IN THE SUPREME COURT OF FLORIDA

Case No. SC18-278
L.T. Case No. 5D16-2333

PROGRESSIVE SELECT INSURANCE COMPANY,

Petitioner,

v.

FLORIDA HOSPITAL MEDICAL CENTER
a/a/o Jonathan Parent,

Respondent.

BRIEF OF AMICUS CURIAE PERSONAL INSURANCE FEDERATION OF FLORIDA AND PROPERTY CASUALTY INSURERS ASSOCIATION OF AMERICA

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PREFACE

Amicus Curiae Personal Insurance Federation of Florida is referred to as "PIFF." Amicus Curiae Property Casualty Insurers Association of America is referred to as "PCI."

With respect to quoted material, unless otherwise indicated, emphasis is supplied and citations and internal quotations are omitted.

IDENTITY OF AMICUS CURIAE AND STATEMENT OF INTEREST

PIFF is a non-profit property and casualty insurers trade association whose members are large national insurers and their subsidiaries doing business in Florida. PIFF members serve 45 percent of the private passenger auto (including personal injury protection ("PIP")) market and 20 percent of the private residential property market. PIFF's goal is to create a dynamic, efficient, and competitive marketplace for personal lines insurance products for all Floridians.

PCI is composed of nearly 1,000 member companies, representing the broadest cross section of insurers of any national trade association. PCI's members write $220 billion in annual premiums, which is 37 percent of the nation's property casualty insurance. Member companies also write 44 percent of the U.S. automobile insurance market, 30 percent of the homeowners market, 35 percent of the commercial property and liability market, and 37 percent of the private workers compensation market. In Florida, PCI members write 44 percent of the property casualty insurance market, including 51 percent of the personal auto market.

Like all automobile insurers in Florida, the members of PIFF and PCI have an interest in protecting the longstanding public policy underlying the PIP statute, which is that PIP deductibles, paid by consumers, and PIP benefits, paid by insurers for the benefit of consumers, should be used only for "reasonable expenses for necessary medical services."

SUMMARY OF THE ARGUMENT

Reasonableness is the cornerstone of the PIP statute. When incorporated into a PIP policy, the statutory fee schedule conclusively determines the reasonable value of a provider's services. Yet, the Fifth District concluded that a provider's billed charges need not be reasonable under the statutory fee schedule until ***after*** an insured's PIP deductible is applied to those charges. In other words, the Fifth District has essentially held that a provider's charges must only be reasonable when billed to the insurer, but not when billed to the insured. This defies common sense and ignores the plain text of the PIP statute and the fundamental requirement that providers must only charge a reasonable amount to both insurers ***and insureds.***

In practice, the Fifth District's interpretation would cause harm to insurers, insureds, and the public. In fact, only providers would benefit, as they would be entitled to recover a windfall directly from injured parties, at the expense of those injured parties, their insurers, and the public. Insureds would be forced to pay unreasonable charges out of pocket and would obtain fewer total services before exhausting their PIP benefits.

Additionally, insurers would lose the benefit of selling PIP policies with deductibles. Insurers must provide PIP coverage at a reduced premium when the insured elects a deductible, but the Fifth District's interpretation of section 627.739(2) deprives insurers of the *quid pro quo* for accepting a lower premium

because the deductible is expended against non-covered billings for which neither insurers nor insureds would otherwise be responsible.

Finally, the Fifth District's interpretation would harm the general insurance-buying public as it would lead, yet again, to increases in PIP premiums and unnecessary litigation—the very same problems the fee schedule method of determining the reasonableness of a provider's charges was created to combat. Just as insurers would lose the benefit of selling PIP policies with deductibles, insureds would lose the benefit of buying such policies for reduced premiums. Accepting the Fourth District's interpretation and rejecting that of the Fifth District is not only consistent with the plain language of the statute and common sense, but would further the very purpose of adopting a fee schedule in the first place.

