SUPREME COURT OF FLORIDA

ALLSTATE INSURANCE COMPANY,

Petitioner. CASE NO.: SC01-2444

vs. L.T. CASE NO.: 1D00-2974

DINO KAKLAMANOS, ET AL.,

Respondent.

/

VERON CARAVAKIS,

Petitioner. CASE NO.: SC02-198

vs. L.T. CASE NO.: 2D00-4027

ALLSTATE INDEMNITY COMPANY, ETC.,

Respondent.

/

ON APPEAL FROM THE FIRST AND SECOND DISTRICT COURTS OF APPEAL (CONSOLIDATED)

AMICUS BRIEF OF NATIONAL ASSOCIATION OF INDEPENDENT INSURERS (NAII)

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TABLE OF CONTENTS

TABLE OF CITATIONS ii

ISSUE PRESENTED ON APPEAL 1

The substantive issue is whether an insured should be permitted to bring a claim against his/her PIP insurer with respect to the insurer's reduction or denial of payment for a medical bill when the insured has suffered no damage, i.e. the medical provider has not made any claim or sought any payment from the insured regarding such bill.

STATEMENT OF INTEREST OF AMICUS CURIAE 1

STATEMENT OF THE CASE 3

SUMMARY OF THE ARGUMENT 3

ARGUMENT 4

CONCLUSION 16

CERTIFICATE OF SERVICE 17

CERTIFICATE OF COMPLIANCE 18

TABLE OF CITATIONS

CASES

Botero v. Fidelity National Insurance Company,
4 Fla. L. Weekly Supp. 440 (Fla. 11th Cir. Ct. 1996) 10

Colonial Penn Insurance Co. v. Magnetic Imaging Systems I, Ltd.,
694 So. 2d 852 (Fla. 3d DCA 1997) 14

Derius v. Allstate Indemnity Co.,
723 So. 2d 271 (Fla. 4th DCA 1998) 14

Ivey v. Allstate Insurance Co.,
744 So. 2d 679, 683-684 (Fla. 2000) 5, 9

Kaklamanos v. Allstate Insurance Company,
796 So. 2d 555 (Fla. 1st DCA 2001) 7, 11, 16

Kochinski v. State Farm Fire and Casualty Co.,
7 Fla. L. Weekly Supp. 807
(Fla. Hillsborough Cty. Ct. September 20, 2000) 8

Lasky v. State Farm Insurance Company,
296 So. 2d 9, 18 (Fla. 1974) 10

Orion Insurance Co. v. Magnetic Imaging Systems I,
696 So. 2d 475, 478 (Fla. 3d DCA 1997) 13

Progressive Express Insurance Co. v. MTM Diagnostics, Inc.,
754 So. 2d 150 (Fla. 2d DCA 2000) 14

Rittman v. Allstate Ins. Co.,
727 So. 2d 391, 394 (1st DCA 1999) 13

United Automobile Ins. Co. v. Stat Technologies,
787 So. 2d 920 (Fla. 3d DCA 2001) 14

Williams v. Gateway Ins. Co.,
331 So. 2d 301, 303 (Fla. 1976) 5

STATUTES AND LEGISLATIVE HISTORY

Ch. 01-271, § 1, Laws of Fla. 6

Florida Statutes, Section 627.0651 . . . . 15, 16

Florida Statutes, Section 627.428 7

Florida Statutes, Section 627.736(1) 4, 9, 10, 12

Florida Statutes, Section 627.736(5)(b)(1) 6

Florida Statutes, Section 627.736(5)(e) 12, 13

Florida Statutes, Section 817.234(8) 6

Staff Analysis and Economic Impact Statement provided in Fla. S. Comm. on Banking and Insurance,
CS for SB 1092 Staff Analysis (March 26, 2001) 6-7

OTHER AUTHORITIES

Orange County Clerk of Courts PIP Open Cases Report 5

Second Interim Report of the Fifteenth Statewide Grand Jury,
Florida Supreme Court Case No. 95,746 . . . . 5-6, 11, 12, 15, 16

ISSUE PRESENTED ON APPEAL

The substantive issue is whether an insured should be permitted to bring a claim against his/her PIP insurer with respect to the insurer's reduction or denial of payment for a medical bill when the insured has suffered no damage, i.e. the medical provider has not made any claim or sought any payment from the insured regarding such bill.

