

IN THE SUPREME COURT OF FLORIDA

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CASE NO. SC18-278

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**PROGRESSIVE SELECT INSURANCE COMPANY,  
Petitioner,**

**v.**

**FLORIDA HOSPITAL MEDICAL CENTER, INC.  
as assignee of Jonathan Parent,  
Respondent.**

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On Discretionary Review of a Question  
Certified by the Fifth District Court of Appeal  
to Be of Great Public Importance

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**PETITIONER'S INITIAL BRIEF ON THE MERITS**

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**TABLE OF CONTENTS**

TABLE OF CONTENTS..... i - ii

TABLE OF AUTHORITIES ..... iii - v

I. STATEMENT OF THE CASE AND FACTS ..... 1

    A. INTRODUCTION..... 1

    B. THE APPENDIX. .... 4

    C. THE FACTS..... 5

II. SUMMARY OF THE ARGUMENT ..... 8

III. ARGUMENT..... 10

    A. STANDARD OF REVIEW. .... 10

    B. THE DEDUCTIBLE IN A PIP INSURANCE POLICY APPLIES AFTER, NOT BEFORE, THE CHARGE IS ADJUSTED BASED ON THE PIP BENEFITS SECTION’S FEE SCHEDULE. .... 10

        1. When an Insurer Limits Reimbursement Based on the Fee Schedule, the “Expenses” Referenced in the PIP Deductible Section are the Fee Schedule Amounts...... 13

        2. Bills Must be Adjusted to Reasonable Amounts to Activate a PIP Claim. ..... 15

        3. The Fourth District’s Ruling Is Consistent with the Interpretation of Insurance Deductibles...... 18

        4. The Fourth District’s Interpretation Is Supported by the Florida Standard Jury Instructions for PIP Claims. ..... 20

5. <u>The Fifth District’s Ruling is Based on a Misreading of the PIP Deductible Section.</u> .....	21
6. <u>The Fifth District Erred by Considering the Legislature’s Failure to Enact a Bill Addressing This Situation.</u> .....	25
7. <u>The Fourth District’s Opinion Favors the Insured; the Fifth District Opinion Does Not.</u> .....	27
(a) <u>The Fourth District Hypothetical</u> .....	28
(b) <u>Fourth District Actual Case.</u> .....	28
(c) <u>This Case.</u> .....	29
(d) <u>This Case - But with the Insured’s 20% Co-Pay.</u> .....	30
CONCLUSION .....	33
CERTIFICATE OF FONT COMPLIANCE .....	34
CERTIFICATE OF SERVICE .....	34

**TABLE OF AUTHORITIES**

*Allstate Ins. Co. v. Holy Cross Hosp., Inc.*,  
961 So.2d 328 (Fla. 2007) ..... 17

*Allstate Ins. Co. v. Orthopedic Specialists*,  
212 So.3d 973 (Fla. 2017) .....2, 8, 10-12, 17, 18, 23

*Digital Med. Diagnostics v. United Auto. Ins. Co.*,  
958 So. 2d 505 (Fla. 3d DCA 2007)..... 16

*Duer v. Moore*,  
765 So.2d 743 (Fla. 1st DCA 2000)..... 25

*Fleeman v. Case*,  
342 So.2d 815 (Fla. 1976) ..... 25, 26

*Geico Gen. Ins. Co. v. Virtual Imaging Servs., Inc.*,  
90 So.3d 321 (Fla. 3d DCA 2012)..... 32, 33

*Geico Gen. Ins. Co. v. Virtual Imaging Servs.*,  
141 So.3d 147 (Fla. 2013) ..... 11, 16, 32, 33

*General Star Indem. Co. v. W. Fla. Vill. Inn, Inc.*,  
874 So.2d 26 (Fla. 2d DCA 2004)..... 19

*Govan v. Int’l Bankers Ins. Co.*,  
521 So.2d 1086 (Fla. 1988) .....22-24, 26, 27

*Hannah v. Newkirk*,  
675 So. 2d 112 (Fla. 1996) ..... 18

*In re Standard Jury Instructions In Civil Cases-Report No. 09-01*  
*(Reorganization of the Civil Jury Instructions)*,  
35 So.3d 666 (Fla. 2010) ..... 21

*Int’l Bankers Ins. Co. v. Arnone*,  
552 So. 2d 908 (Fla. 1989) ..... 18, 22-24

<i>Landers v. State Farm Fla. Ins. Co.</i> , 234 So.3d 856 (Fla. 5th DCA 2018).....	18, 32
<i>Metro. Cas. Ins. Co. v. Tepper</i> , 2 So.3d 209 (Fla. 2009) .....	25
<i>Northwoods Sports Med. &amp; Physical. Rehabilitation, Inc. v. State Farm Mut. Auto. Ins. Co.</i> , 137 So. 3d 1049 (Fla. 4th DCA 2014), <i>rev. denied</i> , 163 So. 3d 516 (Fla. 2015) .....	16
<i>Progressive Select Ins. Co. v. David A. Blum, M.D., P.A.</i> , 238 So.3d 852 (Fla. 4th DCA 2018), <i>rev. stayed</i> , No. SC18-0502 (Fla. April 6, 2018) .....	4
<i>Progressive Select Ins. Co. v. Fla. Hosp. Med. Ctr., Inc.</i> , 236 So.3d 1183 (Fla. 5th DCA 2018), <i>rev. granted</i> , No. SC18-0278 (Fla. Mar. 20, 2018).....	2, 4
<i>State Farm Mut. Auto. Ins. Co. v. Care Wellness Ctr., LLC</i> , 43 Fla. L. Weekly D573 (Fla. 4th DCA 2018), <i>rev. stayed</i> , No. SC18-0429 (Fla. Mar. 23, 2018) .....	2, 4, 8, 28, 33
<i>Tampa-Hillsborough Cty. Expressway Auth. v. K.E. Morris Alignment Serv., Inc.</i> , 444 So.2d 926 (Fla. 1983) .....	32
<i>USAA Gen. Indem. Co. v. William J. Gogan, M.D.</i> , 238 So.3d 937 (Fla. 4th DCA 2018), <i>rev. stayed</i> , No. SC18-0500 (Fla. April 6, 2018) .....	4
<i>Volusia Cnty. v. Aberdeen at Ormond Beach, L.P.</i> , 760 So. 2d 126 (Fla. 2000) .....	1

