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The Current State of Assignment of Benefits Litigation in Florida

CLIENT ALERT

August 5, 2022

By: Senior Counsel Nhan T. Lee with Associate Wayne A. Comstock

Client Alert

The NLRB Limits the Reach of Confidentiality and Non-Disparagement Provisions in Severance Agreements Overruling Trump-Era Policies

March 14, 2023

Posted by Bryan Meek and Angelina Gingo

Client Alert

Ohio Medical Board Releases New Telehealth

On May 25, 2022, Florida lawmakers approved property insurance reforms that remove attorney's fees, with respect to assignment of benefits ("AOB") property insurance litigation.[1] One-way attorney's fees are a longstanding problem in Florida,[2] and the reforms come at a time when AOB litigation increasingly affects homeowners in a negative way.[3]

Homeowners typically experience property damage and use contractors to repair the damage as quickly as possible.[4] An assignment of benefits, or AOB, is an agreement "in which a contractor begins the work [on the property owner's home] without charging the property owner and agrees to seek compensation from the insurer."[5] An AOB can be beneficial to a homeowner because an AOB eliminates the processing of a claim through the insurance company.[6] Without contacting the insurance company, "the insured can hire a contractor, wait for the contractor to finish the work, then pay the deductible."[7] Despite the time saving benefit to a homeowner, AOBs can lead to costly litigation and higher premiums.[8]

In Florida, AOB abuse first started with Personal Injury Protection ("PIP") claims.[9] A PIP claim works similar to an AOB property damage claim.[10] In a PIP claim, "[t]he assignment lets a medical provider seek reimbursement for their services directly from an insurer. The injured person receives medical care and does not have to deal directly with their insurance company."[11] PIP claims led to abuse because plaintiff's attorneys filed many lawsuits on behalf of the assignee "for inflated claims or potentially unnecessary medical treatment."[12]

Prior to 2019, AOBs frequently resulted in costly litigation primarily because Florida law provided for one-way attorney's fee provisions.[13] In a first-party lawsuit, Florida law required insurers to pay plaintiff's attorneys a court determined "reasonable sum."[14] However, Florida law did not require plaintiffs to compensate the insurer's attorneys.[15] This imbalance pressured insurers to settle claims "rather than face expensive litigation, which, if they lose, means they must pay the other side's lawyers."[16]

The public policy rationale supporting one-way attorney's fee provisions in Florida stems from *Feller v. Equitable Life Assurance Soc.*[17] In *Feller*, the Supreme Court of Florida described the purpose of one-way attorney's fee provisions as "to discourage

Rules

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the contesting of policies in Florida courts, and to reimburse plaintiffs reasonably their outlay for attorney's fees when suing in Florida courts."[18] In *Ivey v. Allstate Ins. Co.*, the Supreme Court of Florida further described the rationale behind one-way attorney's fee provisions as "to level the playing field so that the economic power of insurance companies is not so overwhelming that injustice may be encouraged because people will not have the necessary means to seek redress in the courts."[19] AOBs defeat the purpose of one-way attorney's fee provisions because AOBs do not serve those individuals one-way attorney's fee provisions are meant to protect: the policyholder and any beneficiaries the policyholder designates.[20]

The Florida legislature enacted PIP reforms in 2012 that curbed "AOB abuse in auto insurance."[21] However, around the same time, AOB abuse began spreading to property damage claims.[22] Vendors targeted homeowners insurers because Florida is home to a large number of insured homes, "which ensures large claimant and plaintiff pools."[23] In addition, hurricanes and tropical storms in Florida carry the risk of water damage.[24] In Florida, "[w]ater damage repairs often need to be undertaken immediately to prevent further damage."[25] To complicate matters further, "the standard homeowners policy *requires* that policyholders protect their property from further damage by making reasonable and necessary repairs."[26] A homeowners policy is more attractive than an auto insurance policy because the average loss is higher: $11,000 compared with $1,300.[27] The higher threshold means that a homeowner assignee in a property claim can potentially "inflate repair bills to a greater degree."[28] As a result of increasing AOB litigation, insurers raised premiums.[29] For example, "the average premium [in Florida] rose 30 percent between 2007 and 2015."[30] AOB abuse is most pronounced in Florida because "insurers' legal costs are rising much faster than losses from homeowners claims" compared with other states.[31]

In an effort to curtail AOB abuse, the Florida legislature enacted significant reforms to AOBs and the one-way attorney's fee provision.[32] The legislation, enacted on July 1, 2019, "require[d] assignment agreements to be in writing and signed by both the assignee and assignor."[33] Other changes to AOB agreements included allowing "assignors to rescind without penalty within seven days of the execution of the agreement" and obligating

Compliance Excellence in 2023

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"[a]ssignees . . . [to] provide a copy of an assignment agreement to an insurer within three business days of the execution of the agreement."[34] The most notable difference, however, involved the one-way attorney's fee provision where the provision "no longer applies to an assignee."[35] Instead, the 2019 reforms encouraged insurers to avoid litigation through negotiation or appraisal.[36] In a lawsuit involving an AOB agreement, attorney's fees may only be recovered as follows:

1. Less than 25 percent of the disputed amount, the insurer is entitled to an award of reasonable attorney fees.
2. At least 25 percent but less than 50 percent of the disputed amount, no party is entitled to an award of attorney fees.
3. At least 50 percent of the disputed amount, the assignee is entitled to an award of reasonable attorney fees.[37]

As companion legislation, the Florida legislature also passed Fla. Stat. 627.7153.[38] Under Fla. Stat. 627.1753, an insurer may restrict an insured's "right to execute an assignment agreement" if the insurer provides (1) an insurance policy that does not restrict the insured's "right to an execute an assignment agreement[,]" (2) the restricted policy at a lower cost compared with the unrestricted policy, (3) the policy restricting or prohibiting assignment in whole at a "lower cost than any policy [restricting or] prohibiting assignment in part[,]" and (4) specific language in any restricted policy as described in the statute.[39]

The Florida legislature enacted the 2019 reforms, in part, to reduce insurance premiums for Florida homeowners.[40] In the year following the reform, Citizens Property Insurance Corporation ("CPIC"), reported that insurance premiums dropped for almost 44,000 policyholders.[41] In addition, the reform helped reduce AOB litigation.[42] In 2020, "Florida [saw] less first party cases being filed . . . . CPIC alone [saw] their caseload drop from 2,000 to 1,750 suit per month."[43] Despite the reduction, Florida lawmakers remained concerned about AOB abuse.[44]

In May 2022, the Florida Legislature approved additional property insurance reforms.[45] The reforms further limit the awarding of attorney's fees in AOB cases.[46] The reform, titled SB 2D, prohibits a court from awarding attorney's fees to an assignee in AOB litigation.[47] The reforms also severely "restrict the awarding of fee multipliers in property insurance disputes to 'rare and exceptional circumstances.'"[48] Florida lawmakers

believed such reforms necessary given Florida's excessive contribution to homeowner insurance lawsuits across the United States.[49] Florida, responsible for "just 9% of property insurance claims, generates 79% of the nation's homeowner insurance lawsuits."[50] Florida lawmakers approved the reforms under the belief that "lawsuits . . . exploded in the past several years" despite the 2019 reforms.[51]

