II. Potential Issues for 2011

Fraud

- Nationwide, claim fraud and buildup estimated to have increased automobile insurance payments by $4.6 to $4.8 billion in 2007

- In Florida, health care provider fraud and staged accidents are the most common types of PIP fraud

Sources: (National information) Insurance Research Council, "Fraud and Buildup in Auto Injury Insurance Claims: 2008 Edition." (Florida information) "Florida's Motor Vehicle No-Fault Law," Report #2006-102, by the Committee on Banking and Insurance of the Florida Senate.

Health Care Provider/Entity Reimbursement under PIP (s. 627.736, F.S.)

PIP provides reimbursement for services and care:

- Lawfully provided, supervised, ordered or prescribed by licensed physicians, osteopaths, chiropractors, or dentists.

- Lawfully provided by the following persons or entities:

  - Hospital or ambulatory surgical centers
  - Ambulance or emergency medical technicians that provide emergency transport or treatment
  - Entities wholly owned by physicians, osteopaths, chiropractors, dentists, or such practitioners and their spouse, parent, child or sibling
  - Entities wholly owned by a hospital or hospitals
  - Licensed health care clinics accredited by specified organizations or
  - Health care clinics that:
    1. Have a medical director that is a Florida physician, osteopath, or chiropractor
    2. Have been continuously licensed for more than 3 years and are a publicly traded corporation *and*
    3. Provide at least 4 of 8 specified medical specialties

Reimbursement Levels to Health Care Providers/Entities under PIP

Insurers may limit PIP reimbursement to 80% of schedules of maximum charges:

- Emergency transport and treatment – 200% of Medicare
- Emergency service and care by a hospital – 75% of hospital's usual and customary charge
- Emergency services and care and related hospital inpatient services by a physician or dentist – usual and customary charges in the community
- Hospital inpatient services – 200% of Medicare Part A
- Hospital outpatient services – 200% of Medicare Part A
- All other medical services, supplies, and care – 200% of Medicare Part B (participating physicians schedule)
- For medical care not reimbursable under Medicare Part B, 80% of the workers' compensation fee schedule. If the medical care is not reimbursable under either Medicare or workers' compensation, then the insurer is not required to pay

Litigation

PIP insurance benefits are payable by the insurer

- Within 30 days after receipt of written notice of a covered loss and the amount due
- Benefits not paid within this time are overdue

Pre-Suit Demand Letter – s. 627.736(10), F.S.

- Before filing a lawsuit for overdue PIP benefits, the aggrieved person must give the insurer written notice of intent to sue
- If the insurer pays the claim (with interest and penalty) within 30 days of receipt of the pre-suit demand letter, a lawsuit cannot be brought against the insurer

Reasonable Attorney Fees Awarded to Parties that Prevail Against Insurers in Litigation (s. 627.428, F.S.)

In determining a reasonable attorney fee award, a court calculates the lodestar amount

- Lodestar = reasonable number of hours the attorney worked multiplied by a reasonable hourly rate

In personal injury cases where the attorney has worked on a contingency fee basis, the court may (or may not) also utilize a contingency risk multiplier of up to 2.5 times the loadstar

For example, if the lodestar is $10,000 and a contingency risk multiplier of 2 is used, the reasonable fee award is $20,000 ($10,000 lodestar x contingency risk multiplier of 2)

Lodestar

Federal lodestar approach adopted by the Florida Supreme Court in 1985 (*Florida Patient's Compensation Fund v. Rowe*, 472 So.2d 1145)

- *Rowe* - In determining a reasonable fee, courts should consider criteria set forth by the Florida Bar:

1. Time and labor required, the novelty and difficulty of the question involved, and the skill requisite to perform the legal service properly
2. The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer
3. The fee customarily charged
4. The amount involved and the results obtained
5. The time limitations imposed
6. The nature and length of the professional relationship with the client
7. The experience, reputation, and ability of the lawyer(s) performing the services
8. Whether the fee is fixed or contingent

Contingency Risk Multiplier

- *Rowe* – In personal injury cases taken on a contingency fee basis, the trial court "must consider" a contingency risk factor (ranging from 1.5 to 3 times the lodestar) when awarding statutorily-directed attorney fees

- Contingency risk multiplier provides plaintiffs in personal injury cases with increased access to courts

- Since attorneys working on a contingency fee basis are not paid if they do not prevail, they must charge more for their services than an attorney who is guaranteed payment

Contingency Risk Multiplier (continued)

The Florida Supreme Court revisited *Rowe* in 1990 (*Standard Guaranty Insurance Co. v. Quanstrom,* 555 So.2d 628)

- *Quanstrom*
  - Application of a contingency fee multiplier not mandated by *Rowe*
  - *Quanstrom* remanded to the trial court to determine whether or not to apply a contingency risk multiplier
  - Established new permissible range for the multiplier of 1 to 2.5 times the lodestar

In 1987, The United States Supreme Court effectively eliminated the use of contingency risk multipliers when computing attorney fees under federal fee-authorizing statutes (*Pennsylvania v. Delaware Valley Citizens' Council for Clean Air*, 483 U.S. 711)

Evidence Required to Support Use of Contingency Risk Multiplier under s. 627.428, F.S.