**OTHER AUTHORITIES:**

Ch. 2007-324, §§9-19, Laws of Fla. ....	24
---	----

Fla. Std. Jury Instr. (Civ.) 413.4 .....	21
§ 627.736, Fla. Stat. ....	1, 6, 10-14, 20, 23, 24
§ 627.736(1), Fla. Stat.....	13, 14, 17
§ 627.736(1)(a), Fla. Stat. ....	14, 15, 21
§ 627.736(5), Fla. Stat.....	24
§ 627.736(5)(a), Fla. Stat. ....	3, 11
§ 627.736(5)(a)1., Fla. Stat. ....	2, 5, 6, 11, 12, 20
§ 627.736(5)(a)1.b., Fla. Stat. ....	5, 6, 7, 33
§ 627.736(5)(a)2., Fla. Stat. ....	12
§ 627.736(6)(b), Fla. Stat.....	15
§ 627.739, Fla. Stat. ....	1, 10, 24
§ 627.739(2), Fla. Stat.....	6, 7, 10, 12-14, 21, 24, 26, 33

## **I. STATEMENT OF THE CASE AND FACTS**

### **A. INTRODUCTION.**

This proceeding presents an issue of statutory interpretation certified by the Fifth District Court of Appeal to be of great public importance. The issue concerns the interaction of two statutory sections of the Florida No-Fault Personal Injury Protection [**“PIP”**] Statute, sections 627.736 and 627.739 of the Florida Statutes, and the proper application of an insurance deductible to a medical provider’s bills. Specifically, the Fifth District was asked to determine whether an insurance carrier applies the policy deductible to the total amount of a medical provider’s charges prior to applying the statutory fee schedule of maximum charges. Thus, the question posed to this Court is: How is the deductible to be applied in a PIP case? The Fourth and Fifth District Courts reached conflicting conclusions.

While this proceeding was pending, the Fourth District Court of Appeal addressed the identical issue certifying direct conflict with the Fifth District decision. Petitioner Progressive Select Insurance Company [**“Progressive”**] submits that the Fourth District opinion correctly states the law of Florida and asks this Court to answer the certified question in conformity with that opinion (and with the Fifth District dissenting opinion).

The Court should focus on two critical facts. First, it is undisputed that Progressive’s PIP Policy [**“Policy”**] permits it to limit reimbursement based on the

PIP Statute's fee schedule of maximum charges. *See* Fla. Stat. § 627.736(5)(a)1. Second, the fee schedule payment has been determined to be a per se reasonable amount by this Court. *See Allstate Ins. Co. v. Orthopedic Specialists*, 212 So.3d 973, 976 (Fla. 2017) [*“Orthopedic Specialists”*]. As a result, the maximum, reasonable reimbursement amount due to Respondent Florida Hospital Medical Center [*“FHMC”*] is determined by the fee schedule of maximum charges.

The Fifth District, in a 2-1 opinion, said the first step in applying the deductible is to subtract the \$1000 deductible from the total amount billed by the provider. *See Progressive Select Ins. Co. v. Fla. Hosp. Med. Ctr., Inc.*, 236 So.3d 1183 (Fla. 5th DCA 2018), *rev. granted*, No. SC18-0278 (Fla. Mar. 20, 2018). The next step is to apply the statutory PIP fee schedule. The Fifth District method is that only after subtracting the deductible amount is the insurer allowed to apply the fee schedule adjustment. The insurer then pays 80% of the remaining amount to the provider. The Fifth District read the PIP Statute to compel this result. However, in reaching this conclusion the Fifth District read reasonableness, a cornerstone of the PIP Statute, out of the statute.

The Fourth District, in a 2-1 opinion, disagreed. *See State Farm Mut. Auto. Ins. Co. v. Care Wellness Ctr., LLC*, 43 Fla. L. Weekly D573 (Fla. 4th DCA 2018), *rev. stayed*, No. SC18-0429 (Fla. Mar. 23, 2018) [*“Care Wellness”*]. Under its method, the insurer first adjusts the provider's bill to a reasonable amount, in

accordance with the fee schedule, and then the deductible is applied to that reasonable amount. After the deductible is met, the insurer then pays 80% of the remaining balance to the provider and the insured pays the other 20% as a co-pay.

The Fourth District opined, in agreement with the Fifth District's dissent, that the Fifth District "majority incorrectly concluded that 'medical expenses' are different than 'medical benefits' under the PIP statute" and that "the majority's conclusion that the deductible must be first applied to the billed charge, no matter if the PIP policy covers the charge, [to be] fundamentally unreasonable." (A.31). Florida Statute § 627.736(5)(a) (2014) mandates that a medical provider charge the "insurer and injured party only a reasonable amount." (emphasis added) (A.28). As the Fourth District stated, "[t]he legislature also established two methods of determining reasonableness; one being the fee schedule. To apply the fee schedule to the billed charges only after applying the deductible, as the provider argues, would allow the provider to recover different amounts depending on the amount of the deductible. It would also allow the provider to [charge and] recover [from an insurer and insured] more than the amount found to be reasonable in the fee schedule. This would render meaningless the portion of the statute precluding a provider from charging more than a reasonable amount." (A.24). The two deductible calculation methods espoused by the district courts yield two different

amounts to be paid to the provider, and different consequences for providers, insurers, and insureds.

## **B. THE APPENDIX.**

For ease of reference, the Appendix includes not only the underlying Fifth District decision [the “*Opinion*”] but also the Fourth District decision (which is set forth in three opinions issued the same day by the same panel). (A.4-42). The providers in the three Fourth District cases sought discretionary review by this Court which has stayed those proceedings pending the outcome of this case. The Appendix includes:

- *Progressive Select Ins. Co. v. Fla. Hosp. Med. Ctr., Inc.*, 236 So.3d 1183 (Fla. 5th DCA 2018), *rev. granted*, No. SC18-0278 (Fla. Mar. 20, 2018);
- *State Farm Mut. Auto. Ins. Co. v. Care Wellness Ctr., LLC*, 43 Fla. L. Weekly D573 (Fla. 4th DCA 2018), *rev. stayed*, No. SC18-0429 (Fla. Mar. 23, 2018);
- *USAA Gen. Indem. Co. v. William J. Gogan, M.D.*, 238 So.3d 937 (Fla. 4th DCA 2018), *rev. stayed*, No. SC18-0500 (Fla. April 6, 2018); and
- *Progressive Select Ins. Co. v. David A. Blum, M.D., P.A.*, 238 So.3d 852 (Fla. 4th DCA 2018), *rev. stayed*, No. SC18-0502 (Fla. April 6, 2018).

### C. THE FACTS.

Petitioner Progressive issued an automobile insurance Policy providing PIP benefits to Jonathan Parent [**“Parent”**] who elected a \$1000 deductible. (A.6). In 2014, while the Policy was in effect, Parent was involved in an auto accident after which FHMC treated Parent and submitted bills to Progressive under an assignment of benefits. (A.6).