While Florida lawmakers acted to protect homeowners,[52] contractors rallied against the reform.[53] In June 2022, the Restoration Association of Florida and Air Quality Assessors, LLC, "filed [a] lawsuit in Leon County circuit court" testing the constitutional validity of the legislation.[54] In filing the lawsuit, "contractors contend that assignment of benefits helps homeowners who are unfamiliar with making sure insurance claims are handled properly."[55] Contractors believe that AOBs help homeowners quickly address home damage due to inclement weather and other unforeseen circumstances.[56]

In Florida, contractors and Florida lawmakers are seemingly at odds with respect to AOBs.[57] The 2022 reforms remove the awarding of attorney's fees altogether from AOB litigation,[58] which may both help and hurt homeowners in Florida by lowering property insurance premiums but making immediate home repair less accessible. AOBs will remain a contentious issue moving forward, and the reforms may lead to additional challenges.

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[1] Jim Ash, *Governor Signs Property Insurance Reforms and Condo Safety Measures*, Florida Bar (May 27, 2022), https://www.floridabar.org/the-florida-bar-news/governor-signs-property-insurance-reforms-and-condo-safety-measures/.

[2] Mark Delegal & Ashley Kalifeh, Restoring Balance in Insurance Litigation: Curbing Abuses of Assignments of Benefits and Reaffirming Insureds' Unique Right to Unilateral Attorney's Fees 9 (2015), https://www.fljustice.org/files/123004680.pdf.

[3] Douglas Scott MacGregor, *Florida Takes Aim at Assignment of Benefits Abuse: A Home Run or a Swing and a Miss?*, *in* New Appleman on Insurance: Current Critical Issues in Insurance Law (2021).

[4] *Id.*

Health Policy Perspectives

Why we need more data on the dental insurance market

Marko Vujicic, PhD; Niodita Gupta, MD, MPH, PhD; Kamyar Nasseh, PhD

Economics teaches us that competition in markets is a good thing. The health care market is a special market, and competition among providers and insurers is closely monitored by the Federal Trade Commission (FTC). In recent years, the FTC has intervened on several occasions to prevent mergers and acquisitions in health care markets that would have reduced competition to a degree deemed harmful to consumers.[1] The theory goes that if, for example, there is only 1 hospital group in town, the hospital will end up charging patients more for its services than if there were many hospitals in town. The empirical evidence tends to confirm this, with less competition among providers leading to higher prices[2] for patients and less competition among insurers leading to higher premiums[3] and lower provider payment rates.[4] Competition matters.

So let us talk about competition in different parts of the dental care sector. The care delivery side is highly fragmented. Dentistry is the last cottage industry in health care composed mostly of small firms and few large firms with any appreciable market share. The most recent data indicate that 88% of dental offices in the United States have 3 or fewer dentists (Health Policy Institute, unpublished data, 2016). This is certainly changing over time, as more and more practices consolidate.[5] But for now, the dental care delivery side for the most part is highly fragmented.

The insurer side, as the figure[6,7] shows, is a different story. The data summarize the market share of various dental insurance carriers in California. This is the first time ever, as far as we know, that data of this nature were made publicly available. This was a big deal for us because the American Dental Association Health Policy Institute has been trying to obtain dental insurer market data for years, not just for California but for all states. We tried several avenues, including requests to the National Association of Insurance Commissioners and the National Association of Dental Plans. The data we obtained were made available as part of California's efforts to monitor the medical loss ratio of medical and dental insurance carriers under the Affordable Care Act (ACA).

The data for California show 1 dominant carrier and a long tail of carriers with much smaller market shares. Delta Dental of California has the highest market share (40.3%) and Metropolitan Life Insurance Company has the second highest (8.0%). Furthermore, 31 of 52 insurers have a market share of less than 1%. The Herfindahl-Hirschman Index (HHI) is a fancy way economists measure the competitiveness of markets. Markets in which the HHI is between 1,500 and 2,500 are considered to be moderately concentrated, whereas levels greater than 2,500 are considered to be highly concentrated.[8] The HHI for the dental insurance market in California is 1,813.

What are possible implications of a moderately concentrated dental insurance market? Market concentration could result in higher premiums for consumers or lower reimbursement for providers.[9] More in-depth research is needed, but our preliminary analysis of newly released premiums data indicates that average premiums for most of Delta Dental of California beneficiaries actually decreased from 2014 through 2016 after adjusting for inflation (Table).[6] We do not have access to data for prior years. We also do not have access to data on Delta Dental of California's reimbursement rates to dentists, but a recent lawsuit settlement suggests reimbursement rates have indeed been declining.[10] Moreover, statewide data covering all dental insurers indicate inflation-adjusted reimbursement rates have declined in recent years in California.[11] If more data were publicly available, a more thorough analysis could be conducted. In the meantime, our take on these preliminary data is that market power is being leveraged by insurers primarily to control costs rather than to increase premiums.

Cost control measures, unquestionably, are a good thing for beneficiaries if such measures do not adversely affect access to dentists, quality of care, or benefit levels. Or, more formally, if the adverse effects are outweighed by savings in premiums. Here again we have another important area for further study. The evidence we are aware of—and it is limited—suggests that younger patients are more willing to trade provider choice for savings in premiums than older patients.[12]

Another way to examine the extent to which market power might affect premiums and provider payments is through medical loss ratio (MLR) data. The MLR measures the share of premium revenue that is spent on patient care. The ACA included a provision that MLRs for medical insurers must be at least either 80% or 85%, depending on the type of insurance.