- 5th DCA (*Progressive Express Insurance Co. v. Schultz*, 984 So.2d 1027, 2007). Use of contingency risk multiplier improper because:
  - The policyholder did not testify that he had any difficulty obtaining legal representation and there was no evidence presented on the issue
  - The lawsuit was essentially a straightforward contract case involving $1,315
- 1st DCA (*Massie v. Progressive Express Insurance Company,* 25 So.3d 584, 2010)
  - Expert testimony that plaintiff would have difficulty securing legal representation without the opportunity for a multiplier supported the use of a multiplier

Evidence Required to Support Use of Contingency Risk Multiplier under s. 627.428, F.S. F.S. (continued)

- Reversed circuit court decision that precluded use of a contingency fee multiplier because plaintiff did not testify that she had difficulty securing legal representation

Examinations Under Oath (EUOs)

- Standard provision in insurance policies that require policyholders to submit to an examination under oath if so requested by the insurer
    - Compliance is required for the policyholder to be eligible for policy benefits

Question of great public importance concerning EUOs certified to the Florida Supreme Court by the 5th DCA in *Shaw v. State Farm Fire and Casualty Company* (37 So.3d 329, 2010)

In Shaw, an injured PIP plaintiff assigned his right to payment of no-fault benefits to a treating health care provider for services rendered. Shaw's insurance policy contained language that sought to extend the duty to submit to an EUO to any person or entity making claim or seeking payment. The health care provider refused to submit to an EUO demanded by the insurer and the insurer denied payment. The health care provider then brought suit.

Examinations Under Oath (continued)

In *Shaw*, the 5th DCA reversed the trial court's judgment for the insurer on the following grounds:

- The assignment of rights to the health care provider did not entail an assignment of duties
- Section 627.736(6)(b), F.S., provides the mechanism for insurers to obtain information from health care providers concerning treatment and expenses
- If there is a dispute regarding an insurer's right to discovery of facts from a health care provider, a court, upon motion, may enter an order permitting discovery

As the decision was not unanimous and had a potential wide ranging impact, the 5th DCA certified the following question of great public importance to the Florida Supreme Court

- Whether a health care provider who accepts an assignment of no-fault insurance proceeds in payment of services provided to an insured can be required by a provision in the policy to submit to an examination under oath as a condition to the right of payment?

First-Party and Third-Party Bad Faith Lawsuits (624.155, F.S.)

First-Party Action – A policyholder brings a lawsuit against his/her insurer

Third-Party Action - The insurer is sued by an injured person who does not have a direct connection to the insurer (for example, a person injured in an automobile accident caused by a policyholder of the insured)

In Florida, insurers have a duty to act in good faith and in the interests of their insureds

- Under s. 624.155, F.S., "any person" (a first party or a third party) can bring a civil action against an insurer when such person is damaged by the following acts or omissions of the insurer:

First-Party and Third-Party Bad Faith Lawsuits (continued)

- Not attempting in good faith to settle claims, when under all circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for the insured's interests
- Making claims payment to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made
- Except as to liability coverages, failing to properly settle claims, when the obligation to settle a claim has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage

First-Party and Third-Party Bad Faith Lawsuits (continued)

- "Bad Faith" actions against insurers often arise in the context of "excess judgment" cases. For example, an injured party is willing to settle a case for the policy limits (e.g., $10,000). The insurer rejects the offer of settlement and the plaintiff subsequently obtains a $500,000 judgment. Depending on the specific facts of the case, the insurer may be subject to a "Bad Faith" lawsuit (from the policyholder or the plaintiff) to recover the amount of the judgment in excess of the policy limits.

- Before filing a "Bad Faith" action against an insurer, the aggrieved person must provide 60 days' written notice

    - Insurers that pay damages or otherwise correct the circumstances giving rise to the violation within 60 days after notice has been filed are not subject to suit

First-Party and Third-Party Bad Faith Lawsuits (continued)

Prevailing Plaintiffs in "Bad Faith" actions can recover

- Damages
- Court Costs
- Reasonable attorney fees

Punitive damages are also recoverable if it is proven that the acts giving rise to the lawsuit occur with such frequency as to indicate a general business practice of the insurer and the acts are either willful, wanton, and malicious or in reckless disregard for the rights of any insured.

Medical Examinations

In *Custer Medical Center v. United Automobile Insurance Company* (2010 WL 4340809), a passenger injured in an automobile accident failed to appear for two medical examinations that were requested by the insurer after the passenger had received all medical treatment and all bills had been submitted to the insurer. Due to the passenger's failure to attend the examinations, the insurer refused to pay the entity that provided treatment. The Supreme Court remanded the case for reinstatement of a decision vacating a directed verdict for the insurer. The Supreme Court based its decision on the following:

Section 627,736(7), F.S. provides that when a person "unreasonably refuses" to submit to an examination, the insurer is not liable for *subsequent* PIP benefits

The failure to attend a medical examination may or may not be "unreasonable" and is not, by itself, a "refusal" as a matter of law

Attendance at a medical examination is not a condition precedent to the existence of the automobile insurance policy