2023 SENATE HUMAN SERVICES

SB 2135

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2135
1/11/2023

Relating to assignment of dental insurance benefits; and to provide for application.

9:47 AM **Madam Chair Lee** called the hearing to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** were present.

Discussion Topics:

- Insurance payments assignments
- Non-custodial parents
- Dental insurance payments
- Reimbursements

9:48 AM **Senator Judy Lee, District 13,** introduced SB 2135 and verbally testimony in favor.

9:49 AM **Lisa Feldner, lobbyist representing ND Dental Association,** introduced Dr. Johnson and Dr. King.

9:50 AM **Dr. Aaron Johnson, a dentist in Bismarck,** testified in favor. #12792

9:53 AM **Dr. Bradley King, Founder of Prairie Rose Family,** testified in favor #12889

10:04 AM **Megan Houn, Vice President Governmental Affairs Public Policy Blue Cross Shield,** verbal testified in opposition.

10:08 AM **Owen Urech, Director of Governmental Relations National Association Dental Practices,** provided neutral online testimony and provided a suggested amendment #12834, #12835

10:10 AM **Scott Miller, Executive Director ND Public Employee Retirement Systems,** testified neutrally. #12781, #12892

10:12 AM **John Godfread, ND Insurance Commissioner,** verbally provided additional neutral information.

10:15 AM **Madam Chair Lee** adjourned the meeting.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2135
1/16/2023

Relating to assignment of dental insurance benefits; and to provide for application.

2:34 PM **Madam Chair Lee** called the meeting to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** are present.

Discussion Topics:

- Patient concerns
- Assigned benefits
- Network benefits

2:34 PM **Madam Chair Lee** handed out an email from **Bradley King, Dentist,** in favor. #13658.

2:36 PM **William Sherwin - Executive Director, North Dakota Dental Association,** testified in favor. #13655, 13656, 13657

2:52 PM **Madam Chair Lee** closed the meeting.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2135
1/23/2023

Relating to assignment of dental insurance benefits; and to provide for application.

3:27 PM **Madam Chair Lee** called the committee meeting to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** are present.

Discussion topics:

- Balance billing
- Transparency

Senator Lee calls for discussion

3:31 PM **Madam Chair Lee** closed the meeting.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2135
1/24/2023

Relating to assignment of dental insurance benefits; and to provide for application.

3:34 PM **Madam Chair Lee** called the committee meeting to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** are present.

Discussion topics:

- Cost sharing
- Balance billing
- Transparency

Senator Lee handed out amendments and information from **Megan Houn, Vice President, Government Affairs and Public Policy,** #16482, 16483, 16484.

3:42 PM **Madam Chair Lee** closed the meeting.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2135
1/25/2023

Relating to assignment of dental insurance benefits; and to provide for application.

2:51 PM **Madam Chair Lee** called the committee meeting to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** are present.

Topic discussion:

- Insurance payments
- Preferred providers
- Benefit assignments

2:53 PM **Levi Andrist, Lobbyist American Council Life Insurance** provided amendment from Owen Urech. #12834

3:01 PM **Meghan Houn, Vice President Public Policy and Governmental Affairs, N D Blue Cross Blue Shield** provided additional information verbally.

3:05 PM **William Sherwin, President North Dakota Dental Association** provided additional information. #16866 #16867

Senator K. Roers makes a motion **DO NOT PASS.**
Motion failed for lack of second.

3:27 PM **William Sherwin**, provided additional information verbally.

3:29 P.M. **Chrystal Bartuska, Director Life and Healthy Medicare Division North Dakota Insurance Department** provides information verbally.

3:38 PM **William Sherwin** provides more clarification verbally.

Senator Hogan makes a motion **DO PASS.**
Senator Cleary seconded.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	N
Senator Kent Weston	Y

Motion passed. 5-1-0

Senator Weston will carry SB 2135.

Additional written testimony:
National Association of Dental Plans #12835
Health Policy Perspective #16865

3:46 PM **Madam Chair Lee** closed the meeting.

Patricia Lahr, Committee Clerk

REPORT OF STANDING COMMITTEE

SB 2135: Human Services Committee (Sen. Lee, Chairman) recommends **DO PASS** (5 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). SB 2135 was placed on the Eleventh order on the calendar. This bill does not affect workforce development.

2023 HOUSE INDUSTRY, BUSINESS AND LABOR

SB 2135

2023 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

SB 2135
3/29/2023

Relating to assignment of dental insurance benefits, and to provide for application.

Chairman Louser called meeting to order 9:04 AM

Members Present: Chairman Louser, Vice Chairman Ostlie, Representatives Boschee, Dakane, Johnson, Kasper, Koppelman, Ruby, Schauer, Thomas, Tveit, Wagner, Warrey.

Member absent: Representative Christy

Discussion Topics:

- Subscribers
- Premiums
- Network
- Out of network
- Marketplace
- Fee scales
- Carriers
- Policies

In Favor:
Senator Judy Lee, District 13, West Fargo, ND (no written testimony)
Dr. Aaron Johnson, Dentist at the Smile Center, Bismarck, ND, #26937
William Sherwin, Executive Director, ND Dental Association of Bismarck, #26922, #26923, #26924, #26925, #26938, #26939

Additional written testimony:
Melissa Young, American Council of Life Insurers, testimony, #26881 and proposed amendment #26882
Scott Miller, Executive Director, NDPERS, #26885

Chairman Louser adjourned the meeting 9:57 AM

Diane Lillis, Committee Clerk

2023 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

SB 2135
3/29/2023

Relating to assignment of dental insurance benefits, and to provide for application.

Chairman Louser called meeting to order 4:19 PM

Members Present: Chairman Louser, Vice Chairman Ostlie, Representatives Boschee, Christy, Dakane, Johnson, Kasper, Koppelman, Ruby, Schauer, Thomas, Tveit, Wagner, Warrey.

Discussion Topics:

- Committee work

Representative Kasper moved a do pass.
Representative Koppelman seconded.

Roll call vote:

Representatives	Vote
Representative Scott Louser	Y
Representative Mitch Ostlie	Y
Representative Josh Boschee	Y
Representative Josh Christy	Y
Representative Hamida Dakane	Y
Representative Jorin Johnson	Y
Representative Jim Kasper	Y
Representative Ben Koppelman	Y
Representative Dan Ruby	Y
Representative Austen Schauer	AB
Representative Paul J. Thomas	N
Representative Bill Tveit	Y
Representative Scott Wagner	Y
Representative Jonathan Warrey	Y

Motion passed 12-1-1

Representative Kasper will carry on the floor.

Chairman Louser adjourned the meeting 4:28 AM

Diane Lillis, Committee Clerk

REPORT OF STANDING COMMITTEE

SB 2135: Industry, Business and Labor Committee (Rep. Louser, Chairman) recommends **DO PASS** (12 YEAS, 1 NAY, 1 ABSENT AND NOT VOTING). SB 2135 was placed on the Fourteenth order on the calendar.

TESTIMONY

SB 2135

TESTIMONY OF SCOTT MILLER

Senate Bill 2135 – Dental Insurance Payment

Good Morning, my name is Scott Miller. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I am here to testify in a neutral position regarding Senate Bill 2135.

NDPERS is aware of and monitoring this bill. Right now we believe the bill would not have any impact on the NDPERS Dental Plan. I have no other input at this time.

Senate Human Services
January 10, 2023
Testimony in Support of SB 2135

Good morning Sen. Lee & Members of the Committee:

Thank you for giving me the opportunity to testify on Senate Bill 2135. I am a dentist and have practiced in Bismarck for almost 20 years. This bill will allow patients the freedom to assign insurance payments directly to the dental office that did the dental work for them.

Dental offices have special staff members or even specialized consultants that work to get coverage for patients. When insurance companies are allowed to send payments directly to patients instead of the dental office, that puts the burden of getting coverage directly on the patients themselves and most people don't have the time or knowledge to take on that responsibility. It works out to insurance companies not wanting to live up to their obligation to their subscribers.

When insurance companies are not required to assign benefits this gets in the way of patient choice. Patients are forced to go to preferred providers for that insurance. Preventing them from going to the dentist that would serve them best or that they feel more comfortable with. There are also issues with non custodial parents that we have run into in my office. We had a child that was a patient and the child was covered under the non custodial parent's insurance. The insurance payment was sent to the non custodial parent, sticking the custodial parent with the bill. A very unfair situation.

In conclusion, this bill would allow dentists to better serve their patients by handing off negotiations with insurance companies to the dental office. Giving patients more choice and not allowing insurance companies to shirk their responsibilities.

I urge you to vote yes on Senate Bill 2135.

Thank you,

Dr. Aaron Johnson

23.0558.01000

Sixty-eighth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2135

Introduced by

Senators Lee, Bekkedahl, Mathern

Representatives Ista, Rohr, Satrom

A BILL for an Act to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to assignment of dental insurance benefits; and to provide for application.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Dental insurance - Assignment.

An individual or group insurance policy covering dental services may not be issued or renewed unless the policy authorizes the insured or beneficiary to assign reimbursement for health or dental care services directly to the provider of services. Under this assignment, the insurer, if authorized by the insured or beneficiary, shall pay directly to the provider the amount of the claim under the same criteria and payment schedule as would have been reimbursed directly to the insured.

A Non-contracted or out of network provider reimbursed by an insurance policy may not bill the insured for the difference between the insurance payment and the provider's charge.

SECTION 2. APPLICATION. This Act applies to insurance policies issued or renewed on or after the effective date of this Act.

January 11, 2023

Chair Judy Lee
CC: Members of the Human Services Committee
North Dakota State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505

Re: SB 2135 "A bill for an Act to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to assignment of dental insurance benefits"

Dear Chair Lee and members of the Human Services Committee,

On behalf of the National Association of Dental Plans (NADP)[1], America's Health Insurance Plans (AHIP)[2], and the American Council of Life Insurers (ACLI)[3], we are writing to share our comments on S. 2135. The bill would allow assignment of benefits for dental benefits in North Dakota. While insured dental patients should be allowed flexibility in utilizing their dental benefits, we offer additional comments on preserving the value of their coverage and preventing balance billing.

Maintaining dental coverage that is affordable and accessible is important in reducing overall health care costs and improving oral health. Individuals with dental coverage visit and take their children to the dentist more often and are more likely to receive the care they need, when compared to individuals without coverage. To that end, we propose that the language of SB 2135 be amended to prevent balance billing of insured patients by out-of-network dental care providers. A typical dental plan will reimburse for dental care at a negotiated rate with a provider who has entered a provider network in order to access insured patients. When patients seek

[1] NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental indemnity and discount dental products to more than 200 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

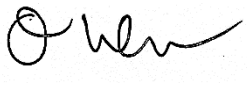
[2] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and to help create a space where coverage is more affordable and accessible for everyone.

[3] The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

treatment from a dentist who is not in network, they should be afforded the same protections as if they were seeing an in-network dentist. Therefore, a provider receiving payment directly from an insurance plan for treatment through an assignment of benefits, should not seek an additional, unexpected payment from a patient.

Thank you again for your attention to this important consumer-protection matter. We have attached our redline to this letter and are available to answer questions or provide additional information.

Sincerely,



Owen Urech
National Association of Dental Plans

Rikki Pelta
American Council of Life Insurers

Amanda Herrington
America's Health Insurance Plans

SB 2135

Dr. Bradley King Founder of Prairie Rose Family Dentists in Bismarck
Largest dental practice in the state. Dentist for 40 years

"Assignment of Benefits" is simply the patient choosing if wants the insurance company to pay their portion to the dentist or have the patient pay the bill in full and then be reimbursed by the insurance company. We believe that patients should have the freedom of choice to see the dentist they want to see and to decide if they want the insurance payment to go to the dentist or to themselves. A number of insurance companies don't allow this freedom of choice.

If patients can choose to have the payment go the dentist, the patient then has the dental office on their side to make sure they get reimbursed by the insurance company like they should. The dentist can refile the claim and argue with the insurance carrier to make sure it is covered. Sometimes this can involve sitting on the phone for an hour or more. Indeed the dentist has a stake in making sure it is taken care of. If the patient cannot assign the benefit they are on their own. As all claims now are handled electronically the patient can't even refile the claim.

This legislation is more than appropriate now than ever. Dental insurance has evolved over the past 40 years so that it is no longer actual insurance. It is now just prepaying for dental care. No longer does the employer pay most of the premium. Like NDPERS the patient decides if they want the dental coverage and then pays most if not all the premium themselves. While the cost of dental premiums has continued to rise, the coverage provided has barely budged over 40 years. $1000 to $2000 a year maximums is still as normal as it was 40 years ago. If the money is the patients, shouldn't they, not the insurance company control how it is paid out and to who.

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

WHO WE SERVE

18,293
Active Contracts

7,086
Retiree Contracts

58,763
Total Covered Lives

225
Participating Employers

KEY HEALTH INSURANCE FACTS

NDPERS administers six health insurance plans for eligible active employees, retirees, and their family members as part of the Dakota Plan.

The Dakota Plan, underwritten by Sanford Health Plan (SHP), was created to promote wellness, reduce personnel turnover, and offer an incentive to individuals to enter and remain in the service of state employment.

3
Active Member Plans

1
Non-Medicare Retiree Plan

2
Retiree Plans Bundled With Medicare

SIX HEALTH INSURANCE PLANS

Grandfathered Plan
PPO/Basic
Total Contracts: 17,191
Total Participating Employers: 223

Non-Grandfathered Plan
PPO/Basic
Total Contracts: 334
Total Participating Employers: 2

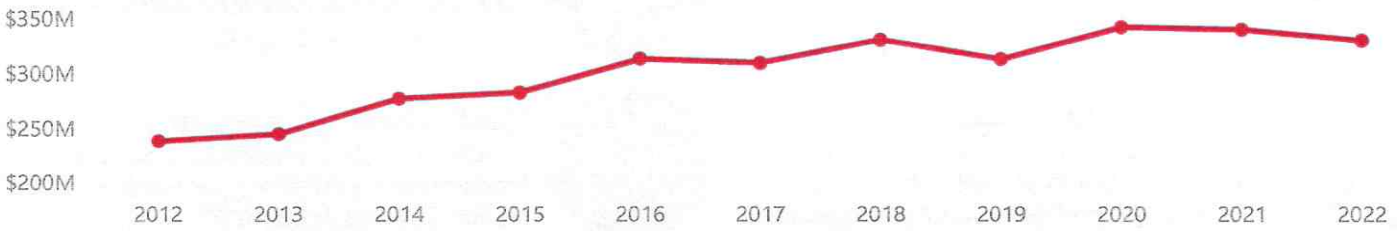
High Deductible Health Plan
Health Savings Account Option
Total Contracts: 768
Total Participating Employers: 223

Dakota Retiree Plan
Bundled With Medicare Part D
Total Contracts: 7,039

Medicare Part D Prescription Drug Plan
Underwritten by Humana
Total Contracts: 9,115

Non-Medicare Retiree
Total Contracts: 47

HEALTH INSURANCE BENEFITS PAID

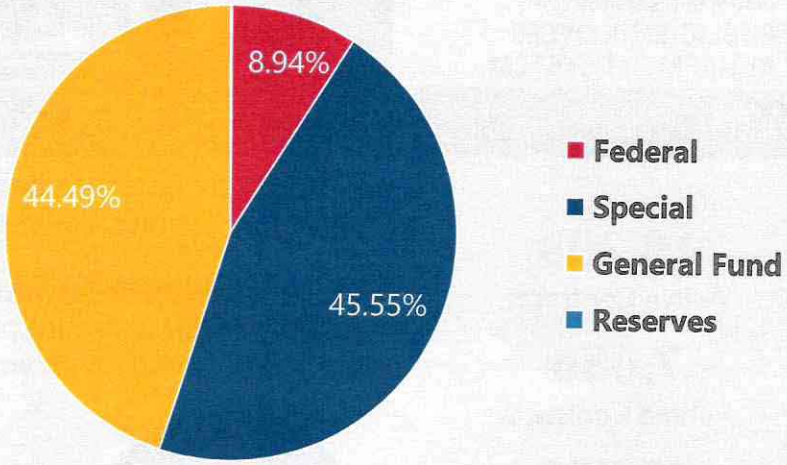


NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

HEALTH INSURANCE PLAN FUNDING

HYBRID Fully Insured/Self Insured Plan

- NDPERS shares in the gains but not the losses
- Reserves cover the administration fee shortage (roughly .01% of premium) and benefit enhancements, and buy down premiums when General Fund monies are not available



OTHER WELLNESS BENEFITS

Diabetes Prevention and Management

NDPERS provides diabetes prevention and management programs, including Livongo, through SHP, and About the Patient through the ND Pharmacy Association.

Healthy Pregnancy

SHP offers the Healthy Pregnancy Program as a free offering with tools and support for expecting parents to give their baby the healthiest start possible with up to $850 in out-of-pocket savings.

Wellness Benefit

The NDPERS Dakota Wellness Program $250 Benefit is available to all eligible members and their covered spouses participating in the NDPERS group health insurance plan.

ND Quits

NDPERS partners with the ND Department of Health to promote the ND Quits program, which offers free counseling, Nicotine Replacement Therapy, and other resources.

OTHER INSURANCE PLANS ADMINISTERED BY NDPERS

Dental Insurance

Underwritten by Delta Dental of Minnesota with 13,092 current contracts.

Life Insurance

Underwritten by Voya Life Insurance with 21,772 current contracts.

Vision Insurance

Underwritten by Superior Vision with 13,255 current contracts.

Employee Assistance Program

Provides confidential, voluntary, short-term assessment and counseling sessions for employees and families.

Flexible Compensation

This benefit allows employees to pretax eligible insurance premiums and contribute to Flexible Spending Accounts.

Health Savings Accounts

Eligible members enrolled in the High Deductible Health Plan can benefit from a Health Savings Accounts.

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Department of Health Policy and Management

Analysis of the Impact of Dental Assignment of Benefit Laws

Report to the American Dental Association and Fleishman Hillard

Leighton Ku, PhD, MPH
Erin Brantley, PhD, MPH

December 2, 2020

Summary. This brief provides a simple, but imperfect, analysis of the number of total dentists participating in insurers' Preferred Provider Organization (PPO) networks in four states that passed Assignment of Benefit laws between 2009 and 2017 (Tennessee, New Jersey, Mississippi and South Dakota). We use data for the years from 2007 to 2019, reported by the National Association of Dental Plans (NADP) in a series of reports about dental networks. The analysis finds that the number of total dentists participating in PPO networks in the states did not decline, but actually rose, following the adoption of AOB laws.

We note, however, that the analysis is imperfect because (1) we are unable to identify the number of dentists participating in specific insurance networks (e.g., Delta Dental, Aetna, Cigna, etc.) in each state by year and (2) the NADP data about dentists in insurance networks were measured inconsistently across years, so the trends may not be accurate. At the end of this report, we discuss our original research plan for this report and the difficulties encountered in trying to conduct more definitive analyses.

Background on Assignment of Benefits. A fundamental aspect of dental insurance is the development of dental provider networks: dentists who agree to treat patients covered by the insurance plan under contractual terms, including terms about reimbursement rates, cost-sharing, dental benefits covered, and other details. Dentists (or their practices) who agree to participate with a given insurance plan sign contracts or agreements and can be listed as participating dental providers by the insurance plan. Participating dentists who care for members of those insurance plans may submit bills directly to the insurer for payment under pre-established terms and the patients are responsible for paying the dentist the authorized cost-sharing amounts, which may include deductibles, copayments or coinsurance. When dentists join insurance networks, they believe that it may help them increase the volume of patients, even if reduces their practice autonomy somewhat.

A common business practice is Assignment of Benefits (AOB). Under AOB, a policy holder (the patient) may permit a third-party (i.e., a non-participating dentist) to bill the insurance plan directly and collect authorized reimbursement from the insurer, while the patient pays the dentist the balance of their bill. Non-participating dentists do not need to limit their rates to contractual levels and patients may pay higher cost-sharing amounts. Some states, including the four states discussed later, require that dental insurers permit AOB. In states that lack state AOB laws, insurers have discretion about whether to use AOB or not; some permit it, while others do not and only reimburse dentists participating in the plan networks.

Milken Institute School of Public Health
950 New Hampshire Avenue, NW | 6th Floor | Washington, DC 20052
t 202-994-4100

Using a hypothetical example, let's say that under an insurance plan, the total authorized fee for a simple dental amalgam filling is $100, of which the patient is responsible for 20%. An in-network dentist who normally charges $150 for a filling may collect $80 from the insurance plan and $20 from the patient. If AOB is in effect, a dentist who does not participate in that insurer's network can bill the insurer for $80 and may seek up to $70 from the patient. Without AOB, the dentist may not directly bill the insurer and seek to collect the $150 fee from the patient, although the patient may be able to receive $80 reimbursement from the insurer. (In practice, the dentist may have discretion about collecting cost-sharing amounts from patients and may accept smaller amounts in some cases.)

Some insurers object to AOB and believe it deteriorates the strength of their provider networks, can increase costs to patients (since patient costs are likely higher with out-of-network providers) and may reduce the quality of patient care, since non-participating providers need not agree to quality-related terms established in contracts. Advocates for AOB believe that it improves provider autonomy, expands patient choice and helps both clinicians and patients since the dentists can bill insurers directly, reducing the patient's initial out-of-pocket payment and easing paperwork.

Analysis of NADP Data on Total Size of Dental Networks. For many years, the National Association of Dental Plans (NADP), often in collaboration with Delta Dental Plans Association, has published statistics about the total number of dentists participating in at least one insurance network in each state.[1] These statistics do not show the number participating in specific plans (e.g., Delta, Aetna, Cigna, etc.), just the overall number participating in insurance networks in the state.

The data collection methodology and the number of plans which are included in the NADP reports have changed over the years. For example, in the 2009 report, NADP surveyed 11 dental plans about their dental networks (dentists participating in HMO and PPO plans) and analyzed data submitted, equivalent to data from their published provider directories. Later reports indicated that data collection was contracted to the Ignition Group, which surveyed 23 networks for 2013, 27 for 2014 and 23 for 2015 (not the same 23 as in 2013) and also collected information for 75 networks (which partially overlapped the firms surveyed) using Netminder, apparently collecting information from online provider directories. The 2019 report was conducted by Zelis Network Analytics (which purchased the Ignition Group); the report did not discuss the data collection methodology, but a representative mentioned that it continued to abstract information from online provider directories. We note that data contained in provider directories are not always correct: a listed dentist may have left the plan or retired but the directory was not updated, or a dentist who joined the network recently is not yet listed in the directory.

In our analyses we focus on PPO networks, which are far larger than HMO networks. In all the years, NADP or its contractor took steps to "unduplicate" dentists who participate in multiple plans, so that the total is the number of unique dentists participating in PPO networks in at least one plan. That is, if a dentist participates in three dental networks, he or she is only counted once for the overall state total.

In Table 1 (below), the final column shows the year-over-year annual growth in the national number of participating dentists. The substantial fluctuations suggest serious data inconsistencies over time,

[1] National Association of Dental Plans. Network Statistics, Provider Networks and similar titles. Published in 2009, 2011, 2012, 2013, 2014, 2015, 2017, 2019. Made available to us from the American Dental Association.

although we believe that there is an overall increase over time because dentists have become more willing to accept dental insurance over time and participate in insurance networks.

Table 1 (below) presents changes in the number of total dentists participating in PPO networks in four states (Tennessee, New Jersey, Mississippi and South Dakota as well as nationally) that adopted AOB laws between 2007 and 2017. (West Virginia adopted an AOB law in 2020, but we lack data for 2020 or 2021 networks). If AOB laws caused dental provider networks to shrink, we might expect to see fewer dentists participating in networks in the years after AOB laws were passed. In all four states, the total number of dentists participating in PPO networks increased over the years. In the next to last row, we show the percentage gain in participating dentists since the AOB law was passed. For example, the number in Tennessee network appeared to grow by 159% between 2007 – when its AOB law was enacted – and 2019.

As noted above, the dental network data appears flawed due to changes in methodology. To try to compensate for this problem, we made a simple adjustment by dividing the change in each state's network size from the AOB year to 2019 by the equivalent changes in the national number of dentists from the AOB year to 2019, called the Adjusted Gain, shown in the last row. This roughly compares the change in the state network size to national network changes over the same period. Even after this adjustment, the number of participating dentists in Tennessee grew by 82% from 2009 to 2019. In Tennessee, New Jersey and Mississippi, there was substantial growth in the number of total dentists, even after reporting adjustments, between the year their AOB laws were enacted to 2019. In South Dakota, there was a small gain from 2017 to 2019.

Table 1. Changes in Total Dentists Participating in PPO Plans After Assignment of Benefit Laws Adopted, by Year (Based on data reported to the National Association of Dental Plans)

Data Yr	Rept Yr	Tennessee	New Jersey	Mississippi	South Dakota	United States	Ann Growth
Year of AOB law		**2009**	**2012**	**2013**	**2017**		US
2008	2009	2,120	6,862	639	122	132,003	
2009	2011	2,085	5,707	526	44	148,347	12.4%
2010	2012	2,258	6,299	667	128	116,978	-21.1%
2011	2013	2,781	6,615	722	152	158,079	35.1%
2012	2014	2,713	6,711	740	134	158,463	0.2%
2013	2015	2,430	6,603	780	205	158,121	-0.2%
2014	2015	3,275	8,124	958	222	193,370	22.3%
2015	2016	4,636	10,991	1,559	508	211,371	9.3%
2016						missing	
2017	2017	5,242	14,597	2,225	558	220,027	4.1%
2019	2019	5,395	15,105	2,404	583	210,304	-4.4%
Gain from AOB Yr to 2019		**159%**	**125%**	**208%**	**4%**	**na**	
Adjusted Gain*		**83%**	**70%**	**132%**	**9%**	**na**	

* The state-specific gain from the AOB year to 2019, divided by the national change in that period.

In Table 2, we present similar data for general dentists, the largest dental specialty, who provide routine preventive and acute dental care, excluding specialists like endodontists and orthodontists. The results are similar to those for total dentists; the number of participating general dentists grew after AOB laws were enacted.

Table 2. Changes in General Dentists Participating in PPO Plans After Assignment of Benefit Laws Adopted, by Year (Based on data reported to the National Association of Dental Plans)

Data Yr	Rept Yr	Tennessee	New Jersey	Mississippi	S Dakota	United States	Ann Growth
Year of AOB law		**2009**	**2012**	**2013**	**2017**		US
2008	2009	1,640	5,159	518	104	112,630	
2009	2011	1,567	4,157	432	40	118,082	4.8%
2010	2012	1,665	4,532	613	110	89,590	-24.1%
2011	2013	2,141	4,757	571	133	123,186	37.5%
2012	2014	2,018	4,853	592	119	122,715	-0.4%
2013	2015	1,919	5,003	643	177	126,105	2.8%
2014	2015	2,524	6,159	769	195	153,531	21.7%
2015	2016	3,579	8,123	1,238	413	196,071	27.7%
2016						missing	
2017	2017	3,798	8,210	1,390	454	203,916	4.0%
2019	2019	3,977	8,260	1,408	471	196,651	-3.6%
Gain from AOB Yr to 2019		**154%**	**70%**	**119%**	**4%**	**na**	
Adjusted Gain*		**52%**	**6%**	**40%**	**8%**	**na**	

* The state-specific gain from the AOB year to 2019, divided by the national change in that period.

