IN THE SUPREME COURT OF FLORIDA

UNITED AUTOMOBILE INSURANCE COMPANY

Petitioner,

vs. **CASE NO.: 00-111**
LT Case NO.: 3D99-1348

MARISOL RODRIGUEZ,

Respondent.

STATE FARM FIRE & CASUALTY COMPANY,
Petitioner,

vs. **CASE NO.:SC 00-112**
LT Case NO. 3D99-1481

JUANA MARIA PEREZ,

Respondent.
/

BRIEF OF AMICUS CURIAE, ALLSTATE INSURANCE COMPANY AND FLORIDA INSURANCE COUNCIL IN SUPPORT OF PETITIONERS

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CERTIFICATE OF FONT STYLE AND SIZE

The amicus curiae, Allstate Insurance Company and Florida Insurance Council, hereby certify that the style and size of the font utilized through out this brief is Times New Roman 14 point, proportionally spaced.

STATEMENT OF THE FACTS AND THE CASE

The amicus curiae, Allstate Insurance Company and Florida Insurance Council, adopt the statements of the facts and the case in Petitioners' briefs.

SUMMARY OF THE ARGUMENT

For nearly thirty years, mandatory personal injury protection ("PIP") insurance benefits have been the centerpiece for payment of medical bills for persons injured in automobile accidents in Florida. Insurers like Allstate Insurance Company[1] ("Allstate") and other members of the Florida Insurance Council[2] ("FIC") handle tens of thousands of PIP claims each year in Florida. The workload of such insurers in processing, reviewing, analyzing and paying PIP claims is enormous. Moreover, their work has

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[1] Allstate is the second largest automobile insurer in Florida.

[2] FIC is Florida's largest trade association for insurance companies, representing more than 200 companies. FIC's membership also consists of national trade associations, including the National Association of Independent Insurers, the Alliance of American Insurers, and the American Insurance Association. Thus, FIC directly or indirectly represents almost every insurance company writing any significant amount of automobile insurance in Florida. FIC exists for the purpose of expressing its members' common positions and representing their interest in legislative, administrative and judicial fora; and has frequently represented these interests as a party or amicus curiae in administrative litigation, Florida trial courts, and Florida appellate courts.

serious, vital impact on the thousands of Florida citizens who incur medical expenses because of automobile accidents each day.

In recent years, civil litigation over PIP benefits has mushroomed as court decisions have interpreted the various provisions of § 627.736, Florida Statutes, regarding various requirements and time deadlines established by that statute. This circumstance is the opposite of what the legislature intended when the Automobile Reparations Act (§§ 627.730, *et seq.*) was adopted to encourage settlements and minimize litigation. See Williams v. Gateway Ins. Co., 331 So. 2d 301, 303 (Fla. 1976). Unfortunately, the number and wide-ranging variety of decisions by courts throughout Florida have created numerous inconsistencies between judicial applications of the PIP statute requirements and the express statutory language used, resulting in an unwarranted expansion of coverage and extreme hardships which risk forfeiture for insurers as they attempt to navigate the morass of PIP decisions within exaggerated time limitations imposed by judicial determinations.

The decision appealed here, Perez v. State Farm Fire and Cas. Co., 746 So. 2d 1123 (Fla. 3rd DCA 1999), results in unwarranted extension of PIP coverage to uncovered, and possibly fraudulent, claims without any statutory basis for doing so.

It would create PIP coverage by estoppel and cause forfeitures as the result of an arbitrary 30-day time limitation entirely unrelated to the substantive merits of any claim for PIP coverage. Accordingly, this Court has the opportunity in this matter, and should take advantage of it, to prevent the injustice which would result from the decision below, and to clarify and resolve issues in controversy regarding PIP coverage in Florida.

ARGUMENT

I. SECTION 627.739(1) PRESCRIBES THE SCOPE OF PIP COVERAGE WHICH FLORIDA AUTOMOBILE POLICIES MUST PROVIDE.

Section 627.736(1), Florida Statutes establishes a mandatory coverage which must be granted in every auto policy in Florida. It provides:

> (1) Required benefits.–Every [automobile] insurance policy ... shall provide personal injury protection ... for loss sustained ... as a result of bodily injury, sickness, disease, or death arising out of the ownership , maintenance, or use of a motor vehicle .....

