IN THE SUPREME COURT OF FLORIDA

GEICO GENERAL INSURANCE COMPANY,

Petitioner,

vs.

VIRTUAL IMAGING SERVICES, INC.,

Respondent. /

Case No. SC12-905

L.T. Case Nos.: 3D11-0581, 09-24293

ON DISCRETIONARY REVIEW OF A DECISION OF THE THIRD DISTRICT COURT OF APPEAL CERTIFIED TO RAISE AN ISSUE OF GREAT PUBLIC IMPORTANCE

BRIEF OF THE AMERICAN INSURANCE ASSOCIATION AND THE PROPERTY CASUALTY INSURERS ASSOCIATION OF AMERICA, AS *AMICI CURIAE* FOR PETITIONER

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IDENTITY AND STATEMENT OF INTEREST OF *AMICI CURIAE*

The American Insurance Association ("AIA") and the Property Casualty Insurers Association of America ("PCI") are leading national trade associations representing property and casualty insurers doing business in Florida, nationally, and globally. AIA and PCI members collectively underwrote a substantial portion of the more than $37 billion in property and casualty premiums written in Florida in 2011, including premiums for personal injury protection ("PIP") insurance. These members range in size from small companies to the largest insurers with global operations. On issues of importance to the property and casualty insurance industry and marketplace, the AIA and PCI advocate sound public policies on behalf of their members in legislative and regulatory forums at the state and federal levels and file *amicus curiae* briefs in significant cases before federal and state courts, including this Court.

The certified question in this case is whether a PIP insurer may reimburse medical providers based on the fee schedules identified in section 627.736(5)(a), Florida Statutes, even if the insurer does not specifically "elect" to rely on those schedules in its automobile policies. This is an issue of great importance to AIA and PCI members, because it affects the costs of providing the PIP insurance their member companies underwrite and the benefits available to consumers under those policies.

SUMMARY OF ARGUMENT

The Court should answer the certified question in the affirmative. For PIP insurance policies issued after January 1, 2008, insurers should be allowed to compute provider reimbursements based on the fee schedules identified in section 627.736(5), Florida Statutes, even if their policies do not specifically refer to those schedules. This result is consistent with the plain language of the statute and the purpose of the 2008 Amendment to the PIP statute, which was enacted to control rising costs that threaten the PIP system.

Medical providers charge higher rates for the same services to PIP insurers than they do to Medicare, workers' compensation insurers, and most private health insurers. These excessive provider charges contribute to rapidly rising PIP premiums and the erosion of benefits provided to consumers under these policies. In an effort to control costs, in 2008 the Legislature amended the PIP statute to allow PIP insurers to reimburse providers based on the same fee schedules that govern Medicare reimbursement, without the need to amend millions of insurance policies.

The district court opinions requiring insurers to specifically elect the Medicare-based schedules in their policies—*Geico Indem. Co. v. Virtual Imaging Servs., Inc.*, 79 So. 3d 55 (Fla. 3d DCA 2011) ("*Virtual I*"), *Kingsway Amigo Ins. Co. v. Ocean Health, Inc.*, 63 So. 3d 63 (Fla. 4th DCA 2011), and *Geico Indem.*

Co. v. Virtual Imaging Servs., Inc., 90 So. 3d 321 (Fla. 3d DCA 2012) ("*Virtual II*") (the case under review here)—are at odds with that important public purpose and the realities of the crisis facing the PIP system today. Those opinions fail to recognize that the Legislature intended the fee schedules identified in the PIP statute to define the maximum "reasonable" cost, and are not a separate method of calculating reimbursement that is distinct from reimbursement of "reasonable" costs. The district court opinions improperly read into the statute a requirement that insurers elect the Medicare-based fee schedules in their policies, which undermines the effort to control provider costs by unduly complicating cost control efforts without any apparent benefit to the parties to those policies. Those opinions also falsely assume, on the issue of provider fees, that the interests of insured policyholders and medical providers are aligned, when in fact they are adverse. These opinions therefore eviscerate the cost-control goals of the 2008 Amendment, to the benefit of providers but to the detriment of insurers and policyholders.