ARGUMENT

I. BECAUSE REASONABLENESS IS THE CORNERSTONE OF THE PIP STATUTE, THE DEDUCTIBLE MUST ONLY BE APPLIED TO REASONABLE EXPENSES CALCULATED PURSUANT TO THE STATUTORY FEE SCHEDULE.

A. The plain language of the PIP statute, the history of its reform, and its underlying principle of reasonableness all support applying the deductible only to reasonable medical expenses as determined by the fee schedule.

Reasonableness is the cornerstone of the PIP statute. *State Farm Mut. Auto. Ins. Co. v. Care Wellness Ctr., LLC,* 43 Fla. L. Weekly D573, at *2 (Fla. 4th DCA Mar. 14, 2018). To that end, the legislature crafted the PIP statute to "set[] forth a basic coverage mandate: every PIP insurer is required to . . . reimburse eighty

percent of ***reasonable expenses*** for medically necessary services." *Geico Gen. Ins. Co. v. Virtual Imaging Servs., Inc.*, 141 So. 3d 147, 155 (Fla. 2013) (emphasis added) (citing § 627.736(1)(a), Fla. Stat. (2008)). As this Court has recognized, this provision is "the heart of the PIP statute's coverage requirements." *Id.*

Throughout the numerous amendments to the PIP statute, the legislature has consistently maintained its key structural element of reasonableness. Most significantly, the legislature's more recent amendments "were designed to regulate the amount providers could charge PIP insurers and policyholders for the medically necessary services PIP insurers are required to reimburse." *Id.* at 153. For example, beginning in 2001, the legislature enacted a series of amendments authorizing insurers to limit reimbursements for medical services pursuant to fee schedules. *See id.* at 153-54.

The 2008 version of the statute provided two alternative methods by which an insurer may determine whether charges are reasonable: the fact-dependent method and the statutory fee schedule method. *See* § 627.736(5)(a), Fla. Stat. (2008). The purpose of the newly adopted fee schedule method was to reduce litigation over the reasonableness of a provider's charges that resulted from application of the fact-dependent method. When incorporated into an insurance policy, the fee schedule method conclusively establishes the ***reasonable*** value of medical services. *See Allstate Ins. Co. v. Orthopedic Specialists*, 212 So. 3d 973,

976 (Fla. 2017) ("Reimbursements made under section 627.736(5)(a)2. satisfy the PIP statute's reasonable medical expenses coverage mandate.").

Also in 2008, the legislature added the following provision to the PIP statute: "Any [provider] . . . may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered." *Virtual Imaging*, 141 So. 3d at 155 (emphasis added) (quoting § 627.736(5)(a), Fla. Stat. (2008)). This provision clearly mandates that the requirement that a provider's charges must be "reasonable" applies whether such charges are to be paid by the insurer or the injured party. Because a provider's charges must be reasonable whether paid by the insurer or the injured party, and because the fee schedule fixes the reasonableness of such charges, it follows that the fee schedule should be applied to all charges, regardless of whether they fall within the insured's deductible or the coverage provided by the insurer. In other words, the express language of section 627.736(5)(a) directly contradicts and conclusively defeats Respondent's argument.

This common thread of reasonableness is woven throughout the fabric of the PIP statute. In *Care Wellness*, the Fourth District recognized this overarching principle and held that the fee schedule should be applied to all charges, regardless of whether they fall within a deductible, to ensure that all charges are reasonable. 43 Fla. L. Weekly D573, at *7-8. Yet, the Fifth District abandoned that central

premise and contradicted the plain language of the statute by concluding that a provider's billed charges need not be reasonable if the insured purchased a PIP policy with a deductible.