The PIP benefits which must be provided include "[e]ighty percent of all reasonable expenses for necessary medical ... services.." Fla. Stat. §627.736(1)(a). The injury for which benefits are sought must "relate to," i.e., "aris[e] out of," a motor vehicle

accident. Moreover,

> [u]nder this statute, an insurer is not liable for any medical expense to the extent it is not a reasonable charge for a particular service or if the service is not necessary.

Derius v. Allstate Indemnity Co., 723 So. 2d 271 (Fla. 4th DCA 1998). No other language in the remainder of § 627.736 expands this coverage grant.[3]

As a result, the PIP coverage afforded pursuant to § 627.736(1) does not exist for charges for medical services rendered to a claimant which are not related to an auto accident, reasonable in amount or necessary for the claimant's injuries or which may be fraudulent. As such, there never is any basis for requiring that an insurer pay PIP benefits for medical bills which are not genuine[4] or which do not have this requisite

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[3] The remainder of this statute describes authorized limitations on coverage (subsection (2)), explains the insured's limited rights to recover special damages resulting from such injuries (subsection (3)), delineates when PIP benefits are due and payable (subsection (4)), establishes applicable medical billing requirements (subsection (5)), prescribes insurers' rights to information about an injured's person's earnings and medical treatment (subsection (6)), defines when medical examinations of the claimant may be required, (subsection (7)), provides that attorneys' fees are recoverable in disputes regarding PIP benefits (subsection (9)), and authorizes PIP PPO arrangements (subsection (10)).

[4] Fraudulent insurance claims are a significant and expensive problem in Florida. For example, as reported in a statewide grand jury report, the Department of Insurance estimated in 1998 that there are $4.8 billion in fraudulent insurance claims each year. See Statewide Grand Jury Report on Health Care Claims Fraud, dated December 8, 1998, Florida Supreme Court Case No. 90,703 (available on the internet at www.legal.firn.edu/swp).

relatedness, reasonableness or necessity.

However, the decision on appeal here impermissibly expands the PIP coverage mandated by §627.736. The Third District held, without regard to whether medical services for which benefits were sought were in fact reasonable, related or necessary or whether they were even genuine, that the insurers were required to pay PIP benefits for bills submitted solely because they had not obtained a medical report providing 'reasonable proof' that they were not responsible for payment of such bills within 30 days of receipt. 746 So. 2d at 1125. This holding is without support in the language of § 627.736(1) which defines the coverage grant of PIP coverage. That statute never states that coverage is extended to bills for medical services which are not related to an auto accident, which are not reasonable, or which were not necessary if the insurer does not obtain within 30 days "reasonable proof" that those bills were not within coverage or which were not genuine. Nor does the statute state that coverage is extended to bills for medical services which are not related to an auto accident, which are not reasonable or which were not necessary if the insurer fails to obtain a "report" of any kind.

The expansion of PIP coverage by the Third District's decision is not only unwarranted by the express statutory language; it cannot be justified on any principle of "maximizing" or "broadening" PIP coverage. This Court expressly rejected that suggestion in Govan v. Int'l Bankers Ins. Co., 521 So. 2d 1086 (Fla. 1988). Govan argued that § 627.739(2), Fla. Stat., regarding the application of his deductible for his PIP coverage, should be interpreted so that the method of calculation in applying his deductible on PIP benefits provides "maximum coverage." 521 So. 2d at 1088. This Court rejected that argument because there is no basis for interpreting the language to effectuate such a policy where the statutory language is clear and unambiguous. Id. ("While we may disagree with the legislative policy underlying the statute, we have no authority to change the clear intent and purpose of a statute that is not vague and ambiguous. Complaints about this policy should be addressed to the legislature.")

Section 627.736 does not in any way contemplate expanding PIP coverage for medical expenses which are not reasonable, related or necessary. The decision of the Third District is unsupportable by the language of § 627.736(1), and, therefore should be reversed.