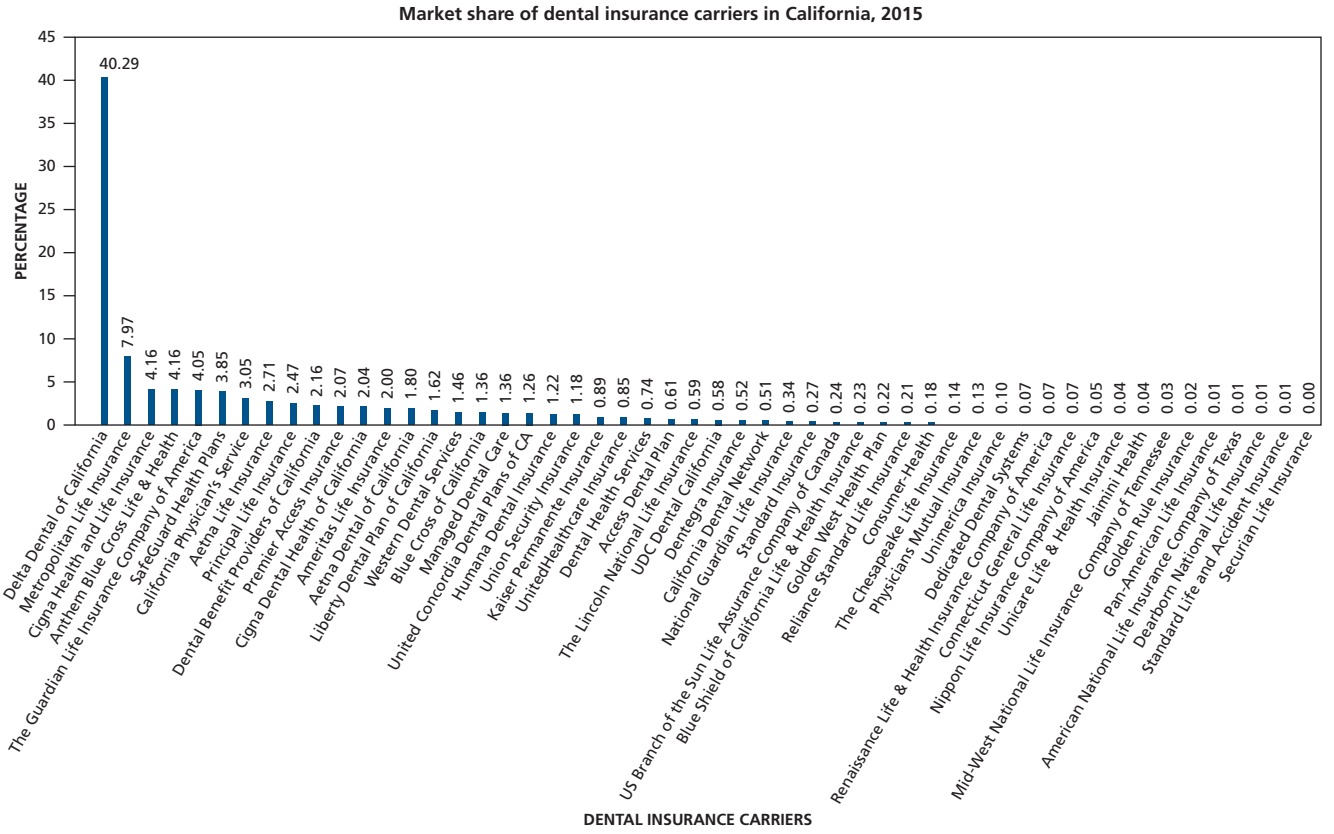

Figure. The total number of covered lives in California in 2015 was 9,891,539 (as of March 31, 2016). The number of covered lives were aggregated to the insurer level. The market share of covered lives for each insurer was calculated as the number of covered lives by the insurer in 2015 (as of March 31, 2016) divided by the total number of covered lives in California in 2015 (as of March 31, 2016). *Source: American Dental Association Health Policy Institute analysis of data from California Department of Managed Health Care*[6] *and California Department of Insurance.*[7]

In other words, insurers must spend at least 80% or 85% of total premium revenue on patient care.[13] In 2015, this MLR provision resulted in an average rebate paid by insurers to beneficiaries of $138 per family.[14]

The MLR provision under the ACA does not apply to dental insurers. However, in California, a law was put in place in 2014 to simply collect MLR data on dental insurers.[15] We examined these data and found that among the 52 dental insurers in California, only 6 had MLR levels of at least 80%, including Delta Dental of California, the market share leader. (The dental MLR was calculated as total incurred claims/[total direct premium earned total federal and state taxes and fees to be excluded from premium]. The aggregate percentages at the insurer level were calculated by adding the total incurred claims, total direct premium earned, and total federal and state taxes and fees to be excluded from the premium at the insurer level and then using the aforementioned formulas. The amounts included for this analysis were noted as of March 31, 2016, in the dental MLR reports.) Eight carriers had MLR levels below 50%, meaning less than one-half of premium revenue was spent on patient care. These preliminary data suggest that expanding the ACA's MLR provision to dental insurance could lead to premium reductions or enhanced outlays for dental care, both of which would presumably benefit consumers.

In big picture terms, our analysis of the California dental insurance market indicates a moderate level of concentration by FTC standards, with 1 dominant carrier. We have outlined some potential effects this level of market concentration might have on beneficiaries and providers, based on our interpretation of the data made available so far. Our analysis is based on 1 state and cannot be generalized to other markets. We urge other state agencies to make similar data publicly available. It is encouraging that several states, including Washington,[16] Rhode Island,[17] Illinois,[18] and Massachusetts,[19,20] are proactively pursuing measures to improve data transparency in the dental insurance market. At the national level, we urge organizations such as the National Association of Insurance Commissioners and the National Association of Dental Plans to make data transparency a priority when it comes to dental insurance. This is the only way researchers can study the implications of dental insurance market dynamics. ■

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Table. Premiums and covered lives for Delta Dental of California.*

DENTAL PLAN TYPE	COVERED LIVES IN 2016†	ESTIMATED AVERAGE MONTHLY PREMIUM			
		2014	2015	2016	Percentage Change (2014-2016)
Large Group DPPO‡	2,628,184 (69)	$43.18	$42.56	$41.44	−4.05
Large Group DHMO§	683,667 (18)	$14.64	$14.40	$14.00	−4.34
Small Group DPPO	251,858 (7)	$53.45	$50.55	$49.37	−7.64
Individual DHMO	142,040 (4)	$10.43	$9.83	$11.22	7.63
Small Group DHMO	76,771 (2)	$18.27	$17.30	$16.67	−8.77
Individual DPPO	10,020 (< 1)	$32.46	NA¶	$52.84	62.82

*The average monthly premium was calculated as the total direct premiums earned (as of March 31 of the next year) divided by the number of member months (as of March 31 of the next year). All amounts are adjusted to 2016 dollars using the Consumer Price Index for Dental Services. Premium data for individual DPPO plans were unavailable for 2015. The percentage of covered lives for each plan is the number of covered lives for that plan divided by the total number of covered lives by Delta Dental of California in 2016. *Source: American Dental Association Health Policy Institute analysis of data from California Department of Managed Health Care.*[6]; †Values are n (%); ‡DPPO: Dental preferred provider organization; §DHMO: Dental health maintenance organization; ¶NA: Not applicable.