ARGUMENT

I. THE 2008 AMENDMENT TO THE PIP STATUTE WAS DESIGNED TO ADDRESS THE SERIOUS PROBLEM OF EXCESSIVE PROVIDER COSTS

Excessive charges by medical providers in recent years have increased the average PIP premium and jeopardized the ability of accident victims to recover for

lost wages. The purpose of the 2008 Amendment is to reduce provider charges by tying them to fee schedules set by Medicare.

A. **The PIP System is Threatened by Excessive Provider Costs**

The Florida Legislature created the PIP system to assure that accident victims would receive a minimum level of medical, disability, death, and wage loss benefits, regardless of fault, in return for a limitation on the right to sue for non-economic damages. *See* SENATE COMMITTEE ON BANKING AND INSURANCE, FLORIDA'S MOTOR VEHICLE NO-FAULT LAW, REPORT NO. 2006-102 at 5 (2005), *available at* http://archive.flsenate.gov/data/publications/2006/senate/reports/interim_reports/pdf/2006-102bilong.pdf (the "Senate Report"). To ensure that victims receive a minimum level of benefits, all drivers in Florida must carry at least $10,000 of PIP coverage. § 627.739(2), Fla. Stat. (2008).

Although the Legislature designed PIP to be affordable, the cost of premiums in Florida has skyrocketed. Senate Report at 55. As of 2005, the average pure premium in Florida was $127.92—42% higher than the national average pure premium of $89.86. By comparison, in 2000, the average pure premium in Florida was $101.70—only 13% higher than the national average pure premium of $89.96. *Id*. PIP premiums continue to rise dramatically; as of 2010, the average pure premium in Florida is nearly $160. FLORIDA OFFICE OF INSURANCE REGULATION, REPORT ON REVIEW OF THE 2011 PERSONAL INJURY

PROTECTION DATA CALL 25 (2011), *available at* http://www.floir.com/sitedocuments/pip_04-08-2011.pdf (the "OIR Report").

The dramatic increase in premiums over the last decade is a direct result of the increase in insurance losses attributable to PIP coverage. According to the Office of Insurance Regulation, incurred losses on PIP insurance policies have increased dramatically, jumping 54% from 2008 to 2010. OIR Report at 20. Insurance companies now pay $1.15 in losses and expenses for every dollar of premium paid. OFFICE OF THE INSURANCE CONSUMER ADVOCATE, REPORT ON FLORIDA MOTOR VEHICLE NO-FAULT INSURANCE (PERSONAL INJURY PROTECTION) 2 (2011), *available at* http://www.myfloridacfo.com/ica/docs/PIP%20Working%20Group%20Report%2012.14.2011.pdf (the "ICA Report"). The increases in frequency and severity of claims have led to "a significant increase in the average premium needed to cover the expected losses per vehicle." OIR Report at 25.

The increase in insurance losses is linked to abuse of the PIP system. In 2000, the Fifteenth Statewide Grand Jury released a report examining the prevalence of fraud in the PIP system and its consequences. It found that "a number of greedy and unscrupulous legal and medical professionals have turned that $10,000 coverage into their personal slush fund." FIFTEENTH STATE GRAND JURY, REPORT ON INSURANCE FRAUD RELATED TO PERSONAL INJURY PROTECTION

2 (2000), *available at* http://myfloridalegal.com/pages.nsf/Main/9ab243305303a0e085256cca005b8e2e (the "Grand Jury Report"). Several subsequent governmental reports have found continued abuses of the PIP system. Senate Report at 32-39; OIR Report at 29-31; ICA Report at 29.

One of the reasons insurance costs are so high is that medical providers charge PIP insurers significantly more for the same service than they charge other insurers. The nation's largest insurer, Medicare, limits the amount it will reimburse medical providers to fee schedules designed to result in a reasonable and sustainable cost structure. *See* 42 U.S.C. § 1395w-4 (2011). Under workers' compensation insurance, reimbursement for physician services is statutorily tied to Medicare. S*ee* § 440.13(12)(b), Fla. Stat. (2011). Most private health insurers also limit the amount they pay providers based on negotiated rate schedules. FLORIDA HOUSE OF REP., HOUSE OF REP. STAFF ANALYSIS, HB 13C at 10-11 (2007), *available at* http://archive.flsenate.gov/data/session/2007C/House/bills/analysis/pdf/h0013Ca.INS.pdf (the "House Staff Analysis").

