. 2011) (internal quotations omitted).

[10] *Goble v. Frohman*, 901 So. 2d 830 (Fla. 2005).

[11] *Id*. at 833-34 (Bell, J., specially concurring, joined by Wells and Cantero, JJ).

[12] *Id*. at 835.

[13] *See id*. at 834 (quoting *Thyssenkrupp Elevator Corp. v. Lasky*, 868 So. 2d 547, 551 (Fla. 4th DCA 2003) and also citing *Cooperative Leasing, Inc. v. Johnson*, 872 So. 2d 956 (Fla. 2d DCA 2004) discussed *infra*).

[14] *See id.* at 833.

[15] *See Nationwide v. Harrell*, 53 So. 3d 1084 (Fla. 1st DCA 2010), *rev. denied*, 2011 WL 2906154 (Fla. July 20, 2011).

[16] *See, e.g., Goble*, 901 So. 2d at 833 (in which the court reduced gross medical expenses of $574,554.31 by over $400,000 in phantom damages to $145,970.76, the amount paid by the plaintiff's HMO pursuant to a pre-existing fee schedule between the HMO and provider).

[17] *See, e.g., Boyd v. Nationwide Mut. Fire Ins. Co*., 890 So. 2d 1240 (Fla. 4th DCA 2005); *Miami-Dade County v. Laureiro*, 894 So. 2d 268 (Fla. 3d DCA 2005); *Cooperative Leasing, Inc. v. Johnson*, 872 So. 2d 956 (Fla. 2d DCA 2004); *Thyssenkrupp Elevator Corp. v. Lasky*, 868 So. 2d 547 (Fla. 4th DCA 2003), *rev. dismissed*, 873 So.2d 1225 (Fla. 2004).

[18] *Cooperative Leasing*, 872 So. 2d at 957.

[19] *Durse v. Henn*, 68 So.3d 271 (Fla. 4th DCA 2011).

[20] Scott Distasio, *Using a Letter of Protection in Personal Injury Claim*, Nov. 18, 2010, *at* http://www.distasiolawfirm.com/Tampa_Personal_Injury_Blog/2010/November/Using_a_Letter_of_Protection_in_Personal_Injury_.aspx (last visited Mar. 12, 2015).

[21] The Arkansas Supreme Court found that a state statute explicitly eliminating recovery for phantom damages was unconstitutional as a rule of evidence that violated separation of powers under the Arkansas Constitution. *Johnson v. Rockwell Automation, Inc.*, 308 S.W.3d 135 (Ark. 2009).

[22] Kansas courts have found that write offs are not a collateral source and are therefore admissible in Medicaid cases, but have excluded evidence of the amount actually paid in cases involving private insurance or Medicare.

[23] The Minnesota Supreme Court, like the Florida Supreme Court in *Goble*, has held that the state's abrogation of the collateral source rule, Minn. Stat. § 548.251, requires the trial court to a set off (deduct) from a jury award reflecting the full billed medical expenses not only the amount of medical expenses paid to the plaintiff by an insurer, but also by the amount discounted pursuant to rates negotiated between the healthcare provider and insurer. *See Swanson v. Brewster*, 784 N.W.2d 264 (Minn. 2010). The Oregon Supreme Court took the opposite approach, limiting the set off to the amount actually received by the plaintiff and permitting the plaintiff to retain amounts billed but discounted or written off. *See White v. Jubitz Corp*., 219 P.3d 566 (Or. 2009).

[24] H.B. 2023 (Okla. 2011) (codified at 12 Okla. Stat. § 3009.1). If no payment has been made at the time of trial, then the new Oklahoma law limits admissible damages to Medicare reimbursement rates, if the provider will accept *payment* at that rate, or where the provider has filed a lien in the case in an amount in excess of the Medicare rate, the amount of the lien.

[25] H.B. 542 (N.C. 2011) (codified at N.C. Gen. Stat. ch. 8C, Rule 414).

[26] Tex. Civ. Prac. & Rem. Code § 41.0105.

[27] *Haygood v. De Escabedo,* 356 S.W.3d 390 (Tex. 2011).

[28] *Howell v. Hamilton Meats & Provisions, Inc*., 257 P.3d 1130 (Cal. 2011). Ms. Howell's medical bills approached $200,000, but her insurer settled with the health care providers for $60,000. Although the trial court permitted introduction of evidence of the billed amounts at trial, after trial, the court reduced the medical part of her judgment to the amount paid. An intermediate appellate court had reversed and restored the phantom damages. 179 Cal.App.4th 686 (2009).

[29] *Howell,* 257 P.3d. at 1138 (emphasis added).

[30] *Id*. at 1146.

[31] Dan Walters, *California Supreme Court Plays Role in Tort War*, Sacramento Bee, Aug. 15, 2011, *at* http://www.modbee.com/2011/08/15/1816272/dan-walters-california-supreme.html.

[32] *See* Neil Vidmar, *Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases*, 43 Duke L.J. 217, 253-54 (1993) ("Some roughly split the difference between the defendant's and the plaintiff's suggested figures. One juror doubled what the defendant said was fair, and *another said it should be three times medical[s]*. . . . A number of jurors assessed pain and suffering on a per month basis. . . . Other jurors indicated that they just came up with a figure that they thought was fair.") (emphasis added).