IN THE SUPREME COURT OF FLORIDA

ALLSTATE INSURANCE CO.
ALLSTATE INDEMNITY CO.,

Petitioners/Cross-Respondents,

vs.

Case No. SC05-435 (Consolidated)
Case No. SC05-545 (Consolidated)

HOLY CROSS HOSPITAL, INC.,
et al.,

Respondent/Cross-Petitioner.
_____/

ON PETITION FOR DISCRETIONARY REVIEW FROM THE DISTRICT COURT OF APPEAL, FOURTH DISTRICT OF FLORIDA

ANSWER/CROSS-INITIAL BRIEF ON THE MERITS OF RESPONDENT/CROSS-PETITIONER, HOLY CROSS HOSPITAL, INC.

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Dated: March 1, 2006

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RESTATEMENT OF THE CASE AND FACTS

The Respondent[1] respectfully restates the Statement of the Case and Facts as follows:

These consolidated appeals arise from a decision of the Fourth District Court of Appeal which certified conflict with the Fifth District's decision in Nationwide Mutual Fire Ins. Co. v. Central Florida Physiatrists, P.A., 851 So.2d 762 (Fla. 5th DCA 2003). The underlying appeals were derived from final judgments entered pursuant to an order granting summary judgment to the Plaintiff in both cases and in which the county court certified questions of great public importance to the Fourth District (R.V. 2, 240, 251-252; R.V. 5, 595, 653-654).

The two underlying cases were nearly identical. Each was brought by HCH as assignee of an Allstate insured, Matthew Winik and Lawrence Wiesner, respectively. Each complaint was a two-count complaint seeking declaratory relief pursuant to Chapter 86, Fla. Stat., and an action for damages pursuant to §627.736(4)(b), Fla. Stat. (R.V. 1, 1-9; R.V. 3, 262-270). In the Winik matter, it was alleged that Matthew Winik was injured in an automobile accident on or about May 20, 2001, in Florida (R.V. 1, 1). In Lawrence Wiesner, it was alleged that he

[1] The Respondent, Holy Cross Hospital, will be referred to as HCH or as Plaintiff. The Petitioners, Allstate Insurance Company and Allstate Indemnity Company, will be collectively referred to as Allstate or Defendant. All record references will be referred to first by volume and then by page number of the record on appeal.

was injured in an automobile accident in Florida on or about April 12, 2001. Each complaint alleged that HCH was a health care provider duly licensed to transact business in Broward County (R.V. 1, 2; R.V. 3, 263). Each complaint alleged that as a direct and proximate result of the injuries sustained by the claimant in the accident, reasonable expenses were incurred for related and necessary medical and rehabilitative care which had been sought from and provided by HCH (R.V. 1, 2; R.V. 3, 263). Each complaint alleged that HCH had accepted an assignment of benefits under a policy of personal injury protection (PIP) automobile insurance from the respective insureds (R.V. 1, 2; R.V. 3, 263). Likewise, each complaint alleged that Allstate had issued a policy of insurance which provided PIP benefits for the claimant as required by §627.730 - §627.7405, Fla. Stat. (R.V. 1, 2; R.V. 3, 263). Each complaint stated that the claimant and/or HCH had provided timely notice to Allstate of the covered losses and had made a demand for PIP benefits for reasonable, necessary and related medical expenses pursuant to the assignment of benefits. Each complaint also alleged that Allstate had reduced the medical bills in excess of those amounts allowed by the PIP statute (R.V. 1, 2-3; R.V. 3, 263-264). Each complaint stated that Allstate had refused to pay the full amount due and owing HCH for reasonable, related and necessary medical services rendered to each insured (R.V. 1, 3; R.V. 3, 264).

Count I of each complaint was for declaratory judgment brought pursuant to Chapter 86, Fla. Stat. HCH maintained that §627.736(10), Fla. Stat., allowed insurers to offer policyholders the option of purchasing preferred provider policies (PPO) and/or a non-preferred provider policy for any covered medical benefits paid by PIP. It was further alleged that to take advantage of such provisions, the insurers were required to offer both a preferred and non-preferred policy to their policyholders and furnish them with a roster of PPO providers in the insured's county of residence. Even under such a plan, Allstate was still required to make payment of the statutory PIP benefits for insureds who utilized non-PPO providers for individual treatment (R.V. 1, 3; R.V. 3, 264). The complaints stated that HCH was in doubt as to its rights under the statute as it related to Allstate's conduct in reducing medical bills based on a preferred provider agreement and the non-preferred policy of insurance purchased by the insureds. It was alleged that since the policyholders did not purchase a PPO policy, but rather a standard indemnity policy, that Allstate was not entitled to take further reductions (R.V. 1, 3; R.V. 3, 264).

Count I also stated that upon the filing of a PIP claim, Allstate sent bills to a bill review company which recommended reductions in excess of those allowed by the PIP statute, and Allstate had followed the recommendations and reduced HCH's bill based upon an alleged PPO contract between HCH and a preferred

provider organization. HCH alleged that it was in doubt as to whether Allstate was indeed a "payor" as defined by the PPO agreement and, moreover, whether it was allowed to take advantage of the agreement without following the dictates of §627.736(1), Fla. Stat. HCH alleged that the agreement it had with the PPO organization did not apply to Allstate's auto policy, but rather, only applied to workers' compensation programs and group health benefit plans. HCH alleged that it was in doubt as to its rights under §627.736(10), Fla. Stat., and the policy of insurance as it related to Allstate's conduct in reducing medical bills (R.V. 1, 4; R.V. 3, 265). HCH further alleged it maintained that Allstate had breached both a contractual and statutory duty which inured to HCH through its assignment of benefits (R.V. 1, 4-5; R.V. 3, 265-266). HCH requested that the court determine the policy of insurance was not a preferred provider policy and, as such, the defendant's payment obligations were governed by §627.730 – §627.7405, Fla. Stat., along with additional supplemental relief (R.V. 1, 5-6; R.V. 3, 266-267).

Count II of each complaint was an action for damages pursuant to §627.736(4)(b), Fla. Stat., and alleged that Allstate failed to make full payment of PIP benefits to HCH within 30 days as required by Florida law (R.V. 1, 7; R.V. 3, 268). Count II also stated that Allstate failed to make the appropriate payments, notwithstanding the fact that it had no reasonable proof to establish that the

benefits were not due or that it was not responsible for full payment pursuant to the PIP statute (R.V. 1, 7; R.V. 3, 268).

Allstate answered each of the complaints denying all allegations and asserting 13 affirmative defenses (R.V. 1, 24-28; R.V. 3, 286-289).[2] Also served with HCH's complaints were request for admissions (R.V. 1, 10-23; R.V. 3, 271-284). In its responses, Allstate admitted that it had not complied with any aspect of the requirements of §627.736(10), Fla. Stat. (R.V. 1, 34-40; F.V. 3, 295-301).