II. PRINCIPLES OF STATUTORY INTERPRETATION DO NOT SUPPORT ALTERING THE SCOPE OF PIP COVERAGE BASED ON OTHER SUBSECTIONS OF SECTION 627.736.

The Third District reached its result based on two other subsections of Section 627.736. First, it utilized language in § 627.736(4)(b) to create the 30 day time period for obtaining "reasonable proof" that the insurer was not responsible for payment of a bill. Second, it impliedly relied on § 627.736(7)(a) to create a requirement that the only "reasonable proof" which could prove that an insurer was not responsible to pay PIP benefits on a given bill was a medical "report." However, neither of these requirements appears on the language of Section 627.736. Indeed, the statutory language and scheme is to the contrary.[5]

A. Section 627.736(4) Does Not State That Insurers Forfeit Their Rights To Refuse Payment Of Non-Covered Claims.

Fla. Stat. §627.736(4)(b) provides, in pertinent part, that PIP benefits “shall be

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[5] The result of the Third District's reliance on different subsections of §627.736 to create such requirements is improper because "while [courts] are required to read statues in their entirety, [they] are not free to add provisions to a statute under the guise of such reading." Fortune Ins. Co. v. Everglades Diagnostics, Inc., 721 So. 2d 384, 385 (Fla. 4th DCA 1998)(refusing to graft the 30-day requirement under §627.736(4)(b) into §627.736(5)).

overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same." That section does not state that PIP coverage is expanded to include non-covered medical expenses, i.e., expenses which are not related to an auto accident, which are not reasonable or which were not necessary, if not paid within 30 days. It also does not say that PIP coverage is expanded to such non-covered items if the insurer fails to obtain within 30 days, "reasonable proof" that it was not responsible to pay such bills.

> When construing a statutory provision, legislative intent is the polestar that guides our inquiry and thus "when the language of the statute is clear and unambiguous and conveys a clear and definite meaning, there is no occasion for resorting to the rules of statutory interpretation and construction."

Pioneer Life Ins. Co. v. Heidenfeldt, 25 Fla. L. Weekly D231, 2000 WL 35809 (Fla. 2nd DCA January 19, 2000)(quoting McLaughlin v. State, 721 So. 2d 1170, 1172 (Fla. 1998)(quoting A.R. Douglass, Inc. v. McRainey, 102 Fla. 1141, 137 So. 157, 159 (1931))). The language of § 627.726(4)(b) is clear and unambiguous. It does not state in any way that an insurer is prohibited from denying PIP benefits at anytime on the basis that a claim was not within the PIP coverage. Its sole statement is that PIP benefits for covered losses are "overdue" if not paid within 30 days. Section

627.736(4)(c) then provides that interest at 10% is due on overdue PIP payments.

In Heidenfeldt, the Second District ruled that an insurer's non-compliance with a statutory notice requirement regarding certain health insurance claims did not create coverage for non-covered claims. Under § 627.613(2), Fla. Stat., health insurers were required to pay claims within 45 days or give written notice that they were contesting or denying a claim within 45 days. § 627.613(6) stated that overdue claim payments would bear interest at 10%. The Court held:

> [F]rom a plain reading of the statute, it is clear that if an insurer fails to reimburse a claim or notify an insured that the claim is contested or denied within the 45-day period, the insurer would be subject to the ten percent interest penalty. This appears to be the only penalty an insurer would be subject to under section 627.613.

25 Fla. L. Weekly at D232, 2000 WL 35809 at *2.

Likewise here, § 627.736(4)(b) imposes no penalty except to state that PIP benefits become overdue after 30 days. The only penalty imposed is 10 percent interest.

In another context, this Court acknowledged that the passage of the 30-days referred to in §627.736(4)(b) did not necessarily establish that PIP benefits must be paid regardless of whether they were within coverage. In State Farm Mut. Auto. Ins. Co. v. Lee, 678 So. 2d 818 (Fla. 1996), this Court considered the question of when the statue of limitations began to run for an insurer's failure to pay PIP benefits. In

concluding that the statute of limitations would commence to run after expiration of the 30-day period under §627.736(4)(b), this Court stated:

> Pursuant to this statute, State Farm had no contractual obligation to pay PIP benefits until thirty days after receipt of respondents' PIP claim. However, once the thirty days elapsed and no benefits were paid on the claim, assuming they were properly due, State Farm had effectively breached their contract with respondent.

