

**IN THE CIRCUIT COURT OF THE TWELFTH JUDICIAL CIRCUIT  
IN AND FOR MANATEE COUNTY, FLORIDA  
CIVIL DIVISION D**

**MICHAEL MEABON,  
Plaintiff,**

vs.

**CASE NO.: 2024-CA- 1376**

**DOLORES MOUSSEAU, as Durable Power of  
Attorney for SANDRA R. MOUSSEAU and  
ALLSTATE INSURANCE COMPANY,  
Defendants.**

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**ORDER GRANTING DEFENDANT'S MOTION IN LIMINE**

**THIS CAUSE** having come before the Court pursuant to the Defendant's Motion in Limine, more specifically entitled Defendant Dolores Mousseau's Motion in Limine Pursuant to Fla. Stat. 768.0427, said motion having filed on July 15, 2025, and the Court having reviewed and considered said motion, having reviewed and considered the Plaintiff's Response in Opposition, said response having been filed on August 1, 2025, having considered the argument of counsel, the case law provided, and being otherwise fully advised in the premises, the Court finds as follows:

This case was filed after March 24, 2023, and therefore Fla. Stat. 768.0427(2) applicable and, in this Court's estimation, required. It appears from the Plaintiff's Answers to Interrogatories that Mr. Meabon was a Medicaid recipient at the time of the accident. It also appears that subsequent to the accident, Mr. Meabon obtained health insurance coverage through Blue Cross/Blue Shield. Inexplicably, he did not submit any of his bills for his care and treatment to either Medicaid or his health insurance carrier.

As an initial matter, this Court finds that the plain language of this statute is unambiguous, straightforward and mandatory. The Court points specifically to the use of the word "shall" in section (2)(b) and 2(c), which, in this Court's estimation,

places the burden of production of evidence as to the prescribed applicable Medicare and Medicaid rates and health insurance provider rates on the Plaintiff, who is seeking the uncovered medical expenses and future medical expenses as damages.

Based upon the foregoing, Fla. Stat. section 768.0427(2)(b)(3) requires that admissible evidence of Mr. Meabon's medical bills at trial must include evidence of 120 percent of the Medicare reimbursement rate in effect on the date of his treatment, or, if there is no Medicare rate for such service, 170 percent of the applicable state Medicaid rate. The reference to the phrase "but not limited to", of course, clearly indicates that the Plaintiff may additionally offer any evidence of the reasonable amounts billed to Mr. Meabon for medically necessary treatment and services beyond those indicated in section (2)(b)(3), subject to objection and admissibility. Similarly, section (2)(c), referring to future medical expenses, mandates that the Plaintiff introduce evidence of "120 percent of the Medicare reimbursement rate in effect at the time of trial... or, if there is no applicable Medicare rate for service, 170 percent of the applicable state Medicaid rate". As indicated, the Plaintiff is certainly free to introduce additional evidence of the reasonable amounts of any future care.

Additionally, because it appears that Mr. Meabon had health insurance coverage for at least some of the time that he was being treated for his injuries, Fla. Stat. 768.0427(2)(b)(1) requires the Plaintiff to introduce "evidence of the amount which such health care coverage is obligated to pay the health care provider to satisfy charges for the claimants incurred medical treatment or devices, plus the claimant's share of medical expenses under the insurance contract or regulation". Again, the Plaintiff may also offer into evidence any other evidence of the reasonable amounts charged by his health care providers.

Based upon the unique facts here (because at times Mr. Meabon was a Medicaid recipient and at other times had health insurance coverage), it appears that both sections (2)(b)(1) and (2)(b)(3) applies.

The Court recognizes that this order is inconsistent with the oral ruling made in open court immediately after the hearing. The fact is that the Court took an opportunity after the hearing to look more closely at section 768.0427, at the legislative history and at the many circuit court orders that have previously addressed this issue. The Court has concluded that, although there are factual question

components to this inquiry, the real question is statutory interpretation of this relatively new statute and its application to each specific case. The Court believes the ruling here is the appropriate analysis and application.

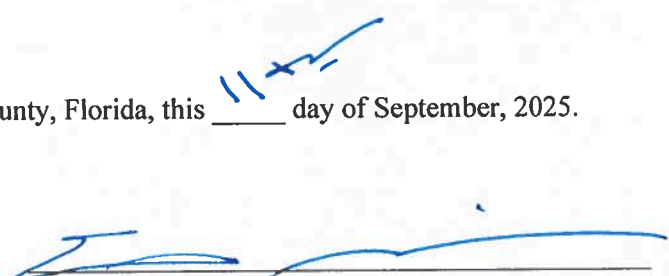
Finally, although a new trial date is not yet set, the Court would be inclined to agree with the Draft Jury Instructions for Discussion found on page 8 of Leon County Circuit Court Judge Stephanie Clark's February 13, 2025 Order entitled Order on Motions in Limine Regarding Medical Expenses (attached hereto). They appear to address the appropriate jury inquiry and effectuates the plain language of this statute.

Based upon the foregoing, therefore, it is hereby

**ORDERED AND ADJUDGED** that:

1. The Defendant's Motion in Limine Pursuant to Fla. Stat. 768.0427 is **GRANTED**.
2. Compliance with Fla. Stat. 768.0427(2)(b)(1) & (2)(b)(3) and 768.0427(2)(c)(1) & (2) is a condition precedent to the admissibility of the Plaintiff's medical expense evidence and the burden is on the Plaintiff to comply and produce such evidence prior to trial.