HCH filed motions for partial summary judgment as to Count I of each complaint (R.V. 1, 45-65; R.V. 3, 308-328). The basis of the motions was straightforward. They stated that on the respective dates alleged in the complaints, the Plaintiffs were involved in automobile accidents and presented to HCH for care. In each instance, Allstate provided PIP insurance to the respective insureds and, in conformity with those policies and the applicable Florida Statutes, HCH properly submitted bills to Allstate for the treatment (R.V. 1, 46; R.V. 3, 309). Each motion stated that the insured assigned his benefits under the policy to HCH. Upon receipt of the bills from HCH, Allstate forwarded them to be reviewed by AP

[2] In each case, HCH moved to strike Allstate's affirmative defenses 1 through 9 and 11 through 13 (R.V. 1, 30-33; R.V. 3, 290-293). None of the affirmative defenses, either as pled in the answer nor now argued on appeal, are relevant to the issues on appeal because Allstate's counsel waived all of the affirmative defenses when he told the trial judge that if she were going to rule that Allstate was required to comply with §627.736(10), Fla. Stat., then she should enter a final judgment against Allstate, and there were no affirmative defenses to try in the trial court (R.V. 5, 626, 645). The Fourth District also concluded the defenses were waived.

Integrated Medical Solutions, Inc., who, in turn, made no determination that the treatment was unreasonable, unnecessary, or unrelated to the accidents. Nor did ADP provide Allstate or HCH with a report of any kind from a physician stating that the bills were unreasonable or unnecessary. Rather, ADP recommended that the medical bills be reduced, that is, not paid at the contractual 80% amount, but, instead, paid pursuant to a PPO contract (R.V. 1, 46-47; R.V. 3, 309-310). It was stated that the recommendation was based upon the alleged existence of an agreement between HCH and a separate, unrelated company called Beech Street Corporation, and the alleged existence of an agreement between Allstate and yet another separate entity, Beech Street Managed Care, Inc. It was further stated that Beech Street Corporation was a company that established health care preferred provider networks and it entered into contracts directly with health care providers who agreed to offer their services for discounted rates in exchange for becoming network providers and receiving patient referrals. It was further stated that Beech Street then contracted, for a fee, with insurance companies and self-insured employer groups who provided group health care benefits to insureds, members, or employees. The motion stated that at no time did HCH have a contract with Allstate for any reduced rates (R.V. 1, 47; R.V. 3, 310).

The respective motions state that in Winik, HCH submitted a bill in the total amount of $310.50 which, if paid at the full contractual amount of 80%, would

have required Allstate to pay $248.40. Allstate was alleged to have unlawfully reduced those bills and paid $186.30, entitling HCH to the difference between the two amounts as well as statutory interest, attorneys' fees and costs (R.V. 1, 47). In Wiesner, it was alleged that HCH submitted total bills in the amount of $1,569.03 which, if paid at the contractual rate of 80%, would have equaled reimbursement of $1,254.82. The motion stated that Allstate unlawfully reduced those bills and paid only $968.02. It was alleged that HCH was entitled to the difference in the two amounts plus statutory interest, costs and fees (R.V. 3, 310311). The motions concluded that the legal issue for determination by the court was whether Allstate was entitled to take PPO reductions in payment of PIP benefits without selling a PPO-PIP policy and without complying with the requirements of §627.736(10), Fla. Stat. (R.V. 1, 48; R.V. 3, 311).

In response to Plaintiffs' motions for summary judgment, Allstate filed a variety of documents along with memoranda in opposition (R.V. 1, 98-126; R.V. 2, 151-239; R.V. 3, 361-389; R.V. 4, 427-594). Additionally, Allstate filed memoranda of law in support of its motion for summary judgment (R.V. 1, 68-97; R.V. 3, 331-360). The records on appeal do not include any motion for summary judgment filed by Allstate in either case.

A hearing was held on the apparent cross-motions for summary judgment in both cases (R.V. 5, 607-652). At the commencement of the hearing, Plaintiffs

objected to the various filings by Allstate and urged the court not to consider the documents based upon various rules of evidence (R.V. 5, 609-612).

During the argument, Allstate's counsel advised the trial judge that if she was going to rule in favor of the Plaintiffs, the court should enter a final judgment and that the parties would work out the numbers to reflect the difference between 80% of what was otherwise reasonable and necessary and the amount that was paid based upon the PPO reduction (R.V. 5, 626). In considering the motions, the trial judge explained her belief that given the objections concerning the contract, her ruling had to be strictly on the limited basis concerning the plain language of the statute (R.V. 5, 643-644). The court noted that there was no genuine issue of material fact that there existed no contract between Allstate and HCH (R.V. 5, 644). Allstate concede that it had failed to comply with the requirements of §627.736(10), Fla. Stat., that it had failed to provide a roster of approved physicians, that there was no separate PPO policy, nor was there any roster available in the county in which the contracted health care physicians were listed in the roster.

Nearing the conclusion of the hearing, Plaintiffs' counsel indicated that, even though he had moved solely for a partial summary judgment, there would be no objection to a final summary judgment, provided the Defendant was not continuing to assert affirmative defenses. Plaintiffs specifically objected to the

entry of a final summary judgment if the defense was attempting to condition entry of the summary judgment upon a preservation of those defenses (R.V. 5, 645). Allstate's counsel's response was as follows:

> We are not offering a stipulation. We are saying we are surrendering on these issues, enter the final judgment. . . If you are going to find in favor of the plaintiff, enter a final judgment and there are no affirmatives defenses to try in the trial court. Id. at 645

The court did not rule on any of the evidentiary objections concerning the existence of any contract given the stipulation that there was no contract in compliance with subsection (10) (R.V. 5, 647-648). Allstate timely filed notices of appeal of the final judgments entered in these cases (R.V. 2, 255-258; R.V. 5, 657-660).

Accepting jurisdiction based upon a question certified to be of great public importance by the county court judge, the Fourth District reversed the judgments in favor of HCH. Allstate Ins. Co. v. Holy Cross Hospital, Inc., 895 So.2d 1241 (Fla. 4th DCA 2005). In its decision, the Fourth District acknowledged the conflict posed by the Fifth District's decision in Nationwide Mutual Fire Ins. Co. v. Central Florida Physiatrists, P.A., 851 So.2d 762 (Fla. 5th DCA 2003) and the Second District's decision in Nationwide Mutual Ins. Co. v. Jewell, 862 So.2d 79 (Fla. 2nd DCA 2003). With no articulated substantive analysis, the Fourth District found Jewell to be move persuasive and aligned itself with the Second District. The court

found that Allstate had waived its affirmative defenses and remanded the matter to the trial court to resolve issues of fact concerning the purported contracts between Beech Street and HCH and Beech Street and Allstate. HCH then timely invoked this Court's jurisdiction.