Here, this Court must determine whether to follow the Fourth District's interpretation of the PIP statute and ensure that all medical charges are reasonable, or whether to follow the Fifth District's interpretation and abandon the central premise of the PIP statute—reasonableness—to allow medical providers to charge unreasonable expenses to injured parties. As the Fourth District aptly explained when addressing this issue: "We think the plain language of the [PIP] statute is clear. The legislature unambiguously emphasized a requirement that expenses be reasonable. We cannot minimize the importance of this reasonableness requirement." *Care Wellness*, 43 Fla. L. Weekly D573, at *4. Thus, "[t]he requirement that charges be reasonable applies to the ***totality*** of the charges." *Id.* To read the PIP statute as the Fifth District did would mean that a provider's charges "need to be reasonable only to the insurer, not the insured." *Id.* This construction of the PIP statute defies the common sense purpose of, and in fact is absolutely barred by, the fundamental reasonableness requirement. *See* § 627.736(5)(a), Fla. Stat.

B. The term "expenses," as used in section 627.739(2) must be considered in context to mean "reasonable expenses."

By its terms, section 627.739(2) requires the Court to first look to the context and description of the term "expenses" in section 627.736 before determining how a deductible is applied to those "expenses." Section 627.736, which outlines the PIP benefits that must be provided to an insured as well as the reimbursement of medical charges for an insured's care, contains multiple references to "expenses." *Care Wellness*, 43 Fla. L. Weekly D573, at *3. As the Fourth District noted, "each [sub]section [of section 627.736] includes, directly or indirectly, a requirement that the expenses be reasonable."[1] *Id.*

Nothing in section 627.736 "describe[s]" an expense as being the amount billed by a provider. In fact, nowhere in the statute does the amount billed by the provider control over the reasonable value of the services provided. Instead, the reasonableness of the provider's charges is always the primary consideration. Section 627.736 expressly states that providers "may charge the insurer and injured party ***only a reasonable amount***." § 627.736(5)(a), Fla. Stat. (emphasis added). Thus, the only logical conclusion to draw from section 627.739(2)'s cross-

[1] *E.g.*, section 627.736(1)(a) (mandating that insurer cover "[e]ighty percent of all reasonable expenses for medically necessary . . . services"); section (1)(b) (same for "all expenses reasonably incurred" in connection with loss of income and earning capacity); section (6)(b) (requiring providers to "furnish a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary").

reference to section 627.736 is that the phrase "expenses . . . described in s. 627.736" means "reasonable expenses." In light of this context, section 627.739(2) can only be read to mean that an insured's deductible is applied to 100 percent of ***reasonable*** expenses, or in other words, after application of the fee schedule.[2] *See generally* Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts*, § 4 at 63 (2012 ed.) (explaining that under the principle of "presumption against ineffectiveness" "[a] textually permissible interpretation that furthers rather than obstructs the document's purpose should be favored").

C. The civil jury instruction regarding the calculation of PIP benefits supports the interpretation adopted by the Fourth District and advanced by Progressive in this appeal.

As explained *supra*, insurers may also determine the reasonableness of a provider's charges based upon "a fact-dependent inquiry determined by a consideration of various factors." *Orthopedic Specialists*, 212 So. 3d at 976 (recognizing "two different methodologies for calculating reimbursements to

[2] Indeed, applying the PIP statute's *reasonable* medical expenses coverage mandate has always been the first step in the insurer's reimbursement calculation. *See Cosme v. Fidelity Nat. Ins. Co*., 5 Fla. L. Weekly Supp. 656a (Fla. 11th Cir. Ct. 1998) (the PIP deductible is applied ***after*** negotiating a reduced bill for services with the provider), cert. denied No. 97-00924 (Fla. 3d DCA, Aug. 8, 1997); *Physicians Injury Care Ctr., Inc. v. Progressive Express Ins. Co.*, 12 Fla. L. Weekly Supp. 693a (Fla. 9th Cir. Ct. 2005) (the insurer correctly applied the reduced bills to the deductible instead of the original amount billed because only a *reasonable* amount, determined by reimbursement levels in the community is covered).

satisfy the PIP statute's reasonable medical expenses coverage mandate"). An examination of this fact-dependent method for determining reasonableness further supports Progressive's construction of section 627.739(2). When the fee schedule method is not used, a jury may determine the reasonable amount of medically necessary expenses. After the jury determines reasonableness, the application of the deductible is a fairly straightforward exercise conducted by the trial court.