**DONE AND ORDERED** in Manatee County, Florida, this 11 day of September, 2025.

  
**EDWARD NICHOLAS**  
**CIRCUIT JUDGE**

**Copies furnished to:**

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**THE SECOND CIRCUIT COURT, LEON COUNTY, FLORIDA**

Shane Brewster, Plaintiff,

v.

Case: 2023CA002412

Mandy Petroski-Moore, and  
Mason Moore, Defendants./

**Order on Motions in Limine Regarding Medical Expenses**

This matter is before the court to address:

"Defendant's Motion in Limine and Memorandum of Law Regarding Applicability of Section 768.0427, Florida Statutes to Plaintiff's Past and Future Medical Expenses" filed January 27, 2025; and

"Plaintiff's Motion in Limine to Allow Evidence of Reasonable and Customary Medical Bills and, If Defendant Submits evidence of Medicare Rates, to Allow Plaintiff to Argue that He is Not a Medicare Recipient Nor Eligible to Be One" filed January 28, 2025.

The court conducted a hearing on the motions by remote technology on January 29, 2025 and is adequately advised.

**The Parties Concede that Section 768.0427(2023) Applies**

The Amended Complaint, filed October 30, 2023, alleges a collision of May 20, 2023 and seeks to recover personal injury damages including "expense of hospitalization, medical and nursing care and treatment. . . ." Section 768.0427 was enacted March 24, 2023 and became effective upon becoming law. 2023 Laws of Florida 14 § 30. So, Section 768.0427 applies to this action by its terms.

**The Issue: § 768.0427(2) and a Plaintiff without Health Insurance**

Both parties agree that the plaintiff had no insurance coverage for medical expenses except for \$10,000 of personal injury protection coverage that has been paid.

As an initial matter, the court's analysis is limited by the record, as will be seen. The question put by these motions is proof of medical expenses, but

no proof of any medical expenses is of record. Likewise, § 768.0427(2) addresses evidence of insurance rates (including Medicare and Medicaid) for medical expenses, but no proof of such rates is of record. To that extent, this ruling is made in the abstract. As a consequence, the effect of this order must be limited to the facts more or less agreed upon by the parties as the court understands them.

Neither party presently asserts that the court is constitutionally limited in applying § 768.0427(1), although this order briefly addresses potential separation of powers concerns.

Section 768.0427(2) provides (emphasis added):

**(2) ADMISSIBLE EVIDENCE OF MEDICAL TREATMENT OR SERVICE EXPENSES.—**Evidence offered to prove the amount of damages for past or future medical treatment or services in a personal injury or wrongful death action is admissible as provided in this subsection.

**(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.**

**(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.**

**1. If the claimant has health care coverage other than Medicare or Medicaid, evidence of the amount which such health care coverage is obligated to pay the health care provider to satisfy the charges for the claimant's incurred medical treatment or services, plus the claimant's share of medical expenses under the insurance contract or regulation.**

**2. If the claimant has health care coverage but obtains treatment under a letter of protection or otherwise does not submit charges for any health care provider's medical**

treatment or services to health care coverage, evidence of the amount the claimant's health care coverage would pay the health care provider to satisfy the past unpaid medical charges under the insurance contract or regulation, plus the claimant's share of medical expenses under the insurance contract or regulation, had the claimant obtained medical services or treatment pursuant to the health care coverage.

**3. If the claimant does not have health care coverage or has health care coverage through Medicare or Medicaid, evidence of 120 percent of the Medicare reimbursement rate in effect on the date of the claimant's incurred medical treatment or services, or, if there is no applicable Medicare rate for a service, 170 percent of the applicable state Medicaid rate.**

**4. If the claimant obtains medical treatment or services under a letter of protection and the health care provider subsequently transfers the right to receive payment under the letter of protection to a third party, evidence of the amount the third party paid or agreed to pay the health care provider in exchange for the right to receive payment pursuant to the letter of protection.**

**5. Any evidence of reasonable amounts billed to the claimant for medically necessary treatment or medically necessary services provided to the claimant.**

**(c) Evidence offered to prove the amount of damages for any future medical treatment or services the claimant will receive shall include, but is not limited to, evidence as provided in this paragraph.**

**1. If the claimant has health care coverage other than Medicare or Medicaid, or is eligible for any such health care coverage, evidence of the amount for which the future charges of health care providers could be satisfied**

if submitted to such health care coverage, plus the claimant's share of medical expenses under the insurance contract or regulation.

2. If the claimant does not have health care coverage or has health care coverage through Medicare or Medicaid, or is eligible for such health care coverage, evidence of 120 percent of the Medicare reimbursement rate in effect at the time of trial for the medical treatment or services the claimant will receive, or, if there is no applicable Medicare rate for a service, 170 percent of the applicable state Medicaid rate.

3. Any evidence of reasonable future amounts to be billed to the claimant for medically necessary treatment or medically necessary services.

(d) This subsection does not impose an affirmative duty upon any party to seek a reduction in billed charges to which the party is not contractually entitled.

(e) Individual contracts between providers and authorized commercial insurers or authorized health maintenance organizations are not subject to discovery or disclosure and are not admissible into evidence.

### **Discussion**

By this order the court solely resolves issues of statutory interpretation. Thus, the familiar canons of interpretation apply. No interpretation is necessary if the intent is clear from the language of the statute. The words of the statute are given their ordinary meaning. Interpreting a legal text begins, "and for good reason often end, with its words. . . . And we give the words of the [text] their plain, usual, ordinary, and commonly accepted meanings at the time they were written." City of Tallahassee v. PBA, Inc., 375 So.3d 178 (Fla. 2023). "To discern that ordinary meaning ... words must be read and interpreted in their context, not in isolation." Id.