Until the 2008 Amendment, PIP insurers were required to pay 80% of the providers' "reasonable" expenses; and a statutory attorneys'-fee provision discouraged challenges to providers' bills because it required insurers to pay providers' attorneys' fees if they lost a cost dispute but awarded them no attorneys' fees if they won. House Staff Analysis at 4, 14. As a result, when

receiving an "'unreasonable' bill, PIP insurers were often forced to pay the amount billed because their sole alternative was costly litigation." *Virtual II*, 90 So. 3d at 328 (Rothenberg, J., concurring); *see also* Grand Jury Report at 13 ("Because there is no fee schedule set by the government in PIP claims, and because of the strict rules regarding PIP claims . . . insurance companies must pay almost any amount billed.").

Aware that insurers will be reluctant to challenge the reasonableness of fees, medical providers charge higher rates for services reimbursable under PIP policies. In this case, for example, the provider charged $3,600 for two magnetic resonance imaging ("MRI") tests. Using the old system, the insurer effectively would be forced to pay $2,880 (80% of the billed amount), while using the Medicare-based schedules, the reimbursable cost would be $1,989.57. *Virtual II*, 90 So. 3d at 323. The court below observed that in a similar case, *MGA Ins. Co. v. All X-Ray Diagnostic Services*, Case No. 3D12-414 (Fla. 3d DCA 2012), an x-ray provider billed $2,475, for which 80% or $1,980 was claimed under the PIP policy. *Id*. Using the Medicare fee schedules set forth under the 2008 Amendment, however, the allowable payment would have been $348.18. *Id*. This means that the provider's claim was 560% higher than what would be paid under the fee schedule in the PIP statute.

High provider costs harm consumers by contributing to higher premiums, which are increasingly unaffordable. As the Office of the Insurance Consumer Advocate observed last year, "the No-Fault system has been stressed to a point that is inflicting staggering rate increases on consumers." ICA Report at 2. Some Florida families now pay more than $3,500 in PIP premiums, which is more than one-third of the $10,000 maximum benefit provided under the system. *Id*. at 2.

Consumers also are harmed by high provider costs because their policy limits are eroded more quickly. To the extent that insurers must pay more for each medical service, consumers have fewer remaining benefits to cover other services and losses within the $10,000 limit of PIP insurance. In particular, this has effectively eliminated the ability of accident victims to recover lost wages. The Office of the Insurance Consumer Advocate observed that "[m]ost of the $10,000 is spent before an injured claimant can even submit the necessary documentation to support the claim for lost wages. This is money that would have gone directly to the insured but by function of the medical provider exhausting those benefits, the consumer receives nothing." *Id*. at 2. In 2011, the Office of the Insurance Consumer Advocate found that only 3 percent of the claims examined had an element of lost wages and over 60 percent of those lost wage claims were for total payments of under $1,000. *Id*. at 17.

B. The Purpose of the 2008 Amendment Was to Ameliorate Excessive Provider Costs by Allowing Insurers to Apply Cost-Saving Fee Schedules

The Legislature has enacted several reforms to the PIP system to reduce abuse by providers and thereby reduce insurance premiums. In 2001, the Legislature adopted most (but not all) of the Grand Jury Report's policy recommendations. *See* Chapter 2001-271, § 1, Laws of Fla.; *see also* Senate Report at 15. Among other things, the Grand Jury recommended that the Legislature "[c]onsider adopting a fee schedule for reimbursement under the PIP Statute similar to the schedule employed in the worker's compensation statute." Grand Jury Report at 19. While the Legislature adopted most of the Grand Jury's recommendations, it enacted a fee schedule only for a narrow class of PIP claims. *See* § 627.736(5)(b), Fla. Stat. (2001). The Legislature enacted additional reforms in 2003, which, among other things, provided for determining procedures that are not medically necessary and specified criteria for determining whether a provider's charge was "reasonable." Chapter 2003-411, Laws of Fla. These reforms, however, failed to stem PIP costs, which continued to grow at significant rates. Senate Report at 62; OIR Report at 13.