STATEMENT OF INTEREST OF AMICUS CURIAE

NAII is the nation's largest full-service property and casualty trade association, representing more than 690 members. NAII member companies range in size from large national companies to regional companies to companies writing in a single state. The purposes of NAII are to promote the economic, legislative and public standing of its members and the insurance industry; to provide a forum for discussion of problems which are of common concern to its members; to keep members informed of regulatory and legislative developments; and to serve the public interest through appropriate activities including the promotion of safety and security of persons and property. NAII also expresses its members' common positions and represents their interests in legislative, judicial and public forums. NAII has frequently represented its members' interests as amicus curiae in Florida courts including this Court.

NAII is headquartered in Des Plaines, Illinois and maintains four regional offices and an office in Washington, D.C. NAII also retains legislative counsel in every state.

NAII's 690 members have insurance writings representing 31 percent of the country's total property and casualty market. In 2000, for example, NAII had 94 member companies writing personal automobile insurance in the State of Florida

for 53.8 percent of the total personal automobile business in Florida. This amounted to more than $4 billion in premium in the state. Twenty-eight NAII members are domiciled in Florida. Given this presence in the Florida marketplace, NAII and its members have a significant interest in the substantive issue presented in these consolidated cases regarding an insured's standing to bring suit.

The substantive decisions in these consolidated cases significantly impact the interests of NAII's members. The decisions expose NAII's members to suits by their insureds who have suffered no damage. The decisions, if not reversed, will result in increased expenses to insurance companies. For these reasons, NAII requested leave to appear as amicus curiae, address the substantive issues raised by the decisions under review, and file a brief in support of Petitioner, Allstate Insurance Company, in Case No. SC01-2444 and in support of Respondent, Allstate Indemnity Company, in Case No. SC02-198.

STATEMENT OF THE CASE

NAII adopts the Statement of the Case by Petitioner, Allstate Insurance Company, in its initial brief.

SUMMARY OF THE ARGUMENT

According to the findings of the Statewide Grand Jury, as adopted by Florida's Legislature, personal injury protection (PIP) insurance coverage has been abused by unscrupulous medical providers and attorneys. Much of this abuse centers on medical providers inflating their charges for treatment and charging for treatment which was not performed. This abuse has created a crisis which has

caused the Legislature to take action to protect Florida consumers as well as PIP insurers.

Despite the intended goal of the PIP statute, litigation involving PIP benefits has mushroomed. There is no reason to expand the litigation by permitting insureds to bring suit against their PIP insurers when the insureds have suffered no damage. Such a result is actually counterproductive to insureds: it causes them increased financial exposure through higher co-payment amounts and leads to the unnecessary reduction of their policy benefits.

Medical providers are sophisticated parties, who have demonstrated the ability to pursue claims when they want to contest a PIP insurer's decision to reduce or deny a bill. When the medical provider has not pursued payment of a bill, there is no logical reason to allow the insured to pursue a remedy instead. If there is no wrong, there is no need for a remedy, or a suit.

The decision by the First District Court of Appeal encourages the filing of unnecessary litigation by insureds seeking a potential windfall and by attorneys seeking fees. There is no reason to allow the doors of Florida's congested courthouses to be open to these suits.

Finally, the Statewide Grand Jury has recognized that abuse of PIP has created a significant and expensive problem in Florida, "taking a large bite out of every Floridian's insurance budget." Allowing insureds to prosecute these unnecessary suits only exacerbates such problem as it will result in increased insurance premiums for Florida policyholders.