[J]udges must exhaust all the textual and structural clues that bear on the meaning of a disputed text. That is because the plainness or

ambiguity of statutory language is determined by reference to the language itself, the specific context in which that language is used, and the broader context of the statute as a whole. . . . It would be a mistake to think that our law of statutory interpretation requires interpreters to make a threshold determination of whether a term has a "plain" or "clear" meaning in isolation, without considering the statutory context and without the aid of whatever canons might shed light on the interpretive issues in dispute.

Conage v. United States, 346 So.3d 594, 598 (Fla. 2022) (citations omitted). It is the intent of the language for which the court is responsible, much less so the intent of legislators or legislative staff.

Although the issue is not raised, it seems to me that the legislature was within its authority to adopt these provisions and the statute does not pose obvious separation of powers concerns. First, no statute is presumed to be unconstitutional and this subject matter seems appropriate for legislative policy-making. Medical expenses are subject to many uncertainties and the court needs little evidence to characterize the U.S. healthcare finance systems and processes as exceedingly complex. The legislature is possessed of many resources to consider such complexity as a policy matter that courts are not. These provisions permit jurors to consider a more specific record of relevant factors of which jurors are undoubtedly aware – some people have private health insurance, some people have public health insurance, some people have no health insurance. This statute attempts to give the jury information to reconcile competing concerns in the context of the plaintiff's specific circumstances. The purpose of this paragraph is to record the court's impression and is not intended to finally resolve the separation of powers issue should either party choose to raise it.

**§ 768.0427(2)(a) Means What it Says.**

As both parties seem to concede, application of (2)(a) is straightforward. It states:

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.

No evidence to prove the amount of damages for medical treatment or services satisfied by personal injury protection coverage shall be offered or admitted into evidence other than the amount actually paid by personal injury protection coverage. In other words, plaintiff will prove no uncovered damages for such expenses.

**§ 768.0427(2)(b)(3): "Evidence Offered" "Shall Include" is Mandatory.**

Section 768.0427(2)(b)(3) addresses the specific circumstance the parties represented exists for this plaintiff – a complete absence of health insurance. It states:

**(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. . . .**

**3. If the claimant does not have health care coverage or has health care coverage through Medicare or Medicaid, evidence of 120 percent of the Medicare reimbursement rate in effect on the date of the claimant's incurred medical treatment or services, or, if there is no applicable Medicare rate for a service, 170 percent of the applicable state Medicaid rate.**

Plaintiff argues that the "shall include" phrase in § 768.0427(2)(b) means that "admissible evidence" shall include the referenced Medicare and Medicaid rates. The defendants argue that the statute means that the evidence "shall include" such rates in order for the jury to award any damages for unpaid charges for medical treatment or services.

The defendants reading of the statute is the more literally accurate and consistent with the plain meaning.

The effect of the literal language is to place a burden of production of evidence of the prescribed multiple of Medicare or Medicaid rates on the plaintiff seeking uncovered medical expenses as damages. The court expects that the parties will undertake a good faith effort to stipulate to the applicable rates out of respect for the jurors' time and responsibilities.

The plaintiff argues that it is incongruous for the plaintiff to be required to admit evidence with which it disagrees. But the import of this statute is that Medicare and Medicaid establish at least a starting point for a reasonable consideration of medical expense damages. As will be discussed below, the statute contemplates that the evidence of the mandated multiple of Medicare and Medicaid rates may be inadequate in a given case, but it is for the plaintiff to demonstrate by other admissible evidence why such rates are the starting point but may not be the end point of the consideration – and again, this order is entered in the abstract with no information as to the applicable Medicare or Medicaid rates or what the plaintiff contends to be “the reasonable amounts billed to the claimant for medically necessary treatment or medically necessary services.”

Any incongruity seems easily reconciled with a jury instruction based on the language of the statute.

**§ 768.0427(2)(b)(5) “but is not limited to” Means What it Says.**  
§768.0427(2)(b)(5) states: “Evidence offered to prove the amount necessary to satisfy unpaid charges for incurred medical treatment or services shall include, but is not limited to . . . (5) Any evidence of reasonable amounts billed to the claimant for medically necessary treatment or medically necessary services provided to the claimant.”

This plain language permits evidence of unpaid charges different than the Medicaid and Medicare rates mandated by 768.0427(2)(b)(3). Limited by the foundational prerequisites – necessary and reasonable – evidence different than the public rates is admissible if the proposed evidence otherwise satisfies the requirements of the evidence code.

#### **The Court Suggests a Stipulation of the Applicable Medicaid and Medicare Rates and an Explanatory Jury Instruction**

At the risk of exposing the court’s bottomless well of ignorance associated with healthcare finance, the court suggests that in the context of a single plaintiff involved in a personal injury action, the parties should consider a stipulation of the Medicaid and Medicare Rates applicable to the claimant’s medical treatment or services. The parties would then be free to offer evidence of other treatment, services or rates, but the statute would be satisfied.

Once the universe of evidence of stipulated and contested rates are before the jury, it would be for the parties to argue and the jury to resolve what damages are proved, if any, guided by an appropriate jury instruction.

The court suggests the following instruction as a starting point:

### **Draft Jury Instructions for Discussion**

#### **501.15 Personal Injury and Property Damages: Introduction**

You should award Mr. Brewster an amount of money that the greater weight of the evidence shows will fairly and adequately compensate him for his loss, injury or damage, including any damage Mr. Brewster is reasonably certain to incur or experience in the future. You shall consider the following elements:

#### **Medical Expenses**

The reasonable [value] [or] [expense] of [hospitalization and] medical [and nursing] care and treatment necessarily or reasonably obtained by (claimant) in the past [or to be so obtained in the future].