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Definition of terms used in left margin:

- *Dental (18 States)* = law applies specifically to dental plans/dentists;
- *General (5 States)* = law does not specify dental or may apply to non-dental professions

- *Non-Par:* at least 8 state AoB laws specify that the patient may assign payment to non-participating providers.
  - (absence of any provision specifying the right to assign payment to non-participating providers SHOULD NOT be seen as expressly prohibiting assignment to non-participating providers)

STATES	CODE CITATION	SUMMARY
Alabama *Dental* *Non-Par* 1994 ***Back to top***	**§ 27-1-19. Reimburse-ment of health care providers.**	The insured, or health or dental plan beneficiary may assign reimbursement for health or dental care services directly to the provider of services. The company or agency, when authorized by the insured, or health or dental plan beneficiary, shall pay directly to the health care provider the amount of the claim, under the same criteria and payment schedule that would have been reimbursed directly to the contract provider, and any applicable interest.
Alaska *Dental* *Non-Par* 1990;1996 ***Back to top***	**21.07.020(5) Required contract provisions for health care insurance policy** **§21.51.120 Payment of Claims**	Sec. 21.07.020. Required contract provisions for health care insurance policy A health care insurance policy must contain a provision (5) describing a mechanism for assignment of benefits for health care providers and payment of benefits Sec. 21.51.120. Payment of claims (a) A health insurance policy delivered or issued for delivery must contain the following provisions: (2) the insurer may, and upon written request of the insured shall, pay indemnities for hospital, nursing,

		medical, **dental,** or surgical services directly to the provider of the services; an insurer who pays indemnities to an insured, **after the insured has given the insurer written notice in the proof of loss statement of an election of direct payment of indemnities to the provider of the services, shall also pay indemnities to the provider of the services**; this paragraph does not require that services be provided by a particular hospital or person;
Arizona *Dental* 2021 ***Back to top***	**20-464.** **Prohibiting payment for services to persons other than the assignee**	**20-464. Prohibiting payment for services to persons other than the assignee** A. If an insured assigns to a covered health care provider performing services covered by the contract payment for benefits under a disability insurance contract, a group disability insurance contract or a blanket disability insurance contract, the contract does not prohibit assignments and the assignment is delivered to the insurer, payment may be made only to the health care provider to whom payment has been assigned. B. Notwithstanding chapter 4, article 3 of this title, this section applies to a service corporation.
Colorado *Dental* 1992 ***Back to top***	**§ 10-16-317.5.** **Assignment of benefits** **&** **§10-16-106.7.** **Assignment of health insurance benefits**	**§ 10-16-317.5. Assignment of benefits** An individual or group nonprofit hospital or medical service contract issued pursuant to the provisions of this article shall not prohibit a subscriber under the contract from assigning, in writing, benefits payable under the contract to a licensed hospital or other **licensed health care provider** for services provided to the subscriber which are covered under the contract. **10-16-106.7. Assignment of health insurance benefits** (1) (a) Any carrier that provides health coverage to a covered person shall allow, but not require, such covered person under the policy to assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist as defined in section 12-40.5-103, C.R.S., or a massage therapist as defined in section 12-35.5-103 (8), C.R.S., also referred to in this section as the "provider", for services provided to the covered person that are covered under the policy. (2) (a) When a provider receives an assignment from a covered person, it is the responsibility of the provider to

		bill the carrier and notify the carrier that the provider holds an assignment on file. The carrier shall honor the assignment the same as if a copy of the assignment had been received by the carrier. Only upon request of the carrier shall the provider be required to give the carrier a copy of the assignment. (b) The carrier shall honor the assignment and make payment of covered benefits directly to the provider. If the carrier fails to honor the assignment by making payment to the covered person and if the covered person, upon receipt of such payment, fails to pay an amount equivalent to such payment to the provider within forty-five days, the carrier shall be liable for the payment directly to the provider. It shall be the responsibility of the provider to notify the carrier if payment has not been received. In such case, the carrier shall make payment of covered benefits as specified in section 10-16-106.5. **10-16-102 Definitions** (26.3) "Licensed health care provider" shall have the same meaning as in section 10-4-601. **10-4-601** "***Carrier***" means any entity that provides health coverage in this state, including a franchise insurance plan, a fraternal benefit society, a health maintenance organization, a nonprofit hospital and health service corporation, a sickness and accident insurance company, and any other entity providing a plan of health insurance or health benefits subject to the insurance laws and rules of Colorado. "***Health coverage plan***" means a policy, contract, certificate, or agreement entered into, offered, or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "***Health care services***" means any services included in or incidental to the furnishing of medical, mental, dental, or optometric care; hospitalization; or nursing home care to an individual, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing, or healing human physical or mental illness or injury. "Health care services" includes the rendering of the services through the use of telehealth, as defined in section 10-16-123 (4) (e). "***Licensed health care provider***" means a person,

		corporation, facility, or institution licensed or certified by this state to provide health care or professional services as a hospital, health care facility, or dispensary or to practice and practicing medicine, osteopathy, chiropractic, nursing, physical therapy, podiatry, **dentistry**, pharmacy, acupuncture, or optometry in this state, or an officer, employee, or agent of the person, corporation, facility, or institution working under the supervision of the person, corporation, facility, or institution in providing health care services.
Connecticut *Dental* 2000 ***Back to top***	**§ 38a-491b. Assignment of benefits to a dentist or oral surgeon**	No insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, continuing or amending any individual health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, and no dental services plan offering or administering dental services, may refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by an insured, subscriber or enrollee, provided (1) the dentist or oral surgeon charges the insured, subscriber or enrollee no more for services than the dentist or surgeon charges uninsured patients for the same services, and (2) the dentist or oral surgeon allows the insurer, health care center, corporation or entity to review the records related to the insured, subscriber or enrollee during regular business hours. The insurer, health care center, corporation or entity shall give the dentist or oral surgeon at least forty-eight hours' notice prior to such review. As used in this section, "assignment of benefits" means the transfer of dental care coverage reimbursement benefits or other rights under an insurance policy, subscription contract or dental services plan by an insured, subscriber or enrollee to a dentist or oral surgeon.
Florida *Dental* 2005 ***Back to top***	**§627.638. Direct payment for hospital, medical services**	**627.638 Direct payment for hospital, medical services.** (2) Whenever, in any health insurance claim form, an insured specifically authorizes payment of benefits directly to any recognized hospital, licensed ambulance provider, physician, **dentist**, or other person who provided the services in accordance with the provisions of the policy, the insurer shall make such payment to the designated provider of such services. The insurance contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to a licensed hospital, licensed ambulance provider, physician, or dentist, or other person who provided the services in accordance with the