In 2007, the Legislature again attempted to reform the PIP statute (effective January 1, 2008). House Staff Analysis at 3 (stating that the 2008 Amendment was "remedial and curative in nature"). In particular, it introduced a

comprehensive fee schedule that allowed PIP insurers to limit provider reimbursement to 80% of 200% of the maximum allowable amount under the physician fee schedule of Medicare Part B. Chapter 2007-324, § 20, Laws of Fla. (the "2008 Amendment"). Under this system, providers' reimbursements would be limited, but still would be higher than the reimbursements they could obtain from Medicare.

On its face, the 2008 Amendment simplifies insurers' efforts at cost control by allowing them to use several different Medicare-based schedules to determine reasonable reimbursement of providers. Significantly, the 2008 Amendment also provides that the law is deemed to be a part of all insurance policies in the state. *See* Chapter 2007-324, § 21(2), Laws of Fla. (stating that any PIP policy in effect on or after January 1, 2008 "shall be deemed to incorporate the provisions of the Florida Motor Vehicle No-Fault Law, as revived and amended by this act."). In contrast to other sections of the statute, the fee schedule provision does not expressly require that the election to use the Medicare schedules be made in the policies themselves. *Compare* § 627.736(5)(a)(2), Fla. Stat. (2008) (providing that insurers "may limit reimbursement" as provided in statute) *with* § 627.736(7)(a), Fla. Stat. (2008) (providing that PIP insurers are "authorized to include reasonable provisions in personal injury protection insurance policies" for mental and physical examination of persons claiming PIP benefits). Relying on

the plain language of the 2008 Amendment, most Florida PIP policies expressly incorporate by reference the PIP statute (as amended), as GEICO did in the policy under review here. *See, e.g., Virtual II,* 90 So. 3d at 324 (Rothenberg, J., concurring).

II. THE DISTRICT COURT OPINIONS ARE INCONSISTENT WITH PRINCIPLES OF STATUTORY INTERPRETATION AND THE PURPOSE OF THE 2008 AMENDMENT

By preventing insurers from applying the fee schedules absent an express election, the district court opinions undermine the purpose of the 2008 Amendment. The district court opinions erred by finding that the Medicare-based fee schedules in section 627.736(5) constitute a separate methodology of calculating provider reimbursement which insurers must expressly elect. As explained more fully below, the statute recognizes the fee schedules as a valid measure of reasonableness. The district court opinions also reached their conclusions based on a faulty legal assumption: that the interests of medical providers and the insured policyholders are aligned on this issue, when in fact they are adverse.

A. The District Courts' Interpretation Eviscerates the Intent of the 2008 Amendment to Control PIP Provider Costs

The district court opinions eviscerate the intent behind the 2008 Amendment. The opinions effectively preclude insurers from taking fee schedule reductions unless an "election" to do so was made in the policy. Most PIP

insurers, however, did not "elect" the Medicare schedules in their policies because the plain language of the PIP statute does not require it. As a result, insurers are now forced to pay the inflated charges of PIP medical providers, which is exactly the problem the Legislature intended to fix by adopting fee schedules. *Virtual I* illustrates this problem: the opinion effectively equates a "reasonable" charge with the amount billed by the provider. *Virtual I,* 79 So.2d at 56-57. The interpretation of the statute in *Virtual I* and *Kingsway* essentially places insurers in the same position they were in before the 2008 Amendment.

The district courts' interpretation of section 627.736(5)(a) undermines the public polices the Legislature sought to advance. As the Office of Insurance Consumer Advocate has noted, fee schedules were introduced in 2008 to establish a ceiling for charges paid to medical providers. ICA Report at 33. The ICA Report observed that the legislation appeared to be "forthright" and designed to reduce PIP litigation as well as fraud and unnecessary medical care. *Id*. Because some district courts have found that insurance policies must specifically contain language adopting the fee schedules, however, insurers must continue to pay the inflated charges billed by medical providers or challenge the "reasonableness" of provider fees through expensive and risky litigation, which could result in an award of all fees incurred by the providers' attorney. Thus, despite the 2008 Amendment, the Office of the Insurance Consumer Advocate observed that "the

utilization[ ] of PIP is governed through litigation." *Id*. at 34. As a result, "the cost of claims [ ] is subsequently passed on to the consumer" through higher premium rates. *Id*.