678 So. 2d at 821 (emphasis added). Thus, in recognizing that an actionable breach arose at the end of the 30-day period under §627.736(4)(b), this Court acknowledged that the underlying question of whether PIP benefits were due at all, i.e., whether the claim was within coverage, was not altered by the passage of the 30 days.[6]

In fact, if the legislature had intended to establish an absolute bar to asserting non-coverage based on the 30-day time period, it could have included clear language to that effect. In 1998, the legislature amended § 627.736(5) to expressly state that in order for a medical services provider to obtain a PIP claim payment :

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[6] See also Jones v. State Farm Mut. Auto. Ins. Co., 694 So. 2d 165, 166 (Fla. 5th DCA 1997)(By failing to pay a PIP claim within 30 days, "State Farm is exposed to the statutory penalties attendant to an 'overdue' claim. State Farm does not, however, lose its right to contest the claim.").

> the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 30 days before the postmark of the statement.... The injured party is not liable for, and the provider shall not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph.[7]

As this provision shows, the legislature knew how to clearly and unambiguously state that a failure to meet a specified time deadline would cause a party to lose their rights under PIP coverage. The legislature did not include any such language in § 627.736(4)(b).

In the absence of any other statutory language indicating that the legislature intended a further penalty, such as requiring the insurer to pay non-covered claims, there is simply no basis for the conclusion by the Third District here that a failure to obtain "reasonable proof" or to pay a claim within 30 days requires insurers to pay non-covered claims.[8]

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[7] Subsection (5) also allows submission of bills within 60 days if the provider had notified the insurer that treatment had been initiated within 21 days if its first exam or treatment.

[8] The statute also authorizes the recovery of attorney's fees by the insured. Fla. Stat. §627.736(8). The attorneys fee recovery imposes a significant penalty on insurers. E.g., State Farm Fire & Casualty Co. v. Palma, 555 So. 2d 836 (Fla.

B. Section 627.736(4)(b) Does Not Establish That A Medical Report Is The Only Acceptable "Reasonable Proof" That The Insure Was Not Responsible for Payment Of A PIP Claim.

The Third District also impermissibly expanded on the PIP statute by imposing a "report" requirement on insurers as the only acceptable "reasonable proof" that payment was not required so that interest for an "overdue" payment would not accrue. 746 So. 2d at 1123. As noted above, section 627.736(4)(b) provides that PIP benefits are not overdue "when the insurer has reasonable proof to establish that the insurer is not responsible for the payment, notwithstanding that written notice has been furnished to the insurer." Section 627.736(4)(b) does not mention a "report" in any way. It only requires that the insurer have "reasonable proof" that it is not responsible to pay PIP benefits for a claim. Had the legislature intended that a medical report could be the only form of "reasonable proof" acceptable under that provision, it certainly could have stated that requirement expressly, as it did in §627.736(7)(a).

Section 627.736(7)(a) expressly requires that an insurer obtain a "report" from a physician only in conjunction with the withdrawal of authorization for a current

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1990)(fee award of $253,500 in PIP suit).

treating physician. Section 627.736(7)(a) does not deal with determinations: that the PIP benefits sought for medical treatment are not related to a covered loss; that the amount of the charges for such medical treatment are not reasonable; or that such medical treatment was not necessary. It only requires that:

> An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a report by a physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn stating that treatment was not reasonable, related or necessary.

Fla. Stat. §627.736(7)(a) (emphasis added).

By its express terms, this provision applies only to the extent that an insurer is withdrawing the treatment authorization of a treating physician. In other words, Section 627.736(7)(a) only applies when the insurer is seeking to terminate PIP benefits for ongoing treatment. See DeFerrai v. G.E.I.C.O., 613 So.2d 101, 103 (Fla. 3rd DCA 1993) (provision "clearly related only to the type of physician whose report could be used to terminate benefits"), review denied, 620 So.2d 760 (Fla. 1993); Allstate Insurance Co. v. Garrett, 550 So.2d 22, 25 (Fla. 2nd DCA 1989) (statute created a limitation on the "type of physician whose report may be used to terminate benefits"),

review denied, 563 So.2d 631 (Fla. 1990).