There is no dispute that the Policy allows Progressive to limit reimbursement to a reasonable amount by applying the fee schedule of maximum charges found in Fla. Stat § 627.736(5)(a)1. The fee schedule establishes the maximum amount covered under PIP to reimburse a medical provider like FHMC.

In this instance, the fee schedule limits reimbursement for emergency medical care to 75% of the provider’s usual and customary charge. *See* Fla. Stat. § 627.736(5)(a)1.b. (“The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges: . . . . For emergency services and care, provided by a hospital licensed under chapter 395, 75 percent of the hospital’s usual and customary charges.”). Thus, the reasonable amount under the Policy is limited to the statutory fee schedule reasonable amount, 75% of the billed amount. The insurer pays 80% of 75% of the billed amount in making its payment under PIP, and an insured pays 20% of 75% of the billed amount. This is important when analyzing the meaning of “100% of expenses and losses as described in

s.627.736,” as that is simply a combination of the insurer and insured’s joint responsibilities under PIP, and is the very reason that the language of § 627.739(2) exists as it does today.

The dispute in this case arose when FHMC challenged the way that Progressive applied the Policy deductible to its bill. Progressive made the fee schedule adjustment (75%) **first** and then applied the PIP deductible **after** the adjustment. The Fifth District illustrated the calculation as follows:

\$2,781.00	Total Charge
x 75%	Applying section 627.736(5)(a)1.b.
<u>\$2,085.75</u>	
<u>-\$1,000.00</u>	Deductible
\$1,085.75	
x 80%	Insurer Pays 80% per section 627.736(5)(a)1.
<b>\$868.60</b>	<b>Amount Paid by Progressive</b>

(A.6-7).

FHMC contends that Progressive should have applied the deductible to the total amount of its bill **before** adjusting the charge based on the PIP fee schedule.

The Fifth District illustrated the calculation as follows:

\$2,781.00	Total Charge
<u>-\$1,000.00</u>	Deductible
\$1,781.00	
x 75%	Applying section 627.736(5)(a)1.b.
<u>\$1,335.75</u>	
x 80%	Insurer pays 80% per section 627.736(5)(a)1.
<b>\$1,068.60</b>	<b>Amount Alleged to be Due Per Provider</b>

(A.6).

FHMC sued Progressive in county court, seeking the \$200 difference resulting from its proposed method of deductible application. (A.7). The county court entered a final summary judgment in favor of FHMC, “adopting [its] argument that the plain language of [the PIP Deductible Section] required Progressive to subtract Parent’s deductible from [FHMC]’s total charges before applying [the PIP Benefits Section’s] reimbursement limitation.” (A.7). Progressive appealed the final summary judgment to the circuit court which affirmed the county court’s judgment. (A.7).

Progressive then filed a petition for writ of certiorari with the Fifth District seeking second-tier review. (A.7). After granting rehearing and issuing a revised opinion, the Fifth District denied certiorari, but certified the following question of great public importance:

WHEN CALCULATING THE AMOUNT OF PIP BENEFITS DUE AN INSURED, DOES SECTION 627.739(2), FLORIDA STATUTES, REQUIRE THAT THE DEDUCTIBLE BE SUBTRACTED FROM THE TOTAL AMOUNT OF MEDICAL CHARGES BEFORE APPLYING THE REIMBURSEMENT LIMITATION UNDER SECTION 627.736(5)(a)1.b., OR MUST THE REIMBURSEMENT LIMITATION BE APPLIED FIRST AND THE DEDUCTIBLE SUBTRACTED FROM THE REMAINING AMOUNT?

(A.19). This Court accepted jurisdiction by Order dated March 20, 2018.

## II. SUMMARY OF THE ARGUMENT

The Fifth District erred by applying the deductible to FHMC's total billed charges without considering the reasonableness of the charged amount. In this case, the maximum reimbursement amount is set by the statutory PIP fee schedule.<sup>1</sup> In a fee schedule case, the correct procedure is, first, to determine the reasonable amount pursuant to the fee schedule – which is the maximum compensable amount – and, second, to subtract the deductible from the remainder.

While this proceeding was pending in this Court, the Fourth District issued its decision in *Care Wellness*, certifying conflict with the Fifth District's Opinion and holding: "that an insurer must reduce the provider's charges to the statutorily-approved permissive fee schedule *before* applying the deductible." (A.25) (emphasis in original). As the Fourth District noted, this holding is "consistent with the general understanding of insurance deductibles" and a contrary interpretation of the two statutory Sections "would effectively render the deductible meaningless." (A.31-32). ("Logically, the deductible only applies to losses covered under the policy of insurance, not the total bills submitted.") (A.31) (citation and internal punctuation omitted).

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<sup>1</sup> See *Orthopedic Specialists*, 212 So.3d at 976 ("Reimbursements made under [the fee schedule] satisfy the PIP statute's reasonable medical expenses coverage mandate.").

The Fourth District also maintained that the Fifth District erred by relying on a proposed amendment to the PIP Deductible Section of the PIP Statute which the Legislature did not enact in 2016. (A.30). The Fourth District properly reasoned that no inference can be drawn when the Legislature fails to enact a proposed bill. (A.30-31).

PIP benefits are regulated by the Legislature, in the often-amended PIP Statute. The statutory fee schedule was enacted by the Legislature and was adopted by Progressive in its Policy. For this reimbursement system to operate as the Legislature intended, the deductible must be subtracted from the adjusted fee schedule amount, not the total billed amount. (A.33-34). The Fourth District's decision correctly interprets the PIP Statute while the Fifth District's methodology leads to an absurd result.

This Court should answer the Fifth District's certified question in accordance with its second option, i.e., "the reimbursement limitation must be applied first, and the deductible subtracted from the remaining amount." This Court therefore should reverse the decision of the Fifth District and answer the certified question accordingly.

### **III. ARGUMENT**

#### **A. STANDARD OF REVIEW.**

The standard of review applicable to the county court’s summary judgment was *de novo*. See *Volusia Cnty. v. Aberdeen at Ormond Beach, L.P.*, 760 So.2d 126, 130 (Fla. 2000). Pure questions of law also are reviewed under a *de novo* standard. See *Orthopedic Specialists*, 212 So.3d at 975 (“Because the question presented requires this Court to interpret provisions of the Florida Motor Vehicle No-Fault Law – specifically, the PIP statute – as well as to interpret the insurance policy, our standard of review is *de novo*.”) (citation and internal punctuation omitted).