#### **Evidence of Medicare or Medicaid Reimbursement Rates**

The parties stipulated and the court now instructs you that in determining the reasonable value or expense of such care and treatment you must consider the following rates derived from Medicare or Medicaid reimbursement rates for the following specified medical treatments or services incurred by Mr. Brewster:

#### **PARTIES TO SUPPLY APPLICABLE REIMBURSEMENT RATES**

#### **Other Evidence of Medical Expenses**

You are not required to award damages solely based on the Medicare or Medicaid Reimbursement Rates listed above.

You may base your determination of past medical expense damages on any evidence of reasonable amounts billed to the claimant for medically necessary treatment or medically necessary services provided to Mr. Brewster.

You may base your determination of future medical expense damages, if any, on any evidence of reasonable future amounts to be billed to Mr. Brewster for medically necessary treatment or medically necessary services.

It is up to you to determine damages based on all the evidence in the case.

In summary, the court intends to apply the plain language of this statute. The draft jury instruction language set out above is intended to effectuate that determination.

IT IS SO ORDERED in chambers at Tallahassee, Leon County, Florida on Thursday, February 13, 2025.

37-2023-CA-002412-02-13/2025 04:09:32 PM



Jonathan S. Johnson, Circuit Judge  
37-2023-CA-002412 02/13/2025 04:09:32 PM

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**Michael S. Meabon v. Dolores Mousseau as Durable Power of  
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Company**

**August 8, 2025**



**LIBERTY COURT REPORTING**

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IN THE CIRCUIT COURT OF THE TWELFTH JUDICIAL CIRCUIT  
IN AND FOR MANATEE COUNTY, FLORIDA  
CIVIL DIVISION

Case No. 2024-CA-1376

MICHAEL S. MEABON,

Plaintiff,

vs.

DOLORES MOUSSEAU as Durable Power of  
Attorney for SANDRA R. MOUSSEAU and  
ALLSTATE INSURANCE COMPANY,

Defendants.

\_\_\_\_\_X

DEFENDANT DOLORES MOUSSEAU'S MOTION IN  
LIMINE

BEFORE: HONORABLE EDWARD NICHOLAS

DATE TAKEN: August 8, 2025

TIME: 10:15 A.M. - 10:50 A.M.

PLACE: VIA ZOOM

PROCEEDINGS REPORTED BY:

SHEILA CARROLL, COURT REPORTER

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1 JUDGE NICHOLAS: We are here on the record.  
2 This is Case Number 2024-CA-1376. That is  
3 Michael Meabon Plaintiff versus Dolores Mousseau,  
4 Durable Power of Attorney for Sandra Mousseau, as  
5 well as Allstate Insurance Company. Again,  
6 that's 2024-CA-1376.

7 Thank you, Madam Court Reporter, for  
8 jumping on last minute. We appreciate that.  
9 We're going to start by identifying ourselves.  
10 We'll start with Plaintiff's counsel.

11 MS. BATTAGLIA: Alyson Battaglia for  
12 Michael Meabon.

13 JUDGE NICHOLAS: And who represents  
14 Defendant Miss Mousseau?

15 MR. WATSON: Good morning, Your Honor.  
16 Attorney Kory Watson for the Defendant Dolores  
17 Mousseau as Durable Power of Attorney for Sandra  
18 Mousseau.

19 JUDGE NICHOLAS: And then on behalf of  
20 Allstate?

21 MS. RIVERA: Natalia Rivera on behalf of  
22 Allstate.

23 JUDGE NICHOLAS: All right. Mr. Watson,  
24 it's your motion, you get to go first.

25 MR. WATSON: Thank you, Your Honor. This

1 case is a personal injury case. I don't think  
2 there's any dispute the date of loss is post-tort  
3 reform, it's October 13, 2023, date of loss. I  
4 don't think there's any dispute that Florida  
5 Statute 768.0427 applies to this case.

6 I think the questions for the Court today  
7 are the Court's interpretation of the statute.  
8 And this is about admissibility of -- it's about  
9 admissibility at trial and we're on Defendant's  
10 motion in limine to exclude medical bills, for  
11 unpaid bills. Exclude evidence of unpaid medical  
12 bills unless Plaintiff also introduces either the  
13 Medicare and Medicaid rates and/or the private  
14 health insurance rates that Plaintiff would have  
15 paid had those bills been submitted to  
16 Medicare/Medicaid or Blue Cross Blue Shield.

17 So there are a number of trial court  
18 orders that I've provided the Court in support of  
19 the Defense's interpretation of what the statute  
20 requires for unpaid medical bills for the  
21 Plaintiff to collect at trial.

22 Subsection 768.0427, Subsection 2, deals  
23 with the admissible evidence. And it's our  
24 position -- it's the Defense's position that the  
25 Plaintiff has to introduce all applicable

1 evidence under this subsection in order to  
2 recover in this case past medical bills and  
3 future medical care.

4 The interpretation from the Defense  
5 hinges on the "shall" language which is under  
6 768.0427, Subsection B. And that provision  
7 reads, "Evidence offered to prove the amount  
8 necessary to satisfy unpaid charges for incurred  
9 medical treatment or services shall include, but  
10 is not limited to, evidence as provided in this  
11 paragraph."