ARGUMENT

I. AN INSURED WHO HAS NOT BEEN DAMAGED BY AN INSURER'S DENIAL OR REDUCTION OF PAYMENT SHOULD BE FOUND TO HAVE NO STANDING TO FILE SUIT AGAINST THE INSURER FOR PIP BENEFITS.

Section 627.736(1), Florida Statutes, part of Florida's Automobile Reparations Act, requires every automobile insurance policy to provide $10,000 in personal injury protection ("PIP") benefits for loss resulting from bodily injury, sickness, disease, or death, arising out of the ownership, maintenance, or use of a motor vehicle, without regards to fault. See § 627.736(1), Fla. Stat. The statute was adopted to encourage settlements and minimize litigation, see Williams v. Gateway Ins. Co., 331 So. 2d 301, 303 (Fla. 1976); and to provide swift payment so that the injured insured may get on with his or her life without undue financial interruption. See Ivey v. Allstate Insurance Co., 744 So. 2d 679, 683-684 (Fla. 2000).

However, contrary to the legislative intent behind the statute, civil litigation over PIP benefits has mushroomed in recent years

[1]. Furthermore, fraudulent PIP claims have become a significant and expensive problem in Florida, "taking a large bite out of every Floridian's insurance budget." See Second Interim Report of the Fifteenth Statewide Grand Jury, Florida Supreme Court Case No. 95,746 ("Second Grand Jury Report")(available on the internet at

www.legal.firn.edu/swp/jury/fifteenth.html

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[1] For example, in Orange County alone there are 4,439 PIP cases currently pending, according to a report by the Clerk of Courts for Orange County, Florida. See Orange County Clerk of Courts PIP Open Cases Report dated 05/28/02 attached hereto as Exhibit "A".

). The Statewide Grand Jury investigation regarding PIP fraud has concluded that a number of "greedy and unscrupulous legal and medical professionals have turned that $10,000 coverage into their own personal slush fund." See Second Grand Jury Report at p. 2. The report noted that this was accomplished through a number of methods including:

> (1) brokering patients between doctors, lawyers and diagnostic facilities, as well as the attendant fraud, which can include the filing of false claims; (2) billing insurance companies for treatment not rendered; (3) using phony diagnostic tests or misusing legitimate tests; (4) inflating charges for diagnostic tests or procedures through brokers; and, (5) filing fraudulent motor vehicle tort lawsuits.

See id. at p. 1. The Statewide Grand Jury also made several recommendations to the Florida Legislature regarding legislation to help remedy this crisis.

[2] In response, the Florida Legislature implemented several of the Statewide Grand Jury's recommendations, and in the process adopted and incorporated the Statewide Grand Jury Report as part of its Legislative Findings. Ch. 01-271, § 1 at pp. 1749-50, Laws of Fla. Also in these Legislative Findings, the Legislature noted that the intent

[2] Many of the newly enacted laws targeted the solicitation and brokering of patients and clients. See § 817.234(8). Fla. Stat. (2001) (expanding prohibition against direct solicitation); and § 627.736(5)(b)(1), Fla. Stat. (2001) (medical benefits are not required to be paid to brokers).

of Florida's PIP law:

> 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.

Ch. 01-271, § 1 at p. 1750, Laws of Fla.-271Staff Analysis and Economic Impact Statement provided in Fla. S. Comm. on Banking and Insurance,

CS for SB 1092 Staff Analysis (March 26, 2001)Kaklamanos v. Allstate Insurance Company,

796 So. 2d 555 (Fla. 1st DCA 2001) Florida Statutes, Section 627.428 and hold that only those insureds who have been damaged by an insurer's denial or reduction of payment for medical expenses have standing to file suit against an insurer for such payments.