		provisions of the policy for care provided. The insurer may require written attestation of assignment of benefits. Payment to the provider from the insurer may not be more than the amount that the insurer would otherwise have paid without the assignment. [*provision added to study costs implications with repealer if costs to state group health plan were excessive and provider network shrunk-neither was reported, so law was NOT repealed*]
Georgia *Dental* *Non-Par* 1992 ***Back to top***	**§ 33-24-54. Payments to nonpartici-pating or nonprefer-red providers of health care services** **§ 33-24-59.3. Payments sent directly to health care provider by insurer**	**33-24-54** …whenever an accident and sickness insurance policy, subscriber contract, or self-insured health benefit plan, by whatever name called, which is issued or administered by a person licensed under this title provides that any of its benefits are payable to a participating or preferred provider of health care services licensed under the provisions of Chapter 4 of Title 26 or of Chapter **9[Dental]**, 11, 30, 34, 35, or 39 of Title 43 or of Chapter 11 of Title 31 for services rendered, the person licensed under this title shall be required to pay such benefits either directly to any similarly licensed nonparticipating or nonpreferred provider who has rendered such services, has a written assignment of benefits, and has caused written notice of such assignment to be given to the person licensed under this title or jointly to such nonparticipating or nonpreferred provider and to the insured, subscriber, or other covered person; provided, however, that in either case the person licensed under this title shall be required to send such benefit payments directly to the provider who has the written assignment. When payment is made directly to a provider of health care services as authorized by this Code section, the person licensed under this title shall give written notice of such payment to the insured, subscriber, or other covered person. **§ 33-24-59.3.** (b) Any other provision of law to the contrary notwithstanding, if a covered person provides in writing to a health care provider, whether the health care provider is a preferred provider or not, that payment for health care services shall be made solely to the health care provider and be sent directly to the health care provider by the health care insurer, and the health care provider certifies to same upon filing a claim for the delivery of health care services, the health care insurer shall make payment solely to the health care provider and shall send said payment directly to the health care provider. This subsection shall not be construed to extend coverages or to require

		payment for services not otherwise covered.
Idaho *Dental* *Non-Par* 1992 ***Back to top***	**§ 41-3417. Subscriber's contracts**	(3) … contract shall permit a subscriber to direct that the payment of dental care benefits to which the subscriber is entitled, pursuant to the contract, be made in the name of the nonparticipant licensee providing covered dental care services authorized by the subscriber's contract.
Illinois 2012** ***Back to top***	CHAPTER 215 INSURANCE INSURANCE CODE ARTICLE XX. ACCIDENT AND HEALTH INSURANCE **§215-5/370a.** **Assignability of Accident and Health Insurance**	…If an enrollee or insured of an insurer, health maintenance organization, managed care plan, health care plan, preferred provider organization, or third party administrator assigns a claim to a health care professional or health care facility, then payment shall be made directly to the health care professional or health care facility including any interest required under Section 368a, of this Code [215 ILCS 5/368a] for failure to pay claims within 30 days after receipt by the insurer of due proof of loss. Nothing in this Section shall be construed to prevent any parties from reconciling duplicate payments. **A 2012 law requires state employee health benefits to be subject to the law above allowing insureds to assign benefits (5 ILCS 375/6.12)
Maine *Dental* 2003 ***Back to top***	**§24-19 (subchapter 1) 2332-H. Assignment of benefits**	All contracts providing benefits for medical or dental care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under this section does not affect or limit the payment of benefits otherwise payable under the contract.
Mississippi *Dental* 2013 ***Back to top***	**§ 83-9-3 Form of policy; commissioner's fees; expedited form and rate review procedure; funding of agency expenses; deposit of monies into**	(3) No individual or group policy covering health and accident insurance (including experience-rated insurance contracts, indemnity contracts, self-insured plans and self-funded plans) or any group combinations of these coverages, shall be issued by any commercial insurer doing business in this state, which, by the terms of such policy, limits or restricts the insured's ability to assign the insured's benefits under the policy to a licensed health care provider that provides health care services to the insured. Commercial insurers doing business in this state shall honor an assignment for a period of one (1) year starting from the initial date of an assignment. Any such policy provision in violation of this subsection shall be invalid.

	State General Fund	83-9-1: The term "policy of accident and sickness insurance," as used in Sections 83-9-1 through 83-9-21, includes any individual or group policy or contract of insurance against loss resulting from sickness or from bodily injury, including dental care expenses resulting from sickness or bodily injury, or death by accident, or accidental means, or both.
Missouri *Dental* *(Includes exemption for insurers that contract with certain members of a class of providers)* 1992 ***Back to top***	**§376.427. Assignment of benefits made by insured to provider--payment, how made--exceptions--all claims to be paid, when** **(**DSGA note: appears to exclude certain non-par/See Section 4**)**	2. Upon receipt of an assignment of benefits made by the insured to a provider, the insurer shall issue the instrument of payment for a claim for payment for health care services in the name of the provider. All claims shall be paid within thirty days of the receipt by the insurer of all documents reasonably needed to determine the claim. 3. Nothing in this section shall preclude an insurer from voluntarily issuing an instrument of payment in the single name of the provider. 4. This section shall not require any insurer, health services corporation, health maintenance corporation or preferred provider organization which directly contracts with certain members of a class of providers for the delivery of health care services to issue payment as provided pursuant to this section to those members of the class which do not have a contract with the insurer.
Nevada *Dental* 1983 ***Back to top***	**§689A.135. Assignment of benefits to provider of health care**	1. A person insured under a policy of health insurance may assign his right to benefits to the provider of health care who provided the services covered by the policy. The insurer shall pay all or the part of the benefits assigned by the insured to the person designated by him. A payment made pursuant to this subsection discharges the insurer's obligation to pay those benefits. 2. If the insured makes an assignment under this section, but the insurer after receiving a copy of the assignment pays the benefits to the insured, the insurer shall also pay those benefits to the provider of health care who received the assignment as soon as the insurer receives notice of the incorrect payment. 3. For the purpose of this section, "provider of health care" has the meaning ascribed to it in NRS 629.031 [*Occupations code that INCLUDES dentist*]. **681A.030. "Health insurance" defined.** "Health insurance" is insurance of human beings against bodily injury, disablement or death by accident or accidental

		means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto, together with provisions operating to safeguard contracts of health insurance against lapse in the event of strike or layoff due to labor disputes.
New Hampshire *Dental* 2002 ***Back to top***	**§420-B:8-n Point of Service Plans**	*Health Maintenance Organizations* VIII. All point-of-service contracts and certificates shall contain a provision permitting the enrollee to assign any benefits provided for medical or dental care on an expense-incurred basis to the provider of care. An assignment of benefits under this paragraph does not affect or limit the payment of benefits otherwise payable under the contract or certificate.
New Jersey *Dental* *Non-Par* 2012 ***Back to top***	**§17:48C-8.3 e(1)** **Payment of out-of-network benefits by dental service corporation**	With respect to a dental service corporation that makes a dental benefit payment to a covered person for services rendered by an out-of-network dentist, if the covered person assigns, through an assignment of benefits, his right to receive reimbursement to an out of-network dentist, the dental service corporation shall issue the payment for the reimbursement directly to the dentist in the form of a check payable to the dentist, or in the alternative, to the dentist and the covered person as joint payees, with a signature line for each of the payees.
North Dakota *General* 1985 ***Back to top***	**NDCC, §26.1-36-12 Provisions prohibited in individual and group accident and health insurance policies, group health plans, and nonprofit health service contracts** (*Application is uncertain as it refers to "medical*	1. Any provision in any individual or group accident and health insurance policy, employee welfare benefit plan, or nonprofit health service contract issued by any insurance company, group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [Pub.L. 99-272; 100 Stat. 281; 29 U.S.C. 1167(1)], or nonprofit health service corporation denying or prohibiting the insured, participant, beneficiary, or subscriber from assigning to the department of human services any rights to medical benefits coverage to which the insured, participant, beneficiary, or subscriber is entitled under the policy, plan, or contract is void. **An individual or group insurance company or nonprofit health service corporation shall recognize the assignment of medical benefits coverage completed by the insured, participant, beneficiary, or subscriber, notwithstanding any provision contained in the policy or contract to the contrary.**