12 And each of those subparagraphs they do  
13 not have an "or" or an "and". So it's unclear in  
14 that context in terms of interpretation that  
15 would make everyone's job a little bit easier.  
16 But there's no "or", there's no "and", it just  
17 says "shall" in the preceding subsection. In the  
18 subparagraph below lists the forms of evidence  
19 that are admissible and when they're admissible  
20 depending on the Plaintiff's status with  
21 insurance.

22 It's the Defendant's position that the  
23 Plaintiff has -- if they want to introduce unpaid  
24 medical bills that they say are reasonable, that  
25 they -- which would be under Subsection 5, that

1 they also have to introduce either the private  
2 health insurance rate or the Medicare rates.

3 The same argument essentially statutory  
4 interpretation can be applied to future care and  
5 future treatment. And in this case, I think it's  
6 undisputed that the Plaintiff currently has  
7 private health insurance with Blue Cross/Blue  
8 Shield. There is some argument, potentially some  
9 dispute, about whether he had Medicaid or no  
10 health insurance before he was insured with Blue  
11 Cross/Blue Shield.

12 And I don't think that that matters under  
13 the statute whether he had Medicaid or whether he  
14 had no insurance. The same provision applies in  
15 terms of past meds. It matters for future care,  
16 but I don't think there's a dispute that he's got  
17 the Blue Cross/Blue Shield currently.

18 So that's the Defendant's position. We  
19 don't think that the Plaintiff should be able to  
20 introduce past unpaid medical bills unless  
21 they're also introducing either the Medicare  
22 rates or the Blue Cross/Blue Shield private  
23 insurance rates.

24 And same argument for future care.  
25 Plaintiff's counsel shouldn't be able to

1 introduce future care of reasonable -- what they  
2 consider reasonable future care without also  
3 introducing either the Medicare or the Blue  
4 Cross/Blue Shield rates.

5 In response to the Defense motion, the  
6 Plaintiff responded and made a constitutional  
7 argument about basically the constitutionality of  
8 768.0427. And the argument is that the Florida  
9 Supreme Court in adjourned decision basically  
10 said that entitlement to future governmental  
11 benefits, it's not admissible.

12 And it's the Defendant's position that  
13 the legislature's enactment of the tort reform  
14 statute, and specifically 768.0427, is a  
15 substantive change in the law and that therefore  
16 the legislature has the power to do that. And  
17 that this is basically the legislature  
18 overstepping a Florida Supreme Court with regard  
19 to the language in the statute and what is  
20 admissible to prove damages for future care.

21 I did not provide the Court this order  
22 yet. I discovered it this morning. I did  
23 provide it to Plaintiff's counsel, but I would  
24 like to rely on a Eleventh Judicial Circuit trial  
25 court order. It's Miami-Dade County. It's in

1 the matter of Adasme, A-D-A-S-M-E v Strategy  
2 Investment Group, LLC. Case Number  
3 2023-025611-61-01.

4 The order was entered on November 5,  
5 2024. And within that order there is an analysis  
6 of Florida Statute 768.0427, and whether it is  
7 procedural or substantive. And that trial court  
8 judge, Honorable Reemberto Diaz, found that  
9 768.0427 is not procedural, it is substantive for  
10 a couple of reasons.

11 One, Subsection 4 of the statute  
12 encompasses more than provisions related to  
13 process and procedure. Subsection 4 changes the  
14 damages that may be recovered by a Claimant in a  
15 personal injury action, which is a substantive  
16 change in the law.

17 And also the section about disclosures of  
18 Letters of Protection as a condition precedent to  
19 the claim is a substantive change.

20 And so the argument is that, in response  
21 to what I anticipate Plaintiff's counsel will  
22 argue, is that 768.0427 is substantive in nature  
23 and therefore the legislature has the authority  
24 to make this change that it did and that there's  
25 no current, that we're aware of, there's no

1 Florida Supreme Court decision or appellate court  
2 decision on the issue of procedural versus  
3 substantive nature of this subsection that we're  
4 asking the Court to enforce in this matter.

5 So I would conclude it by asking again  
6 that the Court hold that the Plaintiff -- it's  
7 the Plaintiff's burden to introduce the Medicare  
8 and/or private health insurance rates with past  
9 unpaid bills and future care.

10 JUDGE NICHOLAS: Miss Battaglia.

11 MS. BATTAGLIA: Yes, Your Honor. So as far  
12 as that order that was just discussed, the Miami,  
13 I have not have had the opportunity to lay eyes  
14 on the order and I don't know if it was signed.  
15 I haven't looked at it.

16 In any event, I think that it's not  
17 binding upon this Court what the Eleventh Circuit  
18 said in that particular case. Although, again, I  
19 haven't had the opportunity to look at that and I  
20 would object to any consideration of that order  
21 for this Court.

22 I wanted to start by saying that the  
23 statute, you know, it puts the Plaintiff in a  
24 very impossible situation to prove out their  
25 medical expenses. And I'm not going to address

1 the facts of this particular case until I go  
2 through what those practical considerations are.

3 So the statute itself says that we're  
4 supposed to put in evidence of insurance if the  
5 person has insurance. However, under Section E  
6 of the Section 768.0427, 2E, it states that  
7 individual contracts between providers and  
8 authorized commercial insurers or authorized  
9 health maintenance organizations are not subject  
10 to discovery or disclosure and are not admissible  
11 in evidence.

12 So it's literally putting the Plaintiff  
13 in an impossible position in discovering what  
14 these insurance rates may be. In addition to  
15 that, Section 624.4212, and Section 90.506,  
16 protect insurance companies and treat that  
17 information as confidential. It basically said  
18 under trade secret laws that they don't have to  
19 provide what their contracted rates are.