[3] Such a holding would serve as a check on much unnecessary litigation and ensure

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[3] The district court implied that the insureds had suffered damages in the form of a potential adverse effect on the doctor/patient relationship as well as potential damage to the insureds' credit history. Id. at fn. 4. In so doing, the district court incorrectly engaged in speculation, which has no support in the record.

that appropriate suits are filed by only those parties with an actual interest in the issues litigated.

The result approved by the district court in Kaklamanos creates another potential for abuse of the PIP coverage. As the Second Grand Jury Report demonstrates, insurers already face abuse in the form of inflated or fraudulent medical billing. The defense/indemnity provision in insurer's policies, such as Allstate's, were obviously intended to assist the insurer in dealing with the providers' abuses. These provisions allow an insurer to make determinations regarding the reasonableness and necessity of medical billing, and keep check on fraud and overbilling, without causing any damage to its insureds. In short, the provisions were intended to remove the insured from the dispute over improper billing. See, e.g., Kochinski v. State Farm Fire and Casualty Co., 7 Fla. L. Weekly Supp. 807 (Fla. Hillsborough Cty. Ct. September 20, 2000) (holding that insured's agreement to defend and indemnify insured from any legal action removed insured from jeopardy).

Any dispute is to be resolved between the provider and the insurer, the real parties in interest: the party billing for services it rendered and the party which pays under the PIP coverage. If the provider sues the insurer for additional PIP payments,

the litigation addresses the reasonableness and necessity of the disputed bills. If the provider instead claims against the insured, the insurer steps in, assumes the defense and protects the insured per the policy provision. In either event, the insured need not be involved in the resolution of issues regarding reasonableness or necessity.

This intended policy framework is destroyed if the Court allows an undamaged insured to file suit against its insurer and contest issues of reasonableness or necessity. The medical provider, rather than the insured, is the real party in interest to this transaction and has the only incentive to defend its billing as reasonable and necessary. The undamaged insured has no economic or other logical incentive to file suit in situations in which a medical provider is not pursuing payment of medical expenses.

The result approved by the district court in Kaklamanos is actually counterproductive to Florida insureds. Rather than enabling the insured to "get on with his [or her] life," see Ivey, 744 So. 2d at 684, the insured is interjected into protracted litigation in which he/she has no legitimate interest. Moreover, the result in such a suit, if successful, causes increased financial exposure to the insured, unnecessary reduction of policy benefits, and increased insurance premiums.

Pursuant to section 627.736, insureds have only $10,000 limits of PIP coverage available with regard to an accident in which bodily injury is suffered. The PIP statute requires that an insurer pay "[e]ighty percent of all reasonable expenses for necessary medical ... services.." leaving the insured responsible for the remaining twenty percent. §627.736(1)(a), Fla. Stat. For example, a $1000.00 medical bill for treatment which was reasonable and necessary would obligate the insured to pay $200.00 as his/her co-payment for this procedure. However, if an insurer challenges the reasonableness of the $1000.00 bill and determines, for example, that $700.00 is the reasonable amount for the service provided, see Lasky v. State Farm Insurance Company, 296 So. 2d 9, 18 (Fla. 1974) (noting that "reasonable expenses" are not to be determined solely by the amount of the bill rendered by the medical provider), the insured's 20% co-payment is applied to $700.00, and becomes $140.00 rather than the original $200.00. See Botero v. Fidelity National Insurance Company, 4 Fla. L. Weekly Supp. 440 (Fla. 11th Cir. Ct. 1996) (holding that insured is responsible for payment of 20% of the reasonable amount determined, not the first billed amount). An insured challenging the reduction or denial of payment for a medical expense is in essence arguing for an increased co-payment amount. There is no need for insureds to expose themselves to this result without the existence of a complaining medical provider. The courthouse doors should not be opened so an insured can pursue this illogical result.