This process is illustrated in Florida Standard Civil Jury Instruction 413.4, which instructs a jury deciding a claim for PIP benefits to make three determinations: (1) whether the medical service provided to the insured was related to the accident; (2) whether the service was medically necessary; and (3) whether the charge for the service was reasonable. If the jury ultimately determines that a charge is reasonable, it is further instructed that it "should award that amount as damages." Fla. Std. Jury. Instr. (Civil) 413.4.

Standard Instruction 413.4 includes the following note on how the trial court is to apply the insured's deductible following an award by the jury:

> This instruction assumes that the jury will be asked to decide the total amount of medical charges. It is anticipated that the judge will adjust this award in entering judgment to account for any payments previously made by the insurer, as well as for the effect of the 80% limitation in F.S. 627.736(1)(a), and any deductible.

Id. at note 1. Thus, even the standard civil jury instructions, which this Court authorized, confirm that the deductible must be applied to a provider's charges

after it is determined that such charges are reasonable. *See In re Standard Jury Instructions in Civil Cases (No. 06-02)*, 966 So. 2d 940, 940 (Fla. 2007) (authorizing a new standard instruction "intended to assist county court judges in handling PIP claims"). It is illogical to suggest that under one reimbursement method, a reasonableness determination would come before applying the deductible, but under the other method, it would be made after the deductible is applied.

In short, the text of the PIP statute is clear that a provider may only be reimbursed for reasonable medical expenses. This mandate, meant to protect insureds and insurers, can only be fulfilled by applying the statutory fee schedule limitations to a provider's billed charges before applying the deductible.

II. AN INSURED'S DEDUCTIBLE TO THE TOTAL BILLED CHARGES BEFORE DETERMINING THE REASONABLENESS OF THOSE CHARGES RENDERS THE DEDUCTIBLE SUPERFLUOUS AND HARMS INSUREDS, INSURERS, AND THE PUBLIC.

The Fifth District's conclusion that an insured's deductible should be applied to a provider's billed charges before applying the statutory fee schedule limitations is unsupported by the plain language of the PIP statute. Furthermore, the Fifth District's interpretation would harm insureds by reducing the total services and benefits they receive within their $10,000 policy limit and undermine the benefit of an insurer's bargain in accepting a lower premium in exchange for a

PIP deductible, which would result in higher premiums for the insurance-buying public.

A. The Fifth District's interpretation would harm insureds because they would be subjected to higher co-pays and would exhaust their benefits faster.

Applying an insured's deductible to billed charges before determining whether those charges are reasonable renders the deductible superfluous. Under this approach, the insured is forced to pay out-of-pocket for medical charges that would not be covered by PIP insurance because they are unreasonable. This directly contradicts the statute's express mandate that providers "may charge the insurer ***and injured party*** only a ***reasonable amount***." § 627.736(5)(a), Fla. Stat. (emphasis added).

This approach also requires the insured to pay a higher co-pay and use more PIP benefits than would be necessary if the reasonableness limitations were applied before the deductible. It follows that if the services that fall within the deductible cost more, the insured will be able to obtain fewer services before exhausting his or her deductible, and in turn, would begin to use his or her PIP benefits sooner. Therefore, applying the fee schedule limitations after applying the deductible would result in insureds obtaining fewer services and exhausting their total PIP benefits faster. *See* Office of the Insurance Consumer Advocate, *Report on Florida Motor Vehicle No-Fault Insurance (Personal Injury Protection)*, at App. 9 (Dec.

2011) (included in the Appendix hereto)[3]. As explained in greater detail in the brief by *amicus curiae*, Florida Justice Reform Institute, insureds may also be responsible for greater co-pays under the Fifth District's interpretation.

