IN THE CIRCUIT COURT, FOURTH JUDICIAL CIRCUIT, IN AND FOR CLAY COUNTY, FLORIDA.

CASE NO.: 10-2023-CA-001410

DIVISION: A

DOMINIC PERTILE,
Plaintiff,

v.

OLIVIA DE MEDICI, an individual, and ELIZABETH DE MEDICI, an individual,
Defendant.
_____/

**ORDER DENYING IN PART AND GRANTING IN PART PLAINTIFF'S MOTION IN LIMINE ON SECTION 768.0427(2), FLORIDA STATUTES, GRANTING IN PART AND RESERVING IN PART DEFENDANTS' MOTION IN LIMINE AND MOTION TO STRIKE PLAINTIFF'S CLAIMS FOR DAMAGES PURSUANT TO SECTION 768.0427(3), FLORIDA STATUTES**

THIS CAUSE came before the Court upon Plaintiff's Motion in Limine on Section 768.0427(2), Florida Statutes ("Plaintiff's Motion in Limine"), Defendants' Response to Plaintiff's Motion in Limine Regarding Florida Statute 768.0427(2) and Motion in Limine ("Defendants' Response") and Defendant's Motion in Limine and Motion to Strike Plaintiff's Claims for Damages Pursuant to Section 768.0427(3), Florida Statutes ("Defendants' Motion to Strike"). The Court having considered the pleadings, oral argument of counsel, and being otherwise fully advised in the premises, finds as follows:

## I. STATUTORY FRAMEWORK AND LEGAL AUTHORITY

On March 24, 2023, Chapter 2013-15, Florida Laws, commonly known as HB 837, was ratified into law and, per Section 31, was made effective immediately. This case was filed after March 24, 2023, and therefore Section 768.0427(2), Fla. Stat. applies, and compliance is required.

The motions present five issues concerning section 768.0427, Fla. Stat.:

1. whether subsection (2)(a) excludes evidence of amounts that were written off from satisfied medical bills;
2. whether subsection (2) limits evidence of unpaid past (2)(b) and future (2)(c) medical expenses;
3. whether subsection (2) creates a burden of production on a plaintiff;
4. whether subsection (2) permits defendants to introduce evidence of Medicare and Medicaid rates; and
5. whether subsection (3) bars any of Plaintiff's claims for damages.

### Rules for Statutory Interpretation

"In interpreting a statute, [a court's] task is to give effect to the words that the legislature has employed in the statutory text." Lab. Corp. of Am. v. Davis 339 So.3d 318, 323 (Fla. 2020). "The courts have compiled a catalogue of rules of statutory construction to provide guidance when determining the meaning of a statute. Of these, we first apply the preeminent rule that legislative intent is the most important factor that informs our analysis." Quarantello v. Leroy, 977 So.2d 648, 651 (Fla. 5th DCA 2008), *citing* Knowles

v. Beverly, 898 So.2d 1, 5 (Fla. 2004)("It is well settled that legislative intent is the polestar that guides a court's statutory construction analysis."). "Because legislative intent is determined primarily from the text of the statute," a court must begin its statutory interpretation "with the 'actual language' used by the Legislature." Quarantello, supra. "If [the actual language] is clear and unambiguous, we proceed no further and apply the provisions as written." Id. Finally, "[R]elated statutory provisions must be read together to achieve a consistent whole, and … '[w]here possible, courts must give full effect to all statutory provisions in harmony with one another.'" Id., *citing* Woodham v. Blue Cross & Blue Shield, Inc., 829 So.2d 891, 898 (Fla. 2002). "One of the most fundamental tenets of statutory construction requires that we give statutory language its plain and ordinary meaning, unless the words are defined in the statute or by the clear intent of the legislature." Green v. State, 604 So. 3d 471, 473 (Fla. 1992); Holly v. Auld, 450 So. 2d 277, 219 (Fla. 1984).

With this understanding of statutory analysis, the Court will address each of the five questions listed above.

**II. SECTION 768.0427(2)(A) - SATISFIED CHARGES**

Florida Statute 768.0427(2)(a) governs evidence of past medical expenses that have been satisfied. It provides: "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."

In interpreting the legislative intent behind section (2)(a), it is not necessary to employ any of the canons of statutory construction. The language used is clear and unambiguous, especially when considering it in the context of the entire statute. Plaintiff argues that the evidence admissible under section (2)(a), must include any amounts that were written off from satisfied medical bills. In support of his argument, Plaintiff highlights the language, "*regardless of the source of payment*." At the hearing, Plaintiff argued that a write-off is considered a "payment" under Goble v. Frohman, 901 So.2d 830 (Fla. 2005). In Goble, the Florida Supreme Court explained that "[v]irtually all dictionaries include, among the first three definitions of 'payment' or 'pay,' the concept of discharge of a debt." Id. at 833. The Court therefore held that the plaintiff's contractual discounts negotiated by an HMO were payments that should be set off posttrial under section 768.76, Florida Statutes. Id.