In addition, the successful maintenance of such a suit further harms the insured by more rapidly exhausting any remaining PIP benefits. Under the above example, the $10,000 PIP limits will be reduced by the insurer's payment either of $800 based on the original $1,000 bill or $560 based on the reduced amount of $700. Although it is in the best interests of the insured to have his/her limits reduced by the smaller amount, a successful PIP suit will result in reduction by the larger amount. There is no reason for the limits to be exhausted more rapidly, especially when the provider is not pursuing additional payment.

Simply put, it makes no sense for an insured to file suit and incur these financial risks when a medical provider is not pursuing payment. The only motivations for such a suit are as follows: (1) the suit is intended to provide a windfall to the insured in the form of an award of "damages" for expenses he or she has not incurred, or (2) the suit is intended to provide a recovery of fees to an attorney even though the result in the suit will harm his/her client as demonstrated above. Neither motivation is legitimate, and they should not warrant this Court recognizing standing under these circumstances.

In situations such as Kaklamanos, in which a medical bill for a diagnostic test

– video fluoroscopy – was denied completely on the grounds that the test was not medically necessary, it is even more clear that the insured's pursuit of such a claim is illogical and counterproductive. As noted by the Statewide Grand Jury Report, many diagnostic tests "are extremely expensive, highly profitable, and generally employed to drain the $10,000 coverage as quickly as possible." Second Grand Jury Report at p. 8. The report noted that "one nationally syndicated diagnostic company boasts in its literature that it can teach professionals to reach 'policy limits in 90 minutes.'" Id. Further, the report described video fluoroscopy as a "test many experts decry as virtually useless as employed in the treatment or diagnosis of auto accident victims" but which because of its profit potential "is extremely attractive to unscrupulous medical practitioners." Id. at pp. 7-8. Thus, allowing an insured to file suit against an insurer arguing that a $650 medical bill for a video fluoroscopy diagnostic test should have been paid because the test was medically necessary,[4] would only serve to more quickly exhaust the insured's policy limits in addition to exposing the insured to a co-payment.

If any party could arguably be harmed in the above scenarios, it is the medical

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[4] An insured would have to make this argument, as the PIP statute only requires insurers to pay eighty percent of all "reasonable" expenses for "necessary" medical services. § 627.736(1)(a), Fla. Stat.

provider, who is the real party in interest. Not only does the medical provider perform the treatment at issue and bill the insurer for such services, the medical provider generally receives payment directly from the insurer either through assignment or by submitting their claim for payment directly to the insurers on a standard Florida Department of Insurance approved "Health Insurance Claim Form." Section 627.736(5)(e). Those forms contain a standard authorization for payment of medical benefits to the provider. Further, section 627.736(5) expressly authorizes payment by the insurance company to medical providers by this method:

> the insurer providing such [PIP] coverage may pay for such charges directly to such person or institution lawfully rendering such treatment, if the insured receiving such treatment or his or her guardian has countersigned the invoice, bill, or claim for, approved by the Department of Insurance upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian.

Section 627.736(5), Fla. Stat. Thus, by statute, health care providers are contemplated as third party beneficiaries of PIP coverage. See Orion Insurance Co. v. Magnetic Imaging Systems I, 696 So. 2d 475, 478 (Fla. 3d DCA 1997); Rittman v. Allstate Ins. Co., 727 So. 2d 391, 394 (1st DCA 1999). These third party beneficiaries have the right to question and litigate payment decisions by PIP insurers and, therefore, there is no

reason to permit insureds to bring suit to defend the reasonableness and necessity of the provider's billing. As demonstrated above, there is a conflict of interest between the insured and provider with respect to the billing, since it should be in the insured's best interest for his/her suit to be unsuccessful.

In cases like the one under review, should the insureds recover additional PIP benefits for payment of medical services, such recovery would result in a windfall as the insureds have not paid the medical provider for the services rendered. Because the medical provider is not a party to such a suit, Allstate's payment in satisfaction of any judgment would go directly to the insured. The undamaged insured has no legal impetus to take the amount paid in satisfaction of such judgment and pass it on to the medical provider, who probably has no knowledge of the suit, or the insured's recovery, since it has not pursued the insured for payment of the disputed bill.

