Succeeding Under Florida Tort Reform Part 3
Understanding the Distinctions Between Subsections (2)(a) and (2)(b)

This is the third article in a series that lights the way to success under Florida Tort Reform's Section 768.0427. This article will provide a deeper analysis of the distinctions between Subsections (2)(a) and (2)(b) and lay the foundation for the deeper dives into the four parts of Subsection (2)(b) that will be presented in later articles.

Section 2 of the Statute governs admissible evidence to prove the amount of damages for medical services. Subsection (2)(a) applies to bills for past medical services that have already been satisfied and Subsection (2)(b) applies to such bills that have not been satisfied.

Subsection (2)(a) states:

> (a) Evidence offered to prove the amount of damages for past medical treatment or services that have been **satisfied** is **limited to evidence of the amount actually paid**, regardless of the **source** of payment.

First, because Subsection (2)(a) deals with admissibility rather than pre-trial discovery, the relevant time to consider the satisfaction of bills is the date of trial. Thus, Subsection (2)(a) applies only to bills satisfied before trial. Second, the only evidence a plaintiff can present to a jury is the amount that was paid to satisfy the bill. Thus, a plaintiff cannot present a medical provider's charged amount. Third, Subsection (2)(a) applies to all pre-trial payment sources: (a) commercial health insurance (including out-of-network payments which can be 100% of the charged amount), (b) government programs, and (c) self-pay patients.

Importantly, Section 4 of the Statute states that a jury **award** cannot exceed the amount that a jury may **consider** under Section 2. Thus, the jury cannot award more than the amount that was paid to satisfy a bill before trial.

Subsection (2)(a) can**not** apply to (a) commercial health insurance payments that were not yet made at the time of trial, such as when a health insurer denies payment and the denial is under appeal at the time of trial; (b) reimbursements from a patient or the patient's law firm that occur after trial; nor (c) assignments of medical bills to purchasers of accounts receivable.

Subsection (2)(b), on the other hand, applies to evidence relating to unsatisfied medical bills:

> (b) Evidence offered to prove the amount necessary to satisfy **unpaid** charges for incurred medical treatment or services shall include, **but is not limited to**, evidence as provided in this paragraph.

First, Subsection (2)(b) applies whenever a medical provider (a) does not take health insurance at all, (b) opts out of Medicare, (c) takes health insurance, but (i) permits patients to waive use of health insurance so the patients can avoid co-payments, (ii) uses modalities that health insurance will not reimburse, or (iii) fails to properly submit bills, or (d) sells the account receivable to a third party. Second, Subsection (2)(b) expressly states that the evidence that can be presented regarding unsatisfied charges is "**not** limited to" the evidence expressly rendered admissible in the four parts contained within Subsection (2)(b). This is critical because Subsection (2)(b)(5) is a "catchall" that renders admissible "any evidence of reasonable amounts billed." For reasons that cannot be addressed in this short article, Subsection (2)(b)(5) will include charged amounts. Thus, unlike Subsection (2)(a), Subsection (2)(b) does allow a plaintiff to present a provider's charged amount.

Importantly, Section 4 of the Statute allows a jury to award an amount that the jury was permitted to consider under Section 2. Because Subsection (2)(b) allows a jury to **consider** charged amounts, a jury may **award** the full charged amount. The subject of upcoming articles is how to convince a jury to award an amount approaching the full charge.