In highlighting the phrase "*regardless of the source of payment,*" Plaintiff unnecessarily complicates a rather straightforward section of the statute. The most important words in the section are not "regardless of the source of payment," but instead the two words that immediately precede it: "actually paid." "Actually," as an adverb is, of course, modifying the word "paid." "Actually" means "In fact; really; in truth." Webster, N. American Dictionary of the English Language (1828). In other words, the Legislature intends for a jury to only consider what was *really* paid for the medical bills that have, at the time of trial, already been satisfied. The phrase "regardless of the source of

payment" simply means that the source of the payment is unimportant in determining what was actually paid. Whether a plaintiff paid the bill out-of-pocket, the bill was paid through PIP coverage, or it was paid by a plaintiff's health insurance carrier or paid from any other source, all that matters is the amount of money—dollars and cents—that was actually paid.

It is also important to consider for what purpose this evidence is being offered: "to prove the *amount of damages* for past medical treatment or services...." (Emphasis added). For this reason, the Court finds Plaintiff's reliance on Goble misplaced. In Goble, the Supreme Court answered a question of great public importance:

> UNDER SECTION 768.76, FLORIDA STATUTES (1999), IS IT APPROPRIATE TO SETOFF AGAINST THE DAMAGES PORTION OF AN AWARD THE AMOUNTS OF REASONABLE AND NECESSARY MEDICAL BILLS THAT WERE WRITTEN OFF BY MEDICAL PROVIDERS PURSUANT TO THEIR CONTRACTS WITH A HEALTH MAINTENANCE ORGANIZATION?

In answering the question in the affirmative, and in affirming the district court's opinion, the Supreme Court found "that contractual discounts off medical bills are 'collateral sources' subject to setoff under section 768.76." Id. at 832. The "payments made" from "collateral sources" "is not limited to the actual remitting of cash but includes any act that discharges a debt or obligation." Id. While this language in Goble is binding authority, the opinion addressed a much different question than what is being presented here. Again,

the question here is not focused on what constitutes a "payment," but instead on the meaning of "actually paid."

Portions of the Goble opinion—non-binding dicta—supports this Court's analysis. In a specially concurring opinion, Justice Bell wrote:

> There is, however, another reason why Goble is not entitled to recover, as compensatory damages [the recovery of damages is exactly what section 768.0427(2)(a) is concerned with], the full (prediscount) amount of his medical bills; and it lies wholly outside the question of 'collateral sources' either as defined by statute or common law. The reason is simple: Goble has not paid, nor is he obligated to pay, the prediscount amount of his medical bills. And, absent any evidence that the discount was intended as a gift, Goble can recover no more than the amount he paid or is obligated to pay. Id. at 833.

Similarly, under section 768.0427(2)(a), a plaintiff (just like plaintiff Goble) is not entitled to recover as damages any amount that has not been "actually paid," either by a plaintiff or by anyone else, nor any amount that a plaintiff is never obligated to pay. To further underscore the point, this Court considered section 768.0427(4). Section (4) provides in part that "damages that may be recovered by a claimant … may not include any amount in excess of the evidence … admitted pursuant to subsection (2), and … may not exceed the sum of the following: (a) Amounts actually paid by or on behalf of the claimant to a health care provider …."

Plaintiff's interpretation of section (2)(a) would mean that the "amounts actually paid" include not just the amounts for the money actually paid but

also includes the amounts where *no* money has been actually paid nor will ever be paid. Such is not a reasonable interpretation of the statute. For these reasons, the Court finds that write-offs or discounts to medical bills, for medical bills that have already been satisfied at the time of trial, cannot be presented to the jury for consideration.

**III. SECTION 768.0427(2)(B) - UNSATISFIED CHARGES**

Unlike section (2)(a), section (2)(b) presents a greater challenge in determining legislative intent. This is primarily due to the Legislature's decision to use the word "shall," a word which has been aptly described as "a semantic mess." Antonin Scalia & Bryan Garner, *Reading Law: The Interpretation of Legal Texts*, s. 11 (2012). Section (2)(b) provides in part:

> (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 provided in this paragraph. (Emphasis added).