This Court should reject the district courts' interpretation of the 2008 Amendment and restore the policy objectives behind the statute by limiting providers' ability to inflate bills and exhaust the $10,000 PIP benefits. Such an interpretation would reduce insurance premiums and allow PIP insureds to receive lost wage benefits as well as reimbursement for medical provider charges.

B. The District Court Opinions Fundamentally Misunderstand the Role of the Medicare Fee Schedules

The district court opinions fundamentally misapprehend the purpose of the Medicare-based reimbursement schedules in the 2008 Amendment. Those opinions construed the Medicare-based schedule identified in section 627.736(5) as somehow establishing a different methodology of calculating provider reimbursement from the provision in section 627.736(1)(a) that insurers reimburse 80% of reasonable expenses. *See, e.g., Virtual I,* 79 So. 3d at 57-58. The Legislature did not include those schedules, however, to create a supplemental method for determining provider reimbursement that was somehow different from the general requirement that insurers reimburse "reasonable" charges. Instead, those schedules were added to the statute to make clear that payment of medical

bills at these rates *is reasonable* as a matter of law. The Legislature had before it multiple reports showing that providers charge substantially more to PIP insurers than they do to Medicare and workers' compensation insurers (which also use those schedules). The Legislature also knew that the one-way attorneys' fee shifting provision had the effect of forcing PIP insurers to pay almost any amount billed, no matter how much higher that amount compared to the amounts billed to Medicare and workers' compensation insurance. Given the Legislature's purpose of controlling provider costs, it makes no sense that the Legislature would have retained an approach to reimbursement that did not resolve the fundamental problem of providers who overbill for treatment provided under PIP insurance. In this context, it is clear that the 2008 Amendment created a unified approach to determining reimbursement centered on the Medicare-based schedules referred to in section 627.736(5)(a). This means that no ambiguity exists in either the amended PIP statute or the policies referring to that statute regarding the calculation of provider reimbursement. The district courts' interpretation of the Medicare-based schedules as a separate method of determining reimbursement, which insurers must elect, misses the proverbial forest for the trees.

C. The District Court Opinions Incorrectly Require Insurers to Elect the Medicare Schedules in their Policies

The district court opinions read into the statute a requirement that for the Medicare-based schedules to apply, individual policies must specifically elect to use them. But nothing in section 627.736(5)(a)(2) so provides. To the contrary, the statute provides that any PIP policy in effect on or after January 1, 2008 "shall be deemed to incorporate the provisions of the Florida Motor Vehicle No-Fault Law, as revived and amended by this act." § 627.7407, Fla. Stat. (2008). Thus the district courts' interpretation violates the principle that courts should not read into a statute words that the Legislature did not use. *See Bennett v. St. Vincent's Med. Ctr, Inc.*, 71 So. 3d 828, 841 (Fla. 2011) (rejecting a statutory construction that "erroneously injected [a] term . . . into the statutory definition when no such term occurs"); *Tasker v. State*, 48 So. 3d 798, 805 (Fla. 2010) (courts are "not at liberty to extend or modify the express and unambiguous terms" of a statute with terms "that do not appear" there); *Valdes v. State*, 3 So. 3d 1067, 1072, 1075 (Fla. 2009) (rejecting a "judicial gloss" on a statute because courts had "added words that were not written by the Legislature"); *Knowles v. Beverly Enters.-Fla., Inc.*, 898 So. 2d 1, 7 (Fla. 2004) (rejecting a construction that would require the court "to add words to the statute").

PIP is solely a creature of statute. Requiring insurers to specifically elect the Medicare-based schedules also violates the principle that parties to an insurance contract are presumed to incorporate into their agreement the applicable insurance statutory provisions. *Grant v. State Farm Fire & Cas. Ins. Co.*, 638 So. 2d 936, 938 (Fla. 1994) ("[W]here a contract of insurance is entered into on a matter surrounded by statutory limitations and requirements, the parties are presumed to have entered into such agreement with reference to the statute, and the statutory provisions become a part of the contract.") (quoting *Standard Marine Ins. Co. v. Allyn*, 333 So. 2d 497, 499 (Fla. 1st DCA 1976)).