STANDARD OF REVIEW

Statutory interpretation is a matter of law to be determined by the trial court. City of St. Petersburg v. Austin, 355 So.2d 486, 488 (Fla. 2d DCA 1978). As such, questions of statutory interpretation are a matter of law subject to *de novo* review. B.Y. v. Dept. of Children & Families, 887 So.2d 1253, 1255 (Fla. 2004).

RESTATEMENT OF THE ISSUE ON APPEAL

Because the trial court certified an issue of great public importance and the various District Courts of Appeal accepted jurisdiction based on that issue, we respectfully restate the issue to be addressed by this Court as follows:

> IS AN INSURER REQUIRED TO COMPLY WITH THE PROVISIONS OF §627.736(10), FLA. STAT., IN ORDER TO TAKE PREFERRED PROVIDER REDUDCTIONS IN THE PAYMENT OF PIP BENEFITS FOR MEDICAL SERVICES RENDERED TO ITS INSUREDS?

SUMMARY OF THE ARGUMENT

The polestar to statutory construction is legislative intent. Borden v. East European Ins. Co., ___ So.2d ___, 31 Fla. L. Weekly S34 (Fla. 2006); State v. Rife, 789 So.2d 288, 292 (Fla. 2001). The primary source to determine legislative intent is the language chosen by the legislature to express that intent within the statute. Maggio v. Fla. Dept. of Labor and Employment Security, 899 So.2d 1074, 1076-77 (Fla. 2005); Donato v. American Telephone & Telegraph Co., 767 So.2d 1146, 1150 (Fla. 2000). There is no need to resort to administrative construction of a statute, its legislative history or other extraneous matters in the absence of doubt concerning the meaning of the statute. Id. at 1153. Likewise, all parts of the statute must be read together in order to achieve a consistent whole. M. W. v. Davis, 756 so.2d 90, 101 (Fla. 2000). Every clause and provision within the statute should be given effect and they should be harmonized with all other parts of the statute. Jones v. ETS of New Orleans, Inc., 793 So.2d 912, 914-15 (Fla. 2001).

Section 627.736(10), Fla. Stat., is clear and unambiguous. It authorizes insurers to directly contract with health care providers for the provision of PIP benefits required by the remainder of §627.736, Fla. Stat. Insurers having entered into such contracts may then offer PPO and non-PPO PIP policies to their insureds. They are then required to provide the insured a roster of all such providers in their

resident county, to maintain a roster of all such providers in their resident county and to maintain a roster of all such providers at its principal office in the state.

Allstate admits that it never complied with the statute. Based upon the clear language of §627.736(10), Fla. Stat., all PIP policies in Florida must pay 80% of the reasonable and necessary expenses incurred by an insured as a result of injuries sustained in an automobile accident. Since Allstate agreed that it did not comply with subsection (10), there is no statutory basis whatsoever for Allstate to pay any amount less than the statutory minimum required by §627.736(1), Fla. Stat.

Allstate, nevertheless, maintains that it is entitled to pay PIP benefits at the reduced PPO rate because §627.736(1), Fla. Stat., does not prohibit its conduct. Such a construction is unreasonable because, in construing the Florida Motor Vehicle No-Fault Act, courts read the provisions of the entire Act *in pari materia*. Stonewall Ins. Co. v. Wolfe, 372 So.2d 1147 (Fla. 4th DCA 1979), cert. den., 385 So.2d 762 (Fla. 1980). Moreover, Allstate's suggested interpretation simply ignores the rule of statutory construction that when the law expressly describes a situation where something should apply, an inference must be drawn that what is not included by specific reference was intended to be omitted or excluded by the legislature. Young v. Progressive Southeastern Ins. Co., 753 So.2d 80, 85 (Fla. 2000).

Allstate and its amicus have extensively argued the perceived benefits of allowing it to continue paying less than the minimum mandatory PIP benefits. They support this argument with their views of public policy, while at the same time extolling the virtues of managed health care. They further suggest that, given these perceived benefits, applying the plain meaning of the statute produces too harsh a result which should be avoided on the basis of these alleged public policy benefits. Of course, this Court is not the appropriate forum for such a discussion. Such discussions occurred in the legislature prior to the initial passage of the statute or its subsequent amendment. If Allstate believes that the statute is too harsh, its remedy lies in seeking repeal or amendment of the statute. Seagrave v. State, 802 So.2d 281, 287 (Fla. 2001).

Allstate also argues that health care providers, such as HCH, do not have standing to complain about the payments they receive, nor does §627.736(10), Fla. Stat., provide a right of private enforcement. In Florida, standing is recognized if one has a sufficient interest in the outcome of litigation which will warrant the court's entering it. General Development Corp. v. Kirk, 251 So.2d 284, 286 (Fla. 2nd DCA 1971). Health care providers who have accepted valid assignments from their insureds have routinely been recognized as having standing to sue an insurance company for the payment of PIP benefits owed under a policy issued to the insured/assignor. See, e.g., Hartford Ins. Co. of Southeast v. St. Mary's

Hospital, Inc., 771 So.2d 1210, 1212 (Fla. 5th DCA 2000). Moreover, HCH has never asserted a right of private enforcement pursuant to §627.736(10), Fla. Stat. Rather, it has consistently sought to enforce its rights pursuant to §627.736(10) and (4), Fla. Stat. It properly did so in an action for declaratory relief under the statute pursuant to Chapter 86, Fla. Stat., and an action for damages.

This Court need not address the arguments regarding "defenses" that Allstate expressly waived. Once the analysis is complete, we believe the Court will conclude that the Fifth District's decision in Nationwide Mut. Fire Ins. Co. v. Central Fla. Physiatrists, P.A., 851 So.2d 762 (Fla. 5th DCA 2003) properly answered the certified question.

This Court should quash the decision of the Fourth District, disapprove Jewell, supra, and approve Central Florida Physiatrists, supra, and remand for reinstatement of the judgments in favor of HCH.

ARGUMENT

AN INSURER IS REQUIRED TO COMPLY WITH THE PROVISIONS OF §627.736(10), FLA. STAT., IN ORDER TO TAKE PREFERRED PROVIDER REDUCTIONS IN THE PAYMENT OF PIP BENEFITS FOR MEDICAL SERVICES RENDERED TO ITS INSUREDS.

I. INTRODUCTION

Rather than address the true issue framed at the trial level, Allstate now argues that the issues in this appeal are whether HCH is trying to avoid contractual obligations under various contracts that were not admitted into evidence, were never authenticated and, based on this record, may not even exist. Allstate uses these contentions to bootstrap its arguments regarding reasonable charges and the like. The fact of the matter is, however, that the Fourth District addressed only one issue. That was one involving statutory construction and we believe it is the only issue properly before the Court.