Plaintiff contends that the word "shall" can have either a permissive or a mandatory sense, depending on the context in which it is used. Plaintiff's Motion in Limine, p. 6. Plaintiff cites to appellate authority for this proposition, including Allstate Ins. Co v. Orthopedic Specialists, 212 So.3d 973, 978 (Fla. 2017)(recognizing that "the term 'shall' can be construed as 'must' *or 'may.'*"). Defendants, on the other hand, contend that "shall" must only be construed in a mandatory sense, citing to, among other authority, Burton v. Oates, 362 So.3d 311 (Fla. 5th DCA 2023)(confirming that "shall" is mandatory language). Defendants' Response, p. 4. As to this point, Plaintiff is correct. "Shall" can

carry both a mandatory and a permissive meaning depending on the context of how it is used. The question here is which meaning did the Legislature intend.

In his Motion in Limine, Plaintiff cites as authoritative the above-cited treatise *Reading Law* by Former Justice Antonin Scalia and legal scholar and lexicographer Bryan Garner. In *Reading Law*, the authors provide detailed analysis of various canons of statutory construction. The eleventh canon is what concerns us here: The Mandatory/Permissive Canon. The authors note the traditional rule is that *shall* is mandatory and *may* is permissive. *Reading Law* § 11 at 112. Unfortunately, "drafters have been notoriously sloppy ["even promiscuously" so!] with their *shalls*, resulting in a morass of confusing decisions on the meanings of this modal verb." Id. To demonstrate the point, the text provides several examples of "shall" being used in a sentence. The authors suggest that if "shall" is mandatory, it ought to be replaceable by either "*has a duty to* or *is required to*." Id. When reviewing these sentence examples, it quickly becomes apparent that the drafters of those sentences should have chosen a word other than "shall" so that their intentions could be clearer.

If that test to determine whether "shall" is mandatory or permissive is used to assist in interpreting 768.0427, section (2)(b) would read as follows: "Evidence offered to prove the amount necessary to satisfy unpaid charges for incurred medical treatment or services *is required to* include, but is not limited to, evidence provided in this paragraph." The sentence is grammatically correct, and it makes sense; it can be easily understood. However, in fairness

to Plaintiff's argument, if the permissive "may" is substituted for "shall," the result is another grammatically correct and logically coherent sentence: "… charges for incurred medical treatment and services *may* include, but is not limited to, …." So how does a court determine which meaning is correct? The answer is to consider the entire context in which the word is used. The Court is not attempting to provide meaning to a single word in the context of a single sentence, but instead of that single word in the context of an entire statute. When considering the entirety of Section 768.0427, it becomes clear that "shall" holds to its traditional, mandatory meaning.

First, the Court has considered the first two categories of evidence listed in section (2)(b):

> 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 ….
>
> 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 ….

In considering just these two subparagraphs, the sea change brought on by the enactment of section 768.0427 to personal injury litigation is manifest. Prior to the statute's enactment, no jury could hear evidence about a plaintiff's health insurance coverage. Now, in trials conducted under 768.0427, a jury

will apparently hear plenty about a plaintiff's health insurance coverage. And if a plaintiff does not have health insurance, the jury will instead hear about Medicaid or Medicare reimbursement rates. See Section 678.0427(2)(b)3 and (2)(c)2.

Second, the Court has considered Section 3, which is concerned with Letters of Protection.[1] Section (3) provides that "as a condition precedent to asserting any claim for medical expenses for treatment rendered under a letter of protection, the claimant must disclose …" various items, to include medical billings, the identity of the plaintiff's health care coverage, if any, and whether plaintiff was referred for treatment under a letter of protection and, if so, the identity of the referral source. The identity of the referral source must be disclosed—and is admissible evidence—even if the referral source is the plaintiff's lawyer, notwithstanding any attorney-client privilege. This is another example of the sea change brought on by 768.0427. Prior to the statute's enactment, a plaintiff's medical records would have been scoured prior to admission to redact any reference of an attorney referral to a doctor. To not make those redactions would risk a mistrial. Now, this information is clearly admissible.