In addition, the district courts failed to recognize that the only parties in this case who benefit from requiring an election in the policies—medical providers—are strangers to those contracts. Neither party to the insurance contract—the insured policyholder and the insurer—has an interest in allowing medical providers to charge more to PIP than they charge to other forms of insurance for the same services. *See Allstate Ins. Co. v. Holy Cross Hosp., Inc.*, 895 So. 2d 1241, 1244 (Fla. 4th DCA 2005) (noting that when an insurer agrees with medical providers to compensate services at set rates, "the only impact on the insured would be to *save* the insured money[, and] since each treatment provided by a PPO provider costs the insurer less than the same treatment given by a non-PPO provider, *more services* will be available to the insured within the $10,000 PIP

policy limits") (emphasis in original); *Nationwide Mut. Ins. Co. v. Jewell*, 862 So. 2d 79, 86 (Fla. 2d DCA 2003) (same). To the contrary, excessive provider fees hurt policyholders by more quickly exhausting the $10,000 PIP coverage and denying them other benefits. ICA Report at 2. The only parties that benefit from an election requirement are the medical providers, who are not parties to the insurance contracts and are in no position to bargain with insurers in those policies. Because both insurers and insureds have a common interest in avoiding excessive medical provider fees, it serves no good public policy to require insurers to elect the cost-control schedules in the insurance policies.

D. The District Court Opinions Incorrectly Assume that Insureds and Medical Providers Share the Same Interests Regarding Providers' Fees, When in Fact they are Adverse

In this case (*Virtual II*), the Third DCA felt bound by its decision in *Virtual I*, where it found that an insurer's failure to include a term within a policy adopting the fee schedules in section 627.736(5)(a)(2) created an inherent ambiguity. *Virtual I*, 79 So. 3d at 58 ("A policy indicating that an insurer may distribute reimbursements according to one method without clarifying alternative methods or identifying the factors to be considered in selecting among methods is ambiguous."). The court noted that ambiguities in insurance contracts are construed in favor of the insured policyholders, stating that medical providers

"stand[] in the shoes of the policyholders," *id*. at 58 & n.2, and on that basis construed the policy in favor of the medical provider.

In granting medical providers a presumption in favor of insureds, the district court opinions ignore the fact that the interests of insured policyholders and medical providers conflict – and, more importantly, that a presumption in favor of insureds would require application of the fee schedules. As noted above, when medical providers charge insurers for unnecessary procedures at inflated rates, they quickly exhaust the insureds' $10,000 in PIP coverage. ICA Report at 2. These practices prevent accident victims from recovering benefits for their lost wages. Moreover, the higher losses associated with abuse of the PIP system force insurers to raise PIP premiums. Insureds and providers do not share the same financial interests. Insureds want to extend their PIP coverage as far as possible; providers want to charge as much for their services as possible. Therefore, providers do not stand in anybody's shoes but their own. The Court should therefore interpret any inherent ambiguities in favor of insureds, who stand to benefit from the Medicare-based fee schedules, rather than in favor of medical providers. *Virtual II*, 90 So. 3d at 327 (Rothenberg, J., concurring) ("[I]nterpreting PIP insurance policies in favor of the insureds actually requires reading the policies to cover the *lowest* amount possible.") (emphasis in original).

CONCLUSION

For the foregoing reasons, the Court should answer the certified question in the affirmative, and find that for PIP policies issued after January 1, 2008, insurers should be allowed to compute provider reimbursements based on the fee schedules identified in section 627.736(5), Florida Statutes, regardless of whether their policies specifically refer to those schedules.

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CERTIFICATE OF COMPLIANCE

I certify that this brief is submitted in Times New Roman 14-point font, which complies with the font requirement. *See* Fla. R. App. P. 9.210(a)(2).

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CERTIFICATE OF SERVICE

I certify that a copy of this brief was mailed and emailed on September 24, 2012 to counsel on the attached service list.

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