Again, we note that these analyses have significant limitations. Ideally, we would like to know the number of dentists participating in each dental plan in each year, measured consistently, but these data were not available (see below). It is plausible that the total number of unduplicated dentists in a state could grow, even if the average membership in each plan shrank.[2] The lack of information about membership in specific plans means that we cannot assess the impact of AOB for a specific insurance plan. Moreover, the completeness of reporting appeared to vary substantially from year to year, so the trends may not be accurate.

Original data collection and analysis plans. The goal of this project was to estimate the effect of state-level AOB laws in the size of insurance plans' dental networks. Four states were of particular importance because they had enacted AOB laws in the past several years, including Tennessee in 2009,

[2] Imagine a simple hypothetical case involving 8 dentists (Dentist A, B, C, D, E, F, G and H) in a state and two networks, Plan 1 and Plan 2. In the first year, Plan 1 includes dentists A, B, C, D and E, while Plan 2 has dentists A, B, C, D and F; the total statewide number of participating dentists is 6 in the first year and each plan has 5 dentists. In the second year, Plan 1 includes dentists A, C, D and H while Plan 2 has dentists B, E, F and G. The total number of participating dentists statewide rises to 8, even though each plans' network declined from 5 to 4. While this is an unlikely scenario, it demonstrates that changes in the number of total statewide dentists and changes in the number of dentists in each plan might not be consistent.

New Jersey in 2012, Mississippi in 2013 and South Dakota in 2017. Ideally, we wanted to find data about the number of participating dentists in each plan in those states in years before and after AOB laws were passed. If we had complete time series data about dental participation and state AOB laws, we could have conducted difference-in-difference analyses that let us examine changes in the size of insurers' dental networks after AOB laws were enacted. Unfortunately, this was not feasible due to the lack of data.

We contacted representatives of dental insurers about the availability of dental network data and their company policies. We learned about the data collected for NADP and were referred to Zelis Network Analytics, which collected those data. A Zelis representative said that we could purchase data about current insurance networks, but that historical data was not available because their computer systems had changed. NADP offered to sell us aggregate data from their annual reports, but we learned that these reports were already available from the American Dental Association, so we could get them without charge for this project.

We also considered the possibility that information about dental networks might be available in readiness documents that insurance plans file to participate in health insurance marketplaces. The readiness documents include data about insurers' provider networks, but we found that the documents just generally just linked to plans' current online provider directories, so they would only have the current 2020 directories even if we wanted to find listings for earlier years. That is, they are not a good resource for historical data.

An analytical alternative we considered, but which was less robust and which became infeasible, was to just use current network information from Zelis. We considered comparing the size of current dental networks in states that had vs. lacked AOB laws for insurers that do vs. do not permit AOB in states where they have the option. In principle, the combination of information about state laws and insurers' AOB policies could let us estimate the effect of state AOB laws.

We contacted a number of other dental insurers about their AOB policies, but the majority did not agree to describe their policies. Based on experience with other insurers, we suspect that this is viewed as proprietary business information which they do not choose to divulge. Delta Dental agreed to speak with us and explained that its corporate policy was to not permit AOB in order to strengthen the position of its provider networks and to provide better consumer protections through its contracts, although they comply with state laws that require AOB. They indicated that they, or their state representatives, sometimes engaged with state legislatures about this policy topic.

After pursuing these data for several months, we determined that it was not possible to get the appropriate data for an analysis that met our research standards. We were able to conduct a very simple analysis of existing data, described above, but understand its limitations.

It is regrettable that it was so difficult to get information about dental insurance networks, including data about the size or composition of networks or even qualitative information about dental insurance policies. In 2018, researchers from the American Dental Association's Health Policy Institute published an article titled "Why we need more data on the dental insurance market."[3] It is important to

[3] Vujicic M, Gupta N, Nasseh K. Why we need more data on the dental insurance market. *Journal of the American Dental Association*. 149(1): 75-77.

understand how dental insurance plans are functioning, providing access to patients and promoting quality and competition. Unless there is greater transparency and availability of data about dental insurance networks, it will be difficult to assess how effective insurance plans are in promoting access to care for their patients.

Removing Financial and Administrative Burdens on Patients Through Assignment of Benefits Laws

In states where these laws don't exist, insurers often pay the patient instead of the dentist, creating confusion and additional hurdles for patients to jump over.

Patient Concerns

When a patient who's seeing their out-of-network dentist wants the insurance payment for covered services to go directly to the dentist, known as "assignment of benefits," insurers can refuse to directly issue payment in many states. Not allowing assignment of benefits has two negative effects for patients:

- The patient may have to pay at the time of dental service and await reimbursement from their insurer, creating financial hardship for some.
- The dentist will have to contact the patient for payment after services have been rendered, which is often confusing to patients who expect their insurers to pay providers directly.

Solution

Assignment of Benefits (AoB) laws require insurers to follow a patient's request to pay their dentist directly for services rendered.

The North Dakota Dental Association is advocating for Assignment of Benefits laws that will allow patients to choose to have payment sent directly to their provider. Insurance companies pay providers no more than they would if they paid the patient directly – and often save money if they aren't required to issue a paper check.

What Are the Benefits of Assignment of Benefits Laws?

- Puts patients in control of their benefits while ensuring that the insurance benefit is used for its intended purpose.
- Alleviates financial and administrative burdens from patients by allowing payment to be sent directly to the dental office, instead of having the patient pay upfront for services and then await reimbursement from the insurance company.
- Allows, but does not require, patients the option to assign their dental benefit directly to the dentist.
- Reduces cost of care associated with collecting debts and managing losses from non-payments for dentists billing patients.
- Insurance companies pay no more than they would if they pay the patient directly – and often save money if they aren't required to issue a paper check.

Assignment of Benefits Laws in North Dakota

Currently in Place	Proposed
None Applicable to Dental	SB 2135

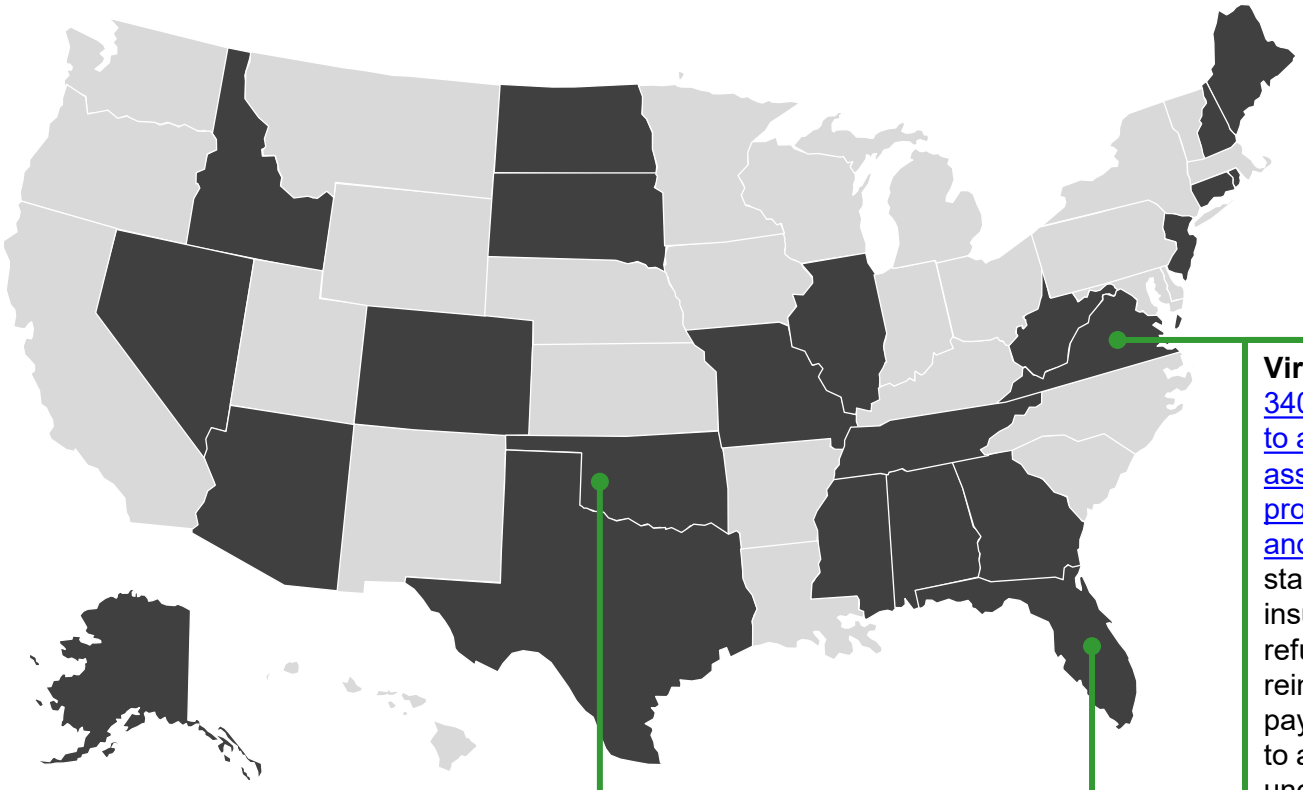
National, Bipartisan Momentum for Assignment of Benefits Legislation

"*Already passed in several states, "assignment of benefits" laws would empower patients to choose whether they want insurance companies to directly pay dental clinics, freeing patients from having to pay upfront and negotiate with insurance companies for reimbursement.*"

- Consumer Choice Center, Policy Note: Dental Insurance Reform

PASSED IN

23 states



Virginia's § 38.2-3407.13. Refusal to accept assignments prohibited; dentists and oral surgeons states that no insurer or plan may refuse to make reimbursement payments directly to a dental provider under an assignment of benefits.

Oklahoma's Health Care Freedom of Choice Act requires that a practitioner be directly compensated by insurers for services and procedures, allowing patients to effectively assign their benefits.

Florida's 627.638 Direct payment for hospital, medical services requires that insurers directly make payments to providers. Furthermore, insurance contracts may not prohibit the direct payment of providers.

To learn more about assignment of benefits legislation in ND, please contact the North Dakota Dental Association at 701-223-8870 or info@smilenorthdakota.com.

Debunking the Insurance Industry's False Claims about Assignment of Benefits Laws

Issue Overview

Assignment of Benefits (AoB) laws require insurers to follow a patient's request to pay their dentist directly for services rendered. In states where these laws don't exist, insurers selectively reimburse the patient instead of the dentist, creating confusion, unpredictability and additional hurdles for patients.

AoB Advantage for Patients

AoB laws remove financial and logistical burdens for patients seeking care, empowering them to visit the dentist more regularly and benefit from consistent, transparent billing practices. Without AoB laws:

- Many patients seeing dentists of their choice have to pay for care upfront, and wait to be reimbursed by their insurance company. For low income patients who may not be able to pay that cost, this is an insurmountable burden to oral healthcare.
- Insurance companies create an extra hurdle for patients when they refuse to pay their healthcare provider directly, potentially creating strain and distrust between the patient and their dentist, and further discouraging patients from seeking care.

Insurance companies claim that AoB laws inadvertently increase costs for patients by weakening provider networks and allowing patients to see dentists outside their insurance network. **Independent research shows this is simply false.**

Research Results

A health policy research team at The George Washington University explored data from the National Association of Dental Plans (NADP) to track the number of dentists participating in insurance networks in four states before and after passing AoB laws. These data clearly show AoB laws do not negatively affect dentist participation in insurance networks.

State (Year of AoB passage)	**Tennessee (2009)**	**New Jersey (2012)**	**Mississippi (2013)**	**South Dakota (2017)**
Participating dentists in year of AoB law passage	2,085	6,711	780	558
Participating dentists in 2019	5,395	15,105	2,404	583
Percent change	+159%	+125%	+208%	+4%

Lack of Transparency in Dental Insurance

As part of their research, GWU requested data from numerous dental insurers, but were repeatedly denied. While the insurance industry rigorously opposes the basic measure of consumer protection based on dubious claims, they refuse to provide transparent information that would provide clear answers to the public.

Wolf, Sheldon

From: Lee, Judy E.
Sent: Sunday, January 15, 2023 8:11 PM
To: -Grp-NDLA Senate Human Services; Wolf, Sheldon; Lahr, Pat
Subject: FW: SB 2135 Assignment of Dental Benefits proposed amendment

Please note these details about the dental benefits bill.

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
Home phone: 701-282-6512
Email: jlee@ndlegis.gov

From: Brad King <bking1@bis.midco.net>
Sent: Saturday, January 14, 2023 7:30 PM
To: Lee, Judy E. <jlee@ndlegis.gov>
Subject: SB 2135 Assignment of Dental Benefits proposed amendment

Dear Senator Lee

Human Services Committee

Re: Assignment of Dental Benefits SB 2135

proposed amendment

I spoke before your committee on Wednesday Dec. 10th in favor of Bill 2135. At that time an amendment was proposed by a national association of insurers. I have read and considered it and was surprised that it was proposed by people who supposedly understand dental insurance and claim to be neutral on the issue. It appears that they think that dental insurance pays 100% of the bill. Dental insurance does not. It is in no way like medical insurance. Over all it pays about 45% of the patients bill (considering deductibles and copays) up until the patient reaches their yearly maximum and then pays nothing.

The amendment says that if you are not in network and the insurance company pays you directly, you would have to accept their payment as payment in full. So if you normally charge $1000 for a crown and the insurance, which normally pays 50% of the charge, pays you that $500 you would have to accept that as full payment. Indeed if the insurance company decided

to pay only $100 the dentist would have to accept that. As dental practices run a 65-75% overhead before the dentist gets paid, this would mean that the dentist would lose money providing those services. The dentist would probably not accept assignments of benefits on patients with dental insurance. The patient would have to pay the full bill at the time of service.

There are many dental insurance companies that allow assignment of benefits even when the dentist is not in network. This amendment would definitely harm those patients with those insurers. Our practice participated with a number of companies that acted responsibly like these insurers.

This is not a realistic nor thought out amendment and would only throw how dentists and patients deal with insurance companies into complete confusion.

Thank you,

Dr. Bradley King

3612 Calypso Dr.

Bismarck, ND 58504

701 426 1088

bking1@bis.midco.net

PROPOSED AMENDMENTS TO SENATE BILL NO. 2135

Page 1, after line 13, insert:

For purposes of this section, “domestic health insurer” means any insurance company that provides health or dental insurance and is incorporated or formed in this state.

The provisions of this section do not apply to a domestic health insurer.

Renumber accordingly

Wolf, Sheldon

From: Lee, Judy E.
Sent: Monday, January 23, 2023 10:44 PM
To: Wolf, Sheldon
Subject: FW: 2135 - Amendments
Attachments: SB 2135 - BCBSND exemption.docx; SB 2135 Dental transparency amendment.docx

Please load these attachments & message for 2135 testimony.

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
Home phone: 701-282-6512
Email: jlee@ndlegis.gov

From: Megan Houn <Megan.Houn@bcbsnd.com>
Sent: Monday, January 23, 2023 10:26 AM
To: Lee, Judy E. <jlee@ndlegis.gov>
Subject: 2135 - Amendments

Good Morning, Senator Lee,
We tried to capture some of the conversations we have had on this bill in a couple of amendments. Please take a look and let me know your thoughts. The first amendment exempts us out. This is important given that we still have a true dental insurance product, and the bill as written will erode our network and will allow balance billing of our networks. The exemption provides us time to evaluate or product and potentially change it to a prepaid dental product similar to what the NDDA was describing in their economics argument.

The second amendment is a transparency amendment. It is consistent with what other providers already have to do. According to NDDA, these conversations are already occurring in the chair, so it seems unlikely they should oppose?

Megan Houn
Vice President, Government Affairs and Public Policy
BLUE CROSS BLUE SHIELD OF NORTH DAKOTA
701-255-5548 (work)
701-255-5595 (fax)
megan.houn@bcbsnd.com | www.BCBSND.com

PROPOSED AMENDMENTS TO SENATE BILL NO. 2135

Page 1, after line 13, insert:

For purposes of this section, “dentist” and “practice of dentistry” have the same meaning as provided by section 43-28-01.

Beginning on January 1, 2024, and annually thereafter, any dentist engaged in the practice of dentistry in this state shall file a report with the commissioner by February 1st detailing the following:

The rates charged by the dentist for each item provided by the dentist;

The rates charged by the dentist for each service provided by the dentist;

The total number of patients who were provided services by the dentist during the previous year; and

The total number of patients who were provided services by the dentist who had Medicaid as their primary form of insurance during the previous year.

The commissioner shall publish the results of the dentists’ reports on a public website maintained by the commissioner.

Renumber Accordingly

Features

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.

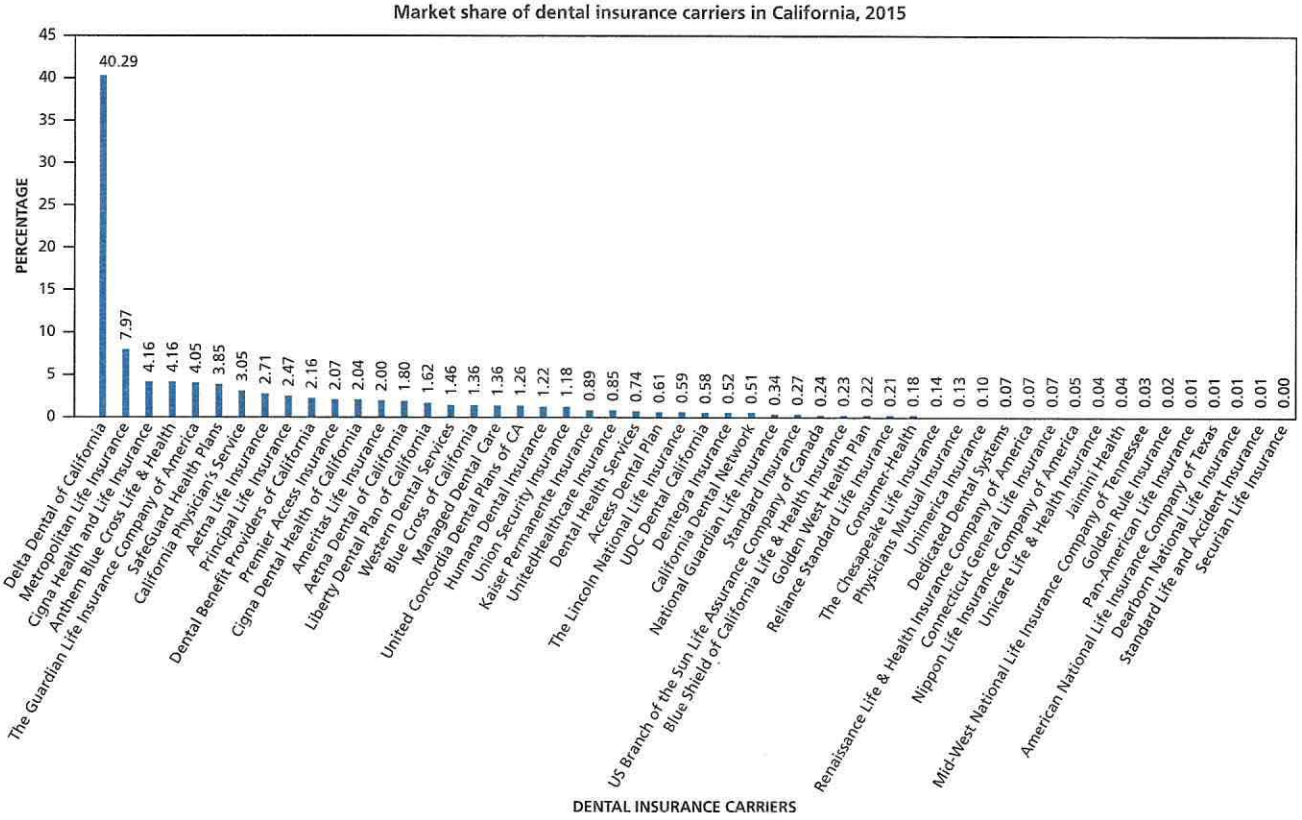


Figure. The total number of covered lives in California in 2015 was 9,891,539 (as of March 31, 2016). The number of covered lives were aggregated to the insurer level. The market share of covered lives for each insurer was calculated as the number of covered lives by the insurer in 2015 (as of March 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. ■

https://doi.org/10.1016/j.adaj.2017.11.016

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.

Dr. Vujicic is the chief economist and the vice president, Health Policy Institute, American Dental Association, 211 E. Chicago Ave., Chicago, IL 60611, e-mail vujicicm@ada.org. Address correspondence to Dr. Vujicic.

Dr. Gupta is a health services researcher, Health Policy Institute, American Dental Association, Chicago, IL.

Dr. Nasseh is a health economist, Health Policy Institute, American Dental Association, Chicago, IL.

This column represents the opinions of the author and not necessarily those of the American Dental Association.

Disclosure. The authors did not report any disclosures.

To receive Health Policy Institute reports and commentary, follow the ADA Health Policy Institute on Twitter @adahpi.

1. Schencker L. NorthShore, Advocate drop merger plan after judge's ruling. *The Chicago Tribune*. March 7, 2017. Available at: http://www.chicagotribune.com/business/ct-advocate-northshore-merger-decision-0308-biz-20170307-story.html. Accessed November 8, 2017.

2. Sun E, Baker LC. Concentration in orthopedic markets was associated with a 7 percent increase in physician fees for total knee replacements. *Health Aff (Millwood)*. 2015;34(6):916-921.

3. Dafny L, Duggan M, Ramanarayanan S. Paying a premium on your premium? Consolidation in the U.S. health insurance industry. *Am Econ Rev*. 2012; 102(2):1161-1185.

4. Roberts ET, Chernew ME, McWilliams JM. Market share matters: evidence of insurer and provider bargaining over prices. *Health Aff (Millwood)*. 2017;36(1): 141-148.

5. Wall T, Guay AH. Very large dental practices seeing significant growth in market share. Health Policy Institute Research Brief. American Dental Association. August 2015. Available at: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0815_2.pdf?la=en. Accessed November 8, 2017.

6. State of California, Department of Managed Health Care. HMO/Health plan's financial statement search. Available at: http://wpso.dmhc.ca.gov/fe/search/Default.aspx#top. Accessed December 18, 2017.

7. California Department of Insurance. Dental medical loss ratio. Available at: http://www.insurance.ca.gov/01-consumers/110-health/60-resources/Dental-MLR.cfm. Accessed December 18, 2017.

8. Department of Justice, Antitrust Division. Horizontal Merger Guidelines. Available at: https://www.justice.gov/atr/horizontal-merger-guidelines-08192010#5c. Accessed November 8, 2017.

9. Council of Economic Advisors. Benefits of competition and indicators of market power. Issue Brief. May 2016. https://obamawhitehouse.archives.gov/sites/default/files/page/files/20160502_competition_issue_brief_updated_cea.pdf. Accessed November 8, 2017.

10. Delta Dental Litigation Resolution. California Dental Association. Available from: https://www.cda.org/portals/0/pdfs/delta_settlement_summary.pdf. Accessed November 8, 2017.

11. Vujicic M. Why are payment rates to dentists declining in most states? *JADA*. 2016;147(9):755-757.

12. Yarbrough C, Nasseh K, Vujicic M. Key insights on dental insurance decisions following the rollout of the Affordable Care Act. Health Policy Institute Research Brief. American Dental Association. August 2014. Available at: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0814_2.pdf?la=en. Accessed November 8, 2017.

13. The Center for Consumer Information & Insurance Oversight. Medical loss ratio: getting your money's worth on health insurance. CMS.gov. Available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/mlrfinalrule.html. Accessed November 8, 2017.

14. The Center for Consumer Information & Insurance Oversight. 2015 MLR rebates by state. CMS.gov. Available at: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2015_Rebates_by_State.pdf. Accessed November 8, 2017.

15. AB-1962 Dental plans: medical loss ratios: reports (2013-2014). California Legislative Information. Available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB1962. Accessed November 8, 2017.

16. Office of Program Research. 2015 Regular Legislative Session. Washington House of Representatives. May 2015. Available at: http://leg.wa.gov/LIC/Documents/Session/Summary_of_Leg_and_Budgets.pdf. Accessed November 8, 2017.

17. Rhode Island House Bill 5700. LegiScan. Available at: https://legiscan.com/RI/bill/H5700/2015. Accessed November 8, 2017.

18. Bill Status of SB2266. Illinois General Assembly. Available at: http://www.ilga.gov/legislation/BillStatus.asp?DocNum=2266&GAID=13&DocTypeID=SB&SessionID=88&GA=99#actions. Accessed November 8, 2017.

19. Bill S.566. The 190th General Court of the Commonwealth of Massachusetts. Available at: https://malegislature.gov/Bills/189/S566. Accessed November 8, 2017.

20. Bill H.951. 190th General Court of the Commonwealth of Massachusetts. Available at: https://malegislature.gov/Bills/189/H951. Accessed November 8, 2017.

NDCC §26.1-36-12

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.**

Dental Transparency Legislation

1. Medical/Dental Loss Ratio (MLR)

MLR laws require insurers to report the percentage of premium revenue that is spent on actual care, as compared to administrative costs. Some proposals may require rebates if plans under-spend on dental care.

2. Explanation of Benefit-Required Format

Commissioner approves explanation of benefits forms, definitions and terms. Sets minimum standards for the format, terms, and definitions for explanation of benefits forms. Commissioner must approve explanation of benefits forms and the standard definitions or terms used on forms to prevent confusing, inconsistent, or misleading information.

3. All Payer Claims Database

Requires insurers and to an extent health care providers to submit certain claims data to the state for collection and reporting purposes.

4. Uniform Benefits and Coverage Disclosure Matrix

Requires carriers to utilize a uniform benefits and coverage disclosure matrix to offer patients a consistent format for determining plans' designs. The matrix could include: deductible, benefit limit, coverage info for basic-preventive-diagnostic-major & orthodontia services, dental plan reimbursement levels/estimated enrollee cost share for services, waiting periods, examples to illustrate coverage and estimated enrollee costs of commonly used benefits.

5. Insurance Identification Card – ERISA Notification

Front desk personnel who see the insurance cards never know if a patient's plan must adhere to state laws such as non-covered services or assignment of benefits regulations. Some laws require notification on insurance cards indicating "fully insured" which clarify that state laws apply to this transaction.

6. Independent Claims Review

Provides a requirement that dental plans include a method for independent claims review for patients wishing to have denied claims reviewed after the plan has exhausted internal reviews.

7. Coordination of Benefits (CoB)

When two dental plans cover the same procedure, laws typically determine how to identify primary and secondary plans (who pays first and second). Significant provisions of CoB laws are those that require the secondary plan to pay a benefit and/or prohibit secondary plans from refusing to pay a benefit.

8. Downcoding Limitations

Prohibition/limitations on dental plans using procedure codes different from the one submitted by the dentist in order to determine a benefit in an amount less than that which would be allowed for the submitted code.

9. Notification of Contract Changes

Insurers' contracts with dentists may include a provision that changes may occur without notice. Some changes can be substantive. These laws require plans to provide early notice of planned substantive contract changes well in advance. Legislative approaches may include opt-in or opt-out options for dentists when contract changes are proposed.