Put simply, the Fifth District's interpretation would do nothing to protect the consumer. In fact, it would do quite the opposite. The PIP statute was designed to protect consumers and provide prompt payment for reasonable and necessary medical services, lost wages and burial costs, without regard to fault. PIP reforms, including the adoption of fee schedules, were intended to combat rising premiums and prevent unnecessary litigation. Rather than protecting insureds and furthering these goals, however, the Fifth District's interpretation would only enhance medical providers' ability to recover unreasonable expenses directly from and at the expense of injured parties. This interpretation contradicts the very purpose of the PIP statute.

B. The Fifth District's interpretation would harm insurers because they would be denied the benefit of selling PIP policies with deductibles.

Insurers must provide PIP coverage at a reduced premium when the insured elects a deductible. *See* § 627.739(4), Fla. Stat. "A deductible is a clause in an insurance policy that relieves the insurer of responsibility for an initial specified

[3] Citations to the Appendix to this brief appear as App. __, with the blank corresponding to the stamped page number on the appendix document.

loss of the kind insured against." *Gen. Star Indem. Co. v. W. Fla. Village Inn, Inc.*, 874 So. 2d 26, 33 (Fla. 2d DCA 2004). As the Second District has explained:

> Generally, the functional purpose of a deductible, which is frequently referred to as self-insurance, is to alter the point at which an insurance company's obligation to pay will ripen. As self-insurance, a deductible requires the insured to share in the risk of loss, and worthy social goals are promoted. The insured is given a monetary incentive to fulfill his or her duty to protect and to adequately maintain his or her property as well as a monetary disincentive to file relatively trivial claims, thereby contributing to the reduction of administrative costs and overall costs of insurance. Conversely, applying the deductible to noncovered loss does not serve the goals of having the insured share in the risk. Indeed, it threatens to render the deductible a nullity.

Id. at 33-34.

Thus, the deductible provision in section 627.739(4) mandates the terms of the contract—the insurer must accept a lower premium if a deductible is elected—and in exchange, the point at which the insurer must start paying benefits for a loss is delayed until the deductible is reached. But the Fifth District's interpretation of section 627.739(2) requires application of the deductible to a provider's billed charges regardless of whether that amount is actually subject to payment of benefits. This deprives the insurer of the benefit of its contract because the deductible is exhausted faster when it is applied to non-covered billings. In turn, this impairs a statutorily mandated contract obligation and right. *See Gen. Star Indem. Co.*, 874 So. 2d at 33 ("A deductible loses its meaning entirely if it is to apply to loss that is not covered by the policy.").

C. The Fifth District's interpretation would harm the public because it would lead to increased premiums and excessive litigation.

The Legislature has mandated that a provider's charges must be reasonable, regardless of whether they are to be paid by an insurer or an injured party. § 627.736(5)(a), Fla. Stat. The statutory fee schedule was adopted to curtail overbilling and reduce litigation over the "reasonableness" of medical charges. If an insurer incorporates the fee schedule into its policy, the reasonableness of a provider's chargers is conclusively determined with reference to the statutory fee schedule. *Orthopedic Specialists*, 212 So. 3d at 976. If accepted by this Court, the Fifth District's interpretation of section 627.739(2) would frustrate the very purpose of the fee schedule and could result in yet another wave of litigation regarding the "reasonableness" of medical charges.

The legislature first introduced fee schedules in 2001 for determining the reasonableness of a limited category of charges for certain diagnostic tests. In doing so, the legislature explained that it was motivated in part by the increased costs of litigation and harm to consumers that resulted from overbilling:

> The Legislature finds that the Florida Motor Vehicle No-Fault Law is intended to deliver medically necessary and appropriate medical care quickly and without regard to fault, and ***without undue litigation*** or other associated costs. The Legislature further finds that ***this intent has been frustrated at significant cost and harm to consumers*** by, among other things, fraud, medically inappropriate over-utilization of treatments and diagnostic services, ***inflated charges***, and other practices on the part of a small number of health care providers and unregulated health care clinics, entrepreneurs, and attorneys.