	benefits")	
Oklahoma 1992 ***Back to top***	**Oklahoma Statutes,** *Title 36*. Insurance *Chapter 2*. Miscellaneous Provisions Health Care Freedom of Choice Act **§ 6055 Accident and Health Policies—Insured's Selection of Care Provider—Permissable Provisions—EOBs, etc.**	F. Benefits available under an accident and health insurance policy, at the option of the insured, shall be assignable to a practitioner, hospital, home care agency or ambulatory surgical center who has provided services and procedures which are covered under the policy. A practitioner, hospital, home care agency or ambulatory surgical center shall be compensated directly by an insurer for services and procedures which have been provided when the following conditions are met: 1. Benefits available under a policy have been assigned in writing by an insured to the practitioner, hospital, home care agency or ambulatory surgical center; 2. A copy of the assignment has been provided by the practitioner, hospital, home care agency or ambulatory surgical center to the insurer; 3. A claim has been submitted by the practitioner, hospital, home care agency or ambulatory surgical center to the insurer on a uniform health insurance claim form adopted by the Insurance Commissioner pursuant to Section 6581 of this title; and 4. A copy of the claim has been provided by the practitioner, hospital, home care agency or ambulatory surgical center to the insured.
Rhode Island *Dental* *Non-Par* 2004 ***Back to top***	**§27-18-63. Dental insurance assignment of benefits**	Every entity providing a policy of accident and sickness insurance as defined in this chapter shall allow…any person insured by such entity to direct, in writing, that benefits from a **health** benefit plan, policy or contract, be paid directly to a **dental** care provider who has not contracted with the entity to provide dental services to persons covered by the entity but otherwise meets the credentialing criteria of the entity and has not previously been terminated by such entity as a participating provider. If written direction to pay is executed and written notice of the direction to pay is provided to such entity, the insuring entity shall pay the benefits directly to the dental care provider. Any efforts to modify the amount of benefits paid directly to the dental care provider under this section may include a reduction in benefits paid of no more than five percent (5%) less than the benefits paid to participating dentists. The entity paying the dentist, pursuant to a direction to pay duly executed by the subscriber, shall have the right to review the records of the dentist receiving such payment that relate exclusively to that

		particular subscriber/patient to determine that the service in question was rendered.
South Dakota *Dental* 2017 ***Back to top***	**§58-17-163** **Dental care insurers to honor assignment of benefits.** **§58-17-164** **Revocation of assignment of dental insurance benefits.**	**58-17-163** Any insurer that provides dental care insurance to a person shall honor an assignment, made in writing by the person insured under the policy, of payments due under the policy to a dentist or a dental corporation for dental care services provided to the person that is insured under the policy. Upon notice of the assignment, the insurer shall make payments directly to the dentist or dental corporation providing the dental care services. A dentist or dental corporation with a valid assignment may bill the insurer and notify the insurer of the assignment. Upon request of the insurer, the dentist or dental corporation shall provide a copy of the assignment to the insurer. **58-17-164** Revocation of assignment of dental insurance benefits. A person may revoke an assignment made pursuant to § 58-17-163 with or without the consent of the dentist or dental corporation. (*additional administrative details removed for space considerations*)
Tennessee *Dental* 2009 ***Back to top***	**§56-7-120. Assignment of benefits to health care provider**	Notwithstanding any provision…to the contrary, whenever any policy of insurance issued in this state provides for coverage of health care rendered by a provider covered under title 63 [Dentists], the insured or other persons entitled to benefits under such policy shall be entitled to assign these benefits to the health care provider.
Texas *Dental* 1999 *(indirectly identified)* ***Back to top***	**Title 8. Chapter 1204** **§ 1204.053. Assignment of Benefits** **§ 1204.054** **Payment of Benefits According to Assignment**	**.053**-An insurer may not deliver, renew, or issue for delivery in this state a health insurance policy that prohibits or restricts a covered person from making a written assignment of benefits to a physician or other health care provider who provides health care services to the person. **.054**-An insurer shall pay benefits directly to a physician or other health care provider, and the insurer is relieved of the obligation to pay, and of any liability for paying, those benefits to the covered person if: (1) the covered person makes a written assignment of those benefits payable to the physician or other health care provider; and (2) the assignment is obtained by or delivered to the insurer with the claim for benefits.

Virginia *Dental* 1999 ***Back to top***	**§38.2-3407.13. Refusal to accept assignments prohibited; dentists and oral surgeons**	No insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, no corporation providing individual or group accident and sickness subscription contracts, and no dental services plan offering or administering prepaid dental services shall refuse to accept or make reimbursement pursuant to an **assignment** of **benefits** made to a dentist or oral surgeon by an insured, subscriber or plan enrollee.
West Virginia 2020 *Dental* ***Back to top***	**§33-15-22 Assignment of certain benefits in dental care insurance coverage**	Any entity that provides dental care coverage to a covered person shall honor an assignment, made in writing by the person covered under the policy, of payments due under the policy to a dentist or a dental corporation for services provided to the covered person that are covered under the policy. Upon notice of the assignment, the entity shall make payments directly to the provider of the covered services. A dentist or dental corporation with a valid assignment may bill the entity and notify the entity of the assignment. Upon request of the entity, the dentist or dental corporation shall provide a copy of the assignment to the entity.

Requires Dual Signature on Payment

Washington *Dental* 1999 *Non-Par* *(For covered services by a non-par - Requires payment to be in the name of non-par provider AND enrollee)* 1999 ***Back to top***	**§48.44.026 Payment for certain health care services**	Checks in payment for claims pursuant to any health care service contract for health care services provided by persons licensed or regulated under chapters [dental]…, where the provider is not a participating provider under a contract with the health care service contractor, shall be made out to both the provider and the enrolled participant with the provider as the first named payee, jointly, to require endorsement by each: PROVIDED, That payment shall be made in the single name of the enrolled participant if the enrolled participant as part of his or her claim furnishes evidence of prepayment to the health care service provider: AND PROVIDED FURTHER, That nothing in this section shall preclude a health care service contractor from voluntarily issuing payment in the single name of the provider.

THE FLORIDA LEGISLATURE
OPPAGA
OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

January 2012 **Report No. 12-01**

Negative Effects on the State's Third Party Provider Network from 2009 Law Not Apparent

at a glance

Statutory changes made by the 2009 Legislature that require the state group health plan's third party administrator to directly pay non-network providers for services did not result in a loss of network physicians. Since December 2009, the number of physicians participating in Blue Cross and Blue Shield of Florida's (BCBS) preferred provider network for the state group has increased by 12.5%. In addition, while the number and amount of non-network physician and other profession claims has increased slightly since 2009, the proportion of these claims to overall physician and other profession claims for the state group has remained at about 2%. Moreover, the discount rate BCBS negotiates with network providers for the state group has remained relatively unchanged.