As should be done in any case involving mandatory insurance coverage, we will analyze the statute to determine the rights and obligations of the parties. Under this analysis, we believe the Court will see the compelling legal justification for following the Fifth District's better-reasoned judgment in Nationwide Mut. Fire Ins. Co. v. Central Fla. Physiatrists, P.A., 851 So.2d 762 (Fla. 5th DCA 2003), while rejecting the Second District's flawed and, most respectfully, erroneous

analysis and holding in Nationwide Mut. Ins. Co. v. Jewell, 862 So.2d 79 (Fla. 2d DCA 2003), which the Fourth District simply adopted as its own here.

II. THE STATUTE

A. Statutory Analysis

Florida courts utilize a variety of rules when interpreting statutory provisions. First and foremost, legislative intent is the polestar that guides the court's inquiry. Borden v. East European Ins. Co., ___ So.2d ___; 31 Fla. L. Weekly S34 (Fla. January 19, 2006); Maggio v. Florida Dept. of Labor and Employment Security, 899 So.2d 1074, 1076-77 (Fla. 2005); State v. Rife, 789 So.2d 288, 292 (Fla. 2001); City of Clearwater v. Acker, 755 So.2d 597, 600 (Fla. 1999); State v. Wilson, 793 So.2d 1003, 1005 (Fla. 2d DCA 2001). The primary source for determining legislative intent when construing a statute is the language chosen by the legislature to express that intent. Borden, supra; Maggio, supra; State v. Rife, supra; Donato v. American Telephone & Telegraph Co., 767 So.2d 1146, 1150 (Fla. 2000); Hayes v. State, 750 So.2d 1, 3 (Fla. 1999); Chase v. Walgreen Co., 750 So.2d 93, 96 (Fla. 5th DCA 1999). In short, the Court first looks to the statute's plain meaning. Knowles v. Beverly Enterprises of Florida, Inc., 898 So.2d 1, 10 (Fla. 2004). There is no need to resort to administrative

construction of the statute,[3] the legislative history of its enactment and other extraneous matters in the absence of doubt concerning the meaning of the statute. Therrien v. State, 914 So.2d 942, 945 (Fla. 2005); Donato v. American Telephone & Telegraph Co., 767 So.2d 1146, 1153 (Fla. 2000); Dept. of Revenue v. Daystar Farms, Inc., 803 So.2d 892, 896 (Fla. 5th DCA 2002); Chase v. Walgreen Co., 750 So.2d 93, 96 (Fla. 5th DCA 1999).

Those basic tenets of Florida law establish the beginning of the analysis. When construing the statute, all parts of the statute must be read together in order to achieve a consistent whole. M. W. v. Davis, 756 So.2d 90, 101 (Fla. 2000); Palm Beach Co. Canvassing Board v. Harris, 772 So.2d 1273, 1287-1288, vacated in part on other grounds, Bush v. Palm Beach Co. Canvassing Board, 531 U.S. 70, 121 S.Ct. 471, 148 L.Ed.2d 366 (2000). A statute should be interpreted to give effect to every clause and provision within the statute and to accord meaning and

[3] Whereas here, it appears that Allstate is asserting that DOI has urged construction of the statutes based on their ordinary, common meaning, the Department of Insurance would actually be disavowing utilizing any agency special expertise in the interpretation of the statute. State Dept. of Ins. v. Ins. Services Office, 434 So.2d 908, 912 n.6 (Fla. 1st DCA 1983); All Seasons Resorts, Inc. v. Dept. of Business Regulations, 455 So.2d 544, 548 (Fla. 1st DCA 1984). Since Allstate and the DOI appear to agree the statutes are unambiguous, Allstate's argument about giving DOI interpretations deference is meaningless and irrelevant. Moreover, Allstate's reliance upon the deposition of an employee of DOI in a completely separate and unrelated matter is wholly inappropriate. See, In Re: Amendments to the Florida Evidence Code, 782 So.2d 339 (Fla. 2000); Price v. City of Boynton Beach, 847 So.2d 1051 (Fla. 4th DCA 2003); and Graham v. Dept. of Health, 816 So.2d 701 (Fla. 1st DCA 2002).

harmony to all of its parts with one another. Jones v. DTS of New Orleans, Inc., 793 So.2d 912, 914-915 (Fla. 2001); Courtney Enterprises Inc. v. Publix Super Markets, Inc., 788 So.2d 1045, 1049 (Fla. 2nd DCA), rev. den., 799 So.2d 218 (Fla. 2001), citing Forsyth v. Longboat Key Beach Erosion Control District, 604 So.2d 452, 455 (Fla. 1992); Ebaugh v. State, 623 So.2d 844, 845 (Fla. 5th DCA 1993). Likewise, it is a cardinal rule of statutory interpretation that courts should avoid readings that render a part of the statute meaningless. American Home Assurance Co. v. Plaza Materials Corp., 908 So.2d 360 (Fla. 2005); The Golf Channel v. Jenkins, 752 So.2d 561, 565 (Fla. 2000). A statutory interpretation that renders a statutory provision superfluous is disfavored. Hechtman v. Nations Title Ins. of N.Y., 840 So.2d 993, 996 (Fla. 2003); Hawkins v. Ford Motor Co., 748 So.2d 993, 1000 (Fla. 1999). The basis for this rule is quite logical as it presumed that the legislature does not intend to enact purposeless and, therefore, useless legislation. Unruh v. State, 669 So.2d 242, 245 (Fla. 1996); United Specialties of America v. Dept. of Revenue, 786 So.2d 1210, 1213-14 (Fla. 5th DCA 2001).

Section 627.736(10), Fla. Stat. (1999) provides:

> An insurer may negotiate and enter into contracts with licensed health care providers for the benefits described in this section, referred to in this section as "preferred providers," which shall include health care providers licensed under Chapter 458, 459, 460, 461 and 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchase of the policy for personal injury protection benefits, if the

> requirements of this subsection are met. If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a non-preferred provider policy, the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider who is a preferred provider, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amounts of any deductible that applies to such medical benefits. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a non-preferred provider policy. The insurer shall provide each policyholder with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy and shall make such list available for public inspection during regular business hours at the principal office of the insurer within the state.[4]

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[4] Section 627.736(10), Fla. Stat., was first enacted in 1991 as part of Chapter 91-106, Laws of Florida. That statute specifically provided:

> 627.736. Required personal injury protection benefits; exclusion; priority.
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> * * *
>
> (10) An insurer may negotiate and enter into contracts with licensed health care providers for the benefits described in this section, referred to in this section as "preferred providers" which shall include health care providers licensed under chapter 458, 459, 460, 461 and 463. The insurer may provide an option to an insured to use a preferred provider at the time that medical services are sought by the insured for the benefits described in this section. If the insured elects to use a provider which is not a preferred provider, the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider which is a preferred provider, the insurer may pay medical benefits in excess

We respectfully submit and agree with Allstate, for that matter, that the statute is clear and unambiguous. It merely authorizes PIP insurers to negotiate and contract with certain licensed health care providers for the benefits described in §627.736, Fla. Stat. Should the insurer enter into such contracts, the insurer "may" then provide an option to an insured, at the time the policy is purchased, to use a "preferred provider" if the requirements of the subsection (subsection (10)) are met. The statute then delineates the additional requirements pertaining to

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> of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. The insurer may not require a policyholder or applicant to make any election in this regard at the time of purchase of the policy or at any time other than at the time that medical services are sought. The insurer shall provide each policyholder with a current roster of preferred providers and shall make such list available for public inspection during regular business hours at the principal office of the insurer within the state.