#### **B. THE DEDUCTIBLE IN A PIP INSURANCE POLICY APPLIES AFTER, NOT BEFORE, THE CHARGE IS ADJUSTED BASED ON THE PIP BENEFITS SECTION’S FEE SCHEDULE.**

There are primarily two relevant sections of the PIP Statute for this Court to consider when determining the proper application of a PIP policy deductible – the PIP Deductible Section, Fla. Stat. § 627.739, requiring insurers to offer each policyholder a deductible, and the PIP Benefits Section, Fla. Stat. § 627.736. The dispositive issue is to determine what the following language within Fla. Stat. § 627.739(2) means: “[t]he deductible amount must be applied to 100 percent of the expenses and losses described in s. 627.736.”

To simplify the narrow issue at hand and facilitate the resolution of this dispute, Progressive has provided context for key terms and phrases to assist this Court with its review of the two statutory sections. First, to determine what “expenses and losses” are, this phrase must be read in conjunction with Fla. Stat. § 627.736. Since its inception in 1971, § 627.736, Fla. Stat., has required insurers provide coverage, but only for reasonable expenses for necessary medical services. *See Geico Gen. Ins. Co. v. Virtual Imaging Servs.*, 141 So.3d 147, 153 (Fla. 2013) (while the PIP statute initially allowed for payment of “all reasonable expenses” it was later amended to “[e]ighty percent of all reasonable expenses.”). This reasonableness requirement not only applies to the insurer, but the insured as well. *See* § 627.736(5)(a), Fla. Stat. (a provider “may charge the insurer and injured party only a reasonable amount”) (emphasis added). Thus, under the plain language of § 627.736, all “expenses” must be reasonable expenses – for both the PIP insurer and insured.

To determine reasonableness, this Court has explained that there are two methods for calculating a reasonable amount. *See Orthopedic Specialists*, 212 So.3d at 976 (quoting *Virtual Imaging*, 141 So.3d at 156). The first method, under § 627.736(5)(a), is a fact-dependent inquiry determined by considering various factors, and under the second method, found within § 627.736(5)(a)1., an insurer may limit reimbursement pursuant to the fee schedules. Reimbursements made

under § 627.736(5)(a)1. “satisfy the PIP statute’s reasonable medical expenses coverage mandate.” *Orthopedic Specialists*, 212 So.3d at 976.<sup>2</sup> Thus, when an insurer has provided the requisite notice, as here, reasonable expenses are those amounts established by the fee schedules.

Based upon an understanding of what “expenses and losses” are under § 627.736, the phrase “100 percent of expenses and losses” within § 627.739(2) can only be read as “100 percent of reasonable expenses described in s. 627.736.” Thus, the deductible is applied to 100 percent of reasonable expenses, those reasonable amounts established by the fee schedules (as described in § 627.736(5)(a)1.). After the deductible has been applied, a PIP insurer pays 80% of the reasonable expenses, up to \$10,000 in “total benefits,” and the insured pays the remaining 20% of the reasonable expenses as a co-pay (80% + 20% = 100%).

As the Fifth District noted, “[b]oth this court and the Florida [S]upreme [C]ourt have held the provisions of Florida's No-Fault Act must be construed liberally in favor of the insured.” (A.8) (internal citation omitted). Applying this principle and the key terms and phrases as described above, there can be no other resolution than the Fourth District’s method – the one that favors insureds as the PIP Statute intends.

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<sup>2</sup> The PIP Benefits Section of the PIP Statute was renumbered from § 627.736(5)(a)2. to § 627.736(5)(a)1. in 2012.

1. WHEN AN INSURER LIMITS REIMBURSEMENT BASED ON THE FEE SCHEDULE, THE “EXPENSES” REFERENCED IN THE PIP DEDUCTIBLE SECTION ARE THE FEE SCHEDULE AMOUNTS.

The starting point for determining how to apply a PIP deductible is the PIP Deductible Section.<sup>3</sup> The disputed statutory language is in the second and third sentences which state:

The deductible amount must be applied to 100 percent of the expenses and losses described in s. 627.736. After the deductible is met, each insured is eligible to receive up to \$10,000 in total benefits described in s. 627.736(1).

Fla. Stat. 627.739(2) (2014).<sup>4</sup> The specific language at issue is “100 percent of the expenses . . . described in s. 627.736.” The Fifth and Fourth Districts differ sharply about what “expenses . . . [are] described in s. 627.736.”

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<sup>3</sup> The PIP Deductible Section provides:

Insurers shall offer to each applicant and to each policyholder, upon the renewal of an existing policy, deductibles, in amounts of \$250, \$500, and \$1,000. **The deductible amount must be applied to 100 percent of the expenses and losses described in s. 627.736.** After the deductible is met, each insured is eligible to receive up to \$10,000 in total benefits described in s. 627.736(1). However, this subsection shall not be applied to reduce the amount of any benefits received in accordance with s. 627.736(1)(c).

Fla. Stat. 627.739(2) (2014) (emphasis added).

<sup>4</sup> The term “losses” is not at issue here. The only “losses” covered by the PIP Statute are the “loss of gross income” and “loss of earning capacity” referred to in the disability benefits provision of Section 627.736(1)(b).

The Fifth District majority held that the “100 percent of the expenses” means 100 percent of the provider’s billed charges, as reflected by the total amount of the provider’s bill – without any reduction regardless of the amount presented. (A.8-11). The court reached that conclusion because the next statutory sentence uses a different term – “benefits” – and says that, after the deductible is met, “each insured is eligible to receive up to \$10,000 in total benefits described in s. 627.736(1).” (A.9) (emphasis in original). The court reasoned that the word “expenses” means expenses billed by the provider, while “benefits” means benefits that have been reduced in accordance with the statutory PIP fee schedule. (A.9). The Fourth District disagreed, concluding that the Fifth District misinterpreted the statute. (A.29-31). Benefits are simply 80% of reasonable expenses. See Fla. Stat. §627.736 (1)(a).

The key part of the PIP Deductible Section states that the deductible is to be applied to “100 percent of the expenses and losses **described in s. 627.736.**” § 627.739(2), Fla. Stat. (emphasis added). The key word is “described,” and the question is: What is described in Section 627.736? In interpreting this provision, the Fourth District turned to the portion of the PIP Benefits Section titled “Medical Benefits” – § 627.736(1)(a). (A.27-28). In the Fourth District’s view, what is “described in s. 627.736” is **reasonable, compensable expenses**, not whatever amount the provider chooses to bill. (A.27-28).

The Fourth District explained that, wherever the PIP Benefits Section refers to “expenses,” there is “directly or indirectly, a requirement that the expenses be **reasonable.**” (A.27-28) (emphasis added) (citing six sub-sections of the PIP Benefits Section referring to “expenses”). For example, “section 627. 736(1)(a) references ‘reasonable expenses for medical services,’ and section 627.736(6)(b) requires a provider to furnish a written report stating . . . why the amount charged is reasonable.” (A.28). Thus, the “expenses” as referenced in the PIP Deductible Section are those *reasonable* expenses under the PIP Benefits Section – the per se reasonable *fee schedule amount*.