Since §627.736(7)(a) does not apply to the denial of PIP benefits by an insurer because they are not within coverage (i.e., because they are not reasonable, related or necessary), that section does not impose any "report" requirement with regard to those determinations. Instead, the propriety of the reduction or denial of PIP benefits is judged on the grounds of reasonableness, relatedness and necessity.

The fact that the legislature used completely different words in §627.736(7)(a) and §627.736(4)(b) demonstrates that the meaning of those provisions and their application are entirely separate. "When the legislature has used a term ... in one section of the statute but omits it in another section of the same statute, we will not imply it where it has been excluded." Leisure Resorts, Inc. v. Frank J. Rooney, Inc., 654 So. 2d 911, 914 (Fla. 1995). The legislature used the word "report" in §627.736(7)(a) in the context of withdrawal of treatment authorization, but omitted it in §627.736(4)(b) in the context of determining when unpaid PIP benefits became overdue. Likewise, the legislature used the words "reasonable proof" in §627.736(4)(b) when discussing when an insurer would not be responsible for interest on overdue PIP claims, but omitted it in §627.736(7)(a) when discussing the

information an insurer must obtain before withdrawing treatment authorization. As such, there is simply no basis for equating the term "report" with the phrase "reasonable proof" under §627.736(4)(b).

The distinction between the withdrawal of authorization for benefits for ongoing treatment and the reduction or denial of payments for treatment rendered on the grounds of relatedness, reasonableness or necessity is clarified in Justice Farmer's concurring opinion in Nationwide Mutual Fire Insurance Company v. Southeast Diagnostics, Inc., 25 Fla. L. Weekly D316, D317, 2000 WL 121801 at *3 (Fla. 4th DCA February 2, 2000). There, with regard to that portion of §627.736(7)(a) quoted above, Justice Farmer explained that it was "obvious that the legislature meant this sentence to apply only when the insurer has previously authorized the services of a particular physician by paying the initial and any subsequent bills, but later seeks to discontinue payment for future services by that physician" and he distinguished such a discontinuance of payment from a denial of an initial claim for payment by a provider. Both the statutory provision and Justice Farmer's concurrence make it clear that §627.736(7)(a) does not apply to the denial or reduction of PIP payments by an insurer and, therefore, a report pursuant to §627.736(7)(a) is not required in those

situations.

This difference between §627.736(7)(a) and §627.736(4)(b) is wholly consistent with the general goal of the PIP statute of providing for prompt payment of medical expenses which result from auto accidents while ensuring that payments are only required for treatment that is reasonable, related and necessary. Under §627.736(7)(a), where a claimant has begun to receive treatment, the legislature has specified that the insurer may interfere with that treatment and declare that continuing treatment would no longer be covered only by providing a medical "report." On the other hand, in cases not involving the withdrawal of treatment authorization, §627.736(4)(b) only requires that the insurer have "reasonable proof" that it is not responsible for medical

charges before any PIP payment could be deemed "overdue."[9]

Although the Third District here, and in United Automobile Insurance Company v. Viles, 726 So. 2d 320 (Fla. 3rd DCA 1998), appeared to discuss a "report" requirement in conjunction with a "reduction" of medical bills, in neither case did that court in fact demonstrate that there is such a requirement. In the instant matter, the insurers who had failed to make certain PIP benefit payments conceded that they had not obtained "reasonable proof" that they were not responsible to make such payments within 30 days of receipt of the required written notice. The issue before the Third District was whether such failure to obtain "reasonable proof" within the 30 day period precluded the insurers from presenting a defense to the overdue claims on the