Under the initial statute, preferred providers were specifically defined as those health care providers with whom an insurer negotiated and entered into a contract. Under the former version of the statute, the insurer was authorized to provide an option to an insured to use a preferred provider at the time that medical services were sought for PIP benefits. If the insured elected to use a health care provider with whom the insurance company had entered into a contract, the statute authorized the insurance company to pay benefits exceeding those required by the statute or waive or reduce any deductible that would otherwise apply to such medical benefits. The statute specifically required each insurer to provide every policyholder with a current roster of preferred providers and to make the list available for public inspection at its principal office within the state. Although Allstate's conduct is not in compliance with either version of the statute, it more closely follows the earlier version when offering the option of using a preferred provider at the time of treatment.

offering PPO and non-PPO policies, the provisions of a list of such "preferred providers" in the insured's county of residence and the availability of such a roster to the public during regular business hours at the principal office of the insurer in Florida. Allstate concedes it did not negotiate or contract with any licensed health care providers, nor did it meet any of the other conditions of the subsection.

Notwithstanding these concessions, and while arguing the statute is clear and unambiguous, Allstate nevertheless insists, however, that it "may" still pay PIP benefits at reduced PPO rates by entering into contracts with existing PPO networks who themselves are not licensed health care providers. Allstate cites no statutory authority for this contention. This "construction," moreover, conflicts with the very rules of statutory construction Allstate cites in it brief to urge that the plain language of the statute needs to be applied. Finally, Allstate's interpretation of §627.736, Fla. Stat., ignores other applicable established rules of statutory construction.

Last, related provisions of a statute are appropriately read *in pari materia* as expressing unified legislative purpose. Zold v. Zold, 911 So.2d 1222, 1230 (Fla. 2005); Young v. Progressive Southeastern Ins. Co., 753 So.2d 80, 84 (Fla. 2000); BMW of North America v. Singh, 664 So.2d 266, 269 (Fla. 5th DCA 1995). In the context of no-fault benefits, courts read the provisions of the entire act *in pari*

materia to decipher the legislative intent. Stonewall Ins. Co. v. Wolfe, 372 So.2d 1147 (Fla. 4th DCA 1979), cert. den., 385 So.2d 762 (Fla. 1980).

Like §627.736(10), Fla. Stat., the language of §627.736(1)(a) is also unambiguous. It requires every policy complying with the security requirements of §627.733, Fla. Stat., to pay 80% of all reasonable expenses for necessary medical, surgical, x-ray, dental and rehabilitative services and the like. Therefore, if any PIP insurer is to pay less than the minimum required benefits of §627.736(1), Fla. Stat., there must be some other statutory basis for such reduced payment. Allstate has not and cannot cite this Court to such a provision because it simply does not exist. In our view, the analysis need not proceed further. The unambiguous language of the statute does not allow for such reduced payments unless the policy complies with §627.736(10), Fla. Stat.

Rather than provide the Court with a clear statutory justification for its conduct, Allstate takes the position that the "permissive" nature of §627.736(10), Fla. Stat., authorizes it to enter into PPO agreements beyond the type specified in the statute. Even if, for the sake of argument, we ignored the glaring inconsistency of Allstate's position that the statute is clear and unambiguous on the one hand, but requires the court to imply the right of an insurer to enter into contracts with networks rather than licensed health care providers on the other hand, basic rules of statutory construction still prohibit Allstate's conduct.

Section 627.736(1), Fla. Stat., requires that any insurance policy complying with the security requirements of §627.733, Fla. Stat., provide personal injury protection to various specified persons to a limit of $10,000 for loss sustained as a result of bodily injury or death arising out of the ownership, maintenance, or use of a motor vehicle. The statute further provides that the policy must pay 80% of all reasonable expenses for necessary medical care, 60% of the loss of gross income and loss of earning capacity from the inability to work caused by the accident, and, if applicable, $5,000 in death benefits. The statute also limits the issuance of such policies solely to insurers writing motor vehicle liability insurance in the state.

Section 627.736(2), Fla. Stat., identifies the only authorized exclusions that an insurer may permissibly include in its policy to exclude benefits. The express requirements of the Act may not be avoided by the use of exclusions not specified in the Act. See, e.g., Christian v. Colonial Penn Ins. Co., 537 So.2d 623 (Fla. 4th DCA 1988). Section 627.736(4), Fla. Stat., specifies the precise time when the benefits are due. Section 627.736(5), Fla. Stat., specifies the amounts that may be charged for treatment of injured persons and limits those charges to a reasonable amount for the services, products, and accommodations rendered.

Section 627.739, Fla. Stat., identifies the sole authorized deductibles that may be included in such a policy, the time that such deductibles must be offered and to whom the deductibles will apply. In short, Florida's Motor Vehicle No-

Fault Act is, for the most part, a self-contained act in which the legislature has specifically identified the type and amount of benefits required and the sole limitations that may be placed upon the payment of such benefits. In this case, Allstate's obligation is clear. It must pay 80% of the reasonable charges for all necessary medical treatment. Allstate has not and cannot cite this Court to any statutory authority that authorizes it to avoid the express obligations of §627.736(1), Fla. Stat.

Allstate's argument that it may, nevertheless, pay PIP benefits at reduced PPO rates even when it admittedly failed to comply with the only statutory provision which would authorize such reduced payments, flies in the face of the basic tenets of statutory construction which we have previously cited. Such an interpretation would render the language of subsection (10) completely useless. There would be no reasonable basis for the legislature to create a statute which authorized insurance companies to directly contract with health care providers to establish PIP PPO networks if, as Allstate asserts, the insurance companies already had the ability to independently contract with third parties to provide PIP PPO networks. Allstate's interpretation also renders the mandatory payment provisions of §627.736(1), Fla. Stat., meaningless. Quite contrary to Allstate's position, its failure to comply with subsection (10) does not provide it with the authority to do an end run around the remainder of §627.736, Fla. Stat. Its failure to comply with

subsection (10) means that it must pay the required personal injury protection benefits specified in §627.736(1), Fla. Stat.