2. **BILLS MUST BE ADJUSTED TO REASONABLE AMOUNTS TO ACTIVATE A PIP CLAIM.**

The PIP Benefits Section of the PIP Statute “requires a provider [to] charge the ‘insurer and injured party only a reasonable amount.’ The legislature established what is reasonable through the adoption of predetermined fee schedule limitations.” (A.32) (citation and internal punctuation omitted). Thus, “to activate the right to claim PIP payments . . . the provider’s bills must be compensable under the [PIP] statute in that they have been determined to be reasonable and necessary . . . . In other words, there is no PIP claim until the provider’s bill is reduced, if necessary, to the amount set forth in [the PIP fee schedule]” – the amount found to be reasonable by the Legislature. (A.31) (internal citation omitted).

This conclusion is derived in part and consistent with a well-established principle of law analyzed in the context of exhaustion of policy benefits. In *Northwoods Sports Med. & Physical Rehabilitation, Inc. v. State Farm Mutual Auto. Ins. Co.*, 137 So. 3d 1049 (Fla. 4th DCA 2014), *rev. denied*, 163 So. 3d 516 (Fla. 2015), the court held that in order to activate a claim for PIP benefits, a bill must first be compensable under the policy such that the amount at issue is determined to be reasonable:

In order to activate the right to claim PIP payments under the assignment, the provider's bills must be compensable under the statute in that they have been determined to be reasonable and necessary. ... Until the necessity of the services and reasonableness of the charges is settled, their compensability under PIP is not established . . .

*Id.* at 1057.

Since the deductible is a “basic part of the policy of insurance,” *Digital Med. Diagnostics v. United Auto. Ins. Co.*, 958 So. 2d 505, 507 (Fla. 3d DCA 2007), any consideration of whether it applies is irrelevant until the bill is determined to be compensable under PIP; meaning it must be medically necessary, related to the subject accident, and reasonable in amount. When an insurer opts to apply the fee schedules, that determination of reasonableness is made by application of the fee schedules. *Virtual Imaging*, 141 So.3d at 156. Accordingly, when an insurer calculates reimbursement by applying the fee schedules, the deductible applies to

that calculation, *i.e.* the deductible applies to the reasonable, fee schedule amount, not the total amount charged.

Contrary to the Fifth District’s view, the PIP Benefits Section defines the term “medical benefits” as “[e]ighty percent of all **reasonable expenses** for medically necessary medical [and certain other] . . . services[.]” Fla. Stat. § 627.736(1) (emphasis added). As this Court has recognized, “benefits” are simply “expenses” minus the insured’s 20% co-pay. *See generally Allstate Ins. Co. v. Holy Cross Hosp., Inc.*, 961 So.2d 328, 332 (Fla. 2007) (“**As to medical benefits**, which are the subject of this case, insurers must pay [e]ighty percent *of all reasonable expenses* for medically necessary medical ... services.”) (italics in original; other emphasis added; citation and internal punctuation omitted).

The Fourth District applied this principle, noting that: “[r]easonableness is the key throughout these provisions. Yet the providers effectively argue that their charges need to be reasonable only to the insurer, not the insured. We disagree. **The requirement that charges be reasonable applies to the totality of the charges.**” (A.28) (emphasis added). If a “reasonable charge” is the most that may be reimbursed under the PIP Benefits Section, and the PIP fee schedule satisfies “the PIP statute’s reasonable medical expense coverage mandate,” then an insurer and insured should never be obligated to pay more than the fee schedule amount when the subject policy limits reimbursement to the fee schedule. *Orthopedic*

*Specialists*, 212 So.3d at 976. “[T]he deductible only applies to losses covered under the policy of insurance, not simply the total bills submitted.” (A.31) (citation omitted). Any other interpretation would be at odds with the “reasonableness” coverage mandate of the PIP Benefits Section of the PIP Statute. *See generally Landers v. State Farm Fla. Ins. Co.*, 234 So.3d 856, 860 (Fla. 5th DCA 2018) (rejecting an interpretation that would have “frustrate[d] the purpose of the statute.”).

**3. THE FOURTH DISTRICT’S RULING IS CONSISTENT WITH THE INTERPRETATION OF INSURANCE DEDUCTIBLES.**

A deductible is beneficial to the insured because “[i]n electing a PIP deductible, an insured pays a lower premium for PIP coverage, and yet will still be substantially compensated by PIP for any damages sustained.” *Hannah v. Newkirk*, 675 So.2d 112, 114 (Fla. 1996). The deductible “is frequently referred to as self-insurance[.]” *Int’l Bankers Ins. Co. v. Arnone*, 552 So.2d 908, 911 (Fla. 1989).

The Fourth District observed that its ruling is consistent with this “general understanding of insurance deductibles.” (A.31). As the court found, applying the deductible to the total billed charges would violate the purpose of the deductible:

Logically, the deductible only applies to losses covered under the policy of insurance, not simply the total bills submitted... The notion that a deductible could be applied to loss that is not covered by the policy is fundamentally unreasonable. ... **To apply the deductible to the billed charge irrespective of**

**whether the charge was reasonable – or even covered – would effectively render the deductible meaningless.**

(A.31-32) (citations and internal punctuation omitted; emphasis added). Indeed, otherwise, a provider could access insurance payments *immediately*, by adding the amount of the insured's PIP deductible to the total amount of its bill. For example, a bill for \$200 would become a bill for \$1200. Not only would the provider be able to seek \$1000 from the insured, it would be able to access PIP coverage *immediately* – thereby rendering the deductible (which is intended for the insured to self-insure for the first \$1000 of *covered and reasonable* medical bills) meaningless.

The Fifth District's ruling violates the established rule that a deductible cannot apply to expenses not covered by a policy. *See General Star Indem. Co. v. W. Fla. Vill. Inn, Inc.*, 874 So.2d 26, 33-34 (Fla. 2d DCA 2004) (“**The notion that a deductible could be applied to loss that is not covered by the policy is fundamentally unreasonable.** . . . [A]pplying the deductible to a noncovered loss does not serve the goals of having the insured share in the risk. Indeed, it threatens to render the deductible a nullity.”) (emphasis added). To not allow an insurer to assess the reasonableness of the charges submitted by the medical provider prior to applying the deductible would place non-deductible insureds and deductible insureds in disparate positions. In fact, the deductible insured would be saddled with paying for expenses that were patently unreasonable, as they exceed the fee

schedule contained in 627.736(5)(a)1., and for which a non-deductible insured would never be required to pay.