The point is that a reasonable interpretation of the entire statute, and particularly the two sections discussed above, can only lead to the conclusion that the Legislature intended for juries to hear and consider this type of now

1 The parties here strongly disagree on whether Plaintiff treated under Letters of Protection. As will be discussed, *infra*, the Court has reserved ruling on whether Letters of Protection were utilized in this case until an evidentiary hearing is conducted.

admissible evidence in reaching their verdicts. And if that was truly the Legislature's overall intent in enacting the statute, then to interpret "shall" as permissive would in a significant manner undermine that very intent. For example, under a permissive interpretation of "shall," a plaintiff could decline to introduce evidence that he had available health insurance at the time of the accident, chose not to use that insurance, and instead treat with doctors who do not accept insurance, whether under letters of protection or otherwise. In that scenario, only one of two outcomes remain: 1) the jury never hears this evidence or 2) the defendant must introduce the evidence in its case-in-chief, something Plaintiff here suggests should occur. The first outcome defeats the Legislative intent behind the statute, and the second outcome ignores the fact that a defendant has no burden to introduce evidence of a plaintiff's damages; the burden to prove damages belongs solely to plaintiffs. While it is *possible* this is what the Legislature intended, it seems to this Court highly improbable. The more reasonable, sensible view is to interpret the "shall" as mandatory.

Finally, one last reference to *Reading Law* where the authors conclude the Mandatory/Permissive Canon with this observation: "All this having been said, when the word *shall* can reasonably be read as mandatory, it ought to be so read." *Reading Law*, s. 11, p. 114. Not only can "shall" be reasonably read as mandatory in 768.0427, but it is also the most reasonable reading.

**IV. SECTION 768.0427(2)(C) - FUTURE MEDICAL EXPENSES**

Florida Statute 768.0427(2)(c) governs the admissibility of evidence offered to prove damages for future medical treatment or services the claimant will receive. Section (2)(c) contains the same pertinent language as is found in (2)(b), and the Court reaches the same conclusions: the language in (2)(c) is mandatory and not permissive.

**V. DOES SECTION 768.0427 CREATE A BURDEN OF PRODUCTION**

Section 768.0427, Fla. Stat. does not contain any language explicitly providing for a burden of production; however, having concluded that the statute requires the admission of certain evidence—when the factual predicates are met—a duty to admit such evidence naturally falls either to one or to both parties. As the statute is solely concerned with the evidence necessary to prove medical damages, and since only plaintiffs carry that burden, the burden of production must naturally fall to them.

In this case, it is the Court's understanding that Plaintiff has had available health insurance through United Healthcare. It is also the Court's understanding that none of the doctors who have treated Plaintiff submitted their bills to United Healthcare for reimbursement. Accordingly, under these facts, Plaintiff is required to submit evidence pursuant to (2)(b)2, for incurred medical treatment and services that remain unpaid, and to submit evidence pursuant to (2)(c)1, for any future medical treatment and services. Sections (2)(b)1, (2)(b)3 and (2)(c)2 do not apply under the facts of this case. Section (2)(b)4

concerns medical treatment provided under a letter of protection. Therefore, it remains unknown whether this subsection applies until the Court determines at a later hearing whether any of Plaintiff's treatment occurred under a letter of protection.

To be clear, the Court's ruling here does not foreclose Plaintiff from submitting other evidence in support of his damages claim in addition to the evidence noted above. This is so because of the "but is not limited to" clause in sections (2)(b) and (2)(c) as well as sections (2)(b)5 and (2)(c)3, the so-called catch-all provisions. The nature of that potential evidence would naturally vary from case to case. One of the inherent dangers in ruling on motions in limine is that sometimes the Court is asked to make preliminary rulings on matters without the benefit of knowing all the facts and circumstances necessary to make that ruling. Considering this, the Court declines to make any definitive ruling on what other evidence may be admissible in case, at least until the Court rules on the letters of protection issue.

**VI. EVIDENCE OF MEDICARE AND MEDICAID RATES**

In his motion, Plaintiff argues that evidence of Medicare or Medicaid reimbursement rates is not admissible unless Defendants satisfy the requirements in subsections (2)(b)3. or (2)(c)2. Plaintiff's Motion in Limine, pp. 9–11. Defendants disagree in their response. Defendant's Response, pp 23–24. This Court concludes that Plaintiff is correct.

Subsection (2)(b)3. states: "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." § 768.0427(2)(b)3., Fla. Stat. (emphasis added). Similarly, subsection (2)(c)2. states: "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." *Id.* § 768.0427(2)(c)2. In short, both provisions allow evidence of Medicaid and Medicare rates only if the claimant "does not have health care coverage or has health care coverage through Medicare or Medicaid."

The party seeking to admit evidence of Medicare or Medicaid rates under subsections (2)(b)3. and (2)(c)2. has the burden to prove any preliminary facts required for the admission of such evidence. *See* Section 90.105, Fla. Stat. Here, Defendants have not presented evidence that Plaintiff "does not have health care coverage or has health care coverage through Medicare or Medicaid." To the contrary, Defendants assert that "Plaintiff has health care coverage through United Healthcare." Defendant's Response, p. 15. Defendants

also acknowledge that Plaintiff has "Personal Injury Protection insurance," which constitutes "health care coverage" as defined in the statute. *See* section 768.0427(1)(b), Fla. Stat. ("'Health care coverage' means any third-party health care or disability services financing arrangement, including, but not limited to, arrangements with entities certified or authorized under federal law or under the Florida Insurance Code; state or federal health care benefit programs; workers' compensation; *and personal injury protection*." (emphasis added)).