20 So the question always is from the  
21 Plaintiff's perspective is where do we get these  
22 rates from? Who do we receive these rates from?  
23 I'm going to get into the burden part of that in  
24 a minute.

25 But as an initial matter I'd like to know

1           how the Plaintiff is supposed to go about  
2           obtaining information. Which, Number 1, in the  
3           statute it says is confidential and doesn't come  
4           into discovery and it's not admissible.

5                     But Number 2, who do we ask for this  
6           information if all that information is protected  
7           as a business trade secret anyways? You know,  
8           the law creates an impossible situation, of  
9           course it's unconstitutional.

10                    The other thing that the Court may not  
11           understand in the legislature is that, you know,  
12           there's already this avoidance and stigma  
13           attached to these accident cases. The idea that  
14           these clients don't want to use their insurance  
15           if they have insurance available is a fallacy.  
16           Because a lot of times the first thing a person  
17           does that have insurance after an accident is  
18           they call their primary care physician and they  
19           report to them, Hey, I just had a car accident,  
20           can I come in and see you tomorrow? And the  
21           primary care physician will tell them, No, we  
22           don't see accident cases. We will not take your  
23           insurance, we will not even see you.

24                    So at that point the Plaintiff is put in  
25           a very difficult situation. Are they to lie to

1 the medical provider and tell them that there was  
2 no car accident and that they just had an injury  
3 at home? I mean, what is the situation upon  
4 which that person is to obtain medical treatment?

5 So if they're refused by their primary  
6 care doctor and they're given -- and this happens  
7 very frequently in this area, the name and number  
8 of a clinic locally that doesn't accept insurance  
9 because they're told, Look, we're not going to  
10 take your insurance because it's an accident  
11 case. How does the Plaintiff control that  
12 situation? What are they supposed to do?

13 The other thing is that now we put all of  
14 these financial -- potential financial disclosure  
15 obligations here in this statute. So the stigma  
16 has worsened now. So it was already like that  
17 and now it's worse because of these  
18 considerations.

19 Providers that take insurance, want no  
20 part of accident cases. And the financial  
21 disclosures that are required pursuant to this  
22 new act are going to cause a huge chilling affect  
23 from these providers because who's going to want  
24 to produce all their financial records just so  
25 they can see a patient? I'll tell you, nobody.

1 No one's going to want to do that. So no doctors  
2 are going to want to see a Plaintiff if they know  
3 that that's a possibility.

4 In addition to that, there's a  
5 requirement for disclosure factor in arrangements  
6 and things like that. So again, it's just  
7 chilling affect for Plaintiffs in addition to the  
8 affect we are already have, which is, doctors are  
9 not going to want to see Plaintiffs and they're  
10 not going to have access to proper medical care.

11 So in addition to not having that access  
12 now, we're additionally limited to these health  
13 insurance rates. And again, if my client can't  
14 go and use their health insurance, why do we have  
15 to prove evidence of what that health insurance  
16 rate is if it's not something they can use.

17 The other consideration with regards to  
18 Medicare and Medicaid. Medicaid is typically  
19 below actual cost of medical. And these rate  
20 calculations, whether it's Medicare or Medicaid,  
21 are constantly changing and they're complex. And  
22 again, go back to the question of are we going to  
23 do a trial within a trial to try and figure all  
24 this stuff out? I understand the stipulation,  
25 discussion about the Court saying, Well, you can

1 always stipulate to these rates beforehand. But  
2 again, we're put in a situation of impossibility  
3 with regards to knowing, at least with respect to  
4 private insurance, what those rates might be.

5 You know, obviously our position is that  
6 this violates the Plaintiff's right to access the  
7 courts. It discriminates against Plaintiffs who  
8 are poor and who are not able to afford health  
9 insurance. What if they can't afford health  
10 insurance and they're on Medicaid. Okay, so  
11 they're going to get treated differently.  
12 They're going to get the bargain basement rates  
13 that don't even cover the cost of the healthcare  
14 provider's services, and that's what Medicaid is.

15 The legislature ended the judicial  
16 autonomy in creating this act. They  
17 impermissibly determined what constitutes and  
18 comes in as relevant evidence.

19 And so those are my practical arguments  
20 with regards to some of the constitutional  
21 issues.

22 Specifically with regards to this case,  
23 this is a completely premature motion. I do  
24 appreciate the opportunity to present this  
25 argument to the Court though because I think

1           there's a lot of uncertainty that remains for all  
2           of us as to how the statute actually is supposed  
3           to work.

4                     The discovery deadline in this particular  
5           case is not until July of 2025 [sic]. Therefore,  
6           it's a premature motion. And if it were  
7           determined by the Court that we had to do this  
8           stipulation on rates, certainly there's time for  
9           us to accomplish that.

10                    But, in any event, it's Plaintiff's  
11           testimony if you reviewed the deposition, that he  
12           was uninsured for most of the time following this  
13           crash. So, you know, this idea that somebody  
14           said that at one point in time that they were on  
15           Medicaid or at one point in time that they had  
16           health insurance.

17                    This is the Defense's affirmative  
18           defense. They have the burden on their  
19           affirmative defenses. And they're trying to put  
20           the burden on the Plaintiff and showing, Well,  
21           what periods of time did they have this health  
22           insurance, when did it start, when did it stop.  
23           Oh then they started getting health insurance  
24           from a different carrier because they started  
25           with a new employer. When did it start, when did

1           it stop.