Overall costs for state group health participants have increased; per enrollee per month costs increased from $479 in Fiscal Year 2008-09 to $541 in Fiscal Year 2010-11. However, these increased costs cannot be directly linked to the 2009 law because many factors contribute to rising health care costs.

Scope

Chapter 2009-124, *Laws of Florida*, directs OPPAGA to examine whether the state's third party insurance preferred provider network experienced a net loss of physicians due to statutory changes requiring the third party administrator to directly pay non-network providers for services.[1] The law also directs OPPAGA to determine if, as a direct result of these statutory changes, costs increased for the state group health plan.

Background

The Department of Management Services, Division of State Group Insurance offers and manages a comprehensive package of pre- and post-tax health and welfare insurance benefits for active and retired state employees and their families, including health insurance; flexible spending and health savings accounts; life, vision, and dental insurance; and other supplemental insurance products. Employees have several health insurance options for which they share the cost of coverage with the state.[2]

- Membership in a self-insured ***preferred provider organization*** (PPO)[3]
- Membership in a fully-insured ***health maintenance organization*** (HMO)[4]

[1] The 2009 law requires insurers to pay directly all non-network providers, including hospitals, surgery centers, physical therapy centers, etc. However, the law directs OPPAGA to examine the effect of the law on physicians in the preferred provider network.

[2] PPO plans are available on a statewide basis, while HMO plans are available only in certain areas. All options provide enrollees access to a variety of services such as physician care, inpatient hospitalization, outpatient services, and prescription drugs. Employees elect to enroll in any of the options and may select individual or family coverage.

[3] Monthly premiums: Single—$549.80 ($50 for enrollee and $499.80 for state); Family—$1,243.34 ($180 for enrollee and $1,063.34 for state).

[4] Monthly premiums: Single—$549.80 ($50 for enrollee and $499.80 for state); Family—$1,243.34 ($180 for enrollee and $1,063.34 for state).

- Access to a ***health savings account*** (HSA) through a PPO or HMO[5]

The state's PPO plan uses funds from the State Employees' Group Health Self-Insurance Trust Fund to pay claims and plan administrative costs. Contributions made by state agencies and enrollees are deposited into the trust fund. The state contracts with a third-party administrator, Blue Cross and Blue Shield of Florida, Inc. (BCBS), for access to its provider network, to process medical claims for the PPO plan, and to provide cost control services such as case management review and coordination of benefits with other insurance plans.

In Fiscal Year 2010-11, the PPO plan included 92,763 enrollees. During this period, the state's costs for PPO medical claims totaled $602.5 million.

Preferred provider organizations rely on a network of physicians, medical facilities, and other health care providers. PPOs contract with various types of health care providers, including physicians, hospitals, and healthcare clinics. Network providers agree to provide health care services at discounted rates in return for certain benefits, such as access to a large patient group, direct prompt payment from the insurer, and other benefits as negotiated by Blue Cross and Blue Shield of Florida.

BCBS benefits from having providers participate in the network, because it can negotiate provider discounts and manage patient costs for the numerous plans that it manages. According to company officials, the self-insured state PPO plan, together with various entities, access a single, statewide provider network.

Recent changes to Florida law affected preferred provider organization payments for non-network services. PPO participants typically receive services from network providers but can choose to obtain services from providers who do not to participate in the PPO's network. Choosing non-network providers may increase a participant's out-of-pocket costs. In the absence of a negotiated discount, the participant may have to pay the difference between the insurer's reimbursement and the amount charged by the non-network provider.

Prior to 2009, when BCBS approved a claim for services from a non-network provider, the payment was made to the plan participant. The participant would then be responsible for paying the provider. Non-network providers argued that this payment policy made it difficult for them to be reimbursed, because sometimes plan participants would spend reimbursement monies for other expenses and fail to pay for services received. However, BCBS argued that the policy helped to attract providers, thus enabling the company to maintain a strong network and contain costs.

In 2009, the Legislature amended s. 627.638(2), *Florida Statutes*, to require the state's third party administrator to directly pay non-network providers for services. Patients must sign a form to transfer their insurance benefit to the non-network provider, allowing these providers to receive direct payment for services (i.e., assignment of benefits).[6] Network providers continue to receive payment in the same manner as they did prior to the legislation.

Findings

BCBS's preferred provider network has not suffered a net loss of physicians since 2009

Physicians may join preferred provider networks for many reasons. By participating in the network, physicians gain access to patients and receive direct prompt payment for services from the insurer. Depending on the insurer's market share, network physicians may also be more or less able to negotiate a favorable reimbursement.

[5] Monthly premiums: Single—$514.80 ($15.00 for enrollee and $499.80 for state); if the employee enrolls in a health savings account, the state contributes up to $500 annually to the account. Family plan—$1,127.64 ($64.30 for enrollee and $1,063.34 for state); if the employee chooses to enroll in a health savings account, the state contributes up to $1,000 annually to the account.

[6] Patients that are members of a health plan, such as state group health insurance, receive coverage for their health costs as a benefit from their employer. Thus, the patient must transfer a portion of their benefit in order for non-network providers to receive payment for services. This is referred to as "assignment of benefits".

Physicians may also leave provider networks for many reasons, including moving out-of-state, ceasing to practice, retirement, or dissatisfaction with network reimbursements. At the time of the 2009 law change, BCBS expressed concern that the amendment would result in a loss of network physicians, because one of the advantages the company uses to attract providers to the network, prompt direct payment, would be available to non-network providers as well.

As shown in Exhibit 1, the overall number of physicians in BCBS's preferred provider network has increased since 2009. Just prior to the enactment of the 2009 law, the number of participating medical doctors (MDs) and doctors of osteopathic medicine (DOs) decreased slightly, from 35,793 to 35,301 (1.4%); the number of other participating professionals (chiropractors, dentists, optometrists, oral surgeons, podiatrists, and psychologists) also decreased from 4,999 to 4,899 (2%). Participation decreased again slightly just after the law was passed, from July to December 2009. However, since December 2009, the number of participating MDs and DOs has increased by 12.5%, and the number of other participating professionals has increased by 14%.

Exhibit 1
The Number of Medical Doctors and Others Participating in the PPO Network has Increased[1]

Date	Participating MDs and DOs	Other Participating Providers	Total
July – Dec 2008	35,793	4,999	**40,792**
Jan – June 2009	35,301	4,899	**40,200**
July – Dec 2009	34,757	4,862	**39,619**
Jan – June 2010	35,707	5,142	**40,849**
July – Dec 2010	38,316	5,860	**44,176**
Jan – June 2011	39,112	6,057	**45,169**

[1] Other participating providers include chiropractors, dentists, optometrists, oral surgeons, podiatrists, and psychologists.