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[9] This dichotomy recognizes the significant difference between the termination of future benefits and the denial of a specific claim. A patient having one claim denied will still submit a claim for his next treatment. In many cases, some claims will be denied or reduced and others will be paid. In contrast, a withdrawal terminates all benefits from the effective date forward, and ends the coverage for the entire course of treatment. See Peachtree Casualty Ins. Co. v. Walden, 25 Fla. L. Weekly D555, 2000 Fla. App. LEXIS 2174 (Fla. 5th DCA, March 3, 2000) (explaining that a withdrawal of benefits is a repudiation of the entire contract); Sensory Neurodiagnostics v. State Farm Mutual Automobile Ins. Co., Fla. L. Weekly Supp. 648 (13th Judicial Circuit, May 25, 1999) (explaining the difference between termination of benefits and denial of a claim).

grounds that they were not reasonable, related or necessary, so that payment of the claims and accrued interest was due immediately, or whether the insurers would be required to pay interest and attorney's fees from the 31st day forward if their defense to the overdue claims ultimately failed. The Third District ruled that the failure to obtain "reasonable proof" within the 30 day period precluded the insurers from presenting any defense and required them to pay both the overdue claims, regardless of whether they were in fact within coverage, and accrued interest. 746 So. 2d at 1125-26.[10]

However, without support, the Third District asserted that its prior holding in Fortune Ins. Co. v. Pacheco, 695 So. 2d 394, 396 (Fla. 3rd DCA 1997), stated that the PIP statute requires that an insurer must obtain, within 30 days, a medical report as such "reasonable proof" that it was not responsible for payment. In Pacheco, the Third District held that an insurer could not, pursuant to the terms of its policy, require that a claimant furnish all medical records before the 30 day period of §627.736(4)(b)

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[10] This conclusion was contrary to the decision in Fortune Ins. Co. v. Everglades Diagnostic, Inc., 721 So. 2d 384, 385 (Fla. 4th DCA 1998), where the Fourth District held that the sole function of §627.736(4)(b) "is to define when interest begins to accrue on unpaid PIP benefits."

would begin to run because that would render the 30-day requirement meaningless. The Pacheco decision did not discuss how an insurer might establish “reasonable proof,” let alone require that it be done solely with the report required by §627.736(7)(a). Thus, the Third District's reliance on Pacheco to import the "report" requirement from §627.736(7)(a) is misplaced, and neither in that case nor the instant case did the court discuss whether there were other means of satisfying the “reasonable proof” requirement.

In Amador v. United Automobile Ins. Co., 748 So. 2d 307 (Fla. 3rd DCA 1999), the Third District did consider the question of the meaning of the term "reasonable proof" as used in §627.736(4)(b) with regard to the requirements for submission of a PIP claim. The court “recognize[d] than an insurer may define ‘reasonable proof’ in its policy...,” acknowledging, in essence, that the words "reasonable proof" are not inherently limited to a “report” or any other restricted meaning. Amador, 748 So. 2d at 308.

Similarly, in United Automobile Insurance Company v. Viles, 726 So. 2d 320 (Fla. 3rd DCA 1998), the Third District did not consider any question about whether "reasonable proof" of non-coverage could only be a medical report. There, the Court

was dealing exclusively with the withdrawal of payment for ongoing treatment, covered by §627.736(7)(a). The insurer had already paid $1100 for medical charges before it withdrew payment for additional treatment. Viles, 726 So. 2d at 320. In that situation, the court agreed "with the trial court's well reasoned analysis concluding that United Auto was required to first obtain a physician's report before refusing to pay further medical bills...as [t]he statute plainly provides that an insurer must first obtain the referenced report before electing to withdraw payment." Id. at 321. (emphasis added.) Thus, the certified question presented to the appellate court in Viles was needlessly overbroad in its use of the terms "reduced benefits" and "reductions" because the actual facts of that case did not involve any "reduction" of bills. Indeed, they only involved a termination of benefits, because the trial court in Viles was not even presented with a bill reduction issue. Accordingly, the Viles decision is only instructive with regard to the §627.736(7)(a) report requirement in the context of a withdrawal of treatment authorization, rather than a denial of coverage benefits on reasonableness, relatedness or necessity grounds.

"Statutes will not be interpreted in a manner that leads to an unreasonable or ridiculous result or a result obviously not intended by the legislature." Viles, 726 So.