Furthermore, medical providers are in a better position to determine whether or not it is appropriate to challenge the denial of payment of a bill based upon an insurer's conclusion that the expense was not reasonable or necessary. Under the PIP 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). Medical providers are sophisticated parties experienced in enforcing their rights against insurers that deny claims. See, e.g., United Automobile Ins. Co. v. Stat Technologies, 787 So. 2d 920 (Fla. 3d DCA 2001); Progressive Express Insurance Co. v. MTM Diagnostics, Inc., 754 So. 2d 150 (Fla. 2d DCA 2000); and Colonial Penn Insurance Co. v. Magnetic Imaging Systems I, Ltd., 694 So. 2d 852 (Fla. 3d DCA 1997). The reasonable conclusion to be drawn from the fact that a medical provider does not contest the denial or reduction of a medical bill is that the provider agrees that the denial or reduction was appropriate. While certainly most medical providers legitimately bill for services rendered, the Statewide Grand Jury Report makes clear that many unscrupulous medical providers routinely inflate the cost of medical services provided and even charge for services that were not provided. See Second Grand Jury Report at p. 1. A medical provider knowingly inflating charges for unnecessary medical treatment is not likely to complain when an insurer acts to protect itself and its insured from these charges by denying or reducing payment. The insured should not be permitted to raise such complaint instead.

Should a medical provider pursue recovery of a reduced or denied payment against the insured, insurers such as Allstate will protect the insured, as they commit

themselves to do under the defense/indemnity provision of the policy. However, under the circumstances presented in this case, in which the provider is not pursuing recovery, the defense/indemnity provision is not implicated and there is no reason for the insured to pursue any remedies, either under the PIP statute or the policy.

Finally, Florida policyholders are harmed by the maintenance and prosecution of these unnecessary suits through increased premium payments as insurers pass on additional expenses resulting from such suits. Under Florida law, premiums are directly linked to insurers' expenses incurred. Section 627.0651, Florida Statutes, requires that the Department of Insurance review motor vehicle insurance rates to determine if such rates are "excessive, inadequate or unfairly discriminatory." See § 627.0651, Fla. Stat. Among the factors considered in making this determination, the Department considers the "cost of medical expenses" incurred by the insurer as well as other "past and prospective expenses" which would necessarily include any legal fees and costs incurred. See § 627.0651(2)(a) and (h), Fla. Stat. Thus, windfalls to insureds and expenses incurred by insurers in defense of these unnecessary suits translate into higher premiums for all Florida policyholders. § 627.0651, Fla. Stat. See also Second Grand Jury Report (noting that fraudulent PIP claims have become a significant and expensive problem in Florida, "taking a large bite out of every Floridian's insurance

budget”).

CONCLUSION

For these reasons, this Court should quash the decision in Kaklamanos and hold that only those insureds who have been damaged by an insurer’s denial or reduction of payment for medical expenses have standing to file suit against an insurer with respect to such payments.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true copy of the foregoing has been sent by U.S. Mail to Yancey Langston/Charles Beall, Post Office Box 13290, Pensacola, Florida 32591-3290; David Lee Sellers, 801 N. 12th Avenue, Pensacola, Florida 32501; Tony Griffith/Timothy Ingram, 2454 McMullen Booth Road, Building C, Suite 501-A, Clearwater, Florida 33759; Anthony Parrino, 8700 4th Street North, St. Petersburg, Florida 33702; and Peter Valeta, 150 N. Michigan Ave., Suite 2500, Chicago, Illinois 60601; this _____ day of May, 2002.

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I HEREBY CERTIFY that the foregoing brief has been typed using the Times New Roman 14-point font, and therefore complies with the font requirements of Florida Rule of Appellate Procedure 9.210(a)(2).

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