2                         And these are the types of discovery  
3 requests that we're being presented with. Why do  
4 we have to prove their affirmative defenses. If  
5 you want a benefit of a contracted rate defense,  
6 you should be able to go out and get that  
7 information and provide that information. But  
8 you don't get to just say, Hey, somebody was  
9 entitled to health insurance at one point in time  
10 and then now we got to prove the absence of that  
11 fact. That's just not how the statute is  
12 written. And that's not what's going to be  
13 appropriate in a situation that basically says  
14 under Florida law that each party is responsible  
15 for proving out their own claims and defenses.

16                         So we're not in a position to sit here  
17 and try to say the exact dates that Mr. Meabon  
18 had Medicaid. The exact dates that he had Blue  
19 Cross. The exact dates that he had Aetna.

20                         If you want to claim the benefit under  
21 reduced rate, I believe that's Defense's  
22 obligation to prove their own affirmative  
23 defenses in that regard.

24                         But, in any event, in this case, the  
25 Plaintiff, they did not have health insurance.

1 So from his testimony was from 2020 through  
2 October of 2024, which is approximately one year  
3 after the accident, he did not have health  
4 insurance and he did not qualify for Medicaid.

5 Then November 2024, through present, he  
6 didn't have insurance he said until January of  
7 2025. Importantly all of the medical treatment  
8 that occurred in this case, if you look at the  
9 billing records, occurred prior to January 2025.

10 So this isn't even an applicable argument  
11 based on the testimony that the Plaintiff has  
12 given. The one provider that he is seeing is his  
13 chiropractor. She does not accept insurance at  
14 all, period. So my client has paid  
15 out-of-pocket.

16 So this is a completely irrelevant  
17 argument to this particular case anyways. And  
18 again, the argument -- and I understand, I read  
19 the orders. Obviously we provided Your Honor  
20 with this Steiger order and we obviously would  
21 urge this Court to accept the analysis of the  
22 judge in that case. And that was the Steiger,  
23 S-T-E-I-G-E-R, versus Nurzod case. This is a --  
24 let me see the date of the order issued by Judge  
25 Frank, and it was November 20th of 2024. Case

1 Number, Your Honor, 2023-C-A-482. It was filed  
2 as an attachment to my response.

3 But, in any event, I believe that the  
4 statute, even if we're looking at it, putting  
5 aside the constitutional arguments that we've  
6 made, doesn't put an additional burden on the  
7 Plaintiff. What it does is it says that Defense  
8 may introduce rates of insurance if they're  
9 available.

10 Again, this is their affirmative defense.  
11 You want the benefit of the lesser amount, then  
12 you have to produce your evidence to support your  
13 affirmative defense and show what it is, what is  
14 it.

15 But the Plaintiff, just because they  
16 don't have that information, and again, pursuant  
17 to statute, they're not even allowed to get that  
18 information because it's protected from discovery  
19 and not admissible. You know, we're then not  
20 precluded now from introducing reasonable rates  
21 of what providers would take for the particular  
22 services that are being offered.

23 So my position is that sure, if we're  
24 reading the statute as a valid statute and it's  
25 not unconstitutional, then Defense can bring in

1 their information and Plaintiff can bring in  
2 their information. Just like we always have.  
3 And a jury can make a decision about which  
4 portion of those records and medical bills are  
5 reasonable and related and medically necessary  
6 and what the amounts should be. And that's what  
7 I believe the statute, if anything, does say.  
8 There's Defense's argument and then the Plaintiff  
9 can produce counter evidence as to what would be  
10 reasonable and the jury will take both amounts  
11 into consideration and make a decision about  
12 what's appropriate. It does not place an  
13 additional burden on the Plaintiff to prove  
14 anything. I don't understand the reading of the  
15 statute as far as "shall include" particularly in  
16 light of Section 2E, where it states that this  
17 information is not admissible.

18 So it's one thing if a person has  
19 insurance and insurance has paid the doctor's  
20 office bills 30,000, and the insurance company  
21 makes a payment and it's for 2,000. I think  
22 everyone's in agreement. Okay, the payment was  
23 2,000. But the remaining 28,000 of that bill is  
24 not admissible. I don't think anybody would  
25 argue with that.

1                   But in a situation where someone has  
2                   insurance and cannot physically go into the  
3                   doctor's office and obtain that same procedure  
4                   under their insurance because they can't find a  
5                   provider who will do it that way, that person  
6                   then being stuck with 2,000 and we have to prove  
7                   that, we have to show that information as well in  
8                   order to be able to show reasonable, I just think  
9                   it's just completely unfair and I don't think  
10                  it's a proper reading of the statute. Your  
11                  Honor, thank you.

12                 JUDGE NICHOLAS: Mr. Watson, I don't have  
13                 the ability to let you -- well, I'll give you  
14                 very briefly the last words. As you can see I  
15                 let the lawyers in for my 10:30 hearing. There's  
16                 a lawyer for the 10:45 in the waiting room. So  
17                 I'll give you very briefly the last word.

18                 MR. WATSON: I appreciate, Your Honor.  
19                 I'll be very brief. With regard to the  
20                 Subsection E that was referenced by Plaintiff's  
21                 counsel, it says, Contracts are not subject to  
22                 discovery, not admissible into evidence. It  
23                 doesn't say that individual rates for the  
24                 procedure codes that the Plaintiff received in  
25                 the case are -- it doesn't say that those are

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inadmissible.

So I think there's ways the Court can handle that followed by protective orders, confidentiality orders, if that health insurer provides the information for those specific rates but isn't giving the full contract out.