It is important to note that when the legislature has wanted to confer the ability upon insurers to enter into arrangements similar to those purportedly reached between Allstate and Beech Street, it has specifically articulated and authorized that ability in the statute. For instance, §627.6471, Fla. Stat., authorizes insurers to use PPO networks in the health insurance industry. Section 627.6471(b), Fla. Stat., defines "preferred provider" to mean any licensed health care provider which the insurer has directly or indirectly contracted for an alternative or reduced rate of payment, which shall include any health care provider listed in §627.419(3) and (4), Fla. Stat., and shall provide reasonable access to such health care providers. Section 440.134, Fla. Stat., authorizes insurers to use managed care arrangements in the workers' compensation arena. Section 440.134(1)(h), Fla. Stat., states:

> "Capitated contract" means a contract in which an insurer pays directly or indirectly a fixed amount to a health care provider in exchange for the future rendering of medical services for covered expenses.

Section 440.134(j), Fla. Stat., states:

> "Provider network" means a comprehensive panel of health care providers and health care facilities who have contracted directly or indirectly with an insurer to provide appropriate remedial treatment, care, and

> attendance to injured workers in accordance with this chapter. (Emphasis added)

One of the obvious differences between these statutory sections and §627.736(10), Fla. Stat., is that the legislature has specifically authorized insurers to both directly and indirectly contract with health care providers for an alternative or reduced rate of payment. Subsection (10), on the other hand, requires the insurers to negotiate and contract directly with the health care providers.[5] When interpreting a statute, courts adhere to the principle that the expression of one thing is the exclusion of the other. That is, when the law expressly describes a situation where something should apply, an inference must be drawn that what is not included by specific reference was intended to be omitted or excluded by the legislature. Young v. Progressive Southern Ins. Co., 753 So.2d 80, 85 (Fla. 2000); St. John v. Coisman, 799 So.2d 1110, 1113, n.3 (Fla. 5th DCA 2001); Mingo v. ARA Health Services, Inc., 638 So.2d 85, 86 (Fla. 2nd DCA 1994). See also, Industrial Fire & Cas. Ins. Co. v. Kwechin, 447 So.2d 1337 (Fla. 1983) (using both this rule of construction and reading §627.739, Fla. Stat., *in pari materia* with remainder of the act to conclude that an insurer who sold a prospective insured a

[5] Legislative efforts to authorize PIP insurers, such as Allstate, to enter into these types of arrangements have been proposed but never made it out of committee. See, Proposed Senate Bill S.B. 1326 (March 23, 1997) and P.C.S./S.B. 1326 (March 24, 1997) (cited in Plaintiffs' summary judgment memos (R.V. 1, 55; R.V. 3, 318). It is rather curious that the insurance industry would see a need to propose this legislation if, as Allstate argues here, it has always had the ability to "contract" for such services.

PIP policy containing deductibles, knowing that the prospective insured did not have collateral coverage as required by the statue, was liable to the insured as if the policy contained no deductible).

Likewise, the legislature is presumed to know the meaning of words it employed in a statute. King v. Ellison, 648 So.2d 666, 668 (Fla. 1994). The legislature chose to employ the term "directly" and "indirectly" in both the workers' compensation and health insurance arena. It did not authorize indirect contracts in the PIP arena. It identified only one method by which an insurer could pay benefits at reduced PPO charges rather than the benefits otherwise required by §627.736(1), Fla. Stat. In specifically authorizing only one method for insurers to pay reduced PPO charges, the legislature was not required to then list all other situations that were not authorized. Most respectfully, this Court is not authorized to add words to the statute which would allow Allstate and all other PIP insurers to indirectly contract with health care providers for the establishment of the PIP PPO network. Hayes v. State, 750 So.2d 1, 4 (Fla. 1999); In Re Order of Prosecution of Criminal Appeals by the Tenth Judicial Circuit Public Defender, 561 So.2d 1130, 1137 (Fla. 1990).

B. Public Policy Arguments of Allstate and Amicus

Allstate and the Amicus have extensively argued their view of public policy in conjunction with extolling their perceived virtues of managed health care in

general and of their conduct in particular. They attempt to justify their conduct by listing the numerous ways they believe that the insurance companies are actually helping their insureds through the use of the programs they have created. They collectively argue that the insureds are actually being damaged by requiring insurers to pay 80% of the reasonable and necessary medical expenses the insureds incur, and that such an interpretation of the Florida No-Fault Act essentially is too harsh because it deprives their respective insureds of these perceived benefits.

The insurance industry's apparent new-found concern for its insureds is commendable. The temptation to engage in a debate about the pros and cons of managed care and how the insurance industry implements it is great. However, we will not waste this Court's time with such an exercise because it is also irrelevant. We will not engage in the debate because this Court does not provide the appropriate forum for the discussion in the first instance. Presumably, the debate concerning the pros and cons of managed care and how PIP insurers would utilize it occurred before the legislature in 1991, 1992, and 1997. If insurers believe that the Florida Motor Vehicle No-Fault Act's mandatory requirements that it pay 80% of all necessary and reasonably-incurred medical expenses is too harsh, the remedy is not found through their proposed tortured construction and interpretation of the statute. Rather, their remedy rests solely in amendment to the statute or in its repeal. Seagrave v. State, 802 So.2d 281, 287 (Fla. 2001); Baker v. State, 636

So.2d 1342, 1343 (Fla. 1994). If Allstate and the amicus are as truly concerned for their insureds' ability to obtain PIP benefits at PPO rates as they profess, then Allstate and all other insurers can easily accommodate their insureds by offering a program and policies that do comply with §627.736(10), Fla. Stat. The insurers may then publicize the virtues of such a program rather than to continue to operate a plan that is shrouded in secrecy.

III. THE CONFLICTING DECISIONS IN CENTRAL FLORIDA PHYSIATRISTS, JEWELL, AND THE PRESENT CASE.

It is against the backdrop of the rules of statutory construction that we have identified that we can analyze the Fifth District's decision in Nationwide Mut. Fire Ins. Co. v. Central Fla. Physiatrists, P.A., 851 So.2d 762 (Fla. 5th DCA 2003) the Second District's decision in Nationwide Mut. Ins. Co. v. Dennis M. Jewell, D.C., P.A., 862 So.2d 79 (Fla. 2nd DCA 21003) and the present case to see which court's decision adheres to these fundamental principles of statutory construction and to determine which decision reached the correct result.

As in this case, both the Fifth and the Second District Courts of Appeal were provided with the same certified question from the county court. In each of these cases, the county court judges had determined that §627.736(10), Fla. Stat., provided the exclusive means by which an insurance company could pay PPO rates for PIP benefits and, since Nationwide failed to comply with the terms of the

statute, it was not entitled to pay the health care providers at the reduced PPO rate. In Central Fla. Physiatrists ("CFP"), supra, the Fifth District examined §627.736(1) and (10), Fla. Stat. The court noted that the language was precise and limited in scope, thereby indicating the legislature's intent that the availability of PPO-PIP benefits is subject to strict compliance with the terms of subsection (10). The court noted that the plain language of the statute stated that an insurance company is permitted to contract with licensed health care providers for PPO benefits, but the statute provides no specific authority for insurance companies to contract with PPO networks. The court concluded that since Nationwide had not complied with subsection (10), it was required to comply with the mandatory provisions of §627.736(1), Fla. Stat.