2d at 321. A requirement that a report be issued on every claim submitted where the insurer had reason to challenge the relatedness, reasonableness or necessity of the treatment at issue would violate these precepts. Consider, for example, a situation where a PIP claimant had been involved in a car accident and suffered injury to his arm. If the medical bills submitted to the insurer included a claim for a completely unrelated procedure, *e.g.*, a cholesterol screening, it would be ludicrous to require that the only "reasonable proof" that such charges were not related would be by a physician's "report." Rather, in such a situation, common sense and the face of the medical bills could provide the "reasonable proof" -- the cholesterol screening and the arm injury have nothing to do with each other. A requirement that the insurer must engage in patently unnecessary "report" gathering not only adds delay and possible unnecessary inconvenience for the insured who may be required to participate in additional examinations in order for such reports to be obtained, but would also add to the costs of claim handling, which ultimately form part of that basis on which premium charges for PIP coverage are calculated.[11] To the contrary, giving the plain

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[11] Additionally, interpreting §627.736(4)(b) as always requiring a "report" within 30 days has yet another unreasonable element. Such medical reports will have to be obtained by insurers from third parties over whom the insurer will have no control to

meaning to the words which the legislature deliberately chose to use in §627.736(7)(a) avoids such needless complication, delay and added expense which would ultimately be borne by policyholders, by restricting the report requirement as intended.

III. SECTION 627.736(4) SHOULD NOT BE INTERPRETED IN A MANNER WHICH CREATES "COVERAGE BY ESTOPPEL" AND RESULTS IN FORFEITURE.

Long-standing principles regarding insurance coverage demonstrate that the decision by the Third District here was entirely improper. Its holding, in essence, would establish "coverage by estoppel" because it would mandate payment of PIP claims based solely on an arbitrary 30-day time period, without regard to whether the claim was actually within coverage (i.e., whether it was reasonable, related or necessary). There is no legislative indication in the statutory language used to support that holding. In fact, this Court has held that estoppel should not be used to create or extend coverage. See Crown Life Ins. Co. v. McBride, 517 So. 2d 660 (Fla. 1987).

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ensure that the report is received within a 30-day deadline. It would be patently unfair to predicate an insurer's ability to avoid payment of PIP claims not within coverage based upon the fortuity that unrelated third party physicians will provide the needed "reports" within such a limited time frame.

In AIU Ins. Co. v. Block Marina Investment, Inc., 544 So. 2d 998 (Fla. 1989), this Court rejected an attempt to create coverage by estoppel under the notice requirements of § 627.426(2), Fla. Stat. That statute states that a "liability insurer shall not be permitted to deny coverage based on a particular coverage defense" unless it satisfied specific notice requirements. Id. When Block Marina submitted a claim for coverage, AIU undertook to provide a defense, informing Block Marina that it was reserving its right to assert a coverage defense. Shortly before trial of that tort action, AIU withdrew its defense, advising Block Marina that there was no coverage for that claim. Block Marina brought an action for coverage and successfully argued to the trial court and to the Third District that because AIU had not complied with the notice requirements of § 627.426(2), AIU could not deny coverage.

This Court reversed and held that AIU's failure to comply with the notice requirements of § 627.426(2) could not give rise to coverage which never existed.

> The effect of the decision below is to give insurance coverage to Block Marina for bailment losses at a time when the ... [applicable] endorsement had been eliminated from the policy and the contract of insurance expressly excluded such losses from coverage. We do not believe that the legislature intended, by the enactment of section 627.426(2), to give an insured coverage which is expressly excluded from the policy or to resurrect coverage under a policy or an endorsement which is no longer in effect, simply because an insurer fails to comply with the terms of the aforementioned statute.... Section 627.426(2), by its express terms, applies only to a denial of coverage "based on a particular coverage defense," and in effect works an estoppel. This Court recently reiterated the general rule that, while the doctrine of estoppel may be used to prevent a forfeiture of insurance coverage, the doctrine may not be used to create or extend coverage. Crown Life Ins. Co. v. McBride, 517 So. 2d 660 (Fla. 1987). We do not believe that it was the legislature's intent that section 627.426(2) change this long-standing rule.