The amount owed in this case prior to applying the deductible and co-pay, as dictated by the PIP fee schedule, is \$2,085.75 ( $\$2781.00 \times 75\%$ ). (A.7). Yet, the Fifth District held that the deductible applied to the total amount of FHMC's charge, \$2,781.00. (A.6). That portion of FHMC's charge above and beyond the amount allowed under the fee schedule, *i.e.* \$695.25 ( $\$2,781.00 - \$2,085.75$ ), is an expense **not covered by the Policy** and is per se unreasonable. In short, the Fifth District incorrectly ruled that the deductible applies to an amount that Progressive or the insured could not possibly owe under § 627.736 and is therefore inconsistent with the application of insurance deductibles to only covered losses.

**4. THE FOURTH DISTRICT'S INTERPRETATION IS SUPPORTED BY THE FLORIDA STANDARD JURY INSTRUCTIONS FOR PIP CLAIMS.**

In addition to the Fourth District's analysis regarding the compensability of a PIP claim and PIP insurance deductibles, its conclusion is further supported by the Standard Jury Instructions applicable to PIP claims, which provide that the jury is to award only a reasonable amount:

**The third issue is whether the charge is reasonable.** If you find the charge for a service or services reasonable, you should award that amount as damages. If you find the charge for a service or services is not reasonable, you should award an amount that the greater weight of the evidence shows is reasonable.

Fla. Std. Jury Instr. (Civ.) 413.4 (emphasis added). As the Notes to Instruction 413.4 state, it is only **after** that determination of a reasonable amount is made that the deductible is applied:

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

Fla. Std. Jury Instr. (Civ.) 413.4, Note 1 (emphasis added).

By adopting Instruction 413.4, *In re Standard Jury Instructions In Civil Cases-Report No. 09-01 (Reorganization of the Civil Jury Instructions)*, 35 So.3d 666, 771 (Fla. 2010), this Court acknowledged that the deductible is applied only after the amount of a reasonable charge has been determined. As such, the Fourth District's method follows the application of the deductible in accordance with the relevant jury instruction.

**5. THE FIFTH DISTRICT'S RULING IS BASED ON A MISREADING OF THE PIP DEDUCTIBLE SECTION.**

Prior to 2003, Section 627.739(2) was much different than it is today. In its prior version, the statute provided: "Insurers shall offer to each applicant and to each policyholder, deductibles in amounts of \$250, \$500, \$1,000 and \$2,000, **such amount to be deducted from the benefits otherwise due** each person subject to the deduction." Fla. Stat. §627.739(2) (2001) (emphasis added).

In *Govan v. Int'l Bankers Ins. Co.*, 521 So.2d 1086 (Fla. 1988), this Court addressed a dispute about how to apply a deductible under earlier versions of the PIP Benefits Section and the PIP Deductible Section. The issue then was whether the PIP deductible should be applied to the 80% (as opposed to 100%) of the medical expenses covered sub-section (1)(a) of a prior version of the PIP Benefits Section. This Court held that, as then worded, the PIP Benefits Section and the PIP Deductible Section required, **first**, a calculation of what PIP benefits are payable under sub-section (1)(a) of the PIP Benefits Section. Because sub-section (1)(a) provided that the insurer pays only 80% of expenses covered by the PIP Benefits Section, the first step was to calculate the 80% the insurer was required to pay. **Second**, the deductible (\$2,000 in that case) was subtracted. The end result was a reduction in PIP benefits for the insured.

In reaching this conclusion this Court said: “While we may disagree with the legislative policy underlying the statute, we have no authority to change the clear intent and purpose of a statute that is not vague and ambiguous. Complaints about this policy should be addressed to the legislature.” *Id.* at 1088.

One year later, in *Arnone*, this Court construed the “benefits otherwise due” language where the insureds’ recoverable expenses exceeded the maximum \$10,000 in PIP coverage. *Id.*, 552 So.2d at 909. In that scenario, the deductible is

subtracted from the statutorily mandated coverage limit of \$10,000. *Id.* at 911. Assuming a \$2000 deductible, the result would be PIP benefits of \$8000.

In response to *Govan* and *Arnone*, in 2003 the Legislature amended the PIP Deductible Section of the PIP Statute to eliminate the “benefits otherwise due” provision to include the “100 percent” provision. The amendment provides two directives. First, it requires that the deductible be applied to 100% of the compensable and reasonable expenses described in section 627.736, and not applied to 80% of the compensable and reasonable expenses. Second, the amendment requires that once the deductible is met, the insured is to receive up to \$10,000 in benefits. The deductible was now a threshold to meet before having access to the full \$10,000 in coverage.

The Fifth District’s view that “100 percent of the expenses” refers to the total amount of the provider’s charge is incorrect. It refers to the 100 percent of the expenses actually compensable under the PIP Benefits Section. 100 percent has a statutory purpose, which is 80% of expenses plus 20% co-pay. Once this is understood, FHMC’s interpretation of a “billed amount” becomes untenable. The overarching principle in the PIP Benefits Section is that, to be compensable, medical expenses must first be reasonable. *Orthopedic Specialists*, 212 So.3d at 976; (A.26-29). The 2003 amendment did not change that element of the PIP Benefits Section. The statutory change has nothing to do with the amount of the

medical provider's charge.<sup>5</sup> It was intended to overturn *Govan* and *Arnone*; indeed, this Court had suggested that legislative attention was warranted. The 2003 amendment in no manner indicates any legislature intent that the deductible applies to the amount charged by the provider, rather than the reasonable compensable amount.

Additionally, the Fifth District overlooked the fact that on October 1, 2007, the No-Fault Law was repealed effective October 1, 2007 by way of “sunsetting.” Ch. 2003-411, § 19, Laws of Fla. Thus, on that date, the prior version of § 627.739 ceased to exist. On October 11, 2007, the Legislature reenacted the “new” Motor Vehicle No-Fault Law. Ch. 2007-324, §§9-19, Laws of Fla., effective January 1, 2008, which reenacted § 627.739(2) in its present form, and incorporated the fee schedules. Thus, § 627.736(5), which was also repealed and reenacted, was incorporated into the new version of § 627.739 which specifically cross-references § 627.736. If the Legislature intended that deductible not apply to the fee schedule amount, it could certainly have stated that in the revised version of 627.739.

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<sup>5</sup> This Court itself has described the issue in *Govan*: “[T]he sole issue . . . was the interrelationship of the deductible amounts authorized under section 627.739(2) and the coinsurance percentages by which eligible benefits under section 627.736(1) are to be reduced.” *Arnone*, 552 So.2d at 910.