10. Equal Payment

Requires dental plans to pay the same benefit for a covered individual whether the rendering dentist is participating or non-participating in the dental plan

11. Disallow Clause Prohibition

This law would prohibit any contract provision that prevents a dentist from charging a covered person for a covered procedure not paid for by the benefit plan. The law would prohibit contract provisions saying no payment will be made for a covered service by the dental plan AND the participating dentist may not collect payment from the covered person for the covered service disallowed by the dental plan

12. Credentialing Improvements

Requires a health care entity or health plan to issue a decision regarding the credentialing of a health care provider within XX calendar days of receiving a complete credentialing application.

13. Fee Reduction Regulation

Insurers would be prohibited from reducing reimbursement paid to health care providers by more than XX% for more than a certain number of consecutive years, and prohibits further reductions without approval of state authority.

14. Provider Rating Systems

Some benefit plans may use a rating systems such as stars to rate dentists based on costs/charges. To help ensure proper profiling of dentists, health care entities may be required to employ rating designations that are fair and accurate based on reliable, diverse and approved data collection methods; these rating entities would have to provide dentists the right to challenge and correct erroneous designations, data, and methodologies.

15. All-Product Clauses - Providers' Right to Choose Act

Would prohibit health insurers from requiring a health care provider to participate in all health plans offered by the health insurer, or to participate in all the insurer's provider network arrangements. It prohibits the health insurer from terminating any contractual relationship with a health care provider for not agreeing to participate in a provider network arrangement.

March 29, 2023

The Honorable Scott Louser
Chair
House Industry, Business and Labor Committee
North Dakota Legislature
600 East Boulevard Avenue
Bismarck, ND 58505

Re: Senate Bill 2135 – AMEND

Dear Chair Louser and Members of the Committee,

The National Association of Dental Plans (NADP)[1], America's Health Insurance Plans (AHIP)[2], and the American Council of Life Insurers (ACLI)[3] appreciate the opportunity to comment on Senate Bill 2135 (SB 2135) which would allow assignment of benefits for dental benefits in North Dakota. While insured dental patients should be allowed flexibility in utilizing their dental benefits, we offer additional comments on preserving the value of their coverage and preventing balance billing.

Maintaining dental coverage that is affordable and accessible is important in reducing overall health care costs and improving oral health. Individuals with dental coverage visit and take their children to the dentist more often and are more likely to receive the care they need when compared to individuals without coverage. To that end, we propose that the language of SB 2135

[1] NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental indemnity and discount dental products to more than 200 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

[2] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and to help create a space where coverage is more affordable and accessible for everyone.

[3] The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

be amended to prevent balance billing of insured patients by out-of-network dental care providers. A typical dental plan will reimburse for dental care at a negotiated rate with a provider who has entered a provider network in order to access insured patients. When patients seek treatment from a dentist who is not in network, they should be afforded the same protections as if they were seeing an in-network dentist. Therefore, a provider receiving payment directly from an insurance plan for treatment through an assignment of benefits should not seek an additional, unexpected payment from a patient.

We have attached a redline of the bill and recommend an amendment to SB 2135.

Thank you for your consideration of this important consumer protection issue.

Respectfully submitted,

Owen Urech
National Association of Dental Plans

Amanda Herrington
America's Health Insurance Plans

Melissa I. Young
American Council of Life Insurers

cc: Members of the House Industry, Business and Labor Committee
Commissioner Jon Godfread, North Dakota Insurance Department
Deputy Commissioner John Arnold, North Dakota Insurance Department
Levi Andrist, Amy Cleary and Dennis Pathroff, GA Group, PC

23.0558.01000

Sixty-eighth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2135

Introduced by

Senators Lee, Bekkedahl, Mathern

Representatives Ista, Rohr, Satrom

A BILL for an Act to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to assignment of dental insurance benefits; and to provide for application.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Dental insurance - Assignment.

An individual or group insurance policy covering dental services may not be issued or renewed unless the policy authorizes the insured or beneficiary to assign reimbursement for health or dental care services directly to the provider of services. Under this assignment, the insurer, if authorized by the insured or beneficiary, shall pay directly to the provider the amount of the claim under the same criteria and payment schedule as would have been reimbursed directly to the insured.

A Non-contracted or out of network provider reimbursed by an insurance policy may not bill the insured for the difference between the insurance payment and the provider's charge.

SECTION 2. APPLICATION. This Act applies to insurance policies issued or renewed on or after the effective date of this Act.

TESTIMONY OF SCOTT MILLER

Senate Bill 2135 – Dental Insurance Payment

Good Morning, my name is Scott Miller. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I am submitting this to testify in a neutral position regarding Senate Bill 2135.

NDPERS is aware of and monitoring this bill. Right now we believe the bill would not have any impact on the NDPERS Dental Plan. I have no other input at this time.

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

February 23, 2023
Posted by Jeana Singleton

Client Alert
The End of the Public Health Emergency is (Finally) Here

February 23, 2023
Posted by Jeana Singleton and Rachel Stermer

Client Alert
Multi-340B Contract Pharmacy Locations on the Brink? The Third Circuit's Ruling Gives a Hint.

February 17, 2023
Posted by Daphne Kackloudis and Jordan Burdick

Client Alert
Five Opportunities for Operations and

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

February 17, 2023
Posted by Daphne Kackloudis and Ashley Watson

Resources

Client Alerts, News Articles, Blog Posts, & Multimedia

Everything you need to know about BMD and the industry.

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

February 23, 2023
Posted by Jeana Singleton

Client Alert
The End of the Public Health Emergency is (Finally) Here

February 23, 2023
Posted by Jeana Singleton and Rachel Stermer

Client Alert
Multi-340B Contract Pharmacy Locations on the Brink? The Third Circuit's Ruling Gives a Hint.

February 17, 2023
Posted by Daphne Kackloudis and Jordan Burdick

Client Alert
Five Opportunities for Operations and

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

February 17, 2023
Posted by Daphne Kackloudis and Ashley Watson

"[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.

---

[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.

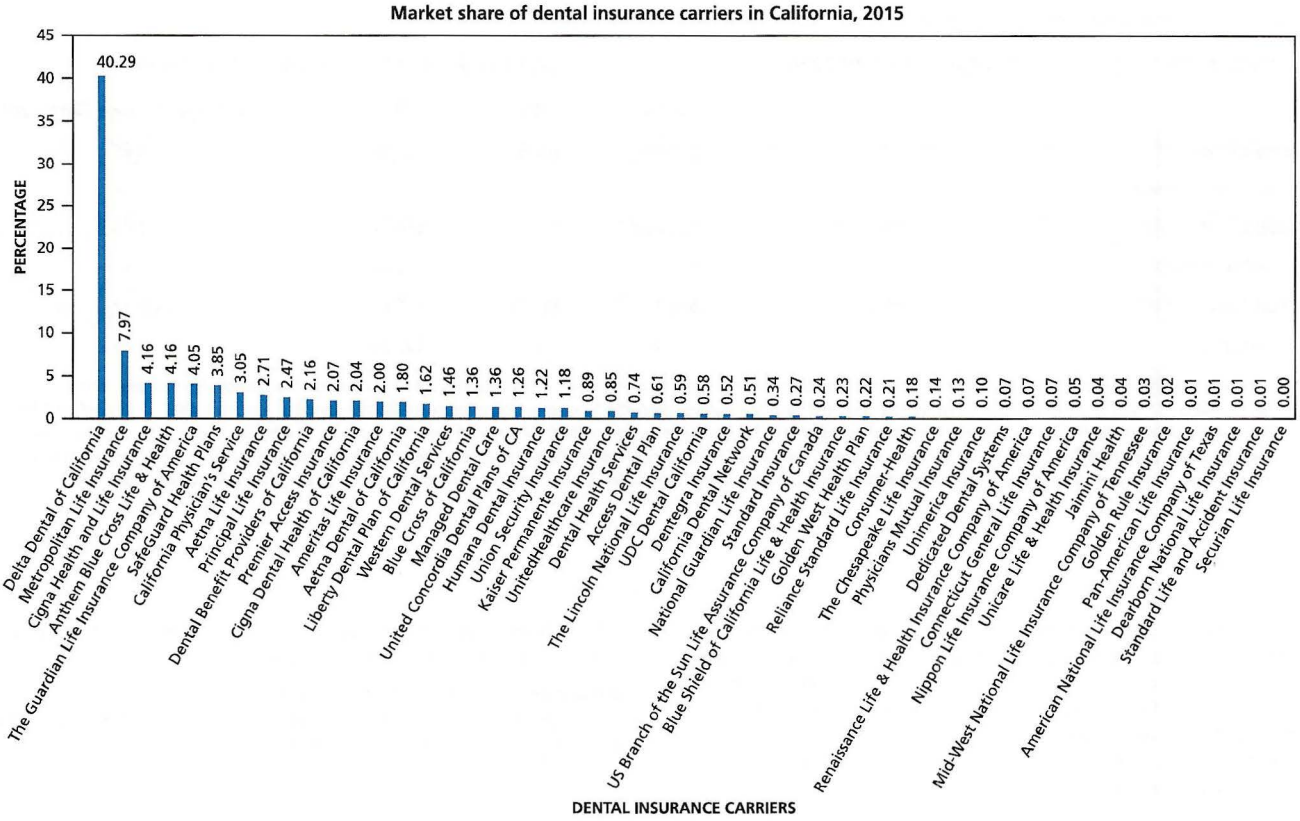


Figure. The total number of covered lives in California in 2015 was 9,891,539 (as of March 31, 2016). The number of covered lives were aggregated to the insurer level. The market share of covered lives for each insurer was calculated as the number of covered lives by the insurer in 2015 (as of March 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. ■

https://doi.org/10.1016/j.adaj.2017.11.016

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.

Dr. Vujicic is the chief economist and the vice president, Health Policy Institute, American Dental Association, 211 E. Chicago Ave., Chicago, IL 60611, e-mail vujicicm@ada.org. Address correspondence to Dr. Vujicic.

Dr. Gupta is a health services researcher, Health Policy Institute, American Dental Association, Chicago, IL.

Dr. Nasseh is a health economist, Health Policy Institute, American Dental Association, Chicago, IL.

This column represents the opinions of the author and not necessarily those of the American Dental Association.

Disclosure. The authors did not report any disclosures.

To receive Health Policy Institute reports and commentary, follow the ADA Health Policy Institute on Twitter @adahpi.

1. Schencker L. NorthShore, Advocate drop merger plan after judge's ruling. *The Chicago Tribune*. March 7, 2017. Available at: http://www.chicagotribune.com/business/ct-advocate-northshore-merger-decision-0308-biz-20170307-story.html. Accessed November 8, 2017.

2. Sun E, Baker LC. Concentration in orthopedic markets was associated with a 7 percent increase in physician fees for total knee replacements. *Health Aff (Millwood)*. 2015;34(6):916-921.

3. Dafny L, Duggan M, Ramanarayanan S. Paying a premium on your premium? Consolidation in the U.S. health insurance industry. *Am Econ Rev*. 2012; 102(2):1161-1185.

4. Roberts ET, Chernew ME, McWilliams JM. Market share matters: evidence of insurer and provider bargaining over prices. *Health Aff (Millwood)*. 2017;36(1): 141-148.

5. Wall T, Guay AH. Very large dental practices seeing significant growth in market share. Health Policy Institute Research Brief. American Dental Association. August 2015. Available at: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0815_2.pdf?la=en. Accessed November 8, 2017.

6. State of California, Department of Managed Health Care. HMO/Health plan's financial statement search. Available at: http://wpso.dmhc.ca.gov/fe/search/Default.aspx#top. Accessed December 18, 2017.

7. California Department of Insurance. Dental medical loss ratio. Available at: http://www.insurance.ca.gov/01-consumers/110-health/60-resources/Dental-MLR.cfm. Accessed December 18, 2017.

8. Department of Justice, Antitrust Division. Horizontal Merger Guidelines. Available at: https://www.justice.gov/atr/horizontal-merger-guidelines-08192010#5c. Accessed November 8, 2017.

9. Council of Economic Advisors. Benefits of competition and indicators of market power. Issue Brief. May 2016. https://obamawhitehouse.archives.gov/sites/default/files/page/files/20160502_competition_issue_brief_updated_cea.pdf. Accessed November 8, 2017.

10. Delta Dental Litigation Resolution. California Dental Association. Available from: https://www.cda.org/portals/0/pdfs/delta_settlement_summary.pdf. Accessed November 8, 2017.

11. Vujicic M. Why are payment rates to dentists declining in most states? *JADA*. 2016;147(9):755-757.

12. Yarbrough C, Nasseh K, Vujicic M. Key insights on dental insurance decisions following the rollout of the Affordable Care Act. Health Policy Institute Research Brief. American Dental Association. August 2014. Available at: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0814_2.pdf?la=en. Accessed November 8, 2017.

13. The Center for Consumer Information & Insurance Oversight. Medical loss ratio: getting your money's worth on health insurance. CMS.gov. Available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/mlrfinalrule.html. Accessed November 8, 2017.

14. The Center for Consumer Information & Insurance Oversight. 2015 MLR rebates by state. CMS.gov. Available at: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2015_Rebates_by_State.pdf. Accessed November 8, 2017.

15. AB-1962 Dental plans: medical loss ratios: reports (2013-2014). California Legislative Information. Available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB1962. Accessed November 8, 2017.

16. Office of Program Research. 2015 Regular Legislative Session. Washington House of Representatives. May 2015. Available at: http://leg.wa.gov/LIC/Documents/Session/Summary_of_Leg_and_Budgets.pdf. Accessed November 8, 2017.

17. Rhode Island House Bill 5700. LegiScan. Available at: https://legiscan.com/RI/bill/H5700/2015. Accessed November 8, 2017.

18. Bill Status of SB2266. Illinois General Assembly. Available at: http://www.ilga.gov/legislation/BillStatus.asp?DocNum=2266&GAID=13&DocTypeID=SB&SessionID=88&GA=99#actions. Accessed November 8, 2017.

19. Bill S.566. The 190th General Court of the Commonwealth of Massachusetts. Available at: https://malegislature.gov/Bills/189/S566. Accessed November 8, 2017.

20. Bill H.951. 190th General Court of the Commonwealth of Massachusetts. Available at: https://malegislature.gov/Bills/189/H951. Accessed November 8, 2017.

ADA American Dental Association®

211 East Chicago Avenue
Chicago, Illinois 60611

T 312.440.2500
F 312.440.7494
www.ada.org

Assignment of Benefits

(click on state to go to state info in document)

Alabama | Alaska | Arizona | Colorado | Connecticut | Florida | Georgia | Idaho
Illinois | Maine | Mississippi | Missouri | Nevada | New Hampshire
New Jersey | North Dakota | Oklahoma | Rhode Island | South Dakota
Tennessee | Texas | Virginia | West Virginia

Requires Dual Signature: Washington

(23 States)

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

OPPAGA provides performance and accountability information about Florida government in several ways.

- Reports deliver program evaluation and policy analysis to assist the Legislature in overseeing government operations, developing policy choices, and making Florida government better, faster, and cheaper.
- PolicyCasts, short narrated slide presentations, provide bottom-line briefings of findings and recommendations for select reports.
- Government Program Summaries (GPS), an online encyclopedia, www.oppaga.state.fl.us/government, provides descriptive, evaluative, and performance information on more than 200 Florida state government programs.
- The Florida Monitor Weekly, an electronic newsletter, delivers brief announcements of research reports, conferences, and other resources of interest for Florida's policy research and program evaluation community.
- Visit OPPAGA's website at www.oppaga.state.fl.us

OPPAGA supports the Florida Legislature by providing data, evaluative research, and objective analyses that assist legislative budget and policy deliberations. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475). Cover photo by Mark Foley.

OPPAGA website: www.oppaga.state.fl.us

Project supervised by Kara Collins-Gomez (850/487-4257)
Project conducted by Mary Alice Nye and Jeanine Brown
R. Philip Twogood, Coordinator

Debunking the Insurance Industry's False Claims about Assignment of Benefits Laws

Issue Overview

Assignment of Benefits (AoB) laws require insurers to follow a patient's request to pay their dentist directly for services rendered. In states where these laws don't exist, insurers selectively reimburse the patient instead of the dentist, creating confusion, unpredictability and additional hurdles for patients.

AoB Advantage for Patients

AoB laws remove financial and logistical burdens for patients seeking care, empowering them to visit the dentist more regularly and benefit from consistent, transparent billing practices. Without AoB laws:

- Many patients seeing dentists of their choice have to pay for care upfront, and wait to be reimbursed by their insurance company. For low income patients who may not be able to pay that cost, this is an insurmountable burden to oral healthcare.
- Insurance companies create an extra hurdle for patients when they refuse to pay their healthcare provider directly, potentially creating strain and distrust between the patient and their dentist, and further discouraging patients from seeking care.

Insurance companies claim that AoB laws inadvertently increase costs for patients by weakening provider networks and allowing patients to see dentists outside their insurance network. **Independent research shows this is simply false.**

Research Results

A health policy research team at The George Washington University explored data from the National Association of Dental Plans (NADP) to track the number of dentists participating in insurance networks in four states before and after passing AoB laws. These data clearly show AoB laws do not negatively affect dentist participation in insurance networks.

State (Year of AoB passage)	**Tennessee (2009)**	**New Jersey (2012)**	**Mississippi (2013)**	**South Dakota (2017)**
Participating dentists in year of AoB law passage	2,085	6,711	780	558
Participating dentists in 2019	5,395	15,105	2,404	583
Percent change	+159%	+125%	+208%	+4%

Lack of Transparency in Dental Insurance

As part of their research, GWU requested data from numerous dental insurers, but were repeatedly denied. While the insurance industry rigorously opposes the basic measure of consumer protection based on dubious claims, they refuse to provide transparent information that would provide clear answers to the public.

Assignment of Benefits (AOB)

Have you heard of the term **assignment of benefits**? Do you know how it impacts you? An AOB is an agreement that, once signed, transfers the insurance claims rights or benefits of your insurance policy to a third party.

An AOB gives the third party authority to file a claim, make repair decisions and collect insurance payments without your involvement.

Review the resources below to better understand how transferring your insurance claims rights can impact you and your family.

Legislative Updates

Recent legislative changes **prohibit a policyholder from assigning any post-loss benefits of a residential or commercial property insurance contract issued or renewed on or after January 1, 2023.** Therefore, Assignment of Benefit agreements may not be established for claims made under contracts subject to this new law.

These legislative changes are part of Senate Bill 2-A which was passed on December 14, 2022, during the Legislative Special Session and signed by Governor DeSantis on December 16, 2022.

Review Summary

FAQS GLOSSARY EDUCATIONAL MATERIALS

What is an assignment of benefits?

An AOB is an agreement that transfers the insurance claims rights or benefits of the policy to a third party. An AOB gives the third party authority to file a claim, make repair decisions, and collect insurance payments without the involvement of the homeowner. AOBs have been used with life and health insurance policies for many years. However, AOBs are now being commonly used in homeowners' insurance claims by restoration companies and contractors. Signing an AOB can be helpful with navigating the claims process, but if misused, it can lead to harmful consequences for the homeowner.

For example, you have a pipe leak in your home that causes water damage. If you call a restoration company to make repairs and sign an AOB that transfers your insurance rights to the company, the company can file a claim on your behalf and be paid directly.

What information must be included in an assignment of benefits?

The AOB must contain a written, itemized, per-unit cost estimate of the services to be performed by the third-party assignee and it must only relate to the work to be performed for services to protect, repair, restore, or replace a dwelling or structure or to mitigate against further damage to such property.

The AOB must contain a notification in 18-point, uppercase, boldfaced font that advises you that you are giving up certain rights under your insurance policy to a third party. The notification must also include the rescission terms.

The AOB must contain a provision that requires the third-party assignee to indemnify and hold you harmless from all liabilities, damages, losses, and costs (including attorney fees) if the policy prohibits an AOB. The execution of the AOB constitutes a waiver by the third-party assignee and its subcontractors of claims against you for payment arising from the AOB. The third-party assignee and its subcontractors may not collect, or attempt to collect money from you, maintain any action of law against you, file a lien against your property or report you to a credit reporting agency.

The AOB prohibits the third-party assignee from seeking payment from you in any amount in excess of the applicable policy deductible unless you have agreed to have additional work performed at your own expense.

The AOB cannot assign the right to recover attorney fees to the third-party assignee. In a suit related to an assignment agreement for claims arising under a residential or commercial property damage, the right to recover attorney fees stays with the assignor.

Florida law prohibits a third-party assignee from including the following charges/fees in an AOB:

- A penalty or fee for rescission of the AOB during the timeframes outlined in the AOB.
- A check or mortgage processing fee.
- A penalty or fee for cancellation of the AOB.
- An administrative fee.

If you are concerned with the language or terms of the contract, you should seek legal advice prior to signing the AOB. If you have questions as to whether the AOB incorporates the provisions required by Florida law, you may contact the Florida Department of Financial Services Insurance Consumer Helpline at 877-693-5236. If the AOB complies with all requirements stipulated by law, once the AOB has been signed, if the third-party assignee will not agree to release you from the contract, the only recourse is to pursue resolution in a court of law.

What responsibilities does the third-party assignee have under an assignment of benefits?

The assignee must provide a copy of the AOB to your insurance company within 3 business days following its execution, or the date work commenced, whichever is earlier.

The assignee must comply with certain policyholder duties as stipulated by the policy including the responsibility to maintain records of all services provided, cooperate with the insurance company's claim investigation and provide the insurance company with requested records and documents related to the services provided. As a pre-condition to filing suit, the assignee must submit to examinations under oath or recorded statements related to the services provided, the associated cost, and the AOB itself.

Is an assignment of benefits a legal contract? How can I get out of the contract?

Yes. An AOB is a legal contract and it must contain three specific cancellation provisions.

1. The AOB must provide you with an option to rescind the AOB contract within 14 days following its execution by submitting written notice to the third party.
2. The AOB must provide you with the option to rescind the AOB at least 30 days following its execution if the AOB does not contain a commencement date, and the third party has not begun substantial work on the property.
3. The AOB must provide you with the option to rescind the AOB if the third party has not "substantially performed" at least 30 days following the scheduled commencement date.

NOTE: Recent legislative changes **prohibit a policyholder from assigning any post-loss benefits of a residential or commercial property insurance contract issued or renewed on or after January 1, 2023.** Therefore, Assignment of Benefit agreements may not be established for claims made under contracts subject to this new law.

If I have suffered damage to my insured property, what should I do first?

If you have damage, you should take the necessary steps to mitigate the damage and prevent any additional damage from occurring. This would include any temporary repairs such as covering the roof or removing standing water. You should also immediately contact your insurance company to inform them of the damage and file a claim.

Do not allow a third party, such as a water remediation firm or contractor, to contact your insurance company for you. You should be the one to make the first contact with your insurance company. You do not need to sign an AOB in order to get your insurance claim processed or your residence repaired.

How does an assignment of benefits impact me, as a homeowner?

An AOB can be helpful with navigating the claims process, but if misused it can lead to harmful consequences. Below are a few things to keep in mind:

- You are signing over the rights and benefits of your insurance policy to a third party.
- Depending on the language in the AOB, the insurance company may only be permitted to communicate directly with the third party and you may lose all rights to the insurance claim, including the right to mediate the claim, or to make any decisions regarding the claim, including repairs.
- Depending on the language in the AOB, the third party may be able to endorse checks on your behalf.
- Once you have signed an AOB, the third party may file suit against your insurance company.

Tips to remember before and after you have suffered damage:

- Thoroughly review your insurance policy to ensure you understand the policy, including your coverage, deductibles and responsibilities after damage has occurred. You must also verify if your policy prohibits or otherwise restricts an AOB.
- Immediately following a loss, you have a contractual duty to mitigate your damages and make any temporary repairs to prevent further damage from occurring. Document any existing damage with photographs prior to making any repairs. Do not make permanent repairs prior to an inspection by the insurance company adjuster. The company has a right to inspect the damage prior to repair.
- Make sure you thoroughly review and understand any contracts you sign with repair companies, including an AOB. If you do not agree with the provisions of the AOB, you may be able to negotiate the provisions of the contract. You do not need to sign an AOB to get your insurance claim processed or your residence repaired. If you are asked to sign an AOB, make sure you read it carefully and clearly understand what rights and benefits you may be signing away.
- Verify the license (if one is required) of any contractor or vendor that you hire to make repairs to your property. You should also verify the company or person's general liability and workers' compensation insurance coverage.

Below is a checklist that may be helpful when reporting a claim:

- Contact your insurance company directly to report the damage and set up a time for the adjuster to inspect the damages. Do not allow a third party, such as a water remediation firm or contractor, to contact your insurance company for you. You should be the one to make the first contact with your insurance company - as soon as possible.
- Take photos of the damage.
- Make emergency or temporary repairs.
- Make an inventory of any damaged items.
- Save receipts for any repairs.
- Do not discard any damaged items without prior approval from the insurance company.
- Make a list of any questions you would like to ask the insurance adjuster.
- Request a copy of the fire or police report, if applicable.

Get Insurance Help
Purchasing Insurance
Understanding Insurance
Mediation/Neutral Evaluation
Disaster Preparedness
Insurance FAQS
Holocaust Victims Assistance
Civil Remedy/Litigation Notices
Consumer Protections
Consumer Guides
Financial Literacy
Medical Providers
Company Search
Licensee Search
Career Opportunities
Sign up for Consumer Alerts
Contact Us
Get Lean

FLORIDA DEPARTMENT OF FINANCIAL SERVICES

Our department manages the financial responsibilities for the State of Florida.

200 East Gaines Street, Tallahassee, FL 32399

Send Us a Message: ASK FLDFS

MOST POPULAR

- Fraud Free Florida
- Prepare Florida
- Unclaimed Property
- Consumer Helpline
- Press Releases
- Public Records Request

EMPLOYEE RESOURCES

- Search Career Opportunities
- Employees' Information Center
- Florida Deferred Compensation
- Employee Emergency Notifications

Long-Range Program Plan | Rulemaking Regulatory Plans | Legal Notices/Accessibility | Privacy Policy

Removing Financial and Administrative Burdens on Patients Through Assignment of Benefits Laws

In states where these laws don't exist, insurers often pay the patient instead of the dentist, creating confusion and additional hurdles for patients to jump over.

Patient Concerns

When a patient who's seeing their out-of-network dentist wants the insurance payment for covered services to go directly to the dentist, known as "assignment of benefits," insurers can refuse to directly issue payment in many states. Not allowing assignment of benefits has two negative effects for patients:

- The patient may have to pay at the time of dental service and await reimbursement from their insurer, creating financial hardship for some.
- The dentist will have to contact the patient for payment after services have been rendered, which is often confusing to patients who expect their insurers to pay providers directly.

Solution

Assignment of Benefits (AoB) laws require insurers to follow a patient's request to pay their dentist directly for services rendered.

The North Dakota Dental Association is advocating for Assignment of Benefits laws that will allow patients to choose to have payment sent directly to their provider. Insurance companies pay providers no more than they would if they paid the patient directly – and often save money if they aren't required to issue a paper check.

What Are the Benefits of Assignment of Benefits Laws?

- Puts patients in control of their benefits while ensuring that the insurance benefit is used for its intended purpose.
- Alleviates financial and administrative burdens from patients by allowing payment to be sent directly to the dental office, instead of having the patient pay upfront for services and then await reimbursement from the insurance company.
- Allows, but does not require, patients the option to assign their dental benefit directly to the dentist.
- Reduces cost of care associated with collecting debts and managing losses from non-payments for dentists billing patients.
- Insurance companies pay no more than they would if they pay the patient directly – and often save money if they aren't required to issue a paper check.