544 So. 2d at 999-1000 (footnote omitted).[12]

By its holding here, the Third District interprets § 627.736(4)(b) as prohibiting an insurer from refusing coverage for a PIP claim simply because the insurer did not pay the claim or obtain "reasonable proof" that it was not responsible to pay, within 30 days, based solely on that arbitrary time period. Its determination is utterly without regard to whether or not the claim was actually covered. That interpretation is erroneous because it creates coverage by estoppel and

> has the effect of rewriting an insurance policy when [the statute] is not complied with, thus placing upon the insurer a financial burden which it specifically declined to accept. Such a construction presents grave constitutional questions, the impairment of contracts and the taking of property without due process of law.

544 So. 2d at 1000 (footnote omitted).

Of course, the financial burden caused by such PIP coverage by estoppel has broad economic effect beyond the insurer. PIP coverage is statutorily mandated to

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[12] The Second District in <u>Heidenfeldt</u>, discussed <u>supra</u>, cited this Court's opinion in <u>Block Marina</u> as further support for its conclusion that "the legislature did not intend section 627.613 to act as a bar to denying uncovered claims" by creating coverage by estoppel. 25 Fla. L. Weekly at D232, 2000 WL 35809 at *3.

be included in every Florida auto policy. Every Florida auto insurance policyholder is therefore required to pay a premium for PIP coverage. Because premium rates are set based upon, inter alia, insurers' loss experience, every time an insurer is forced to pay medical expenses under PIP claims which are not reasonable, related or necessary, and therefore not within coverage, such added losses will ultimately cause higher PIP premiums.[13] Therefore, the result of the Third District's decision will add to the costs of insurance for all Florida auto policyholders based on losses not within coverage, an effect clearly not intended by this legislative enactment.

As the Third District itself recently pointed out in U.S. Security Ins. Co. v. Cahuasqui, 25 Fla. L. Weekly D701, 2000 WL 293691 (Fla. 3rd DCA, March 22, 2000),

> the PIP statute does not deprive the PIP carrier of its defenses. Indeed, a PIP carrier may dispute a claim based on a coverage defense or on grounds that the medical treatment was not reasonable, necessary or related to the

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[13] Additionally, as noted supra, the additional, and possibly unnecessary examinations which would be required in order for insurers to obtain "reports" as the "reasonable proof" that they were not responsible to pay claims, would also add to the costs of claim handling, and would, therefore also contribute to higher premium charges for PIP coverage.

automobile accident.

25 Fla. L. Weekly at D701, 2000 WL 293691, at *2 (concluding that the offer of judgment statute applies to PIP claims). Indeed, the effect of the Third District's decision here would work as a forfeiture of insurers' rights to assert questions about coverage of PIP claims. "Forfeitures are not favored in law or equity and a statute authorizing the same must by the courts be strictly construed." Gen. Motors Acceptance Corp. v. State, 152 Fla. 297, 11 So. 2d 482, 484 (1943); see also Cabrera v. Dep't of Natural Resources, 478 So. 2d 454 (Fla. 3rd DCA 1985). There is no specific language in §627.736 which directly supports the conclusion by the Third District here that insurers, in essence, forfeit their right to disclaim coverage for claims outside PIP coverage. Strict construction, not expansive, should be applied, and the Third District's imposition of such a forfeiture should be rejected.

CONCLUSION

For these reasons, the decision by the Third District should be reversed.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true copy of the foregoing has been sent by U.S. Mail to John H. Ruiz, Esquire, 198 NW 37th Avenue, Miami, FL 33125; Steven E. Stark, Esquire, Bank of America Tower, 17th Floor, 100 Southeast Second Street, Miami, FL 33131; James K. Clark, Esquire, Suite 720, Biscayne Building, 19 West Flagler Street, Miami, FL 33130; Amado Alan Alvarez, Esquire, Sunset International Center, 7000 S.W. 97th Avenue, Suite 209, Miami, FL 33173; Amando A. Brana, Esquire, 3971 SW 8h Street, Suite 301, Coral Gables, FL 33134; Shelley Senecal, Esquire, 100 North Biscayne Boulevard, 2300 New World Tower, Miami, FL 33132; and Robert A. Robbins, Esquire, Suite 400, 9200 South Dadeland Boulevard, Miami, FL 33156, this _____ day of June, 2000.

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