6. THE FIFTH DISTRICT ERRED BY CONSIDERING THE LEGISLATURE'S FAILURE TO ENACT A BILL ADDRESSING THIS SITUATION.

In its interpretation of the PIP Deductible Section, the Fifth District relied in part on the Legislature's failure to pass a bill that would have resolved the issue presented by this case in 2016. According to the court, had it been enacted, the amendment would have stated that the deductible applies to the fee schedule amount. (A.13-16). But in interpreting an existing statute, it is impermissible for a court to consider the fact that the Legislature failed to enact a law. The Fourth District opinion addressed this very point. (A.30-31). Simply stated, the Legislature's choice to not enact or revise a law indicates nothing about its intent. The Legislature simply could have believed that the PIP Statute is clear as is, or it could have had other, higher priorities, or perhaps it simply ran out of time. (A.30). It is not appropriate to speculate.

Although the Legislature's words may indicate its intent, *Metro. Cas. Ins. Co. v. Tepper*, 2 So.3d 209, 213 (Fla. 2009), its failure to act indicates nothing. *Duer v. Moore*, 765 So.2d 743, 745 (Fla. 1st DCA 2000) ("Nor do we rely in any way on the reported failure, in a subsequent legislative session, of an effort to amend section 944.275(4)(b) to require DOC to treat "indeterminate offense dates" as dates certain); *see also Fleeman v. Case*, 342 So.2d 815, 817 (Fla. 1976) ("We

decline to divine legislative intent . . . from one attempt to amend . . . the proposed law in one chamber of the Legislature.”).

It appears that the Fifth District’s error – relying on a statutory amendment which failed to pass – was based on a misreading of this Court’s decision in *Govan*:

The court in *Govan* noted that during the 1987 legislative session, the Legislature failed to enact a bill that would change the methodology described in the prior version of section 627.739(2). Similarly, it should be noted here that during the 2016 legislative session, the Florida Legislature failed to enact a proposed bill that would amend section 627.739(2) to incorporate the methodology of subtracting the deductible amount after reimbursement limitations are used[.]

(A.14) (italics added). The Fifth District misapprehended the point this Court made in *Govan*. The *Govan* Court found that the then-existing deductible provision of the PIP Statute was clear and that any complaint about the Statute should be addressed to the Legislature. *See* 521 So. 2d at 1088; *see also id.* at 1088n.\* (“We note the legislature, during the 1987 session, failed to enact a bill which would have amended the statute to make it consistent with the statutory interpretation presented here by the petitioner. House Bill 1015”).

This Court’s opinion stated that the then-existing Statute was clear on its face. *Id.* Thus this Court did not consider the failed amendment as having any bearing on its interpretation of the Statute. Read in context, the footnote invited attention to the PIP issue and made clear that relief, if any, would have to come

from the Legislature. This Court did not authorize or invite courts to interpret statutes based on proposed legislation the Legislature failed to enact. Based on the Court's statement in *Govan* it is clear that the Fifth District should never have considered the Legislature's failure to act to support its erroneous conclusion.

**7. THE FOURTH DISTRICT'S OPINION FAVORS THE INSURED; THE FIFTH DISTRICT'S OPINION DOES NOT.**

The Fifth District began its discussion by observing that the PIP Statute should be construed "liberally in favor of the insured," providing "broad PIP coverage for Florida motorists." (A.8) (citations omitted). The court returned to that theme at the end of the Opinion stating:

Third, it bears repeating that the provisions of the No-Fault Law must be construed in favor of the insured. Interpreting the pertinent statutory provisions in a manner that supports the methodology urged by Progressive and the dissent would not further the principle of providing broad PIP coverage to the insured. Rather, . . . that interpretation would allow the insurer to pay less benefits than would otherwise be due.

(A.18). But the Fifth District majority proceeded on a mistaken premise to reach its conclusion. The majority assumed that a higher payment to the provider is favorable to the insured. It is not.

From the viewpoint of the insured, the insured has a \$10,000 PIP benefit. That \$10,000 amount is set by Statute. Every dollar paid out by the insurer reduces the \$10,000 in available PIP coverage. When providers are paid larger amounts, the insured's \$10,000 in coverage is depleted more rapidly. On exhaustion of the

\$10,000 in coverage any further medical expense is borne solely by the insured. To construe the PIP Statute in favor of the insured and provide broad coverage, the Fourth District's method should be followed.

(a) **The Fourth District Hypothetical.** The Fourth District decision illustrates its calculations which favor the insured. (A.32-33). The court assumed a hypothetical situation of a \$5000 billed amount, a statutory fee schedule cap of \$2000, and a \$500 deductible. Using the Provider's method (the method endorsed by the Fifth District), the insured pays the provider \$500 and the insurer pays the provider \$2000. (A.32). Using the Insurer's method (the method endorsed by the Fourth District), the insured pays the provider \$500 and the insurer pays the provider \$1500. (A.32).

Under the Fifth District's method, the insurer pays the provider \$2000; but under the Fourth District's method, the insurer pays the provider only \$1500. In other words, under the Fifth District's method, the insurer's payment consumes \$500 more of the insured's PIP coverage (\$2000 as opposed to \$1500). **Thus, the Fourth District's method is more favorable to the insured as it results in the availability of \$500 more in benefits.**

(b) **Fourth District Actual Case.** The Fourth District also considered the actual factual situation in *Care Wellness* illustrating the calculations which benefit the insured. (A.33). There was an \$1812 billed amount, a statutory

fee schedule amount of \$825.96, and a \$1000 deductible. (A.33). Using the Fifth District's method, the insured pays the provider \$1000 and the insurer pays \$812. (A.33). Using the Fourth District's method, the insured pays the provider \$825.96 and the insurer pays \$0. (A.33).

Under the Fifth District's method, the insurer pays the provider \$812; but under the Fourth District's method, the insurer does not make any payment. The Fifth District's method of application consumes \$812 more of the insured's PIP coverage (\$812 as opposed to \$0). **Again, the Fourth District's method is more favorable to the insured.**

(c) **This Case.** The same analysis applies to this case. The math is set forth in the Fifth District opinion. (A.6-7). There was a billed charge of \$2781, the applicable statutory fee cap is 75% of usual and customary charges, and the deductible was \$1000. (A.6-7). Using the Fifth District's method, the insured pays the provider \$1000 and the insurer pays \$1068.60. (A.6). Using the Fourth District's method, the insured pays the provider \$1000 and the insurer pays the provider \$868.60. (A.6-7).