The Fifth District also rejected Nationwide's claim that the trial court's ruling improperly voided Nationwide's agreement with Beech Street, that CFP lacked standing to assert a claim against Nationwide and the statute provided no private right of enforcement. The Fifth District rejected all of these contentions as being without merit. The Fifth District explained that the trial court's ruling did not void the agreement, but merely held that it was inapplicable under the facts presented in the case. It further explained that CFP had asserted its breach of contract claim against Nationwide in its capacity as assignee of its insured's rights under her PIP contract, not as a medical provider. As such, CFP possessed the

same rights as the insured possessed, vis-à-vis her insurer, including the right to institute a lawsuit to enforce the terms of the contract. Moreover, the court explained that it was clear from the record that CFP had not sought to invoke the terms of subsection (10), but rather was suing merely for the recovery of benefits under the standard PIP statute.

In reaching its holding, the Fifth District vigilantly followed the statutory rules of construction we have identified above. That is, the court applied the plain meaning of the statute, read related statutory terms *in pari materia* with one another, and properly drew an inference that the conduct of the insurer which was not included in the statute by a specific reference was intended to be omitted and thereby excluded by the legislature. In short, the Fifth District's decision complies with every cardinal rule of statutory interpretation relied upon by Florida courts for more than a century.

The Fifth District's decision in Central Fla. Physiatrists, supra, and the court's faithful adherence to the rules of statutory interpretation must be contrasted with the Second District's decision in Jewell, supra. Nationwide there also admitted that it did not comply with §627.736(10), Fla. Stat. The Jewell court stated that it reached two conclusions regarding subsection (10). First, that subsection authorized insurers to contract with preferred providers using both direct and indirect contractual arrangements. Second, subsection (10) did not

prohibit insurers that had not issued PPO-PIP policies from contracting to pay providers at PPO rates.

In conducting its "analysis," the Second District stated that it was by no means clear that the authorization to enter into contracts with licensed health care providers for the provision of PIP health care benefits was limited to direct contracts between PIP insurers and providers. The court explained that to a reasonable person using the English language, the authorization to contract in this context also encompassed third-party contractual arrangements through an intermediary PPO network. The Second District acknowledged, but then ignored, that the legislature has, in other insurance contexts, specifically conferred the authority upon insurance companies to enter into direct and indirect contracts. The court stated that its conclusion that the authorization to contract encompasses both direct and indirect contractual arrangements did not mean that Nationwide had violated subsection (10). Such a violation would only exist if the court concluded that the statute required all insurers that contract to pay providers at PPO rates to issue preferred provider policies. Remarkably, the court concluded that was unnecessary.

The Second District concluded that it would be unreasonable to read the provision that insurers "may negotiate and enter into contracts" with providers in the first sentence of the subsection with the subsequent provision permitting the

issuance of a PPO policy, as prohibiting the PIP insurer from having a contractual relationship with a provider unless the insurer has also issued a PPO policy. The court believed that these statutory authorizations were separate and independent of one another and that neither was mandatory. The court then concluded that the health care providers had, by entering into contracts with third-party PPO networks, established what were reasonable expenses for covered medical expenses and the insurance companies had done nothing inconsistent with the clear language of §627.736, Fla. Stat.

With all due respect to the Second District, it is difficult to imagine an opinion which could conflict with more rules of statutory interpretation than its Jewell decision. While the errors are numerous, the most glaring examples include the Second District's incorporating language not chosen by the legislature into the statute. Where the legislature stated that insurance companies could contract with preferred providers, the Second District essentially rewrote the statute to authorize contracts with third parties who were not preferred providers. Those entities, in turn, could enter into separate contracts with the preferred providers, and this relationship that, at best, could create some third-party beneficiary relationship, satisfied the ordinary definition of the word "contract" as used within the statute. The court ignored the fact that when the legislature has chosen to allow insurance companies to indirectly contract for these services, it has specifically said so in the

statute. Moreover, the court's decision overlooks the rule of law that when the legislature expressly mentions one thing, its silence on another is deemed to be a rejection of that latter proposal. Finally, the Second District's decision ignores the rule of statutory interpretation which prohibits rendering meaningless a piece of legislation. It cannot be forgotten that the statute was amended from its 1991 version in 1992. In 1991, the insurance companies were allowed to do many of the things that Allstate implemented in this case, including offering PPO rates at the time of service. In 1992, the legislature changed the statute, requiring the insurance companies to advise the insured of such policies at the time of sale, not at the time of delivery of the services. The Second District's interpretation of the statute completely renders subsection (10) and the 1992 amendment useless. Moreover, it implements the 1997 proposed bill that failed to make it out of committee and was never approved by the legislature. Under the Second District's interpretation, the insurer could have established such a plan even in the absence of any statutory authority. If either result was the legislature's intent, one has to wonder why the legislature repealed the 1991 version instead of merely including the word "or" between the 1991 and 1992 versions or, for that matter, why there was any legislation at all.

When a statute is clear and unambiguous, as the Fifth, Fourth and Second Districts have held, there is no need for interpretation and certainly no need for a

tortured analysis as utilized by the Second District. Most respectfully, the Fifth District's decision is the one that most vigilantly follows long-standing rules of statutory interpretation in this state. This Court should reject the Second District's decision in Jewell.

Allstate maintains that HCH has no legal standing and that subsection (10) provides no private right of enforcement. As such, Allstate concludes that even if subsection (10) is the sole means by which insurers may pay reduced PIP benefits, HCH does not have the legal ability to ask the court for relief requiring Allstate to pay PIP benefits as required by §627.736(1), Fla. Stat. As with the first part of its argument, Allstate is, at best, mistaken concerning the issue here. HCH has not sought any private right of enforcement pursuant to subsection (10). Nor has HCH claimed standing pursuant to that statute. Rather, HCH merely asserted rights to payment of 80% of all reasonable and necessary medical expenses pursuant to §627.736(1), Fla. Stat., and in a timely fashion pursuant to §627.736(4), Fla. Stat. The assignments and those statutes provide HCH with both standing and a right of enforcement.

The concept of legal standing in Florida is not complicated. It has been succinctly stated in General Development Corp. v. Kirk, 251 So.2d 284, 286 (Fla. 2nd DCA 1971) as being a sufficient interest in the outcome of litigation which will warrant the court's entertaining it. See also, Jamlynn Investments Corp. v. San

Marco Residences of Marco Condo. Assn., 544 So.2d 1080, 1082 (Fla. 2nd DCA 1989). As the Second District explained in Kirk, it is beyond doubt that standing is, in most states, no longer determined by first determining some abstract question such as privity, General Development Corp. v. Kirk, supra, at 286. See also, State Farm Automobile Ins. Co. v. K.A.W., 575 So.2d 630, 632 (Fla. 1991) (applying Kirk definition of standing to allow uninsured motorist insurer to seek disqualification of attorneys who had represented insured and family in earlier stages of personal injury lawsuit); Argonaut Ins. Co. v. Commercial Standard Ins. Co., 380 So.2d 1066, 1067 (Fla. 2nd DCA 1980); St. Martin's Episcopal Church v. Prudential-Bache Securities, Inc., 613 So.2d 108, 110, n.4 (Fla. 4th DCA 1993).