With regard to whether it's relevant or not in this case, it's absolutely relevant in terms of the application of this statute. The analysis doesn't change whether he had Medicare or had no insurance, the analysis is the exact same. So I don't think that impacts the Court's ruling. This really comes down to statutory interpretation. And I close with that, Your Honor.

JUDGE NICHOLAS: All right. So this issue has come before me before, although the facts here are a little unique, at least as I see it.

So basically the challenge that Plaintiff's counsel has outlined with regard to access in determining Medicaid rates or Blue Cross/Blue Shield reimbursement rates or health insurance rates, while I'm sensitive to that challenge, that is not a legal basis for denying what otherwise would be an appropriate defense

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motion in limine.

Having said that, simply because Mr. Meabon had received Medicaid benefits in the past, in my opinion, does not necessarily mean that he is forever a Medicaid recipient.

It's different from Medicare wherein once somebody turns 65 and they become eligible for Medicare, they are largely a Medicare recipient and the statute that applies to that applies.

Based upon the Plaintiff's response, it appears that he was a Medicaid recipient in the past but because of increased income he wasn't a Medicaid recipient at the time of this collision and wasn't a Medicaid recipient during his treatment.

Similarly it does not appear, at least based upon the response, that Mr. Meabon was receiving healthcare benefits, was a beneficiary of Blue Cross/Blue Shield benefits during the period of his treatment. At least according to response it took a while for that to kick in and even when it did kick in, it doesn't appear that his current doctor accepts insurance.

The long and short of it is as least as I see it, this is a fact question. If the

1 Defendant had no insurance, if he was not a  
2 Medicaid recipient during the time in question,  
3 during the time of treatment, then there is no  
4 obligation for the Plaintiff to introduce the  
5 reimbursement rates of an insurance company or  
6 the reimbursement rates of Medicaid.

7 And I think it's the obligation of the  
8 Defense, who's suggesting that the Plaintiff has  
9 this obligation to establish that either he was  
10 in fact a Medicaid recipient or was eligible for  
11 Blue Cross and Blue Shield. While I certainly  
12 understand that he can't turn down benefits  
13 simply to seek the higher amounts of  
14 reimbursement payments, not accessing Medicaid or  
15 not accessing Blue Cross and Blue Shield, as I  
16 see it, it's a fairly specific fact question here  
17 as to whether or not the Plaintiff either did  
18 have insurance or was a Medicaid recipient.

19 Again, if he chose not to avail himself  
20 of those two benefits, then that's on him. He  
21 still is a Medicaid eligible and would be  
22 required to submit the bills, or at least the  
23 Plaintiff would be -- he would only be entitled  
24 to recover the Medicaid reimbursement rates.

25 But what I'm hearing from the Plaintiff

1 is that that was not the case. That he was not  
2 Medicaid eligible during this time and he did not  
3 have the health insurance through Blue Cross and  
4 Blue Shield at this time.

5 So it's a fact question that needs to be  
6 determined before I could grant the Defendant's  
7 motion in limine.

8 As an aside, I would suggest that given  
9 the uncertainty of Mr. Meabon's insurance  
10 coverage, whether it's Medicaid or Blue Cross and  
11 Blue Shield, the Defense does always have the  
12 ability to introduce the reimbursement rates that  
13 he may be eligible for to suggest to the jury  
14 that those are the reasonable rates and that is  
15 indeed what should be recoverable and not the  
16 fully boarded costs of all the care, etcetera.

17 So this is kind of a hybrid ruling, not  
18 necessarily determining whether it's substantive  
19 or procedural, but more based upon the unique  
20 circumstances of Mr. Meabon and the uncertainty  
21 as to whether or not he was Medicaid eligible or  
22 whether or not he was able to submit the bills to  
23 Blue Cross and Blue Shield.

24 The response indicates that he was not  
25 Medicaid eligible or the response indicates that

1 he did not have health insurance at the time.  
2 And if that's true, I would deny the motion in  
3 limine with the caveat that the Defense can  
4 certainly introduce those rates to the jury to  
5 suggest that that's what should be recoverable  
6 instead of what the Plaintiff is seeking.

7 But I'm going to deny the motion in  
8 limine without prejudice. Because again, this is  
9 a fact question that I think could potentially be  
10 resolved, or at least I need further information  
11 with regard to it. All I have here is the  
12 response and a little bit of transcript,  
13 deposition transcript from Mr. Meabon.

14 But based upon that response and based  
15 upon the fact that he was not Medicaid eligible,  
16 that he did not have the ability to submit the  
17 bills to Blue Cross and Blue Shield based upon  
18 the timing of his employment, I'm going to deny  
19 without prejudice the motion in limine.

20 That was a lot. I'm going to ask your  
21 assistance in preparing an order here. I've got  
22 to jump off fairly quickly. I'm well behind now.

23 Thank you, Madam Court Reporter, for your  
24 assistance here on such a last minute basis.  
25 We're going to go off the record in Case Number

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2024-1376.

MS. BATTAGLIA: Thank you.

MR. WATSON: Thank you, Your Honor.

(Hearing concluded at 10:50 a.m.)

CERTIFICATE OF COURT REPORTER

STATE OF FLORIDA  
COUNTY OF PINELLAS

I, SHEILA CARROLL, Shorthand Reporter, do hereby certify that I was authorized to and did stenographically report the proceedings before the Honorable Edward Nicholas; and that the foregoing transcript is a true and complete record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, or attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

Dated this 12th day of August, 2025 at Pinellas County, Florida.



SHEILA CARROLL,  
COURT REPORTER