Assignment of Benefits Laws in North Dakota

Currently in Place

Current law NDCC §26.1-36-12 applies only to medical and not dental.

Proposed

SB 2135

North Dakota DENTAL ASSOCIATION

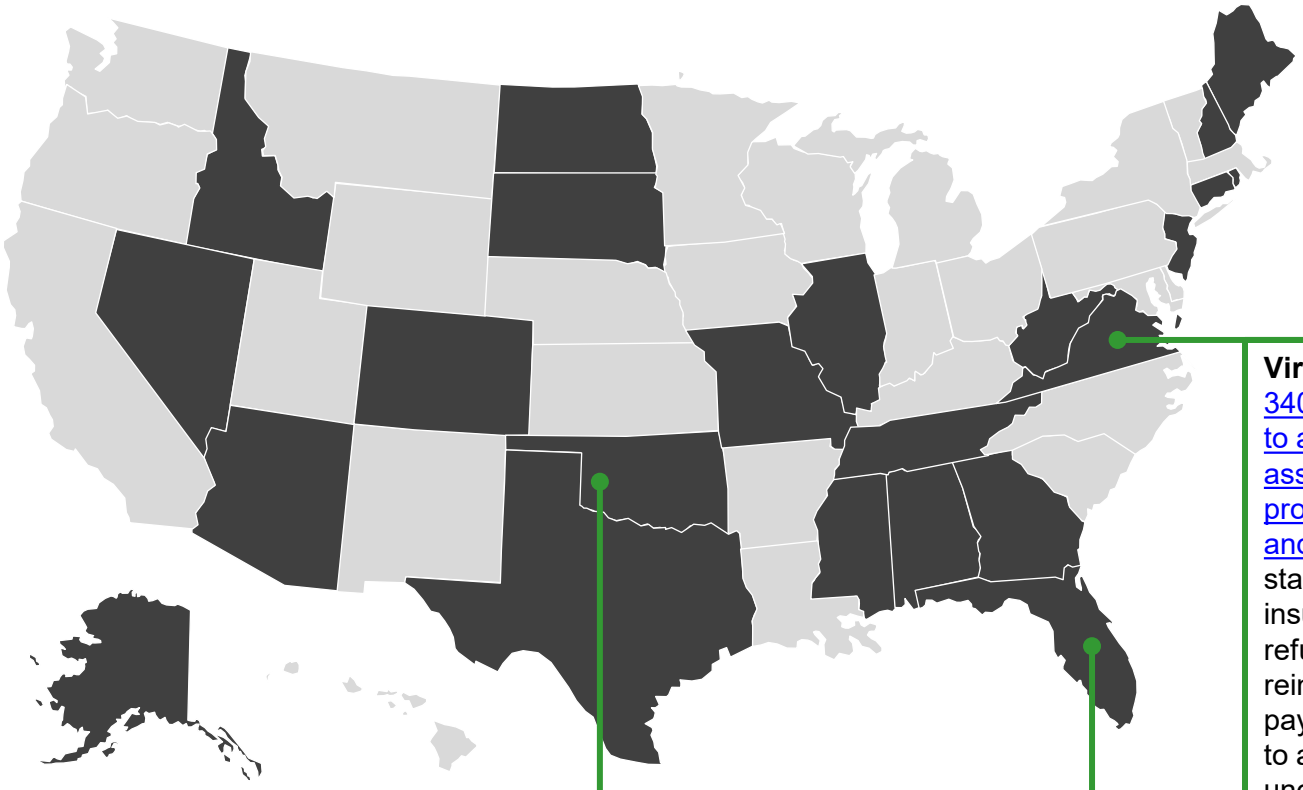
National, Bipartisan Momentum for Assignment of Benefits Legislation

"*Already passed in several states, "assignment of benefits" laws would empower patients to choose whether they want insurance companies to directly pay dental clinics, freeing patients from having to pay upfront and negotiate with insurance companies for reimbursement.*"

- Consumer Choice Center, Policy Note: Dental Insurance Reform

PASSED IN

23 states



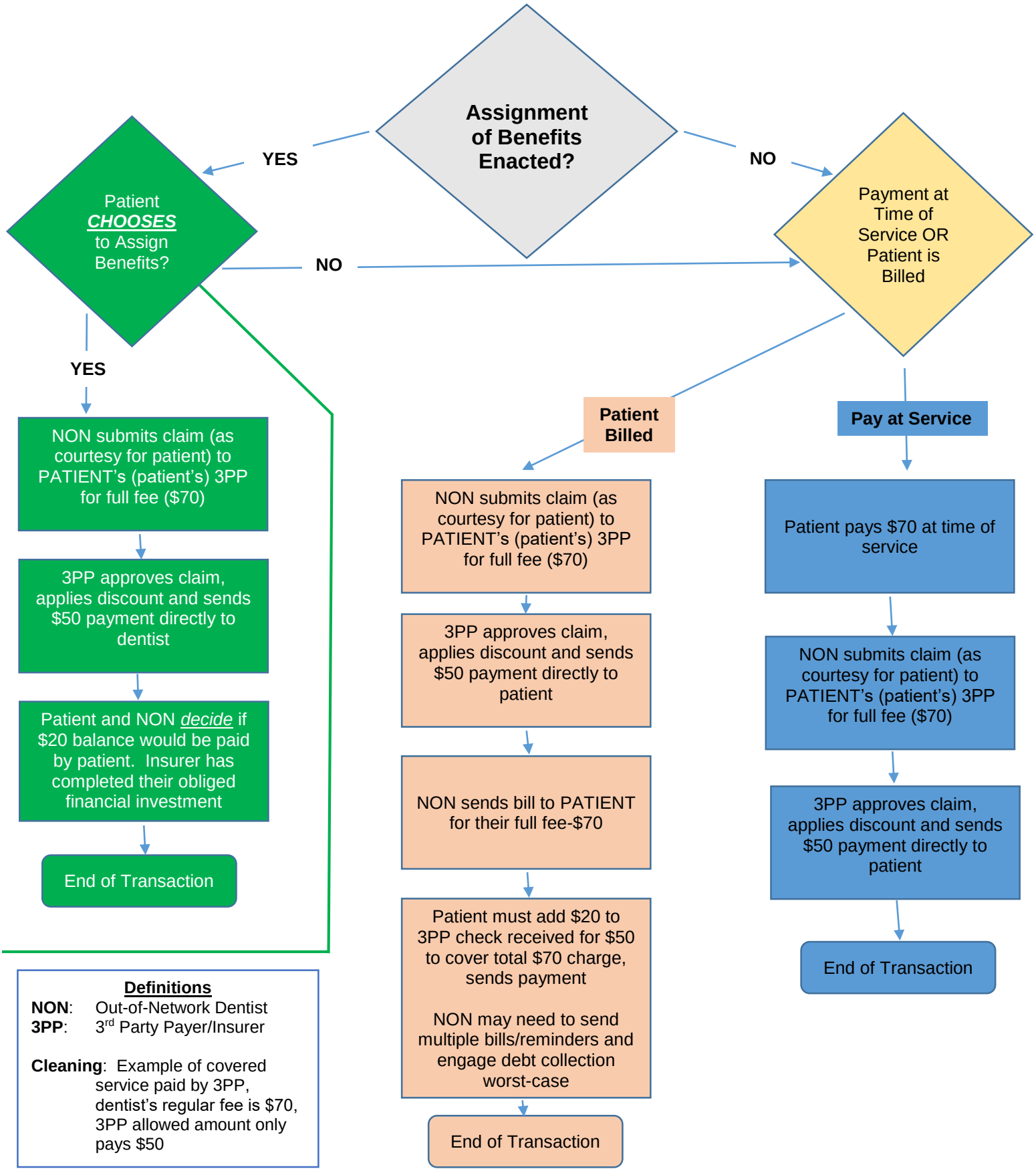
Virginia's § 38.2-3407.13. Refusal to accept assignments prohibited; dentists and oral surgeons states that no insurer or plan may refuse to make reimbursement payments directly to a dental provider under an assignment of benefits.

Oklahoma's Health Care Freedom of Choice Act requires that a practitioner be directly compensated by insurers for services and procedures, allowing patients to effectively assign their benefits.

Florida's 627.638 Direct payment for hospital, medical services requires that insurers directly make payments to providers. Furthermore, insurance contracts may not prohibit the direct payment of providers.

To learn more about assignment of benefits legislation in ND, please contact the North Dakota Dental Association at 701-223-8870 or info@smilenorthdakota.com.

Enrolled Patient Chooses Non-Participating Dentist



Definitions

NON: Out-of-Network Dentist
3PP: 3rd Party Payer/Insurer

Cleaning: Example of covered service paid by 3PP, dentist's regular fee is $70, 3PP allowed amount only pays $50

* Patient Chooses AoB-Pays Nothing
* NON is paid directly ($50)
* 3PP paid $50
* Balance Billing = Dr./Patient Rel.

* Pnt awaits $50 Insurance check
* Pnt must add $20 OOP; pays Dr.
* NON is paid regular fee $70
* 3PP paid $50

* Pnt paid dentist full fee of $70 ($50 Insurance fee + $20 out-of-pocket)
* NON is paid regular fee $70
* 3PP paid $50

NDCC §26.1-36-12

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.**

Dental Transparency Legislation

1. Medical/Dental Loss Ratio (MLR)

MLR laws require insurers to report the percentage of premium revenue that is spent on actual care, as compared to administrative costs. Some proposals may require rebates if plans under-spend on dental care.

2. Explanation of Benefit-Required Format

Commissioner approves explanation of benefits forms, definitions and terms. Sets minimum standards for the format, terms, and definitions for explanation of benefits forms. Commissioner must approve explanation of benefits forms and the standard definitions or terms used on forms to prevent confusing, inconsistent, or misleading information.

3. All Payer Claims Database

Requires insurers and to an extent health care providers to submit certain claims data to the state for collection and reporting purposes.

4. Uniform Benefits and Coverage Disclosure Matrix

Requires carriers to utilize a uniform benefits and coverage disclosure matrix to offer patients a consistent format for determining plans' designs. The matrix could include: deductible, benefit limit, coverage info for basic-preventive-diagnostic-major & orthodontia services, dental plan reimbursement levels/estimated enrollee cost share for services, waiting periods, examples to illustrate coverage and estimated enrollee costs of commonly used benefits.

5. Insurance Identification Card – ERISA Notification

Front desk personnel who see the insurance cards never know if a patient's plan must adhere to state laws such as non-covered services or assignment of benefits regulations. Some laws require notification on insurance cards indicating "fully insured" which clarify that state laws apply to this transaction.

6. Independent Claims Review

Provides a requirement that dental plans include a method for independent claims review for patients wishing to have denied claims reviewed after the plan has exhausted internal reviews.

7. Coordination of Benefits (CoB)

When two dental plans cover the same procedure, laws typically determine how to identify primary and secondary plans (who pays first and second). Significant provisions of CoB laws are those that require the secondary plan to pay a benefit and/or prohibit secondary plans from refusing to pay a benefit.

8. Downcoding Limitations

Prohibition/limitations on dental plans using procedure codes different from the one submitted by the dentist in order to determine a benefit in an amount less than that which would be allowed for the submitted code.

9. Notification of Contract Changes

Insurers' contracts with dentists may include a provision that changes may occur without notice. Some changes can be substantive. These laws require plans to provide early notice of planned substantive contract changes well in advance. Legislative approaches may include opt-in or opt-out options for dentists when contract changes are proposed.

10. Equal Payment

Requires dental plans to pay the same benefit for a covered individual whether the rendering dentist is participating or non-participating in the dental plan

11. Disallow Clause Prohibition

This law would prohibit any contract provision that prevents a dentist from charging a covered person for a covered procedure not paid for by the benefit plan. The law would prohibit contract provisions saying no payment will be made for a covered service by the dental plan AND the participating dentist may not collect payment from the covered person for the covered service disallowed by the dental plan

12. Credentialing Improvements

Requires a health care entity or health plan to issue a decision regarding the credentialing of a health care provider within XX calendar days of receiving a complete credentialing application.

13. Fee Reduction Regulation

Insurers would be prohibited from reducing reimbursement paid to health care providers by more than XX% for more than a certain number of consecutive years, and prohibits further reductions without approval of state authority.

14. Provider Rating Systems

Some benefit plans may use a rating systems such as stars to rate dentists based on costs/charges. To help ensure proper profiling of dentists, health care entities may be required to employ rating designations that are fair and accurate based on reliable, diverse and approved data collection methods; these rating entities would have to provide dentists the right to challenge and correct erroneous designations, data, and methodologies.

15. All-Product Clauses - Providers' Right to Choose Act

Would prohibit health insurers from requiring a health care provider to participate in all health plans offered by the health insurer, or to participate in all the insurer's provider network arrangements. It prohibits the health insurer from terminating any contractual relationship with a health care provider for not agreeing to participate in a provider network arrangement.

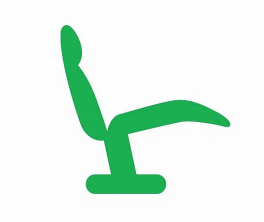
Join Us

Why Join the Delta Dental PPO℠ Network?

National Exposure

- Delta Dental is the largest and most experienced dental carrier in the nation
- Delta Dental member companies serve more than one-third of Americans with dental insurance, providing dental coverage to more than 83 million people in more than 153,000 groups nationwide.

Patient Access



- People with dental insurance visit the dentist nearly twice as often as those without[1]
- More Americans seek care from in-network dentists
- Delta Dental focuses on getting patients into the dental office on a regular basis
- Our dental benefits actively encourage patients to seek care

Easy Administration

- Quick, accurate claims processing
- Online and phone features to provide immediate access to patient eligibility, claims status and more
- Professional Relations staff ready to serve you and your office

Guaranteed Payment

- You are guaranteed to receive payment for services based on the agreed upon fees, regardless of which Delta Dental member company administers a patient's dental program

Value-Added Benefits

As a network dentist, you will receive access to value-added benefits:

- Oral health materials
- Discounts on supplies and services
- State training programs:
    - CPR certification
    - Access to continuing education (CE) events (past events include special needs dentistry, Dentist By 1 seminars and clinic based training seminars)

Shared Mission

Nationwide, Delta Dental member companies donate and support programs that:

- Prevent dental disease
- Expand access to care
- Advance dental science
- Educate the connections between oral and overall health

In Illinois, our Foundation improves the oral health of Illinois children and families through educational programs and support of organizations that provide access to care.

ANTHEM DENTAL PROVIDER SAVINGS PROGRAM

Exclusive Savings on Costly, In-Demand Materials & Services

Discounts of up to 40% are available to Anthem network providers through our Provider Savings Program

We understand the unique challenges of running a dental office, and want to thank you for serving Anthem Blue Cross and Blue Shield members. We appreciate everything you and your staff do to provide outstanding dental care to all your patients. That's why we are pleased to announce Anthem's Provider Savings Program.

Anthem's Provider Savings Program offers network providers savings on some of the most costly and in-demand dental materials and services—including implants, orthodontic aligners, scanning equipment, antiseptics, personal protection equipment (PPE), dentures, and turnkey software platforms to support growing demand for at-home patient care through teledentistry.

Anthem's Provider Savings Program Partner Discounts

AvaDent, a market leader for digitally designed implant-supported prostheses, is now offering discounts of up to 40% to Anthem network providers. AvaDent's patented XCL bio-hygienic, monolithic, fracture and bacteria-resistant dentures enhance performance, fit, and comfort for your patients. Discounts for Anthem network providers include AvaDent dentures and denture products like:

- Dentures
- Implant-supported dentures
- Overdentures

For more information about AvaDent's special savings for Anthem providers, please visit **http://www.avadent.com/anthem1225/**

Anthem

Align Technology, Inc. is offering Anthem network providers the opportunity to experience the benefits of going digital with their iTero Element® family of intraoral scanners, designed to help grow your practice while making workflows easier. Enjoy special pricing of 20% or more discounts on the following iTero family of scanners:

- The iTero Element 5D Plus Series imaging system is the latest generation. It's a powerhouse of capabilities designed to improve the practice and patient experience with state-of-the-art computing power, elegant design, and ergonomics.
- The iTero Element 5D imaging system is the powerful hybrid platform that optimizes your workflows by simultaneously recording 3D images, intraoral color, and near-infrared imaging (NIRI) that aids in the detection and monitoring of interproximal caries above the gingiva, without using harmful radiation.*
- The iTero Element 2 intraoral scanner is designed to work with the trusted iTero digital platform, transforming your restorative and orthodontic workflows.

For more information about exclusive discounts for Anthem providers, visit **https://cloud.info.itero.com/iTero-Anthem**

*Data on file at Align Technology, as of December 4, 2018

Park Dental, an innovative leader in lab and manufacturing services with over 50 years of experience, is offering Anthem network providers discounts of up to 20% on products, materials and equipment as well as clear orthodontic aligners. Discounts for Anthem network providers include:

- Clear aligners
- Mini, conventional and narrow ridge implants
- Guided Tissue Regeneration (GTR)/Guided Bone Regeneration (GBR) products

For additional details about exclusive Park Dental discounts for Anthem network providers, please visit:
https://www.parkdentalresearch.com/welcome-Anthem-overview.html

---

The TeleDentists, the nation's largest virtual dental service, is offering savings on end-to-end, HIPAA-compliant teledentistry solutions. Your office has access to advanced virtual care technology so you can deliver consultations, diagnosis, follow-up care and e-scripts for antibiotic and/or any necessary non-narcotic pain medications, via a patient's laptop, tablet, or smartphone. The TeleDentists' special savings for Anthem network providers includes:

- Savings of $10 per month on hosting fees
- Program includes a media kit with a press release, social media templates, patient newsletter notifications, and keywords to increase traffic to your website

For more information about special savings from The TeleDentists for Anthem providers, please visit
https://www.theteledentists.com/myanthemtd

To find discounts available to you, log into **www.Anthem.com/provider/dental**, where you'll find the link for Anthem's Provider Savings Program.

Anthem

*** Note:** All discounts are subject to change without notice. Please click on links provided for additional details on ways you can save.

Aetna Dental® PPO network

aetna®

43.02.800.1 G (12/18)

joinaetnadentalnetwork.com

All the benefits you deserve — and more

We invite you to join the Aetna Dental preferred provider organization (PPO)* network, one of the largest dental PPO networks, with millions of members nationwide.

From our competitive fee schedule to prompt payments and benefits to enhance your practice, there are so many ways to brighten your smile. Be part of a well-established network of dentists when you join today.

More ways to expand your practice

As a participant, your practice will automatically be listed in our handy provider search tool, as well as in other Aetna Dental PPO network directories. You can even add a link to your website in our provider search tool. It all adds up to more exposure to new patients for your practice.

We're always here to help

Personalized, one-on-one service is what you'll find when you're part of our network. Have a question? Need help with a claim or form? Simply call our dedicated dentist hotline to speak with an experienced Aetna Dental agent. We're here when you need us and always looking for ways to improve.

Submit claims your way

Online or by paper? You choose what works best. Submit claims at **aetnadental.com** or use the standard Aetna® or American Dental Association approved dental claims form. Just another way we're working to make the claims process simple and easy for you.

Payments made your way

No one likes waiting to get paid on their claim. That's why the Aetna Dental PPO network turns your payment around the moment your claim is processed. To date, close to 98 percent of our dental claims were processed within 15 days. Plus, our track record for financially accurate claims paid is over 99 percent.[1] That means less time chasing down payments. And more time focusing on patients.

Get paid even faster when you enroll for electronic funds transfer (EFT). With EFT, your payment is deposited directly into the account of your choice. It's really that simple. Get our EFT enrollment form at **joinaetnadentalnetwork.com**.

All the tools you need

Check claims status, access Explanation of Benefits (EOB) statements, get real-time eligibility and benefits data, and more — anytime, anywhere. With our tools, you can access the up-to-date information you need 24/7 at **aetnadental.com**. Or by calling our self-service Aetna Voice Advantage® system at **1-800-451-7715 (TTY: 711)**.

Exclusive discounts on products and services

Save thousands of dollars on everyday products and services. As part of our dental PPO network, you have access to our Value Plus℠ program** for discounts on dental supplies, laboratory services and more. Even better, participating in the Value Plus program comes at no cost to you.

Healthy outcomes start with oral health

Research shows that oral health is connected to overall health, with almost 90 percent of systemic diseases originating in the mouth.[2] That makes you key in helping to prevent, detect and treat potential conditions.

We're doing our part, too. Using integrated medical and dental data, we identify disease patterns and share our findings with members and doctors. While also educating and reminding members about the importance of regular dental care for their overall health. Together, we can achieve healthier outcomes one checkup at a time.

*In Texas, the dental PPO is known as the Participating Dental Network (PDN).

**Aetna's provision of access to the discounts included in the Value Plus program does not constitute medical advice; an endorsement of any vendor, product, drug, pharmaceutical or service offered as part of the program; nor is it a guarantee of any outcomes or medical/dental results. All vendors are independent contractors and are not employees or agents of Aetna or participating providers with Aetna.

[1]Aetna Dental Dialog. Spring 2018. Available at: aetnadental.com/professionals/pdf/dental-dialog.pdf. Accessed November 2018.

[2]Academy of General Dentistry. Importance of oral health to overall health. Available at: knowyourteeth.com/infobites/abc/article/?abc=O&iid=320&aid=1289. Accessed November 2018.

We're here to answer your questions

Find answers to commonly asked questions. For all other requests, call **1-800-451-7715 (TTY: 711)**.

What is the fee schedule of maximum allowable charges?

By joining, you accept our schedule of maximum allowable charges as payment in full when treating members. The fee schedule lists the total amount you will receive, which includes payments from us and applicable member payments.

How will I know if a patient is eligible for Aetna Dental PPO benefits?

We ask that PPO patients identify themselves when making appointments and upon arrival. You can also verify eligibility using our National Dentist Line at **1-800-451-7715 (TTY: 711)**, or at **aetnadental.com**.

Can I bill the patient?

Coinsurance and/or deductibles can be billed to patients and should be discussed before starting treatment.

Can you tell me more about the Aetna Dental Access® program?

This program provides discounts through dental programs like the Aetna® Vital Savings discount program. Enrolled patients simply show their ID card and pay the same rate listed on your PPO fee schedule. No forms, no claims and no waiting periods.

Can you tell me more about the Aetna Dental® Administrators program?

Using our network of extended relationships with third-party administrators and payers, this program can help you bring in more patients. Like any standard PPO plan, services you provide to Aetna Dental Administrators patients are paid according to your PPO fee schedule.

Participation has its benefits

- Competitive fee-for-service arrangement
- Listing in provider search tool
- Dedicated dentist hotline
- Electronic claims submissions
- Direct deposit and prompt payments
- Real-time eligibility data
- Discounts with Value Plus program, and more

Apply at **joinaetnadentalnetwork.com**.

Ready to join our dental PPO network?

Complete your online application at **joinaetnadentalnetwork.com**, or call our contracting hotline. Be sure to provide copies of all requested licenses and certifications. If accepted, you'll receive a notification and next steps.

Questions? Call our Dentist Contracting Hotline at **1-800-776-0537 (TTY: 711)** from **8 a.m. – 6 p.m. PT, Monday – Friday**.

aetna®

joinaetnadentalnetwork.com

43.02.800.1 G (12/18)

Solstice Provider Blog

Three Advantages of Becoming a Contracted Dental Provider

Posted by Deborah Pinnock on Dec 28, 2016 10:28:57 AM

Opening your own dental practice is one of the hardest things you've ever done. Whether you took over an existing practice or you started from scratch, taking this leap took determinatio n, grit, faith

and a tenacity to succeed. And it requires that, because opening and maintaining a successful business is downright hard. Per the SBA Office of Advocacy, only 50 percent of businesses that are opened survive beyond five years. And after 10 years, the survival rate drops to one-third. But chances are, you already knew this before you started, and the fact that you opened your practice anyway is likely proof that you have what it takes to succeed.

So, what does it take to succeed? Well, you already have the knowledge gained from years of study, your experience from working in various dental practices and an entrepreneurial spirit. However, the way to beat the odds and have a thriving dental practice that stands the test of time is patients. That's where joining a dental insurance network comes in. Three advantages of becoming a contracted dental provider are: patient base growth, steady income source and free marketing.

Want to reach more patients with social media? Download our free 5 step guide.

Advantage #1: Patient Base Growth

It's going to be great once you become an established office with name recognition and a solid patient base, which you got through your hard work and through satisfied patients referring others to you. But what happens in between now and then? You still have bills to pay and you need patients to do it. Joining a dental network gives you access to hundreds, even thousands of patients who are encouraged to visit contracted dental providers. And members want to visit network dentists or specialists because they save money when they do so. Plus, future growth is highly likely with new members purchasing dental insurance every year.

Advantage #2: A Steady Income Source

What a beautiful phrase in the ears of any small business owner. A steady income. Your fixed costs for maintaining an office are as sure as taxes. You also have a staff that expects to be paid in a timely manner. So, a steady income is imperative to your practice's survival. Joining a network can provide that. Patients with various types of dental plans, all with varying compensation models, will be visiting your office. For example, some patients will have a traditional DHMO plan or a unique, hybrid DHMO plan. The latter is unique in that it has an open access network, which allows patients to see any network dentist instead of being assigned to only one; it also compensates providers on a fee for service basis. DPPO plans, which allow in- and out-of-network benefits, also compensate providers on a fee for service basis. Additionally, there are discount plans, which can also be an income source as well.

Advantage #3: Free Marketing

You went to school to become a dentist or specialist but as a small business owner, you have had to wear many hats. One of those hats is that of a marketing manager as you try to get the word out there about your office in an effort to get more patients in the door. As a contracted provider, you score some free business marketing with dental insurance carriers. Dental insurance companies include your office information in their dental directories. Additionally, they market your office on their member portals and websites, as well as in open enrollment meetings, making it easy for patients to find you.

Aaron D. Johnson DMD
Smile Center

March 28, 2023

Testimony in support of SB 2135:

Chairman Louser & Member of the House Industry, Business & Labor Committee,

Thank you for giving me the opportunity to testify on SB 2135. I am a dentist and have practiced in Bismarck for almost 20 years. This bill will allow patients the freedom to assign insurance payments directly to the dental office that did the dental work for them.

Dental offices have special staff members or even specialized consultants that work to get coverage for patients. When insurance companies are allowed to send payments directly to patients instead of the dental office, that puts the burden of getting coverage directly on the patients themselves and most people don't have the time or knowledge to take on that responsibility. It winds up that insurance companies not wanting to live up to the obligation they have to their subscribers.

When insurance companies are not required to assign benefits, this gets in the way of patient choice. Patients are forced to go to preferred providers for that insurance. Preventing them from going to the dentist that would serve them best or that they feel more comfortable with.

There are also issues with non-custodial parents that we have run into in my practice. We had a child that was a patient, and the child was covered under the non-custodial parent's insurance. The insurance payment was sent to the non-custodial parent, sticking the custodial parent with the bill. A very unfair situation.

In conclusion, this bill would allow dentists to better serve their patients by handing off negotiations with insurance companies to the dental office. Giving patients more choice and not allowing insurance companies to shirk their responsibilities.