S.B. 1092 (2001) (emphasis added). In 2007, after further changes to the PIP statutes in 2003 fell short of correcting the problem, the PIP statute was due to sunset. Against this backdrop, the legislature re-enacted PIP and adopted a fee schedule method of reimbursement for all medical expenses under PIP, which became effective January 1, 2008. *See* H. B. 13C (2007).

The overbilling and abuse that led to the legislature's adoption of fee schedules resulted in increased premiums to consumers. The rampant litigation over the application of those fee schedules caused premiums to increase even further. According to a 2011 report from the Florida Office of Insurance Regulation, many insurers found it necessary to increase rates by more than 10% per year. *See* Office of Insurance Regulation, *Report on Review of the 2011 Personal Injury Protection Data Call* (April 11, 2011). *See* App. 72.

Additionally, a December 2011 report from the Insurance Consumer Advocate revealed that paid PIP losses per car, per year, increased more than 66% over the previous 2.5 years, which put PIP premiums on pace to double every 3 years. App. 13. While PIP premiums and paid losses have increased at drastic rates, the number of motor vehicle accidents during the same period has decreased. App. 14. Perhaps the most telling statistic in the Insurance Consumer Advocate's report is that, in 2010, "for every dollar of premium taken in by insurance

companies, $1.15 was paid out in losses and expenses not including overhead expenses." App. 9. In other words, PIP was underwater.

A large driver of this premium increase was the drastic increase in litigation regarding PIP claims. From 2006 to 2010, "the number of lawsuits pending at year end increased by 387%, while the number settled during the year increased 315%." App. 76. Thereafter, PIP-related lawsuits continued to increase, "from 22,327 for the first eight months of 2010 to 46,842 in 2011, an ***110 percent increase***." App. 10 (emphasis added). The application of the statutory the fee schedule, and more specifically, the proper method of incorporating the fee schedule into a PIP policy, was a main subject of this litigation. Last year, this Court finally put an end to that issue in *Allstate Ins. Co. v. Orthopedic Specialists*, 212 So. 3d 973 (Fla. 2017).

As occurs all too often in PIP litigation, however, when one door closes, another door opens. Adopting the Fifth District's interpretation of section 627.739(2) would once again lead to increased premiums and open the floodgates for excessive litigation regarding the proper application of the fee schedule—a method that was intended to avoid such litigation and reduce premiums. Neither insurers, insureds, nor the public can afford to endure another onslaught of fee schedule litigation and further increases in PIP premiums.

CONCLUSION

Common sense informs that a PIP deductible cannot be applied to medical bills that are not within PIP coverage. Because a PIP deductible is a term of the insurance policy, it has no application outside that policy. Application of a PIP deductible cannot be triggered unless and until there is a medical charge that is within the policy's PIP coverage.

As discussed in Section I, the PIP statute only requires coverage for ***reasonable*** medical expenses and mandates that providers may only charge insurers ***and injured parties*** a reasonable amount. In other words, regardless of who is responsible to pay a provider's medical bill (the insurer or the insured), the charges must be reasonable. When the statutory fee schedule is incorporated into a PIP policy, reasonableness is determined solely by reference to that fee schedule. Therefore, the fee schedule must be applied to determine the reasonable value of medical services regardless of whether those services fall within the deductible and must be paid by the insured or exceed the deductible and must be paid by the insurer.

For these reasons, PIFF and PCI respectfully suggest this Court should adopt the Fourth District's interpretation of section 627.739(2) and answer the certified question to require that the reimbursement limitation be applied first and the deductible applied to the remaining amount.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 21st day of May, 2018 a true and correct copy of the foregoing was furnished by e-mail to all counsel listed below.

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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the font requirements set forth in Florida Rule of Appellate Procedure 9.210 because it was prepared using Times New Roman 14-point font.

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