To the extent that there ever was a legitimate doubt about standing, Allstate need only look to the last decision in which it made that assertion to this Court to have that doubt removed. In Allstate Ins. Co. v. Kaklamanos, 843 So.2d 885, 895 (Fla. 2003), this Court specifically rejected the same standing argument Allstate asserts here to justify yet another of its illegal schemes. As noted there, Florida courts have authority over any matter not expressly denied them by the State Constitution.

In this case, HCH made its claims as assignee of Allstate's insureds. As recently noted by this Court in Nationwide Mut. Fire Ins. Co. v. Pinnacle Medical, Inc., 753 So.2d 55, 57 (Fla. 2000), the right of an assignee to sue for breach of

contract to enforce assigned rights predates the Florida Constitution. Citing, Robison v. Nix, 22 Fla. 321 (1886). In the context of PIP insurance, Florida courts have recognized that health care providers can legally assert claims for PIP benefits against insurers where the insured has assigned them the right to the benefits.[6] Hartford Ins. Co. of The Southeast v. St. Mary's Hospital, Inc., 771 So.2d 1210, 1212 (Fla. 5th DCA 2000); Parkway General Hospital, Inc. v. Allstate Ins. Co., 393 So.2d 1171, 1172 (Fla. 3d DCA 1981). Allstate recognized this right at the summary judgment hearing when it waived defenses. In short, under Florida state law, health care providers who have accepted assignments from their patients have both standing and a right to enforce the statutory rights of the insured to payment of 80% of all reasonable and necessary medical expenses to the same extent as if the insured were to bring suit. Because Florida courts have recognized both standing and a right to sue for breach of contract in medical providers who have taken assignments from their insured under the Florida No-Fault Act, we see very little reason to respond to the vast majority of Allstate's argument on this point.

Allstate's argument also ignores that Count I of each complaint was for declaratory judgment. Section 86.021, Fla. Stat., clearly confers standing on HCH

[6] In Florida, where a contract of insurance is entered into on matters surrounded by statutory limits and requirements, it is presumed the statutory provisions become part of the contract. Weldon v. All America Life Ins. Co., 605 So.2d 911, 914-15 (Fla. 2d DCA 1992).

to have its rights under §627.730, et. seq., Fla. Stat., construed. As such, Allstate's argument concerning a private right of enforcement and the voiding of some contract pursuant to subsection (10) of the statute is, at best, misplaced, and, at worst, irrelevant. HCH has not used subsection (10) as the basis for a cause of action. Nor has HCH argued subsection (10) defensively to void any contract between Allstate and any person or entity as Allstate suggests. Nor did the trial court ever enter such a ruling. Instead, HCH has consistently maintained that Allstate, and any other insurance company issuing a PIP policy in this state, is statutorily required to pay 80% of all reasonable and necessary medical expenses, and any exception to that statutory mandate would have to be included within the terms of the No-Fault Act.[7]

The only provision of the No-Fault Act that would arguably allow Allstate to pay less than 80% of all reasonable and necessary medical expenses is subsection (10), a statute that Allstate freely concedes it has not complied with and, moreover, a statute that it maintains does not govern its conduct with the PPO networks. Allstate did not and has not identified any other provision of the No-Fault Act that would authorize it to pay less than the statutorily-mandated benefits. As such, all

[7] Allstate recognized that it paid less than required by §627.736(1), Fla. Stat., and stipulated to the amount as it represented at the hearing. Therefore, the argument that there are no damages is completely without merit. The amount of damages is reflected in the judgment. Allstate's policy of indemnity insurance must pay those damages.

the trial court was asked to rule was that Allstate was required to pay the statutory minimum amount of benefits. Whether subsection (10) provides a right to private enforcement or not, is simply irrelevant to the issues that were actually decided in this case. Allstate may not set up a strawman argument, proceed to predictably knock it down, and then claim victory.

IV. CONTRACTS WITH NETWORKS

As noted earlier, the trial court entered no ruling regarding the purported contracts between the networks and the health care providers on the one hand and the networks and Allstate on the other. Even if one assumes, for sake of argument, that an actual contract existed, the contract documents demonstrate that the health care providers and the networks contemplated reduced payments for services rendered in the networks' workers' compensation and health services plans.

Allstate has argued that the contracts with the health care providers were modified when the network sent a letter announcing Allstate's participation in the auto plan. Again, even assuming, for sake of argument, that the letter could constitute a modification, to be enforceable, there still must be a mutuality of obligation between the parties. There, likewise, must be consideration for the agreement. In the absence of such, Allstate's insureds, as well as the policyholder of other insurers who illegally reduce their payment obligations are subjecting their insureds to receiving bills for the balance owed.

Recently, the Eleventh Circuit addressed a similar situation arising out of Georgia in HCA Health Services of Georgia, Inc. v. Employers Health Ins. Co., 240 F.2d 983 (11th Cir. 2001). After extensively analyzing managed care and the pros and cons for patients and health care providers alike, the court held that the health care providers were not bound by agreements similar to Allstate's here, as there was no consideration for the reduced payments. That analysis applies equally here.

As mentioned, the court did not rule upon the contracts and we do not believe that Allstate may obtain such a ruling for the first time on appeal. However, we do believe that the same arguments that were addressed by the Eleventh Circuit in the HCA, supra, decision apply here.

CONCLUSION

Based upon the above and foregoing authorities, HCH respectfully request this Court to quash the decision of the Fourth District, approve the decision in Central Florida Physiatrists, disapprove Jewell, and hold that a PIP insurer who has not complied with §627.736(10), Fla. Stat., is required to pay benefits in accordance with the mandatory provisions of §627.736(1), Fla. Stat.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and accurate copy of the foregoing has been furnished by U.S. mail to **Richard C. Godfrey, Esq.**, Richard C. Godfrey, P.C., and **Andrew A. Kassof, Esq.**, Kirkland & Ellis LLP, 200 E. Randolph Drive, Chicago, IL 60601, and **Jack R. Reiter, Esq.**, Adorno & Yoss LLP, 2525 Ponce de Leon Blvd., #400, Miami, FL 33134, on March 1, 2006.

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CERTIFICATE OF COMPLIANCE

I hereby certify that the Answer/Cross-Initial Brief on the Merits of Respondent, Holy Cross Hospital, Inc., (Matthew Winik) and Holy Cross Hospital, Inc., (Lawrence Wiesner), complies with the font requirements pursuant to Rule 9.100(1) and 9.210(a)(2), Fla. R. Civ. P.

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