I urge you to vote yes on SB 2135.

Thank you,

Dr. Aaron Johnson

THE CASE FOR STATE MANDATORY ASSIGNMENT OF BENEFITS LEGISLATION

Elliott McKinnis*

---

* J.D., 2010, Indiana University School of Law—Indianapolis; B.A., 2002, Ball State University.

I. INTRODUCTION

After visiting a non-network urologist, a Virginia woman's insurer sent her a check to cover a portion of the expenses incurred. Around the same time she received the check, her son's college tuition also came due. The woman used the money from her health insurance check to pay the university. She still owed her urologist, however, and when the urologist tried to collect from her sometime later, he was unable to do so because she had declared bankruptcy.[1] This story is not unique. In fact, some doctors say it occurs often enough that it threatens their ability to provide health care services.[2] A potential solution is to require insurance companies to honor an individual's wish to send payments directly to her provider, even if the provider is not in the insurer's network. In other words, an individual should have the power to assign her benefits to an out-of-network provider.

Some states have passed mandatory assignment of benefits ("AOB") legislation.[3] A mandatory AOB law requires insurers to send payments directly to out-of-network providers who have executed an AOB agreement with the covered individual. Proponents of mandatory AOB legislation suggest there are other important advantages to AOB beyond making it eas-

---

1. Tammie Smith, *Va. Doctors Make Their Case They Are Lobbying Legislators For Changes in How Benefits, Reimbursements Are Handled*, RICHMOND TIMES DISPATCH, Jan. 24, 2005, at A1.

2. *See, e.g.*, *id*, Smith *supra* note 1.

3. *See* ALA. CODE § 27-1-19 (2010); ALASKA STAT. § 21.51.120 (2010); CAL. HEALTH & SAFETY CODE § 1371.4 (Deering 2010); COLO. REV. STAT. § 10-16-317.5 (2010); CONN. GEN. STAT. 38A-472 (2010); FLA. STAT. § 627.638 (2009); GA. CODE ANN. § 33-24-54 (2010); IDAHO CODE ANN. § 34-3417(3) (2010); 215 ILL. COMP. STAT. ANN. 5/370a (LexisNexis 2010); LA. REV. STAT. ANN. § 40:2010 (2010); ME. REV. STAT. ANN. tit. 24, § 2332-H (2010); MO. REV. STAT. § 376.427 (2010); NEV. REV. STAT. ANN. § 689A.135 (LexisNexis 2010); N.H. REV. STAT. ANN. § 420-B:8-n (LexisNexis 2010); N.C. GEN. STAT. § 58-3-225 (2010); OHIO REV. CODE ANN. § 3901.386 (LexisNexis 2008); R.I. GEN. LAWS § 27-18-63 (2010); S.D. CODIFIED LAWS § 58-17-61 (2010); TENN. CODE ANN. § 56-7-120 (2010); TEX. INS. CODE ANN. § 1204.053 (West 2009); VA. CODE ANN. § 38.2-3407.13 (2010); WYO. STAT. ANN. § 26-15-136 (2010); *see also* OR. REV. STAT. § 743-531 (2009) (allowing but not requiring insurers to honor AOB); WASH. REV. CODE § 48.44.026 (West 2010) (generally requiring the signature of the out-of-network provider in order to deposit a check from an insurer).

ier for health care providers to collect payments.[4] However, critics contend that mandatory AOB would have negative effects on the health care system.[5] Section II of this note presents background information on the history of the AOB issue. Section III examines the arguments in favor of mandatory AOB legislation, and Section IV explores the arguments against mandatory AOB. Finally, Section V explains why the arguments in favor of mandatory AOB prevail and how Indiana should structure mandatory AOB legislation.

II. BACKGROUND: HISTORY OF HEALTH CARE PLANS AND AOB

A brief history of the development of the health care industry provides a helpful basis on which to analyze the AOB issue. The most basic reason for the existence of health insurance plans is that people want to share the risk of financial loss due to illness or injury.[6] A health insurance plan generally includes four parties: consumers, providers, sponsors, and intermediaries.[7] Consumers, often referred to as "insureds," "patients" and "subscribers," are those who receive care from providers.[8] Sponsors include employers who offer a group health benefit plan to their employees and pay a majority of the plan's expenses.[9] In the case of Medicare and Medicaid, the government plays the role of sponsor.[10] Intermediaries provide an administrative framework, which includes the bill paying process (i.e., payers, insurers, health plans, etc.).[11]

A. Managed Care and the Alphabet Soup

Many health plans today fall under the label of "managed care."[12] Definitions of managed care vary.[13] However, a common definition describes it as a system that attempts to control health care cost, access, and

---

4. *See, e.g.*, Steven R. West, Fla. Med. Ass'n President, Op-Ed., *More Choices, Access Needed for Patients*, SUN SENTINEL (Fort Lauderdale), June 4, 2009, at 12A.

5. *See, e.g.*, Catherine Dolinski, *Gaetz Says Health Bill Is Good for Workers*, TAMPA TRIBUNE, May 22, 2009, at 10.

6. PETER R. KONGSTVEDT, MANAGED CARE: WHAT IT IS AND HOW IT WORKS 21 (3rd ed. 2009); Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL. POL'Y & L. 75, 81 (1993).

7. Weiner & de Lissovoy, *supra* note 6, at 80-81.

8. *Id.*

9. *Id.* at 80.

10. *Id.* at 80-81.

11. *Id.* at 81.

12. *See generally* KONGSTVEDT, *supra* note 6, at 17-53 (describes the types of managed care plans in existence today); WILLIAM N. TINDALL ET AL., A GUIDE TO MANAGED CARE MED. 8-14 (2000) (describes the types of managed care plans in existence today).

13. KONGSTVEDT, *supra* note 6, at 230.

quality.[14] Defining the separate classes of managed care health plans is also a difficult task.[15] Some analysts describe the health care system as an "unintelligible alphabet soup of three-letter health plans."[16] Examples of the three-letter health plans include health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), and point-of-service plans ("POSs").[17]

At one time, the individual models included unique features that distinguished them from each other.[18] HMOs, in their purest form, involve prepaid arrangements where the payer offers subscribers health care services in exchange for a monthly fee.[19] HMO models attempt to control health utilization and quality more than other plans.[20] HMOs are designed to include a primary care physician who operates as a gatekeeper by overseeing the patient's care and providing referrals to specialists.[21] Except under limited circumstances, a subscriber is responsible for the total health care costs when visiting a provider outside of the HMO.[22]

The PPO design involves less control of health care cost and quality than HMO plans, but generally gives the patient more freedom in choosing providers.[23] PPOs contain a network of physicians who bill for each service at a discounted rate.[24] A subscriber may have a deductible, which is a fixed out-of–pocket amount the consumer is required to pay before the health plan will cover any fees.[25] After the deductible is met, the subscriber then may pay a coinsurance amount, which is a small percentage of each service he receives.[26]

Some providers, specialists in particular, are often outside of PPO networks.[27] If the patient wants to use an out-of-network provider, the health plan will reimburse the subscriber, usually at a rate that is reduced by a difference of twenty percent.[28] For example, if a health plan pays eighty

---

14. *See id.*
15. *Id.* at 17.
16. Weiner & de Lissovoy, *supra* note 6, at 75.
17. *See generally* KONGSTVEDT, *supra* note 6, at 17-53; TINDALL ET AL., *supra* note 12, at 8-14; Carol K. Lucas & Michelle A. Williams, *The Rights of Nonparticipating Providers in a Managed Care World: Navigating the Minefields of Balance Billing and Reasonable and Customary Payments*, 3 J. HEALTH & LIFE SCI. L. 132, 135 (2009).
18. *See* KONGSTVEDT, *supra* note 6, at 17-18.
19. *Id.* at 226.
20. *Id* at 32.
21. Lucas & Williams, *supra* note 17, at 135.
22. KONGSTVEDT, *supra* note 6, at 32.
23. *See id.* at 30-31; *see also* Lucas & Williams, *supra* note 17, at 135.
24. KONGSTVEDT, *supra* note 6, at 30-31.
25. *Id.*
26. *Id.* at 30-31, 213.
27. MANDATED HEALTH BENEFIT TASK FORCE, REPORT OF THE MANDATED BENEFIT TASK FORCE 5 (2008), *available at* http://www.in.gov/legislative/igareports/agency/ reports/IDOI37.pdf.
28. KONGSTVEDT, *supra* note 6, at 31.

percent of the cost of a certain service offered by an in-network provider, the plan would pay sixty percent for that same service when offered by an out-of-network provider.[29]

A POS plan is a hybrid of plans similar to HMOs and PPOs.[30] POS plans operate similar to HMOs when the consumer follows HMO procedures.[31] When the subscriber wants to use an out-of-network provider, the POS operates more like a PPO.[32]

B. The Development of Managed Care Plans

Researchers assert that managed care originated in 1910, when a group of providers in Washington began offering a broad range of services to Tacoma lumber mill workers for a monthly premium of $0.50 per member.[33] This concept evolved during the Great Depression when physician groups and hospitals established health plans to maintain or increase patient revenue.[34] By World War II, employers began creating HMOs as a benefit for employees and other consumers demanding greater access to less expensive health care.[35]

In the 1960s, the cost of health care skyrocketed.[36] In an effort to support the development of more private sector health plans, Congress passed the HMO Assistance Act of 1973.[37] Meanwhile, in the 1970s the health care system saw the creation of PPOs.[38] Despite this growth in managed care, by 1980 approximately ninety percent of employed Americans received health coverage from indemnity insurance.[39] However, in the 1980s traditional indemnity plans began to decline, while the prevalence of HMOs and other managed care entities grew.[40] By 1990, indemnity plans covered

---

29. *See generally* Peter R. Kongstvedt, *Compensation of Primary Care Physicians in Managed Health Care, in* THE MANAGED HEALTH CARE HANDBOOK 132 (Peter R. Kongstvedt ed., 4th ed. 2001) (describing out-of-network fees).

30. KONGSTVEDT, *supra* note 6, at 31-32; *see also* Lucas & Williams, *supra* note 17, at 135.

31. KONGSTVEDT, *supra* note 6, at 31-32.

32. *Id.* at 31.

33. *Id.* at 1; *see also* TINDALL ET AL., *supra* note 12, at 4-6 (describing the evolution of managed care).

34. KONGSTVEDT, *supra* note 6, at 2.

35. *Id.* at 2-3.

36. TINDALL ET AL., *supra* note 12, at 5.

37. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified as amended at 42 U.S.C. §§ 300e – 300e-17 (2010)); *see also* KONGSTVEDT, *supra* note 6, at 2; TINDALL ET AL., *supra* note 12, at 5.

38. KONGSTVEDT, *supra* note 6, at 6.

39. Weiner & de Lissovoy, *supra* note 6, at 76. *See generally* KONGSTVEDT, *supra* note 6, at 29 (noting that indemnity plans traditionally did not include networks and made little or no attempt to control health care costs).

40. KONGSTVEDT, *supra* note 6, at 9 (stating that "[i]n the mid-1980s, HMOs grew fastest, but by the early 1990s, PPOs began to grow even faster"); *see also* Weiner & de Lissovoy, *supra* note 6, at 77 ("By the end of the 1980s traditional insurance plans and estab-

less than half of all Americans.[41]

Another spike in health care costs over the past decade led to an increase in the consumer's responsibility to pay for care.[42] Today, the distinctions among the numerous types of health care plans have been blurred.[43] Plans identified as HMOs, for example, are adopting some characteristics of PPOs and vice versa.[44]

C. Health Insurance Contracts

Regardless of the label used, the health insurance industry utilizes contracts as the basis for the rights and responsibilities that one party owes another.[45] The features of the contract include agreements on the services a plan provides, the process consumers must use to access those services, and the manner of reimbursement.[46] Contracts that include networks generally require the payers to reimburse the in-network providers directly for the services that those providers render to their patients who are consumers under the plan.[47] However, an insurance company has no contractual obligation to directly reimburse out-of-network providers because those providers do not share a contractual relationship with the plan.[48] Even though contracts specify duties, laws, and regulations, courts also govern the relationships among the parties.[49]

A modern view of courts interpreting contracts is that parties generally can assign, or in other words transfer, their contractual rights to a third party.[50] Receiving health insurance benefits is a right a policyholder has from a contract with the insurer, assuming that the policyholder does not violate any of the terms.[51] Therefore, under this modern approach to contract law, a covered individual could transfer the right to health insurance benefits to a

---

lished HMOs were joined by a stunning array of new health care financing and delivery entities.").

41. Weiner & de Lissovoy, *supra* note 6, at 77 (citing Elizabeth W. Hoy et al., *Change and Growth in Managed Care*, 10 HEALTH AFF. 18 (1991)).

42. KONGSTVEDT, *supra* note 6, at 15.

43. *Id.* at 17-18; *see also* Weiner & de Lissovoy, *supra* note 6, at 75 ("There is little agreement about which characteristics distinguished one type of plan from another.").

44. KONGSTVEDT, *supra* note 6, at 10-11.

45. Lucas & Williams, *supra* note 17, at 136; *see also* Weiner & de Lissovoy, *supra* note 6, at 81.

46. Lucas & Williams, *supra* note 17, at 136-37.

47. *See* KONGSTVEDT, *supra* note 6, at 29.

48. Lawrence Foust, *A Proposal for Resolving Differences in Managed Care Contract Negotiations Between Providers and Payers, in* HEALTH LAW HANDBOOK § 3:3 (Alice G. Gosfield ed., 2006).

49. Lucas & Williams, *supra* note 17, at 137.

50. Somerset Orthopedic Assocs., P.A. v. Horizon Blue Cross and Blue Shield of N.J., 785 A.2d 457, 460 (N.J. Sup. Ct. App. Div. 2001) (citing Rumbin v. Utica Mut. Ins. Co., 757 A.2d 526, 531 (Conn. 2000)); *see also* RESTATEMENT (SECOND) OF CONTRACTS § 317 cmt. c (1981) (stating that "the historic common-law rule that a chose of action could not be assigned has largely disappeared.").

51. *See* Lucas & Williams, *supra* note 17, at 136-37.

third party, such as an out-of-network provider. Under this scheme, the insurer would send reimbursement directly to the out-of-network provider.

D. Legal Challenges to Anti-Assignment Provisions

Before the last decade, insurers in Indiana generally allowed policyholders to assign benefits to out-of-network providers.[52] Currently, some health plans have contractual provisions with policyholders that prohibit the covered individual from assigning benefits to out-of-network providers.[53] Courts usually do not allow parties to assign their rights when the contract includes provisions that explicitly prohibit assignment.[54] When consumers have challenged prohibitions on assignment, courts have generally upheld the provision by reasoning that assigning benefits is against public policy.[55] Nonetheless, there is at least one outlier decision in which the court used public policy considerations to actually require an insurer to honor AOB.[56]

---

52. Interview with Michael Rinebold, Dir. of Gov't Relations, Ind. State Med. Ass'n, in Indianapolis, Ind. (Nov. 24, 2009) [hereinafter Interview with Rinebold]; *see also, e.g.*, Letter from Stacey Breidenstein, Director, Provider Contracting & Institutional Relations, CareFirst BlueChoice, Inc., to Providers (Aug. 8, 2005), *available at* http://www.bmbassoc.com/issues/aob/docs/BCBS_2008%20CareFirst%20Reimbursement%20for%20Non-Par%20Svcs.pdf (explaining that the insurer would stop sending reimbursements directly to out-of-network providers).

53. Interview with Rinebold, supra note 52; see, e.g., Parrish v. Rocky Mountain Hosp. & Med. Servs. Co., 754 P.2d 1180, 1181-82 (Colo. Ct. App. 1988) (quoting a Blue Cross Blue Shield ("BCBS") of Colorado contract provision that read: "All benefits stated in the Contract are personal to the Employee or Dependent. Neither those benefits nor [BCBS] of Colorado's payments to the covered individual may be assigned to any person, corporation or entity: Any attempted assignment shall be void. The only exception to this provision is [BCBS] of Colorado's right to pay Participating Facility and Professional Providers directly."); *see also* KONGSTVEDT, *supra* note 6, at 2.

54. *Somerset Orthopedic Assocs.*, 785 A.2d at 460 (citing Owen v. CAN Insurance/Continental Cas. Co., 771 A.2d 1208, 1213-14 (N.J. 2001)); *see* RESTATEMENT (SECOND) OF CONTRACTS § 317(2) ("A contractual right can be assigned unless . . . assignment is validly precluded by contract.").

55. *See, e.g.*, St. Francis Reg'l Med. Ctr. v. Blue Cross Blue Shield of Kan. Inc., 810 F. Supp. 1209 (D. Kan. 1992), *aff'd*, 49 F.3d 1460 (10th Cir. 1995); *Parrish*, 754 P.2d at 1182 ("[N]on-assignment clauses in this type of contract are valuable tools in persuading health providers to keep their health care costs down . . . ."); Kent General Hosp., Inc. v. Blue Cross and Blue Shield of Del., Inc., 442 A.2d 1368 (Del. 1982); Augusta Med. Complex, Inc. v. Blue Cross of Kan., Inc., 634 P.2d 1123 (Kan. 1981); Obstetricians-Gynecologists, P.C. v. Blue Cross and Blue Shield of Neb., 361 N.W.2d 550 (Neb. 1985); *Somerset Orthopedic Assocs.*, 785 A.2d at 464 ("[T]he anti-assignment clause is a critical tool to [the insurer's] efficient and effective functioning . . . ."); Kassab v. Med. Serv. Ass'n. of Pa., Inc., 39 Pa. D. & C.2d 723, 725 (1966) (holding that the anti-assignment clause was valid and essential to the continued success of the insurer's plan), *aff'd per curiam*, 230 A.2d 205 (Pa. 1967); *see infra* Part IV (discussing why courts have found assignment of benefits to out-of-network providers against public policy).

56. Am. Med. Int'l, Inc. v. Ark. Blue Cross and Blue Shield, 773 S.W.2d 831, 832 (Ark. 1989) (noting that an insured has an "interest in freely assigning the right to payment . . . ."); *see also* St. Francis Reg'l Med. Ctr., v. Blue Cross and Blue Shield of Kan., 49 F.3d 1460, 1468-70 (10th Cir. 1995) (Ebel, J., dissenting) (explaining that the district court's de-

E. AOB Laws around the Country

1. Overview of AOB Laws Around the Country

Because the position of the majority of courts is to enforce anti-assignment provisions when they exist in health insurance contracts, some states have enacted laws to force insurers to accept a patient's request for AOB.[57] As of January, 2010, approximately two dozen states had enacted mandatory AOB laws.[58] Approximately half of those states have AOB laws that cover many types of providers.[59] The AOB laws of the remaining states only apply to certain categories like dental or emergency care.[60]

Further, some people who participate in the AOB debate believe that whether a state has an Any-Willing-Provider ("AWP") law is relevant to the question of whether AOB legislation is appropriate.[61] AWP laws require insurers to accept into their networks any provider that meets the general standards set by the insurer.[62] Nearly half of the states in the nation have AWP laws, most of which are limited to dental and pharmacy services.[63] Fewer than ten states apply their AWP laws to health care providers beyond dental services.[64] Indiana's AWP law, for example, establishes that "[n]o hospital, physician, pharmacist, or other provider . . . willing to meet the terms and conditions of [a network agreement] may be denied the right to enter into a [network]."[65]

---

cision to dismiss the hospital's claim that BCBS of Kansas's nonassignability clause violates public policy should be reversed).

57. Foust, *supra* note 48.

58. *See supra* note 48; *see also* AM. DENTAL ASS'N, ASSIGNMENT OF BENEFITS (2010), *available at* http://www.ada.org/sections/advocacy/pdfs/thirdparty_assignment_benefits.pdf; MANDATED HEALTH BENEFIT TASK FORCE, *supra* note 27, at 4.

59. MANDATED HEALTH BENEFIT TASK FORCE, *supra* note 27, at 2 (states with broad AOB laws as of July 2008, are Alabama, Alaska, Colorado, Georgia, Illinois, Maine, Missouri, Nevada, Tennessee and Texas); *see also* AM. MED. ASS'N, MODEL ASSIGNMENT OF BENEFITS LEGIS. (2004), *available at* http://www.bmbassoc.com/issues/aob/docs/AMA_2004-AOB%20model%20legislation.pdf.

60. MANDATED HEALTH BENEFIT TASK FORCE, *supra* note 27, at 3 (states with limited AOB laws as of July 2008, are Connecticut, Idaho, Louisiana, Massachusetts, Ohio, Rhode Island, South Dakota, Wyoming and Virginia). *See, e.g.*, OHIO REV. CODE ANN. § 3901.386 (LexisNexis 2008) (applying only to "hospital services provided on an emergency basis"); R.I. GEN. LAWS § 27-18-63 (2010) (applying only to dental care providers).

61. *See infra* Part V.B.4.

62. MANDATED HEALTH BENEFIT TASK FORCE, *supra* note 27, at 3; *see, e.g.*, IND. CODE ANN. § 27-8-11-3 (West 2003). *See generally* Richard I. Smith & Kristin Stewart, *State Regulation of Managed Care, in* THE MANAGED HEALTH CARE HANDBOOK 1332, 1334-5 (Peter R. Kongstvedt ed., 4th ed. 2001) (describing state regulatory structures for managed care organizations).

63. MANDATED HEALTH BENEFIT TASK FORCE, *supra* note 27, at 4; *see, e.g.*, IND. CODE ANN. § 27-8-11-3 (West 2003).

64. MANDATED HEALTH BENEFIT TASK FORCE, *supra* note 27, at 4.

65. IND. CODE ANN. § 27-8-11-3(c) (West 2003); *see also* VA. CODE ANN. § 38.2-3407 (2008) ("No hospital, physician or a type of provider [as defined by a separate statute] willing to meet the terms and conditions offered to it or him shall be excluded [from a net-

States have many different combinations of AOB and AWP laws.[66] Some states have a broad AOB law and a limited AWP law or vice versa.[67] However, only Georgia has both a broadly applied AOB law and a broadly applied AWP law.[68]

2. Florida's Recent AOB Law

In 2009, Florida joined the ranks of states with mandatory AOB.[69] Despite strong opposition from Blue Cross Blue Shield ("BCBS") of Florida and from consumer groups, the Florida Legislature passed a mandatory AOB bill.[70] The bill, which took effect July 1, 2009, amended Florida's statutes to require mandatory AOB to all providers.[71] Florida's AOB statute now reads as follows:

> 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, 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.

---

work].").

66. MANDATED HEALTH BENEFIT TASK FORCE, *supra* note 27, at 4.

67. *Id.*

68. Id.; see, e.g., Ga. Code Ann. § 33-24-54 (requiring insurers that pay benefits directly to network providers to also pay benefits 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. "); GA. CODE ANN. § 33-20-16 (2006) (requiring "[e]very doctor of medicine, every doctor of dental surgery, every podiatrist, and every health care provider within a class approved by the health care corporation who is appropriately licensed to practice and who is reputable and in good standing shall have the right to become a participating physician or approved health care provider for medical or surgical care, or both, as the case may be, under such terms or conditions as are imposed on other participating physicians or approved health care providers within such approved class under similar circumstances in accordance with this chapter. ").

69. *See* 2009 Fla. Laws. 2009-124 (codified at FLA. STAT. § 627.638 (2009)).

70. Dolinski, *supra* note 5.

71. FLA. STAT. § 627.638(2) (2009).

> Payment to the provider from the insurer may not be more than the amount that the insurer would otherwise have paid without the assignment.[72]

3. Indiana's Efforts to Pass an AOB Law

Between 2005 and 2010, Indiana legislators worked to enact broadly applied, mandatory AOB legislation.[73] As of the end of the 2010 session, the furthest point an AOB bill reached in the legislative process in Indiana was a vote in the chamber where it originated.[74] In February, 2009, twenty-five members of the Indiana Senate voted in favor of a mandatory AOB bill, twenty-four members voted against it, and one member was excused from the vote.[75] Even though the bill received more votes in its favor, it failed because it lacked a constitutional majority.[76] The bill would have required insurers to send benefit payments directly to all out-of-network providers when the provider and the consumer have an assignment of benefits agreement.[77]

Legislators have continued their efforts beyond the 2009 session.[78] In the 2010 session, three senators introduced a bill similar to those introduced in previous years that would require broadly applied, mandatory AOB.[79] However, this Senate bill was never voted on during the short legislative session.[80]

In addition to working on AOB legislation during sessions of the Indiana General Assembly, state lawmakers and an independent state government commission have analyzed the issue between sessions.[81] In October

---

72. *Id.*

73. Telephone Interview with Patricia Miller, Ind. State Senator, Ind. State Senate, in Indianapolis, Ind. (Dec. 10, 2009).

74. *See* S.B. 75, 116th Gen. Assemb., 1st Reg. Sess. (Ind. 2009), *available at* http://www.in.gov/apps/lsa/session/billwatch/billinfo?year=2009&session=1&request=getBill&docno=0075&doctype=SB.

75. *Roll Call Vote on S.B. 75*, IND. GEN. ASSEM., http://www.in.gov/legislative/bills/2009/PDF/Srollcal/0168.PDF.pdf (last visited Sep. 7, 2010).

76. *See* Ind. Const. art. IV, § 25 (requiring a majority of the Senate's fifty members to pass a bill in the Indiana Senate).

77. S.B. 75, 116th Gen. Assemb., 1st Reg. Sess. (Ind. 2009), *available at* http://www.in.gov/apps/lsa/session/billwatch/billinfo?year=2009&session=1&request=getBill&docno=0075&doctype=SB. *See generally* IND. CODE § 27-8-11-1 (2009) (defining provider as "an individual or entity duly licensed or legally authorized to provide health care services.").

78. *See* S.B. 326, 116th Gen. Assemb., 2d Reg. Sess. (Ind. 2010), *available at* http://www.in.gov/apps/lsa/session/billwatch/billinfo?year=2010&session=1&request=getBill&docno=326).

79. *See id.*

80. *See id.*

81. *See generally* MANDATED HEALTH BENEFIT TASK FORCE, *supra* note 27; IND. HEALTH FIN. COMM'N, INTERIM STUDY COMMITTEE MEETING MINUTES OF SEP. 1, 3-4 (2009), *available at* http://www.in.gov/legislative/interim/committee/minutes/HFCOC91.pdf.

2008, the Mandated Benefits Task Force[82] issued findings and recommendations regarding AOB proposals.[83] The report suggested that a mandatory AOB law in Indiana should only apply to situations where health care consumers "have no choice in the selection of provider."[84] As the report elaborated, those situations could include providers who are emergency room physicians, anesthesiologists, radiologists, or pathologists.[85] The task force further recommended that a mandatory AOB law may need to include provisions to protect consumers from receiving a bill for unreimbursed services after their providers receive payment directly from their insurers.[86]

III. ARGUMENTS IN FAVOR OF STATES MANDATED AOB

As the Indiana General Assembly and other state legislatures debate the issue of whether to require insurers to honor AOB agreements, many different interest groups have visited statehouses around the country.[87] The primary proponents of broadly applied, mandatory AOB legislation include different groups of providers.[88] For example, representatives from the Indiana State Medical Association ("ISMA") and from individual associations of chiropractors, psychologists, and dentists have appeared before state lawmakers in Indiana to present their case as to why the state should have a mandatory AOB law.[89]

A. Mandatory AOB Would Provide Fairness to Providers

Proponents of mandatory AOB legislation argue it would provide fairness to providers by ensuring that they would receive compensation for the services they offer.[90] The Indiana Psychological Association ("IPA") says denying patients the right to assign benefits to their out-of-network providers "often prevents the Psychologist's [sic] office from ever receiving payment."[91] An association of Maryland medical group administrators conducted a survey revealing that eighty-four percent of respondents indicated that patients frequently fail to pay their medical bills after receiving

---

82. The governor appoints a ten-member task force with representatives from insurance companies, consumers, health care providers, employers, and independent actuaries. IND. CODE ANN. § 27-1-3-30 (West 2003).