Under the Fifth District's method, the insurer pays the provider \$1068.60; but under the Fourth District's method, the insurer pays the provider \$868.60. In other words, under the Fifth District's method, the insurer's payment consumes

\$200 more of the insured's PIP coverage. **Therefore, the Fourth District's method of application is more favorable to the insured.**

**(d) This Case – But with the Insured's 20% Co-Pay.**

For simplicity and to be consistent with the illustrations in the Fourth District opinion, the above discussions in sub-parts (a)-(c) omit the 20% co-pay which the insured is responsible to pay the provider. However, the absurdity of the Fifth District's method is further exposed when the insured's 20% co-pay is considered.

To illustrate, under the Fifth District's method, when considering the 20% co-pay and what the insured would owe in total, the calculation is as follows:

\$2,781.00	Total Charge
<b><u>-\$1,000.00</u></b>	<b>Insured's Deductible</b>
\$1,781.00	
x 75%	Statutory Fee Schedule for Hospitals
<u>\$1,335.75</u>	
x 20%	Insured pays 20% per PIP Benefits Section
<b>\$267.15</b>	<b>Additional Amount Paid by Insured</b>

**Total Amount Owed By Insured: \$1,000.00 + \$267.15 = \$1,267.15**

(A.6). Thus, in addition to what the insurer would owe (\$1,068.80 or 80% of \$1,335.75), the **provider would recover \$2,335.95 total** from the insurer and insured, an amount **above** the per se reasonable amount under the statutory fee schedule, or 75% of the hospitals usual and customary charge (\$2,085.75). (A.6).

Under the Fourth District’s method, when considering in the 20% co-pay and what the insured would owe in total, the calculation is as follows:

\$2,781.00	Total Charge
x 75%	Statutory Fee Schedule for Hospitals
<u>\$2,085.75</u>	
<b><u>-\$1,000.00</u></b>	<b>Insured’s Deductible</b>
\$1,085.75	
x 20%	Insured Pays 20% per PIP Benefits Section
<b>\$217.15</b>	<b>Additional Amount Paid by Insured</b>

**Total Amount Owed By Insured: \$1,000.00 + \$217.15 = \$1,217.15**

(A.6-7). In this situation, in addition to what the insurer would owe (\$868.60 or 80% of \$1,335.75), the **provider would recover \$2,085.75 total** from the insurer and insured – **the per se reasonable amount** under the fee schedule. (A.6-7).

Not only does the Fifth District’s method generate a higher total amount owed to the provider (an amount above the reasonable amount as established in the fee schedule), but the insured’s 20% co-pay is higher in the Fifth District’s method than in the Fourth District’s method. Based upon the above illustrations, the insured’s co-pay would be **\$50.00 higher** (\$267.15 – \$217.15 = \$50.00). **Therefore, the Fourth District’s method of application is, again, more favorable to the insured.**

As set forth above, the Fifth District’s Opinion leads to an absurd result: the insured is charged based on the total amount of the provider’s bills – an unreasonable amount. Then, to add insult to injury, after the deductible is applied

to such unreasonable amount, the insured's total benefits are exhausted faster (where the insurer is forced to pay more) and the insured is subject to higher co-pays. Such an interpretation is absurd and clearly harmful to the insured. See, e.g., *Tampa-Hillsborough Cty. Expressway Auth. v. K.E. Morris Alignment Serv., Inc.*, 444 So.2d 926, 929 (Fla. 1983) (“[C]ourts should endeavor to avoid giving [a statute] an interpretation that will lead to an absurd result.”); *Landers*, 234 So.3d at 869 (rejecting interpretation of a statute that would have “frustrate[d] the purpose of the statute”).

While the Fifth District observed that “the insured certainly has the right to contest any bill that the insured is required to pay to meet the deductible,” the idea that the insured has the knowledge and ability to challenge the reasonableness or propriety of medical bills (an issue that obviously confounds insurers and providers alike) is quite simply unrealistic. Furthermore, pursuant to the Fifth District’s ruling that the deductible applies to the medical provider’s total charge even if the fee schedule applies, the reasonableness of the provider’s charge must still be factually determined by a jury in every case – even those in which the fee schedule applies. This overlooks the intent of the Legislature when enacting the fee schedules “to reduce costs and eliminate litigation regarding what is a ‘reasonable’ charge.” Florida Senate, Bill Analysis and Fiscal Impact Statement, CS/SB 40-C, Oct. 4, 2007, p. 18. See also, *Geico Gen. Ins. Co. v. Virtual Imaging Servs., Inc.*,

90 So.3d 321, 333 (Fla. 3d DCA 2012), approved, 141 So.3d 147 (Fla. 2013) (Salter, J. concurring) (“The Legislature amended the PIP statute to include the PIP fee schedule in an effort to reduce the fraud and enormous costs associated with PIP litigation.”). The Fourth District’s method presents a more straightforward and practical reading and application of the PIP Deductible Statute.

#### **IV. CONCLUSION**

Progressive submits that the decision of the Fourth District Court of Appeal in *Care Wellness* correctly analyzes the interaction between the PIP Benefits Section and PIP Deductible Section of the PIP Statute. Progressive asks that this Court answer the certified question as follows: When calculating the amount of PIP benefits due an insured, section 627.739(2), Fla. Stat., requires that the reimbursement limitation under Section 627.736(5)(a)1.b. be applied first and the deductible subtracted from the remaining amount. Progressive further requests that this Court reverse the Fifth District’s decision and remand this case for further proceedings consistent herewith.

Respectfully submitted,

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**CERTIFICATE OF TYPE SIZE**

In accordance with Florida Rule of Appellate Procedure 9.210(a)(2), this Brief has been prepared using Times New Roman 14 point font.

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**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that the foregoing document has been furnished to: **Rutledge M. Bradford, Esq.**, [debbieb@bradfordlaw.com](mailto:debbieb@bradfordlaw.com), 2900 East Robinson Street, Orlando, Florida 32803; **Chad A. Barr, Esq.**, [service@chadbarrlaw.com](mailto:service@chadbarrlaw.com), [chad@chadbarrlaw.com](mailto:chad@chadbarrlaw.com), 986 Douglas Avenue, Suite 100, Altamonte Springs, Florida 32714; **Eric Biernacki, Esq.**, [ebiernacki@abdmplaw.com](mailto:ebiernacki@abdmplaw.com), One South Orange Avenue, Suite 403, Orlando, Florida 32801; and **Mac S. Phillips, Esq.**, [mphillips@phillipstadros.com](mailto:mphillips@phillipstadros.com), 212 Southeast 8<sup>th</sup> Street, Suite 103, Ft. Lauderdale, Florida 33316, by e-filing portal e-service on this **9<sup>th</sup>** day of **May, 2018**.

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