Evidence of Medicare and Medicaid rates is not admissible under the catchalls in subsections (2)(b)5. and (2)(c)3. The statute sets forth a specific condition precedent to introduce evidence of Medicare and Medicaid rates in subsections (2)(b)3. and (2)(c)2. "[A] specific statute covering a particular subject area always controls over a statute covering the same and other subjects in more general terms." Bank of N.Y. Mellon v. Glenville, 252 So. 3d 1120, 1129 (Fla. 2018) (citation omitted).

A party cannot circumvent that condition precedent by relying on the catchalls. That would render meaningless the language in subsections (2)(b)3. and (2)(c)2., which allows evidence of Medicare and Medicaid rates only if "the claimant does not have health care coverage or has health care coverage through Medicare or Medicaid." "[A] basic rule of statutory construction provides that the Legislature does not intend to enact useless provisions, and courts should avoid readings that would render part of a statute meaningless." State v. Knighton, 235 So. 3d 312, 316 (Fla. 2018) (citation omitted).

In sum, unless Defendants can satisfy the requirements in subsections (2)(b)3. and (2)(c)2.—which it appears they cannot—evidence of Medicare and Medicaid rates are inadmissible. In other words, unless the statutory conditions are met, the collateral-source rule would continue to exclude such evidence. *E.g.*, Farrington v. Richardson, 16 So. 2d 158, 161 (Fla. 1944) ("The statute limits the common-law rule only to the extent set forth in the statute.").

**VII. DEFENDANTS' MOTION TO STRIKE**

Defendants move to strike Plaintiff's claims for damages alleging that Plaintiff failed to meet the conditions precedent necessary for introduction of medical bills and services provided under Letters of Protection. The Court is reserving on this issue until an evidentiary hearing is conducted to determine whether any letters of protection exist in this case.

In view of the above, it is:

**ORDERED AND ADJUDGED**:

1. Plaintiff's Motion in Limine Regarding Florida Statute 768.0427(2) is DENIED in part and GRANTED in part.

2. Defendant's Motion in Limine Regarding Florida Statute 768.0427(2) is GRANTED in part and DENIED in part.

3. Regarding Section 768.0427(2)(a) - Satisfied Medical Charges, Plaintiff is precluded from introducing evidence of past medical charges that have been satisfied that exceed the amounts actually paid to satisfy those charges, not including contractual write-offs or adjustments.

4. Regarding Section 768.0427(2)(b) - Unsatisfied Medical Charges, Plaintiff is precluded from introducing any evidence of past unpaid medical charges unless Plaintiff also introduces evidence of the amount Plaintiff's health care coverage would pay the health care provider to satisfy the past unpaid medical charges under the insurance contract or regulation, plus Plaintiff's share of medical expenses under the insurance contract or regulation, had Plaintiff obtained medical services or treatment pursuant to the health care coverage.

5. Regarding Section 768.0427(2)(c) - Future Medical Expenses, Plaintiff is precluded from introducing any evidence of future medical treatment costs unless Plaintiff also introduces evidence of the amount for which the future charges of health care providers could be satisfied if submitted to Plaintiff's health care coverage, plus Plaintiff's share of medical expenses under the insurance contract or regulation.

6. Evidence of Medicare or Medicaid reimbursement rates are not admissible as "evidence of reasonable amounts billed" for past medical charges under section 768.0427(2)(b)(5) as Plaintiff had available health insurance under United Health Care and no coverage under either Medicare or Medicaid.

7. Plaintiff may not introduce evidence of any future care that exceeds the amounts necessary to provide for any reasonable and necessary medical treatment or services the claimant will receive in the future, as required by section 768.0427(4)(c).

8. The Court reserves ruling on whether Plaintiff treated with doctors under Letters of Protection.

**DONE AND ORDERED** in Green Cove Springs, Clay County, Florida on Wednesday, August 27, 2025.

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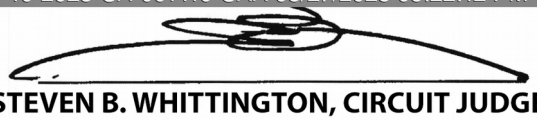

**STEVEN B. WHITTINGTON, CIRCUIT JUDGE**

Steven B. Whittington, Judge
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