83. *See* MANDATED HEALTH BENEFIT TASK FORCE, *supra* note 27.

84. *Id.* at 5.

85. *Id.*

86. *Id.*

87. *See, e.g.*, Dolinski, *supra* note 5; IND. HEALTH FIN. COMM'N, *supra* note 81, at 3-4.

88. *See, e.g.*, IND. HEALTH FIN. COMM'N, *supra* note 81, at 3-4.

89. *See, e.g.*, *id* at 4.

90. *Id.*

91. IND. PSYCHOL. ASS'N, AOB POSITION PAPER (2009) (on file with Ind. Legis. Servs. Agency and with author).

reimbursements.[92]

The IPA explains that when patients receive reimbursement from their insurer, they often think that they no longer have a debt to their health care provider.[93] Meanwhile, the patients may use the reimbursements to cover other outstanding debts like a child's college tuition, resulting in an inability to pay their medical provider.[94] Some medical group administrators and doctors note that collection problems involving patients who have received reimbursements are becoming an increasingly common occurrence.[95]

Also, these situations are not limited to people who use their reimbursement checks for reasons as noble as paying a child's college tuition bill.[96] In a newspaper opinion piece, the chief executive officer of a Florida addiction-treatment program described the story of a man whose health insurance company sent him a reimbursement check.[97] The man, who had received treatment for a drug addiction, did not pay his provider, but rather used the money to buy drugs off the street.[98] The executive also described another man who received reimbursement of more than $1,000 and used it to take a trip, where he committed suicide.[99]

Regardless of the reasons why patients fail to pay their providers after receiving a reimbursement check, the result is that at least some providers accumulate a significant amount of charges that must be written off as a loss and re-classified as an expense because it is unable to be collected (i.e., bad debt).[100] The Indiana Dental Association ("IDA") compiled anecdotal data to show how collection issues are affecting providers.[101] A survey of dentist offices in central and northern Indiana showed that each accumulat-

---

92. Letter from Kem Tolliver, Gov't Affairs Chair, Md. Med. Grp. Mgmt. Ass'n, to Thomas Middleton, State Senator, Comm. Chairman, Md. S. Fin. Comm. (Mar. 17, 2009) [hereinafter Letter from Tolliver], *available at* http://www.bmbassoc.com/issues/aob/docs/MD_2009%20MGMA%20Letter%20to%20Middleton.pdf.

93. IND. PSYCHOL. ASS'N, *supra* note 91.

94. Smith, *supra* note 1.

95. *Hearing on S.B. 852 before the Senate Finance Committee*, 2010 Leg., 426th Sess. (Md. 1999) (written testimony of the Hosp. Based Physician Coal. in support of S.B. 852), *available at* http://www.bmbassoc.com/issues/aob/docs/MD_2009%20SB%20852%20AOB%20Testimony.pdf; Letter from Tolliver, *supra* note 92 ("With the current state of our economy, it is highly improbable that the patient would turn over the payment to pay the provider for their services.").

96. *See* IND. HEALTH FIN. COMM'N, *supra* note 81, at 3 (representative of the Indiana Dental Association stating states generally that people do not always have noble reasons for their alternative uses of their reimbursement checks).

97. Chris Crosby, The Watershed Addiction Treatment Programs President, Op-Ed., *Paying Mental Health Facilities Directly Saves Lives*, PALM BEACH POST, June 2, 2009, at 8A.

98. *Id.*

99. *Id.*

100. *See* IND. DENTAL ASS'N, 2008/2009 AOB EXPERIENCE (on file with Ind. Legis. Servs. Agency and with author).

101. *See id.*

ed $8,000 to $13,000 of bad debt in six months,[102] or roughly ten percent of the revenues an average dentist office would receive after overhead expenses are subtracted.[103] One dentist stated that his billing staff spends forty percent of its time trying to locate money from patients who have received reimbursement from their insurers but have yet to pay their debt with their dentist.[104] Providers who experience collection problems may incur bad debt and subsequently raise rates.[105]

Proponents further argue that insurers may deny AOB as a way to force providers into a network that has low reimbursement rates.[106] Some providers say allowing health insurance companies to reject AOB presents them with the undesirable choice of either entering a network and accepting lower reimbursement rates or staying outside the network and chasing payments that the insurer sends to their patients.[107] Therefore, some providers suggest that using the direct payment incentive as leverage is an unfair business practice.[108] Some doctors say this is especially unfair in the current health insurance system because providers have a decreasing amount of bargaining power in negotiations with health plans.[109] While insurance companies acknowledge that direct payments are used to attract providers to their networks, they argue that the direct payment incentive is justified because it helps them build or maintain strong networks, which leads to a reduction of health care costs.[110]

B. Mandatory AOB Would Eliminate Many Administrative Problems Associated with Payments and Billing

AOB proponents also assert that the process of insurers reimbursing patients for out-of-network medical services is cumbersome without

---

102. *Id.*

103. Interview with Ed Popcheff, Director of Gov't Relations, Ind. Dental Ass'n, in Indianapolis, Ind. (Dec. 10, 2009).

104. IND. DENTAL ASS'N, *supra* note 100.

105. *See* IND. HEALTH FIN. COMM'N, *supra* note 81, at 3; *see also* Smith, *supra* note 1 (quoting an internist who said that "[y]ou can't run a practice with thousands of dollars not coming in.").

106. IND. HEALTH FIN. COMM'N, *supra* note 81, at 3; *see also* Lucas & Williams, *supra* note 17, at 143; IND. PSYCHOL. ASS'N, *supra* note 91 ("Some insurers pressure Psychologists [sic] into signing their PPO contract by refusing to honor assignment of benefits for non-PPO patients.").

107. IND. HEALTH FIN. COMM'N, *supra* note 81, at 3.

108. *See, e.g., id.* (stating that rejecting AOB to force dentist to join networks is "simply wrong").

109. Smith, *supra* note 1 (describing the struggles some providers have during negotiations with health plans); AM. MED. ASS'N, AOB LEGISLATION TALKING POINTS (2004), *available at* http://www.bmbassoc.com/issues/aob/docs/AMA_2004- AOB%20Talking%20 Pionts.pdf (describing that the "playing field" is becoming more unbalanced in favor of the insurers over the providers).

110. *See infra* Part. IV.A-B.

AOB.[111] The IPA says that barring an individual from assigning benefits to a provider "disrupts payments to the Psychologist's [sic] office [and] creates confusion . . . ."[112] The IPA explains that the provider's office may not be informed that the patient received compensation, which could cause weeks of delay in the billing process.[113] This confusion, caused by the inability to assign benefits, may be compounded when the patient has coverage by more than one insurer.[114] Finally, the IPA asserts that in some cases involving dual coverage, these administrative complications result in a patient failing to receive all of the benefits to which he or she is entitled.[115]

There is also concern that the effects of administrative billing difficulties may discourage patients from visiting out-of-network providers, and thereby decrease patient access.[116] The IDA contends that AOB would eliminate many of the administrative problems associated with payments and billing.[117] Even if a provider eventually receives payment, some note that the provider might experience delays and cash flow disruptions if it cannot receive payments directly from the insurer.[118] Some say that these delays harm patients because they reduce the time that providers can spend focusing on actual health care.[119]

C. Mandatory AOB Would Reduce the Amount of Litigation between Insurers and Providers

It is also argued that mandatory AOB laws would provide efficiency, consistency, and predictability.[120] Many times when there are issues re-

---

111. IND. HEALTH FIN. COMM'N, *supra* note 81, at 3; *see also* Mark R. Stetzel & Bob Ketcham, *Dentists Split about States Benefit Bill: Pro*, JOURNAL J. GAZETTE (Fort Wayne, Ind.), Jan. 30, 2009, at 13A ("For patients not expecting an insurance check, it's confusing when it arrives in the mail . . . . For those who do forward the check to their dentist, it's just another hassle they don't need."); AM. MED. ASS'N, *supra* note 109.

112. IND. PSYCHOL. ASS'N, *supra* note 91.

113. *Id.*

114. *Id.* ("If the patient is covered by more than one insurance company or by Medicaid (dual coverage) the Psychologist [sic] cannot file for secondary benefits on behalf of the patient until an explanation of benefits (EOB) is received from the first carrier.").

115. *Id.*

116. DIANE D. ANDERSON, HEALTHCARE CONSULTANTS, LLC, AOB LEGIS. FOR HEALTHCARE PROVIDERS 7 (2005), *available at* http://www.bmbassoc.com/issues/aob/docs/FINALReport.doc (prepared for Virginians for Fairness in Healthcare).

117. IND. HEALTH FIN. COMM'N, *supra* note 81, at 3 (A representative of the Indiana Dental Association states that "the current process is a hassle to the patient and intrusive on administering a dental practice."); *see also* MD. GEN. ASSEM. DEP'T OF LEGIS. SERVS., H.B. 594 FISCAL AND POL'Y NOTE 1 (2010), *available at* http://mlis.state.md.us/2010rs/fnotes/bil_0004/hb0594.pdf.

118. Karin Bierstein, *Rejecting a Bad Payer Contract*, AM. SOC'Y OF ANESTHESIOLOGISTS NEWSLETTER, June 2005, *available at* http://www.asahq.org/ Newsletters/2005/06_05/pracMgmt06_05.html.

119. *See, e.g.*, Steven West, *supra* note 4.

120. Foust, *supra* note 48.

garding payments between insurers and out-of-network providers, the end result is litigation.[121] This creates significant transactional costs.[122] The ISMA fears that those transactional costs may negatively affect the cost of health care in general.[123] The ISMA states that health care providers do not want to play the role of creditor, but they are often forced to do so.[124] Proponents think that allowing AOB would help remove the need for providers to go to court after patients fail to pay, because when the patient assigns the benefits, the insurer's reimbursement goes directly to the provider.[125]

Furthermore, when an insured is unable to assign benefits to an out-of-network provider, the provider generally cannot challenge the insurer's reimbursement[126] The American Medical Association says that providers are more willing and capable of investigating and appealing the reimbursements when a dispute exists concerning the amount the health plan should cover.[127] Therefore, the organization says that it is unfair to give patients the responsibility of legally challenging a reimbursement.[128]

D. Mandatory AOB Would Reduce the Amount of Out-of-Network Providers Who Require Full Payment Up Front

Proponents argue that AOB would reduce the number of out-of-network providers who require full payment before services are rendered because they know they will receive some reimbursement from an insurer.[129] For example, many Indiana psychologists have begun to ask for up-front payments because of the difficulty of collecting payments after they provide services.[130] Many dentists who do not participate in a network are also forced to choose whether to require up-front payments or risk that the

---

121. *Id.*
122. *Id.*
123. Interview with Rinebold, *supra* note 52.
124. *Id.*
125. *Id.*
126. David M. Hyman et al., *Hey, What About Me? Non-Participating Healthcare Providers' Ability to Sue Health Insurance Companies Regarding Payment of Claims*, N.J. LAWYER, February 2007, at 37 ("Without a valid assignment, non-participating providers face a considerable hurdle in establishing the right to demand or contest payment from health insurance companies.").
127. AM. MED. ASS'N, *supra* note 109.
128. *Id.*
129. *See* Dolinski, *supra* note 5; AM. MED. ASS'N, *supra* note 109 ("If an assignment is given by the patient and ignored by the insurer, the patient is forced to 'front' the cost of the service, until the insurer either sends payment to the patient or the provider reimburses the patient. This is an unreasonable burden to place on the consumer.").
130. IND. HEALTH FIN. COMM'N, *supra* note 81, at 3; *see also* IND. PSYCHOL. ASS'N, *supra* note 91 ("[AOB] often allows patients to leave the office without making full payment for services, knowing that the psychologists will bill them for any balance not paid by the insurance company.").

patient will not pay later.[131] Because of this, the IDA argues that AOB would lead to "little or no up-front costs at the time of treatment."[132]

IV. ARGUMENTS AGAINST STATES MANDATING AOB

A. Mandatory AOB Would Weaken Insurers' Health Care Networks

As proponents of mandatory AOB present their arguments to state lawmakers, health insurance companies, employers, and labor unions join forces to argue their opposing positions.[133] A chief argument against enacting broadly applied, mandatory AOB is that it would weaken insurers' health care networks.[134] Insurance companies contend that a doctor's ability to receive reimbursements directly from an insurer is an important incentive for the physician to join the insurer's network.[135] The argument is that if any provider can receive direct payments from any insurer, then there is less of an incentive to stay in a certain network.[136]

During AOB legislative debates in Maryland, an insurer presented evidence regarding the effect AOB had on other health plans.[137] The Maryland-based insurer, CareFirst BCBS, reported that when Idaho enacted mandatory AOB in 1992, half of the dentists in one network dropped out of it within a matter of weeks.[138] CareFirst also noted that a survey of Hawaiian providers indicated that slightly more than half would leave a network if insurers were required to honor AOB.[139] CareFirst also presented data that

---

131. IND. HEALTH FIN. COMM'N, *supra* note 81, at 3.

132. *Support Patient Rights – Support Assignment of Benefits*, IND. DENTAL ASS'N, http://www.supportpatientrights.com (last visited Dec. 7, 2010).

133. *See, e.g.*, IND. HEALTH FIN. COMM'N, *supra* note 81, at 3-4; Dolinski, *supra* note 5; Smith, *supra* note 1.

134. *See* Lucas & Williams, *supra* note 17, at 143-44; VA. DEP'T OF PLANNING AND BUDGET, H.B. 253 FISCAL IMPACT STATEMENT 1 (2006), *available at* http://leg1.state.va.us/cgi-bin/legp504.exe?071+oth+HB253F122+PDF; JOHN M. WANDER & DANIEL FREIER, RENDEN & ANDERS, LTD., THE POTENTIAL IMPACT OF STATE MANDATORY ASSIGNMENT LEGIS. ON CONSUMERS 10 (2003), *available at* http://www.bcbsok.com/grassroots/pdf/bcbsa_assignmentofbenefitsrpt_oct03.pdf (prepared for BCBS Ass'n); Smith, *supra* note 1; IND. HEALTH FIN. COMM'N, *supra* note 81, at 3-4.

135. FLA. S., S.B. 1122 ANALYSIS AND FISCAL IMPACT STATEMENT 4 (2009), *available at* http://www.flsenate.gov/data/session/2009/Senate/bills/analysis/pdf/2009s1122.ga.pdf; *see also* Dolinski, *supra* note 5; MANDATED HEALTH BENEFIT TASK FORCE, *supra* note 27, at 4 ("Direct payment of claims to participating providers is a key benefit of contracting with a health care payer."); Letter from William Casey, V.P. Gov't Affairs, CareFirst BCBS, to Thomas Middleton, State Senator, Md. S. Fin. Comm. 1 (Mar. 4, 2009) [hereinafter Letter from Casey], *available at* http://www.bmbassoc.com/issues/aob/docs/BCBS_2009%20Letter%20to%20Middleton%20SB%20852.pdf.

136. Smith, *supra* note 1.

137. Letter from Casey, *supra* note 135, at 3.

138. *Id.*

139. *Id.* (The source does not state whether this survey was scientific).

a Virginia insurer had a stronger network after adopting a policy to refuse AOB.[140] It was further mentioned by CareFirst that insurers in Nevada and Colorado have experienced difficulty in establishing strong networks because of mandatory AOB legislation.[141] Advocates for the health industry argue that a weakened network would result in less access to care for patients because there would be fewer providers participating in a network.[142]

B. Mandatory AOB Would Increase Health Care Costs

In addition to decreased access to health care services, many argue that weakened networks would generally result in higher health care costs.[143] During the AOB debate in the Virginia General Assembly in 2006, a representative of a health insurance company explained to a journalist that "[h]ealth plan networks are all that stand between consumers and full charges."[144] Health insurance industry representatives say that networks exist so insurers can negotiate rates with providers in an effort to contain or reduce the amount of money consumers pay out of their pockets for health care services.[145] A provider would agree to this lower rate in exchange for a higher volume of patients.[146] Health insurance representatives say that the agreement of in-network doctors to provide services at a discounted rate "substantially reduces health-care premiums."[147]

The BCBS Association commissioned a study in 2003 that showed discounts and protections that patients receive from using networks for their care amount to thousands of dollars for people with major medical conditions.[148] The study looked at five patient "profiles,"[149] and found estimated annual cost savings of $3,234 to $13,482 for in-network physician services and $6,751 to $30,404 for in-network hospital services.[150] The study con-

---

140. *Id.*

141. *Id.* Nevada first enacted an AOB law in 1983, and Colorado did the same in 2005. MANDATED HEALTH BENEFIT TASK FORCE, *supra* note 27, at 2.

142. Bob Lotane, Commc'ns and Pol. Affairs Dir., Nat'l Ass'n of Ins. Fin. Advisors, Op-Ed., *Direct Assignment Bill Guts Preferred Provider Plans*, PALM BEACH POST, June 4, 2009, at 12A.

143. *See* Jed Jacobson, V.P. of Delta Dental of Ind., Guest Commentary, *Assignment of Benefits Hits Patients in Pocketbooks*, THE TIMES OF NORTHWEST IND., Jan. 29, 2009; Cyrus Jollivette, Senior V.P. of Public Affairs, BCBS of Fla., Op-Ed., *SB 1122 Will Undermine PPO Networks, Raise Health-care Costs*, PALM BEACH POST, June 11, 2009, at 10A; IND. HEALTH FIN. COMM'N, *supra* note 81, at 3.

144. Smith, *supra* note 1.

145. WANDER & FREIER, *supra* note 134.

146. Smith, *supra* note 1.

147. Lotane, *supra* note 142.

148. *See* WANDER & FREIER, *supra* note 134.

149. *See id.* at 7-8 (noting the five profiles as, "woman with advanced breast cancer," "man with coronary artery heart disease," "child with severe asthma," "woman with ischemic stroke," "man with diabetes mellitus").

150. *Id.* at 10.

cluded that savings like these might be reduced if networks were weakened as a result of mandatory AOB.[151] Some argue that even if doctors do not leave their networks, AOB to out-of-network providers may give network doctors more leverage in their negotiations with insurers to argue for higher reimbursements.[152] This leverage could interfere with the insurer's ability to negotiate with network providers for a lower reimbursement rate and thus could translate to higher medical costs for consumers.[153]

According to the insurer, CareFirst, AOB legislation in Idaho in 1992 resulted in a twenty-nine percent increase in out-of-pocket health care costs.[154] CareFirst estimates that for every ten-percent loss in provider participation in its network, the health care costs for consumers would increase by eight percent.[155] The health insurance industry further argues that the deterioration of their PPO networks would increase the number of uninsured citizens.[156]

Some employers and labor unions fear that weakened networks would translate to higher premiums.[157] Employers are worried that by weakening health care networks, mandatory AOB would interfere with an insurer and an employer negotiating a contract.[158] Legislative staff in Virginia who analyzed the issue came to the conclusion that weakened health care networks would lead to higher premiums for both employers and their employees.[159]

When Florida considered passing a mandatory AOB bill in 2009, BCBS of Florida asserted that a mandatory AOB would impose a significant cost to Florida's State Employees' Health Insurance Trust Fund because of the effect of a weakened network.[160] A BCBS of Florida analysis showed that it would cost the trust fund between $9.9 million and $25.7 million in one fiscal year.[161] Florida's Department of Management Services contracted out a study to review BCBS of Florida's analysis of how much mandatory AOB would cost the state. That study showed a range of $5.1

---

151. *Id.*

152. Dolinski, *supra* note 5.

153. *See* FLA. S., *supra* note 139.

154. Letter from Casey, *supra* note 135, at 3.

155. *Id.* at 2.

156. Jollivette, *supra* note 143.

157. *See, e.g.*, IND. HEALTH FIN. COMM'N, INTERIM STUDY COMMITTEE MEETING MINUTES OF SEP. 1, Exhibit 7, 3 (2009) ("[Mandatory AOB legislation would] have a very significant impact on increasing the cost of health care and forcing even more employers to discontinue providing coverage.") (on file with Ind. Legis. Servs. Agency and with author); IND. HEALTH FIN. COMM'N, *supra* note 81, at 4 (AFL-CIO representative stating that strong networks result in millions of dollars worth of savings and "direct payments to out-of-network providers would increase costs").

158. IND. HEALTH FIN. COMM'N, *supra* note 81, at 4.

159. VA. DEP'T OF PLANNING AND BUDGET, *supra* note 134.

160. FLA. S., *supra* note 135; *see also* VA. DEP'T OF PLANNING AND BUDGET, *supra* note 134.

161. FLA. S., *supra* note 135.

million to $18.5 million.[162] The state's independent study also showed that mandatory AOB would increase an individual's out-of-pocket expenses by seventy-five percent.[163]

C. *Mandatory AOB Would Interfere with an Insurer's Ability to Manage Quality of Care*

In addition to managing the cost of health care, insurers attempt to control the quality of care.[164] Some believe that conferring the right to collect directly from insurers would blur the distinction between network providers and out-of-network providers, which could be harmful to the system.[165] For good or bad, networks play a central role in the benefit design of our health care system.[166] The ability to collect reimbursements directly from insurers is often only available to providers who are in the health plan's network.[167] However, the method of receiving reimbursements for services is not the only distinction between network providers and out-of-network providers. Among the many important differences are quality assurance and credentialing.[168] Therefore, some argue that blurring the distinction between network providers and out-of-network providers would harm the insurance companies' ability to create what they think is the most "intelligent, legally acceptable, and commercially attractive" benefit design.[169] Furthermore, insurers argue that mandatory AOB would result in providers exiting their networks.[170] If this occurs, the health insurance companies would not be able to manage the quality of health care as effectively because the network would have fewer participating providers.[171] Also, insurers may not be able to offer some specialized services like chronic care management because of a lack of participating providers.[172]

---

162. *Id.* (citing GABRIEL ROEDER SMITH & CO., REVIEW OF MANDATORY ASSIGNMENT MODEL (2009)).

163. *Id.*

164. *See* KONGSTVEDT, *supra* note 6, at 230.

165. Foust, *supra* note 48.

166. *Id.*

167. *See* KONGSTVEDT, *supra* note 6, at 139.

168. Foust, *supra* note 48.

169. *Id*; *see also, e.g.*, Letter from Casey, *supra* note 135, at 3 ("CareFirst, like other carriers, continually strives to improve the quality of our networks.").

170. Letter from Casey, *supra* note 135, at 3.

171. *Id.*

172. *Id.*

V. WHY THE ARGUMENTS IN FAVOR OF MANDATORY AOB PREVAIL AND HOW LEGISLATION SHOULD BE STRUCTURED

A. Why Indiana Should Mandate AOB

The parties who participate in the AOB debate have in large part tried to present their arguments within the frame of what is best for consumers.[173] However, both insurance companies and doctors have interests in making profits. One possible solution falls somewhere between the positions of providers, insurers, and sponsors. Indiana legislators should require that health plans honor AOB, as well as create a conditional sunset provision for the AOB legislation. The legislature should also consider imposing requirements on the amount of reimbursement paid to out-of-network providers, prohibiting balance billing for emergency care services, and repealing the state's AWP law.

1. How the Refusal of Insurers to Honor AOB Harms the Health Care System

Considering that anecdotal data dominates the AOB debate, legislators likely have a difficult time weighing the potential outcomes of their decision regarding the AOB issue.[174] At least in Indiana, opponents of mandatory AOB note that proponents do not use empirical data to support their arguments.[175] For example, the testimonies of Indiana providers detail the experience of only some medical offices.[176] Nonetheless, these testimonies show that the inability of at least some out-of-network doctors to receive direct reimbursements poses significant financial burdens on their practices.[177] Assuming that these providers will shift at least some of the financial burden to patients, it follows that the insurers' refusal to honor AOB raises the cost of care that these out-of-network doctors provide.[178]

The evidence also shows that some consumers covered by a network plan choose to receive services from out-of-network providers at least some of the time.[179] When the insureds are unable to assign their health insurance benefits to their out-of-network providers, they often experience a cumbersome process of waiting to receive payments from the health plan and paying their doctor's bills.[180] The evidence further shows that the insurer's

---

173. *See, e.g.*, *id.* at 4.
174. *See* IND. HEALTH FIN. COMM'N, *supra* note 81, at 3-4.
175. *See id.* at 3.
176. *See id.* at 3-4.
177. *See id.*
178. *See generally supra* Part III.A.
179. IND. HEALTH FIN. COMM'N, *supra* note 81, at 3-4.
180. *See generally supra* Part III.B.

refusal to honor assignment requests increases the transactional costs of health care delivery, as doctors spend more time trying to collect payment from patients and patients have more disputes with their health plans regarding reimbursements.[181] Furthermore, the refusal to honor AOB requires some providers to demand up-front payments from consumers because of the uncertainties of being able to collect from them.[182] These additional consequences that result from an insurer's refusal to honor AOB further raise or at least threaten to raise the cost of receiving services from out-of-network providers. These consequences also likely affect, to some degree, access to care from out-of-network providers.[183]

2. *The Evidence Fails to Show That Mandatory AOB Weaken Networks*

While the evidence shows that allowing insurers to prohibit AOB increases the cost of health care that some out-of-network doctors provide, the health insurance industry argues that a mandatory AOB law would create a net increase in health care costs.[184] However, information presented by health insurance companies does not prove such a position.[185] In AOB discussions, insurers primarily argue that AOB laws threaten the strength of their networks.[186]

For example, when the Maryland General Assembly considered an AOB bill in 2009, an insurer, CareFirst, presented data in an effort to show the effect of AOB laws on the strength of health plan networks.[187] As discussed more fully in Section IV, CareFirst's information included anecdotal data about Idaho dentists from 1992, a survey of Hawaii providers, the effect of a Virginia insurer's anti-assignment policy on its own network, and general statements about the strength of the networks of insurers from Nevada and Colorado.[188] While this evidence supports the argument that AOB laws may weaken health plan networks, it provides an insufficient basis to conclude that this result would happen in Indiana if the legislature enacted mandatory AOB.

---

181. *See generally supra* Part III.C.

182. *See generally supra* Part III.D.

183. *See* ANDERSON, *supra* note 116, at 7.

184. *See, e.g.*, IND. HEALTH FIN. COMM'N, *supra* note 81, at 3-4.

185. *See* MGT OF AM., INC., RESEARCH CONCERNING PREMIUM RATE CHANGES FOR THE FLA. MED. ASS'N 7 (2008) (on file with author) (finding that "[t]he direct impact of incorporating mandatory assignment of benefits and/or a reduction of the repayment period on health insurance premiums cannot be determined").

186. *See, e.g.*, IND. HEALTH FIN. COMM'N, *supra* note 81, at 3-4; *See generally supra* Part IV.A.