Source: Blue Cross and Blue Shield of Florida.

BCBS formed several workgroups to address changes from the 2009 law, including a group to make the technical changes necessary to provide for the direct payment of non-network providers, a team to address customer satisfaction issues that could arise related to non-network provider billing practices, and a group focused on increasing provider recruitment.

While the network has not experienced a net loss of physicians, we could not determine how many physicians may have left the network due to the law change or what effect BCBS recruitment efforts had on the network. As a result, we cannot assess the full impact of the law on provider participation.

BCBS's non-network state group claims have increased slightly since the law change

In 2009, Blue Cross and Blue Shield of Florida officials suggested that state group health plan costs would increase due to an increase in non-network claims. Officials also suggested that the company might need to adjust its discount rate to encourage participating providers to remain in the network.

According to BCBS data, non-network claims for the state group for physicians and other professionals have increased slightly since 2009. As shown in Exhibit 2, the number of such non-network claims increased from 88,078 in Fiscal Year 2008-09 to 89,246 in Fiscal Year 2010-11, a 1.3% increase. Despite the increase in non-network physician claims, the percentage of non-network claims remains very low. For the three fiscal years from Fiscal Year 2008-09 through Fiscal Year 2010-11, non-network physician claims for the state group represent only about 2% of the cost of total physician and other profession claims, suggesting no appreciable change in non-network claims following the 2009 law.

In order to encourage providers to continue participating in the BCBS network, company officials also anticipated altering the discount rate the company negotiates with certain network providers. Physicians and other providers agree to discount the fees they charge to BCBS from their normal and customary rates in return for the benefits provided by network participation. BCBS officials anticipated renegotiating these discount rates with certain physicians in order to maintain the network and discourage physicians from leaving the network after passage of the 2009 law.

Exhibit 2
Non-Network State Group Claims for Physician and Other Professional Services Have Increased, but Such Claims as a Percentage of Total Costs has Remained Stable

	State PPO Plan (State Group Health Plan)					
Fiscal Year	Number of Plan Enrollees and Dependents	Total Number of Claims[1]	Total Claims Costs[1,2]	Total Number of Non-Network Claims	Total Non-Network Claims Costs	Non-Network Claims Costs as a Percent of Total Claims Costs
2008-09	194,463	2,104,900	$207,438,193	88,078	$4,568,427	2.20%
2009-10	187,239	2,083,259	$215,974,790	83,104	$4,726,247	2.19%
2010-11	182,948	2,033,679	$222,408,839	89,246	$4,763,969	2.14%

[1] Claims for MDs, DOs, and other professions as reported in Exhibit 1.
[2] Figures for claim amounts reflect what BCBS paid in physician and other profession claims; an amount equal to the difference between the amounts allowed less member responsibility. Medical claims for the State Group Health Plan for all providers including physicians totaled $602.5 million for Fiscal Year 2010-11 according to the Office of Economic and Demographic Research.

Source: Blue Cross and Blue Shield of Florida.

BCBS officials reported that since the legislation, the discount rate has remained relatively unchanged, but they declined to provide specific information about rate changes. The officials consider such information confidential, proprietary business information and a trade secret. While they reported that the discount rate remains generally unchanged, officials noted that even small changes in the discount rate could affect the cost of claims for specific providers, depending on utilization of services.

Preferred provider network costs have increased, but many factors likely contributed to these increases

Evidence shows that costs for the state group health plan have increased in recent years. As shown in Exhibit 3, from Fiscal Year 2008-09 through Fiscal Year 2010-11, the number of PPO participants has declined, while per enrollee per month costs have increased. Specifically, PPO enrollment declined from 98,589 to 92,763, while per enrollee per month costs increased from $479 in Fiscal Year 2008-09 to $541 in Fiscal Year 2010-11. Enrollment figures in Exhibit 3 include state plan enrollees only and do not include dependents.

According to Blue Cross and Blue Shield of Florida officials, it would be very difficult to attribute these cost increases to the 2009 law, because many factors influence rising health care costs. For example, health care inflation—a product of health care prices, utilization, and population size—has contributed to rising health care costs nationwide. For the month of October 2011, the health care inflation rate was 3.1%. While the Consumer Price Index measures inflation for all consumer spending, health care inflation focuses on health care services and measures the increased consumer spending needed to purchase the same services at new prices.[7] Since 2001, the annual health care inflation rate has been as high as 4.7% (2002) and as low as 3.2% (2009).

BCBS officials also mentioned the effect of federal health care reform on insurance and healthcare costs.[8] These national reforms include a wide range of measures to modify the nation's health insurance system. The changes introduced by the federal law will affect numerous entities and programs, including insurance companies, Medicare, and Medicaid.

Exhibit 3
PPO Enrollment has Declined but per Enrollee per Month Costs Have Increased[1]

Fiscal Year	PPO Enrollment	Per Enrollee Per Month Costs For Medical Services[1]
2008-09	98,589	$479.26
2009-10	95,843	$512.64
2010-11	92,763	$541.25

[1] Does not include costs for prescription drug services.

Source: Florida Office of Economic and Demographic Research.

[7] The goal of the Consumer Price Index is to measure the percentage by which consumers would have to increase their spending to be as well off with the new prices as they were with the old prices.

[8] In March 2010, the federal government enacted the Patient Protection and Affordable Care Act (referred to as the Affordable Care Act).

Agency Response

In accordance with the provisions of s. 11.51(5), *Florida Statutes*, a draft of our report was submitted to the Secretary of the Department of Management Services for review and response. The written response has been reproduced in Appendix A.

Appendix A

RICK SCOTT
Governor

DEPARTMENT OF MANAGEMENT SERVICES

JOHN P. MILES
Secretary

4050 Esplanade Way | Tallahassee, Florida 32399-0950 | Tel: 850.488.2786 | Fax: 850.922.6149

January 9, 2012

Mr. R. Phillip Twogood, Coordinator
Office of Program Policy Analysis and
Government Accountability
Claude Pepper Building Room 312
111 West Madison Street
Tallahassee, FL 32399-1450

Dear Mr. Twogood:

Pursuant to Section 11.51(2), Florida Statutes, this is our response to your preliminary and tentative report, ***Negative Effects on the State's Third Party Provider Network from 2009 Law Not Apparent.***

While the report did not include recommendations for the Department of Management Services, the department agrees with the findings and conclusions contained in the report. The department recognizes the importance of any issue that affects health care for active and retired state employees.

We appreciate your staff's efforts and cordial working relationship over the past few months. If you need additional information, please contact Steve Rumph, Inspector General, at 488-5285.

Sincerely,

John P. Miles
Secretary

cc: Brett Rayman, Chief of Staff
Barbara Crosier, Director, State Group Insurance
Stephanie Leeds, Legislative Affairs Director
Kris Purcell, Communications Director

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

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