187. Letter from Casey, *supra* note 135, at 3-4. *But cf.* Letter from Tolliver, *supra* note 92 (stating that a survey of Maryland providers shows that ninety-percent would remain in-network even if legislature would enact AOB law).

188. Letter from Casey, *supra* note 135, at 3-4; *see also supra* Part IV.A.

In 2005, a consulting group that studied the AOB issue for a Virginia group of doctors concluded that AOB laws had not interfered with insurers' ability to provide "adequate cost-effective networks."[189] The consultants observed that three of the four main health insurance companies in the United States – United Healthcare, Aetna, and Cigna – honor AOB but have not incurred any negative financial consequences for doing so.[190] According to some reports, the insurance company, Humana, also honors AOB while containing costs with a "strong" network.[191] The evidence that several insurers voluntarily allow AOB and maintain strong networks indicates AOB laws would likely have minimal effect on the strength of health plan networks. Other incentives, such as higher patient volume, will likely keep a large number of doctors in network, even if they can receive direct payments out of network.[192]

Even if the networks of insurers would weaken in the coming years, the decline of strong networks would not necessarily be a result of mandatory AOB. "An increasing number of physicians do not contract with managed care companies."[193] Some providers believe a major reason for doctors leaving networks is because insurers' reimbursement rates are too low regardless of whether there is AOB.[194]

3. *The Evidence Fails to Show That Mandatory AOB Increases Health Care Costs Generally*

Even assuming that AOB laws weaken networks, health insurance companies have failed to prove the resulting weak networks would cause a net harm by increasing costs or limiting access to health care. As discussed previously, health insurance representatives commonly testify to the amount of health care savings members receive for participating in a plan that uses a network.[195] For example, representatives often cite a 2003 study that a consulting group completed for the BCBS Association.[196] This study tracked the savings that some types of patients realized when they used in-network doctors.[197] In at least one AOB debate, an insurer asserted that out-of-pocket costs of consumers covered by a network increased by an esti-

---

189. ANDERSON, *supra* note 116, at 28.
190. *Id.*
191. Dolinski, *supra* note 5; West, *supra* note 4.
192. Dolinski, *supra* note 5.
193. Hyman et al., *supra* note 126.
194. *E.g.*, Smith, *supra* note 1. *But cf., e.g.*, Letter from Casey, *supra* note 135, at 3 (explaining that the insurers' rates are "fair and reasonable").
195. *See, e.g.*, IND. HEALTH FIN. COMM'N, *supra* note 81, at 3-4; *see also supra* Part IV.B.
196. *See* WANDER & FREIER, *supra* note 134.
197. *Id.*

mated twenty-nine percent in Idaho in 1992 because of AOB legislation.[198]

Despite empirical evidence showing savings consumers realize for using network doctors, and anecdotal data like the experience of Idaho patients, no one has established a correlation between AOB and an overall increase of health care costs.[199] Even assuming that mandatory AOB laws increase health care costs for some consumers, health insurance companies have failed to show this would cause a net increase in total costs. Furthermore, the evidence does not show that the increase in costs insurers fear would outweigh the financial burdens that out-of-network providers incur because of their inability to receive direct reimbursements.

The extent of the harm that out-of-network providers in Indiana experience because insurers refuse to honor AOB is unknown. Nonetheless, evidence shows that allowing payers to reimburse consumers directly increases the cost of out-of-network services, assuming that out-of-network doctors share some of their financial burdens with their patients. Meanwhile, AOB opponents base their arguments on speculation, which does not show that mandatory AOB would create a net harm to health care costs. Therefore, Indiana should enact a broadly based, mandatory AOB law.

B. Structure of the Legislation

1. Indiana Legislators Should Consider a Conditional Sunset Provision

When Florida implemented a broadly applied, mandatory AOB, it included a conditional sunset provision.[200] The amendment to Florida's AOB law are automatically repealed three years after its effective date if the Office of Program Policy Analysis and Government Accountability finds that "the amendments made by this act have caused the third-party administrator of the state group health plan to suffer a net loss of physicians from its preferred provider plan network and, as a direct result, caused an increase in costs to the state group health plan."[201] Indiana has entertained a similar

198. Letter from Casey, *supra* note 135, at 2 (stating that "member out of pocket costs increased by an estimated 29% as a direct result of the passage of assignment of benefits legislation").

199. *See* ANDERSON, *supra* note 116, at 28.

200. 2009 Fla. Laws. 2009-124 (codified at FLA. STAT. § 627.638 (2009)); *see also About OPPAGA*, OFFICE OF PROGRAM POLICY ANALYSIS AND GOV'T ACCOUNTABILITY, http://www.oppaga.state.fl.us/shell.aspx?pagepath=about/about.htm (last visited Dec. 7, 2010) (The Florida OPPAGA is a staff unit of the Legislature responsible for examining agencies and programs "to improve services and cut costs when directed by state law, the presiding officers, or the Joint Legislative Auditing Committee." OPPAGA supports the Florida Legislature by providing data, evaluative research, and objective analyses that assist legislative budget and policy deliberations.)

201. 2009 Fla. Laws. 2009-124 (codified at FLA. STAT. § 627.638 (2009))

mechanism in its debate over imposing a mandatory AOB.[202] A conditional sunset provision could be a good tool to help protect the health care system in Indiana if the insurance companies' worst fears were to occur because of AOB legislation.

2. *Indiana Legislators Should Consider Imposing Requirements on Reimbursement Amount*

Requiring insurers to send payments directly to out-of-network providers could result in "wasteful disputes" over the amount of reimbursements.[203] However, state legislators could create a more predictable business environment by imposing requirements on the reimbursement amount for out-of-network payments.[204] Only a limited number of states have enacted legislation that governs the amount insurers pay to out-of-network providers.[205]

Florida's mandatory AOB law, for example, prohibits insurers from paying providers more than what the insurer would pay the insured if there were no assignment.[206] If an insurer in Oklahoma pays a provider less than what the provider billed, the payer must furnish, upon request, the rationale for the reimbursement amount.[207] In Utah, payers must reimburse out-of-network doctors at an amount that is at least seventy-five percent of the participating provider rate.[208] Colorado insurers must reimburse out-of-network providers the lesser of the following amounts: the provider's billed charges; a "negotiated rate"; and the "the greater of the carrier's average in-network rate for the relevant geographic area or the usual, customary, and reasonable rate for such geographic area."[209] Meanwhile, California's regulations require insurers to pay out-of-network providers the "reasonable and customary value for the health care services," which is calculated based on the following:

> (1) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider;

---

202. IND. HEALTH FIN. COMM'N, *supra* note 81, at 4.

203. Foust, *supra* note 48.

204. *Id.*

205. *Id. See generally* Kongstvedt, *supra* note 29, at 132 (describing the method insurers generally use to reimburse out-of-network providers).

206. FLA. STAT. § 627.638(2) (2009) ("Payment to the provider from the insurer may not be more than the amount that the insurer would otherwise have paid without the assignment.").

207. OKLA. STAT. ANN. tit. 36 § 6571 (West 2009).

208. UTAH CODE ANN. § 31A-22-617(2)(b) (2009).

209. COLO. REV. STAT. § 10-16-704(2)(c) (2007). The statute defines the "usual, customary, and reasonable rate" as "a rate established pursuant to an appropriate methodology that is based on generally accepted industry standards and practices." § 10-16-704(2)(f)(III).

> (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case.[210]

Although there is no consensus among the states on how to govern out-of-network reimbursements, these examples provide guidance on how the Indiana General Assembly should control the reimbursement amount if or when it enacts a mandatory AOB law.

3. *Indiana Legislators Should Consider Prohibiting Out-of-Network Providers from Balance Billing*

Indiana legislators may also want to consider implementing a prohibition on balance billing in some situations as a compliment to AOB legislation. Balance billing occurs when a provider bills a patient for the cost that exceeds the amount that the insurer covers.[211] Most states do not explicitly prohibit balance billing and insurers rarely can prohibit out-of-network providers from engaging in the billing practice.[212] However, some states restrict out-of-network providers from balance billing.[213] For example, New York providers cannot balance bill patients for emergency ambulance services.[214] Meanwhile, Maryland and Florida prohibit providers from balance billing any HMO member.[215]

The Indiana Mandated Benefits Task Force in its analysis of the AOB issue in 2008 recommended the state legislature to consider providing pro-

---

210. CAL. CODE REGS. tit. 28, § 1300.71(a)(3)(B) (2008).

211. KONGSTVEDT, *supra* note 6, at 210.

212. Lucas & Williams, *supra* note 17, at 147. *See generally* Foust, *supra* note 48 (providing a background on balance billing).

213. Lucas & Williams, *supra* note 17, at 148.

214. N.Y. INS. LAW § 3221(l)(15)(B) (McKinney 2010) (An ambulance service reimbursed pursuant to this section shall not charge or seek any reimbursement from, or have any recourse against an insured for the services provided pursuant to this paragraph, except for the collection of copayments, coinsurance or deductibles for which the insured is responsible for under the terms of the policy.).

215. FLA. STAT. § 641.3154(4) (2004)(A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable.); MD. CODE ANN., HEALTH-GEN. § 19-710(p) (LexisNexis 2008)(A health care provider or any representative of a health care provider may not collect or attempt to collect from any subscriber or enrollee any money owed to the health care provider by a [HMO] . . . . A health care provider or any representative of a health care provider may not maintain any action against any subscriber or enrollee to collect or attempt to collect any money owed to the health care provider by a [HMO] . . . .).

tection against balance billing for emergency care services.[216] The task force suggested that Indiana enact something similar to California's regulation of balance billing.[217] In 2006, the California Court of Appeal held that state law did not prohibit out-of-network providers to balance bill patients for emergency services.[218] The California Department of Managed Health Care subsequently created a rule that declares that balance billing of HMO members for emergency services is an "unfair billing pattern."[219]

In January 2009, the California Supreme Court reversed the Court of Appeal's decision, holding that balanced billing of HMO subscribers is illegal under California law when the provider has recourse to collect from the insurer.[220] As previously discussed, California's regulations require insurers to pay out-of-network providers a "reasonable and customary value for the health care services."[221] The California Supreme Court analyzed the issue of balance billing by considering whom the emergency room provider should involve when he or she disputes the "reasonable and customary" amount paid by the insurer for services rendered.[222] The court determined that the dispute should be between the provider and the insurer.[223] In reaching its conclusion, the court explained "a patient will have little basis by which to determine whether a bill is reasonable and, because the HMO is obligated to pay the bill, no legitimate reason exists for the patient to have to do so."[224]

Because of the nature of emergency care services, consumers have less choice as to who provides them medical care. For example, a consumer can generally choose which doctor to visit when he has a cold but may be unable to choose the emergency room to which an ambulance will take him. A prohibition on balance billing is appropriate in a situation where the emergency-care provider requires the patient to assign benefits, and where state law mandates the insurer to honor AOB. A balance billing prohibition in this case would likely reduce "wasteful disputes."[225] Therefore, Indiana legislators should consider a balance billing prohibition for emergency care services.

---

216. MANDATED HEALTH BENEFIT TASK FORCE, *supra* note 27.
217. *Id.*
218. Prospect Med. Grp., Inc. v. Northridge Emergency Med. Grp., 39 Cal. Rpt. 3d 456 (Cal. Ct. App. 2006), *rev'd*, 198 P.3d 86 (Cal. 2009).
219. CAL. CODE REGS. tit. 28, § 1300.71.39(a) (2008).
220. *Prospect Med. Grp., Inc.*, 198 P.3d at 92.
221. CAL. CODE REGS. tit. 28, § 1300.71(a)(3)(B) (2008).
222. *Prospect Med. Grp., Inc.*, 198 P.3d at 93.
223. *Id.*
224. *Id.*
225. *See* Foust, *supra* note 48 (examining topic of AOB and balance billing).

4. *Indiana Legislators Should Consider Repealing the State's AWP Law*

Indiana legislators should consider repealing the State's AWP law when they enact a mandatory AOB statute.[226] Much of the Indiana Mandated Benefits Task Force five-page report includes a chart of states comparing AOB and AWP laws.[227] In its analysis of the AOB issue, the task force emphasized that only one state, Georgia, has a broadly based AWP law and a broadly based AOB law.[228] Therefore, it is reasonable to assume that the task force considers AWP and AOB to be incompatible.

Some assert that the AWP law has "already severely damaged the ability of insurance networks to contain costs."[229] As previously discussed, opponents of mandatory AOB argue that an AOB law would exacerbate the problems for an insurer to manage costs.[230] Therefore, some insurers see the existence of an AWP and an AOB law as two legislative measures that negatively affect their ability to manage networks.[231] However, the bulk of the evidence shows that a mandatory AOB law would not harm a payer's ability to control costs.[232] Nonetheless, repealing the AWP law may be a political compromise that could help ensure the passage of a mandatory AOB law. For example, a health care policy expert at the Indiana Chamber of Commerce states that he would not oppose AOB legislation if the state would repeal its AWP law.[233]

VI. CONCLUSION

The debate over whether patients should have the right to assign health insurance benefits to out-of-network providers includes interesting, yet competing, public policy arguments. This important issue has garnered the attention of state legislators around the country.[234] Requiring broadly applied, mandatory AOB would likely have many advantages. Perhaps the biggest benefit is ensuring that providers receive payment for their services

---

226. *See supra* Part. II.E.1 (concerning background information on AWP).

227. MANDATED HEALTH BENEFIT TASK FORCE, *supra* note 27, at 2-3.

228. *Id.* at 4; *see also* GA. CODE ANN. § 33-24-54 (2008) (AOB law); GA. CODE ANN. § 33-20-16 (2008) (AWP law).

229. IND. HEALTH FIN. COMM'N, *supra* note 157, at 3; *see also* Smith & Stewart, *supra* note 62, at 1334-35 (examining AWP laws and their effect on health care costs). *But cf.* Interview with Rinebold, *supra* note 52 (arguing that AWP does not harm an insurer's ability to maintain its network and health care costs because insurers can easily remove providers from their networks).

230. *See generally supra* Part IV.B.

231. Interview with Mike Ripley, V.P., Health Care Pol'y, Ind. Chamber of Commerce, in Indianapolis, Ind. (Nov. 20, 2009) [hereinafter Interview with Ripley].

232. *See generally supra* Part V.A.

233. Interview with Ripley, *supra* note 231.

234. *See, e.g.*, IND. HEALTH FIN. COMM'N, *supra* note 81, at 3-4.

so they can continue to provide care without raising their rates.[235] Another important advantage to mandatory AOB comes from the elimination of many of the administrative problems associated with payments and billings that providers and policyholders experience.[236]

However, many argue that mandatory AOB would do significant harm to the health care system.[237] A principal argument is that mandatory AOB would weaken networks, which in turn would lead to higher costs for policyholders, their employers, and others.[238] Nonetheless, the empirical data related to this argument is weak.[239] In addition, there is evidence that mandatory AOB would do little, if anything, to weaken networks and increase health care costs overall.[240] Furthermore, legislators can structure laws to help protect against any harm by including a sunset provision.[241] For the foregoing reasons, Indiana should adopt a broadly applied, mandatory AOB law.

---

235. *See generally supra* Part III.A.
236. *See generally supra* Part III.B.
237. *See, e.g.*, Letter from Casey, *supra* note 135, at 1.
238. *See generally supra* Part IV.A-B.
239. *See supra* Part V.A.
240. *See* ANDERSON, *supra* note 116, at 28.
241. *See generally supra* Part V.B.

Assignment of Benefits Legislation For Healthcare Providers

January 2005

Prepared by:

Diane D. Anderson, MS, MHA

At the Request of Virginians for Fairness in Healthcare

Healthcare Consultants, LLC
An Affiliate Company of Biegler & Associates, P.C.
5501 Patterson Avenue
Richmond, Virginia 23226
(804) 288-5888, x 304
(804) 288-4512 (fax)
danderson@biegler.net

Table Of Contents

I. Executive Summary

Assignment of benefits (AOB) allows insured patients to authorize their health insurers to pay their policy benefits directly to healthcare providers not participating in the health insurer's network. It is a routine and accepted insurance industry transaction. However, the largest health insurer in the country, comprised of the 41 affiliate plans of the Blue Cross Blue Shield Association (BCBSA) and representing approximately 90 million subscribers, as a matter of policy, does not typically honor assignment of benefits. Even when BCBS subscribers are willing to pay a higher premium for physician choice and choose plans that provide for out-of-network services, non-network providers are not directly compensated for providing services to subscribers, often resulting in lost revenues, increased bad debt, and collection expenses incurred when insured patients do not pay for services rendered because the health plan sent payment directly to the patient instead of the provider. The other three largest publicly traded health insurers in the country, UnitedHealthcare, Aetna, and CIGNA, which have traditionally honored assignment of benefits for their combined 46 million subscribers, continue to meet their shareholders' financial performance expectations, without negative consequences from assignment of benefits.

This study reviewed the prevalence of assignment of benefits legislative activity throughout the country and whether or not assignment of benefits has had a negative impact on consumers through increased expenditures for healthcare services or reduced access to quality care. The study also addressed the current relationship between health insurers and healthcare providers.

In order to collect the data for this study, the following organizations were contacted to determine if any research has been conducted on the potential fiscal impact of assignment of benefits on consumers and managed care networks: the American Medical Association (AMA), the American Association of Health Plans (AAHP), the Blue Cross Blue Shield Association (BCBSA), the National Academy for State Health Policy, the National Association of Insurance Commissioners (NAIC), the National Conference of State Legislatures, the National Governor's Association, and the medical societies and departments of insurance representing the fifty states. A literature search was also done.

At this time, we have not been able to establish any empirical evidence or data to support Virginia's dominant health insurer's claims that direct assignment of benefits to healthcare providers has a negative impact on insured consumer healthcare expenditures or access to quality care. Health plans' claims that direct assignment of benefits "causes harm" to consumers have not been substantiated. Health plans' abilities to provide adequate cost-effective networks have not been weakened. Actuaries in states with direct assignment of benefits but without an inclusion of a "no balance billing" requirement for out-of-network healthcare providers have not seen a correlation between assignment of benefits and increased health insurance premiums or overall healthcare expenditures. These states include Alaska, Florida, Georgia, Illinois, Louisiana, Maine, Tennessee, and Texas. The general consensus of conversations with representatives of the departments of insurance and medical societies in these states is that direct assignment of benefits has enhanced insured patients' choice of healthcare providers as well as access to services. Managed care networks have not deteriorated due to an exodus of providers electing non-participatory status.

From a Virginia perspective, Anthem's dominance of the health insurance industry represents a

70% market share in the Commonwealth, covering approximately 2.8 million subscribers. Prior to 1983, most BCBS plans in Virginia honored their subscribers' assignment of health plan benefits. As Blue Cross plans began competing for increased market dominance, Blue Cross of Virginia revised its policy on assignment of benefits to prohibit subscribers from assigning their benefits to non-participating providers in order to increase provider participation in its networks. In 1984, Delegate Thomas W. Moss, Jr., sponsored a bill that would have required all Blue Cross plans in Virginia to honor their subscribers' assignment of benefits. Blue Cross Blue Shield of Southwestern Virginia supported the assignment of benefits bill, stating that assignment of benefits favored consumer choice and did not prevent the Roanoke plan from negotiating favorable reimbursement contracts with providers, which ensured an adequate network. An official from the Roanoke plan said at the time, "No carrier should be able to usurp the consumer's right to assign benefits he has paid for, either directly or through his group health coverage plan. To attempt to remove this freedom under the banner of cost containment is especially false; benefit levels are the same regardless of assignment of benefits." Assignment of benefits was not mandated during the 1984 General Assembly session. Eventual consolidation of several non-profit BCBS plans in Virginia led to the formation of Trigon, which converted to investor ownership in 1997. During 2000, the current Virginia statute for direct assignment of health plan benefits, which applies only to dentists and oral surgeons, was passed. Anthem BCBS acquired Trigon in 2002, culminating in Anthem's recent merger with Wellpoint Health Networks Inc., creating the largest private health insurer in the country with 28 million subscribers.

A preliminary review of The Commonwealth of Virginia Health Benefits Program's annual reports from 2000 through 2003 indicates that direct assignment of benefits to dentists and oral surgeons has not increased costs as a percentage of total healthcare claims paid. During the four-year period, dental claims represented between 6.4% (2003) and 6.8% (2001) of the total expenditures for health benefits provided to active state employees and non-Medicare eligible retirees. For the four-year period, increases in overall spending for dental claims (43%) were more than the increases in physician services (39%) but less than increases in hospital inpatient services (52%), hospital outpatient services (50%), or prescription drugs (52%). It is assumed that the increase in employees utilizing dental care benefits through the State's health plan is proportionate with the total increase in enrollees utilizing medical care benefits, which increased 10% between 2000 and 2003, from 80,180 to 88,361 enrollees. A fiscal impact study conducted during 2004 indicated that healthcare expenditures for state employees and non-Medicare eligible retirees would increase dramatically if assignment of benefits was mandated in Virginia. The study implied there would be a major exodus of physicians from Anthem's networks, which would dramatically increase healthcare premiums and out of pocket expenditures. States with direct assignment of benefits have not experienced deterioration in managed care networks—employers and/or their health insurers have successfully negotiated appropriate reimbursement rates with providers without jeopardizing employees' benefits or health insurers' profitability. State employees still have a choice in determining the level of benefits provided as well as access to healthcare providers.

A 2003 BCBSA study on assignment of benefits stated "health plans negotiate contractual arrangements with providers that save consumers thousands of dollars in health care costs"…"consumers with serious medical conditions save significant amounts of out-of-pocket costs due to the contracts health plans negotiate with physicians." Typically, providers in Virginia are not given the opportunity to negotiate equitable contract terms with Anthem. The unequal

bargaining position created by Anthem's "extraordinary" market power has forced many providers to enter into one-sided contracts, which threaten the doctor-patient relationship and continuity of care.

Not only is declining physician reimbursement by both public and private health insurers prompting more contract terminations and physicians exiting the marketplace or changing the scope of their practices in Virginia, it also threatens access to health services because medical practices are finding it more difficult to retain and recruit qualified physicians. Some of the Virginia locales currently experiencing physician shortages include Fredricksburg, Lynchburg, Newport News, Rappahannock, Southwest Virginia, Williamsburg, and Tidewater. The demand for many high-risk specialties (e.g., emergency medicine, neurosurgery, obstetrics/gynecology, orthopedic surgery, thoracic surgery, , trauma, etc.) and lack of adequate physician coverage in numerous communities throughout the Commonwealth is causing delays in patients receiving treatment and increasing patient transfers between hospitals. Per a recent report from Virginia's Joint Legislative Audit and Review Commission, the most critical issue threatening access to trauma care in Virginia is inadequate physician coverage.

The profitability of the largest health insurers does not indicate an industry in crisis, quite a contrast to the practice environment many physicians are experiencing in Virginia and throughout the rest of the country. While health insurers have experienced unprecedented profitability during the last five years, due to double-digit increases in health insurance premiums, which have outpaced medical costs, and declining medical cost ratios, medical practices continue to struggle with financial viability. An illustration of health plan profitability in a state with direct assignment of benefits to healthcare providers is Georgia. Wellpoint reported a 28% increase in profits during the 3rd quarter 2004—revenue increased 16% to $5.85 billion from $5.05 billion a year earlier, attributed to a 15% climb in premium revenue. The recently completed $16.4 billion merger of Wellpoint Health Networks by Anthem BCBS will provide Georgia with approximately $126.5 million for health care programs as well as a promise to not increase premiums for Georgia's 3.2 million BCBS members. Even though California does not have direct assignment of benefits to health care providers, the new Wellpoint Inc. will also provide California with $265 million to fund health care programs and guarantees that expenditures on patient care will increase but premiums for the 7 million BCBS members in California will not increase to help finance the merger. It is expected that 293 Wellpoint executives will receive as much as $356 million in compensation, which does not include millions of dollars in stock options.

Assignment of benefits is a relatively simple and effective means to help restore some balance to the relationship between healthcare providers and health insurers. Providers have the opportunity to negotiate more favorable terms with the insurers, which allows patients greater access to necessary services. Providers can choose not to participate in health plans providing inadequate reimbursement without being financially disadvantaged or causing disruption to patient care. Assignment of benefits creates an environment where insurers have an incentive to recruit and retain providers in their networks.

II. Introduction

Healthcare Consultants, LLC was engaged by Virginians for Fairness in Healthcare to determine the prevalence of assignment of benefits (AOB) legislative activity throughout the country and whether or not direct assignment of benefits to healthcare providers has had a negative impact on consumers by either increasing expenditures for health services and/or by reducing access to quality care due to erosion of managed care networks. The study also addresses the relationship between providers and insurers as consumers continue to struggle with increasing healthcare expenditures in the midst of unprecedented health insurer profitability.

In order to collect the data for this study, the following organizations were contacted to determine if any research has been conducted on the potential fiscal impact of assignment of benefits on consumers and managed care networks: the American Medical Association (AMA), the American Association of Health Plans (AAHP), the Blue Cross Blue Shield Association (BCBSA), the National Academy for State Health Policy, the National Association of Insurance Commissioners (NAIC), the National Conference of State Legislatures, the National Governor's Association, and the medical societies and departments of insurance representing the fifty states. A literature search was also done.

III. Overview of Assignment of Benefits to Healthcare Providers

Assignment of benefits allows insured patients to authorize their health insurers to pay their policy benefits directly to healthcare providers not participating in the health insurer's network. Out-of-network providers then receive timely payment for services rendered to insured patients while also eliminating the paperwork burden and time required of subscribers having to submit their own claims. Balance billing allows the provider an opportunity to bill the insured patient for any balance due for services rendered. Reasons providers may be out-of network with a health insurer's plans include the interval of time required for the health insurer to process credentialing for the provider or the provider has determined the health insurer's plan is an "unhealthy" contract due to reimbursement structures that do not cover the cost of doing business.

Assignment of benefits is a routine and accepted insurance industry transaction. Insured patients receive care through their chosen health plans. However, Blue Cross Blue Shield (BCBS) plans, which provide health insurance to approximately 90 million subscribers throughout the country, routinely deny their subscribers the right to assign benefits to non-participating healthcare providers as a matter of policy. Even when BCBS subscribers are willing to pay a higher premium for physician choice and choose plans that provide for out-of-network services, non-network providers are not directly compensated for providing services to subscribers, often resulting in lost revenues, increased bad debt, and collection expenses incurred when insured patients do not pay for services rendered because the health plan sent payment directly to the patient instead of the provider.

Patients receiving payment from a health insurer for services provided by out-of-network providers, sometimes months after services were delivered and without a full explanation of benefits, often do not realize the payment was intended for medical services provided by specific providers and simply cash the check. In addition, patients may ignore the need for medical care to avoid the administrative burden of dealing with outstanding bills.

Providers choosing network participation with health insurers are offered incentives to accept lower reimbursement in exchange for patient volume. Without the ability to offset increased overhead expenditures by fee adjustments, more providers are opting out of network participation with various health insurers' products not covering the cost of providing services to the plan's subscribers. However, the insurer may then deny patients access to necessary medical services provided by out-of-network providers or the patients may have to assume complete financial responsibility for services provided.

A Virginia Perspective on Assignment of Benefits: Most BCBS plans in the Commonwealth honored subscribers' assignment of benefits until 1983, when the law providing for the creation of unique territories for Blue Cross plans was repealed. As a consequence, the Blue Cross plans tried to improve market positions by vigorous competition with each other. Blue Cross of Virginia revised its policy on assignment of benefits to prohibit subscribers from assigning their benefits to non-participating providers in order to increase provider participation in its networks. In 1984, Delegate Thomas W. Moss, Jr., sponsored a bill that would have required all Blue Cross plans in Virginia to honor their subscribers' assignment of benefits. Blue Cross Blue Shield of Southwestern Virginia supported the assignment of benefits bill, stating that assignment of benefits favored consumer choice and did not prevent the Roanoke plan from negotiating favorable reimbursement contracts with providers, which ensured an adequate network. An official from the Roanoke plan said at the time, "No carrier should be able to usurp the consumer's right to assign benefits he has paid for, either directly or through his group health coverage plan. To attempt to remove this freedom under the banner of cost containment is especially false; benefit levels are the same regardless of assignment of benefits." Assignment of benefits was not mandated during the 1984 General Assembly session. Eventual consolidation of several non-profit BCBS plans in Virginia led to the formation of Trigon, which converted to investor ownership in 1997. During 2000, the current Virginia statute for assignment of health plan benefits, which applies only to dentists and oral surgeons, was passed. Anthem BCBS acquired Trigon in 2002, culminating in Anthem's recent merger with Wellpoint Health Networks Inc., creating the largest private health insurer in the country with 28 million subscribers. Anthem provides 2.8 million Virginians with health plans ranging from Medigap insurance to employer benefits. With the exception of Medicaid, Anthem is the market leader in every segment it serves in Virginia with approximately 70% of the combined HMO/PPO health plan benefits provided to privately insured citizens.

Based upon federal regulations, physicians providing services to patients seen in hospital emergency departments are not allowed to turn away patients, regardless of their insurance status. Recent examples of lost revenues due to out-of-network emergency medicine physician practices providing services to subscribers in an Anthem BCBS' plan are found in Table III.1. Anthem's payments were sent directly to the patients, who then did not remit payment to the physicians. For these three practices, the annual financial losses ranged between $300,000 and $400,000. Some emergency departments throughout the Commonwealth are now having to deal with Anthem subscribers seeking unnecessary services in order to collect payments from Anthem--the patients are "gaming the system," since they know the physicians have to see them and checks for services provided by the physicians will be sent directly to them even though they have no intent of paying the physicians.

Table III.1.Illustration of Negative Financial Impact to "Non-Par" Emergency Medicine Physicians.

Emergency Medicine Physician Groups 2002-2003	Number of Physicians in Group	Number of Annual Patients Seen by Group in Emergency Departments	Lost Revenues Due to Direct Payment Sent by Anthem BCBS to Patients
Group One	Eight (8)	36,000	> $300,000
Group Two	Seven (7)	32,000	> $300,000
Group Three	Seventeen (17)	75,000	> $400,000

The Blue Cross Blue Shield Association is a major opponent of any legislative or regulatory proposals directing assignment of benefits to healthcare providers. BCBSA asserts direct payment is a windfall for providers, disruptive to cost-efficient provider networks, and denies consumers critical network protections. During 2003, BCBSA had a study done by Reden and Anders on the potential impact of mandatory assignment of benefits to healthcare providers. The authors state "health plans negotiate contractual arrangements with providers that save consumers thousands of dollars in health care costs…"consumers with serious medical conditions save significant amounts of out-of-pocket costs due to the contracts health plans negotiate with physicians." Typically, providers in Virginia are not given the opportunity to negotiate more favorable contract terms with Anthem. The consensus amongst all medical practices interviewed is that Anthem has a "take it or leave it attitude" relative to contractual terms with providers in its networks. Anthem's "extraordinary" market power allows more aggressive negotiating with healthcare providers, resulting in reduced reimbursement rates. This unequal bargaining position has forced many providers to enter into one-sided contracts, which threaten the doctor-patient relationship and continuity of care. Studies have reported BCBS plans have been increasingly aggressive in exercising their market power by reducing provider payments, resulting in more contract terminations (Foreman, Wilson and Scheffler, 1996). Not only is declining physician reimbursement by both public and private health insurers prompting more contract terminations and physicians exiting the marketplace or changing the scope of their practices in Virginia, it also threatens access to health services because medical practices are finding it more difficult to retain and recruit qualified physicians. Some of the Virginia locales currently experiencing physician shortages include Fredricksburg, Lynchburg, Newport News, Rappahannock, Southwest Virginia, Williamsburg, and Tidewater. It is becoming increasingly more difficult to provide coverage for several medical specialties including emergency medicine, general surgery, infectious disease, internal medicine, nephrology, neurosurgery, obstetrics, ophthalmology, thoracic surgery, and trauma, etc.

BCBS asserts high-quality provider networks will be adversely affected by mandated assignment of benefits due to more physicians choosing not to participate in various health plan products. As a practical business matter, physicians should be able to contract with the networks they wish to participate in. Reimbursement rates that do not keep up with medical practice inflation are a disincentive for physicians to join or continue participation in health plans' networks. Many states have established access standards that health insurers must meet to ensure subscribers are provided adequate networks for healthcare services.

Per the 2001 policy statement from Wellmark BCBS, BCBS' public policy positions include supporting fair and equitable competition in the marketplace, such as level regulation for all

players in the health insurance and managed care market. BCBS supports customer service, which is market driven, exceeds customer expectations and enhances the development of new services and products while adapting to a changing environment. However, Virginian physicians' inability to negotiate appropriate reimbursement from health insurers does not ensure a level playing field in the health care marketplace in the midst of insurer dominance.

The recent class action lawsuit settlements against Aetna and Cigna (the third and fourth largest publicly held health insurers with 13.6 million and 9.9 million enrollees, respectively), both mandated assignment of health plan benefits to out-of-network providers. These prominent national health insurers have not argued dire financial consequences as a result of the suits—both companies have honored their subscribers' assignment of health benefits to providers for many years, as has UnitedHealthcare Group, Inc., now the second largest publicly traded health insurer with 22 million subscribers. However, since Anthem BCBS, the dominant health insurer in Virginia, prohibits its subscribers from assigning benefits to providers, other health insurers are not legally obligated to submit payment directly to their subscribers' out-of-network healthcare providers.

A preliminary review of The Commonwealth of Virginia Health Benefits Program's annual reports from 2000 through 2003 indicates that mandating assignment of benefits to dentists and oral surgeons has not increased costs as a percentage of total healthcare claims paid. During the four-year period, dental claims represented between 6.4% (2003) and 6.8% (2001) of the total expenditures for health benefits provided to active state employees and non-Medicare eligible retirees. For the four-year period, increases in overall spending for dental claims (43%) were more than the increases in physician services (39%) but less than increases in hospital inpatient services (52%), hospital outpatient services (50%), or prescription drugs (52%). It is assumed that the increase in employees utilizing dental care benefits through the State's health plan is proportionate with the total increase in enrollees utilizing medical care benefits, which increased 10% between 2000 and 2003, from 80,180 to 88,361 enrollees. From the information presented in the annual reports, it appears Virginia's expenditures for costs attributed to average daily hospital and admissions are higher than costs experienced in other states covered by Anthem plans. The state's plan was restructured in 2004, resulting in a different premium structure with more costs shifted to employees, a three-tier prescription plan, and more preventive services provided. The annual report for 2004 has not yet been released.

IV. Assignment of Benefits Legislative Activity

Table IV.1 provides a brief summary of legislative activity pertinent to assignment of benefits, which has been addressed in numerous states.

Table IV.1. Assignment of Benefits: National Summary of Legislative Activity.

STATE	DIRECT ASSIGNMENT	BALANCE BILLING	COVERED PROVIDERS
Alaska	Yes. 2002. Statute 21.07.020 (10).	Silent.	All healthcare providers
Alabama	Yes. 1994. Statute 27-1-19 (b) Amended 2001.	No. Non-par receives same rate as par.	All healthcare providers. Interpretation of ERISA doesn't apply to HMOs.
Arkansas	Yes. Awaiting reply.	Awaiting reply.	Awaiting reply.
Colorado	Yes. Statute 10-16-317.5. 2002.	Silent.	All healthcare providers
Connecticut	Yes. 2000. HB 5126.	Silent.	Dentists and oral surgeons
Florida	Yes. 2003. Statute: 627-638. HMOs not included.	Silent.	All healthcare providers
Georgia	Yes. 1981. Statute 33-24-54. Amended 1992 and 2002. Statute: 33-24-59.3	Silent.	All healthcare providers
Hawaii	Yes. Awaiting reply.	Awaiting reply.	Awaiting reply.
Illinois	Yes. Statute 215 ILCS 5/370a. 215ILCS 5/368c. (b); 215ILCS 5/370i (c) 1999. Amended: 2000 and 2004.	Silent.	All healthcare providers
Iowa	No. 2001 Senate File 2003. BCBS Wellmark payments payable to providers are sent to patients who are expected to reimburse the provider .	Silent. 2004 Legislature opposed bill that would have prohibited balance billing.	All healthcare providers.

STATE	DIRECT ASSIGNMENT	BALANCE BILLING	COVERED PROVIDERS
Louisiana	Yes. 2001. Statute 854: Fee schedules; discounts. Yes. Act 1157: 2004 Health Care Consumer Billing and Disclosure Protection Act. Requires insurers and providers to provide adequate billing information to patients. Yes. Statute 40:2010. Assignment of Benefits. 2002. Requires BCBS to honor assignment of benefits based on state law which pre-empts federal ERISA laws.	Balance Billing Contingencies. Yes. Collaborative effort between healthcare providers and insurers. Silent.	Hospitals. Facility-based and on-call healthcare providers. Hospitals.
Maine	1999. Statute 33:2755.	Not mandated unless access standards not met.	All healthcare providers
Maryland	No. 2000. 19-710.1 Payment to healthcare providers.	Silent. Defines rates paid to out-of-network providers.	All healthcare providers.
Mississippi	No. 1992. Senate Bill 2648 did not get out of committee. Yes. Statute 43-13-305: Medicaid 1985. Amended 1991, 1993 & 2000.	Awaiting reply.	Awaiting reply. Medicaid. All healthcare providers
Missouri	Yes. Statute 376.427.1. 2003: Applies to par only.	No.	All healthcare providers
Nevada	Yes. Statute 689A.135. 1983	Silent.	All healthcare providers
New Hampshire	Yes. 2002. Amended 2003. Statute 420-B-8-n. Point of Service Plans.	Yes.	All healthcare providers

STATE	DIRECT ASSIGNMENT	BALANCE BILLING	COVERED PROVIDERS
New Jersey	Yes. 2004.	No.	Dentists and oral surgeons
New York	Yes. Statute 3235. 1993. Amended 1994 and 2003.	Silent.	Medicare
North Carolina	No. Statute 58-3-200 (d) addresses adequate access to networks.	Yes, if inadequate access to networks.	All healthcare providers
North Dakota	No. Unsuccessful attempt.	Silent.	All healthcare providers
Oklahoma	No. BCBS prevented passage of assignment/direct pay legislation, Article 36, section 3631.1.	No.	Awaiting reply.
Oregon	Yes. .Statute 743.531 1967. Amended 1985 & 1989	No.	All healthcare providers.
Rhode Island	Yes. 2002	Silent.	Dentists and oral surgeons
South Carolina	Yes. Statute 38-71-10. 1987. No. S644 stalled for the 2004 session.	Silent. No. Non-par would have received par rates.	Hospitals. All healthcare providers
South Dakota	Yes. Statute 58-17-61. 1983 .	Silent.	Hospital Services.
Tennessee	Yes. Statute 56-7-20:1992. Amended 1992, 1997, and 2003.	Silent.	All healthcare providers-- excludes Medicaid program.
Texas	Yes. 1991. Statutes: 1204.053 & 1204.054; Art 21.24-1.	Silent. 2003 Legislature opposed bill 1313 that would have prohibited balance billing for non-par.	All healthcare providers

STATE	DIRECT ASSIGNMENT	BALANCE BILLING	COVERED PROVIDERS
Vermont	Yes. Awaiting reply	Awaiting reply.	Awaiting reply.
Virginia	Yes. 2000. Statute 38.2-34067.13	Silent	Dentists and oral surgeons
Washington	Yes. Statute 48.44.026 Payment for certain health care services. 1999	Silent.	All healthcare providers
West Virginia	No. Statute 33-11-4. 2001.	Silent.	All healthcare providers
Wyoming	Yes. Statute 26-15-136. 1993	Silent.	Hospitals, MDs, and agencies with state sponsored plans.

The American Medical Association (AMA) has supported assignment of benefits to providers for several years: D-390.995. *Our AMA will seek (1) legislation or regulation, or develop model state legislation to ensure that third party payers be required to issue payment directly to providers when the patient has signed an authorization for the assignment of benefits; and (2) legislative relief mandating that health plans notify physicians when claim payments are issued to the insured rather than the physician who has an assignment agreement. (Res. 127, A-00).*

During 2004 legislative sessions held throughout the country, nine states considered directing assignment of benefits/direct pay legislation to healthcare providers but due to BCBS opposition, only New Jersey's legislature passed an assignment of benefits bill, which applies only to dentists and oral surgeons and does not allow balance billing provisions (BCBSA, 2004).

In Alabama, assignment of benefits for health care providers was mandated in 1994 but BCBS sought exemptions based on ERISA provisions pre-empting state law—the Alabama Department of Insurance concurred so the statute does not apply to BCBS or other HMOs. In Iowa, the House and Senate overwhelmingly passed legislation directing the assignment of benefits to all healthcare providers in 2001, but the Governor vetoed the bill due to pressure from Wellmark BCBS. A subsequent compromise with Wellmark created dual endorsement of checks payable to the provider but remitted to the patient. Washington State reached a similar compromise where health plans send checks requiring dual endorsement to patients for payment of health services provided by non-participating providers.

Some states have assignment of benefits provisions limited to network providers or specific entities (e.g., hospitals) or programs (e.g., Medicare or Medicaid) while several states have bills providing assignment of benefits to all health care providers. At least four states (e.g., Connecticut, New Jersey, Rhode Island and Virginia) have direct assignment of health plan

benefits applicable only to dentists and oral surgeons.

Balance billing has not been specifically addressed by all the states with direct assignment of health plan benefits, and is often a "silent" issue. BCBS is opposed to any balance billing provisions associated with direct assignment of benefits. However, Iowa and Texas legislators recently defeated proposed legislation that would have prevented balance billing by out-of-network healthcare providers. BCBS is currently seeking legislation that will mandate par reimbursement rates to non-par providers working in par facilities in Colorado. Louisiana has passed legislation intended to prevent duplicate billing processes by healthcare providers. It was a collaborative effort by legislators, providers and health insurers to ensure adequate and correct billing information is provided patients. Contrary to BCBS' successful overturn of Alabama's mandated assignment of benefits pertinent to health plans and ERISA exemptions, Louisiana's Supreme Court determined ERISA regulations do not pre-empt state statutes for assignment of health plan benefits and consequently, BCBS must honor patients' assignment of benefits to their healthcare providers. The Court also found the anti-assignment provisions language in Blue Cross health plan contracts specifies assignment of benefits will not be honored "except as required by law."

Legislators in North Carolina and Colorado have not yet directed assignment of benefits but the health insurers must adhere to "access standards" for adequate provider networks. If the standards are not met, out-of-network providers are assigned health plan benefits and reimbursed at 100% of billed charges—patients are not financially responsible for the health insurers' inability to maintain adequate networks due to contractual terms offered to providers.

In order to understand why direct assignment of benefits is important for ensuring adequate access to healthcare services in Virginia, the current relationship between healthcare providers and health insurers, and consumers, is discussed in the next three sections of this report.

V. Healthcare Expenditures

On average, national private health insurance premiums rose 11.2% in 2004, lower than the 13.9% increase in 2003 but still the fourth consecutive year of double-digit increases (Kaiser Family Foundation and the Health Research and Education trust, Employer Trust, Employer Health Benefits Survey, 2004). During 2004, premiums rose most substantially at HMOs with an average increase of 12.0%, down from the average of 15% in 2003. Between 2001 and 2004, the average annual cost of health insurance increased by 59%. Although most employers kept the same level of benefits, more costs were passed on to employees via increased premium contributions, deductibles, co-payments, prescription costs, etc. During 2005, employers' health insurance premiums are expected to increase an average of 11.3% (Hewitt Associates, Lincolnshire, Ill.).

Per the 2004 Kaiser Family Foundation and Health Research and Educational Trust Employer Benefit Survey. The national average for annual premiums for family coverage and single coverage were $9,950 and $3,695, respectively. Table V.1 illustrates average annual health plan premiums for Employer Health Plans during 2004.

Table V.1 Employer-Sponsored Health Insurance: Average Annual Premiums: 2004.

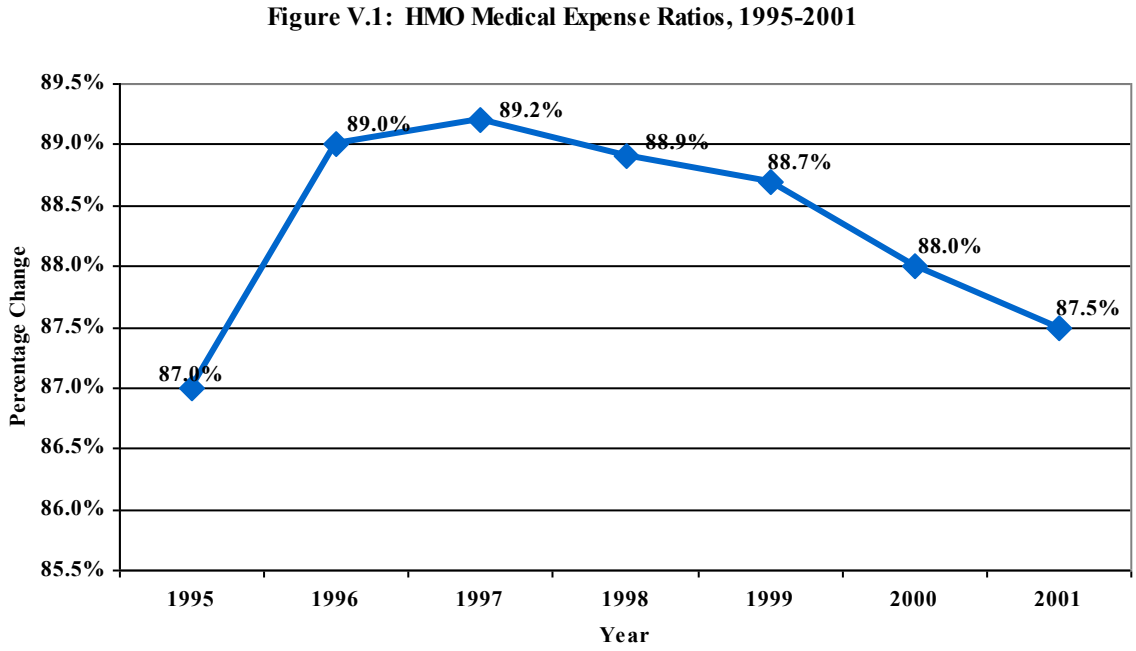
	ALL REGIONS	NORTHEAST	MIDWEST	SOUTH	WEST
Single Coverage					
Conventional	$3,820	$4,041	$3.919	$3,485	$3.977
HMO	$3,458	$3,542	$3,661	$3,470	$3,217
PPO	$3,808	$3,971	$3,832	$3,701	$3,899
POS	$3,627	$3,756	$3,536	$3,514	$3,698
All Plans	$3,695	$3,789	$3,769	$3,627	$3,629
Family Coverage (4 members)	ALL REGIONS	NORTHEAST	MIDWEST	SOUTH	WEST
Conventional	$9,602	$10,256	$9,627	$8,675	$10,286
HMO	$9,504	$9,848	$9,945	$9,621	$8,777
PPO	$10,217	$11,010	$10,428	$9,761	$10,317
POS	$9,813	$10,347	$10,366	$9,293	$9,411
All Plans	$9,950	$10,449	$10,280	$9,625	$9,629

Source: Kaiser Family Foundation and Health Research and Educational Trust: Employer Health Benefits, 2004.

Health plan premiums vary by geographic region. Overall, HMO premiums were less in the West while PPO premiums were highest in the Northeast. Premiums representing the average of all plans for family coverage were highest in the Northeast, followed by the Midwest. Mandated benefits by individual states also cause regional variation in health plan premium expense.

Revenues from health plan premiums paid to health insurers are divided into two categories—the medical expense ratio is the portion of revenue spent on medical claims while administrative costs include all operating expenditures and profits of the plans. Figure V.1 illustrates average HMO medical expense ratios between 1995 and 2001. At year-end 2003, medical expense ratios continued their decline for several proprietary health insurers doing business in Virginia (i.e., Anthem--80.8%; Aetna—78.3%, Cigna—86.9%, Coventry--80.9%; UnitedHealth—80.0%, and Wellpoint—80.5%, etc.). The Abell Foundation reported a significant portion of the profit margins of investor-owned Blues plans result from lower payment rates to health care providers (Schramm, 2001). In addition, Abell determined medical expense ratios associated with for-profit BCBS plans are about five to ten percentage points lower than those of nonprofit BCBS plans and that BCBS plans medical expense ratios in Virginia are significantly lower than that of some other health insurers in that market**.**

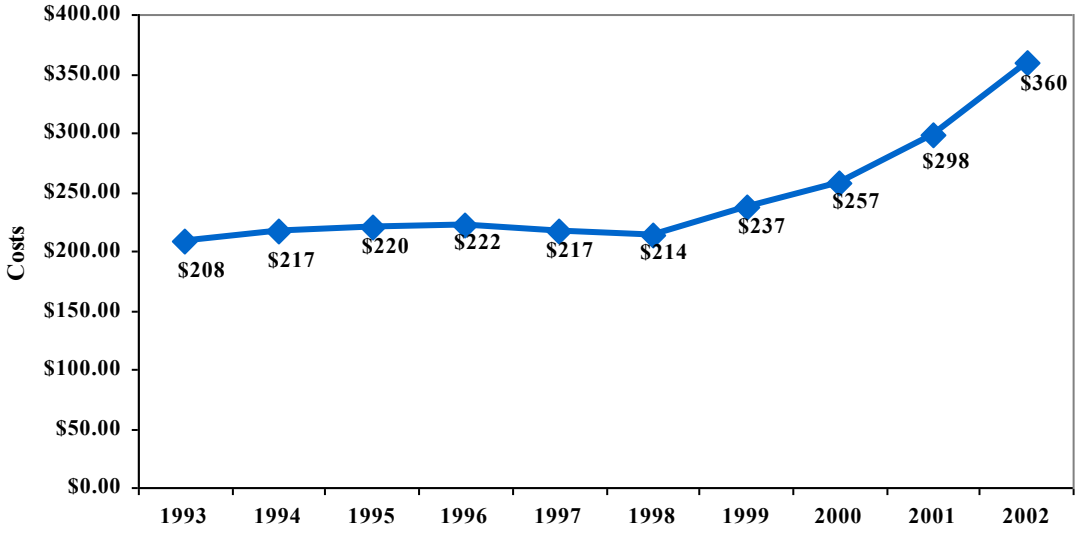
Figure V.1. Average HMO Medical Expense Ratios, 1995-2001.



Source: InterStudy Publications, The InterStudy Competitive Edge 12.2, Part II: HMO Industry Report, October 2002, Figure 7, p. 51.

Administrative costs per health plan subscriber have continued to increase during the last four years, contributing to the excessive profitability reported by many health insurers. Figure V.2 illustrates the average health insurer administrative costs per subscriber for the period between 1986 and 2002.

Figure V.2. Private Health Insurance Administrative Costs per Person Covered, 1986-2002



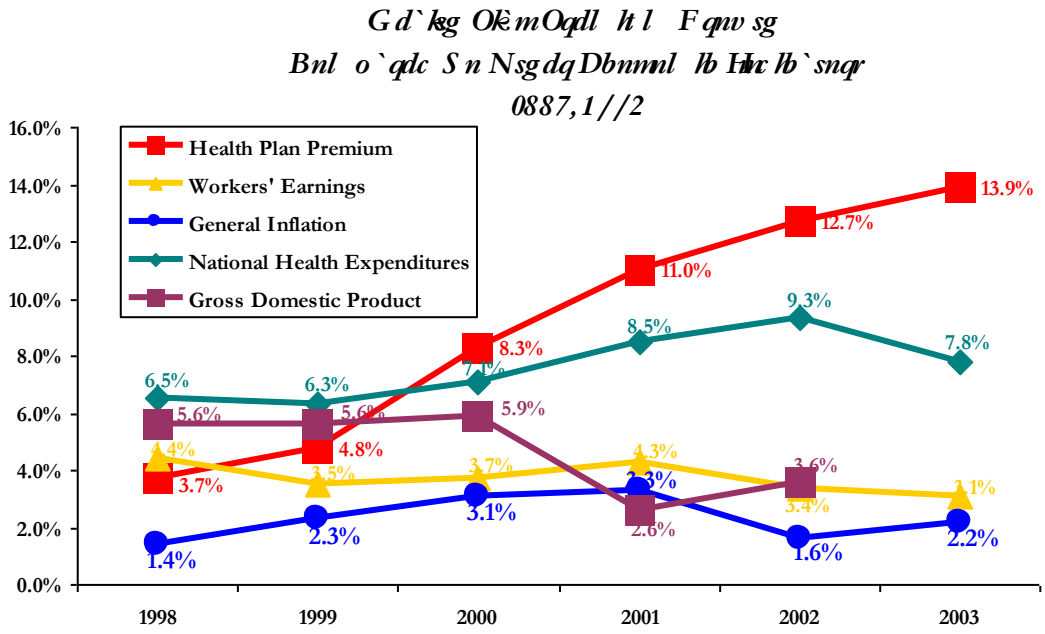
Source: Centers for Medicare and Medicaid Service, Office of the Actuary, National Health Statistics Group

A correlation between direct assignment of benefits to out-of-network providers and increased health insurance premiums has not been established. According to the most recent Families-USA survey illustrating a four-year average premium increase for all states, premium increases in some of the states with mandated assignment of benefits were higher than the national average while others were lower. However, it is difficult to make an exact comparison of premium increases in different states due to variation in health plan products, insurance regulations, and how enrollment in the various plans is determined.

Figure V.3 compares national health plan premium growth to other economic indicators (i.e., workers' earnings, general inflation, national health expenditures and gross domestic product) between 1998 and 2003. Per a report released by the Center for Studying Health System Change (HSC) and the Employee Benefit Research Institute (EBRI), the 5.7 percent increase in healthcare spending for the first six months of 2004 was less than the previous five years, but still double the growth in the overall economy. During 2002 and 2003, health plan premiums rose 7.9 and 6.3 times, respectively, as fast as general inflation; 3.7 and 4.5 times, respectively, as fast as workers' earnings; and 1.37 and 1.78 times, respectively, as fast as national health expenditures.

Harvard economist David Cutler estimates that if medical costs rise 5% above inflation for each of the next four years, at least 3 million more US residents will be without coverage. If health plan premiums continue to rise about 10% a year, today's average premium could double in just over seven years. Wages, however, are only expected to grow at about 3% a year.

Figure V.3. Health Plan Premium Growth Compared to Economic Indicators, 1998-2003.

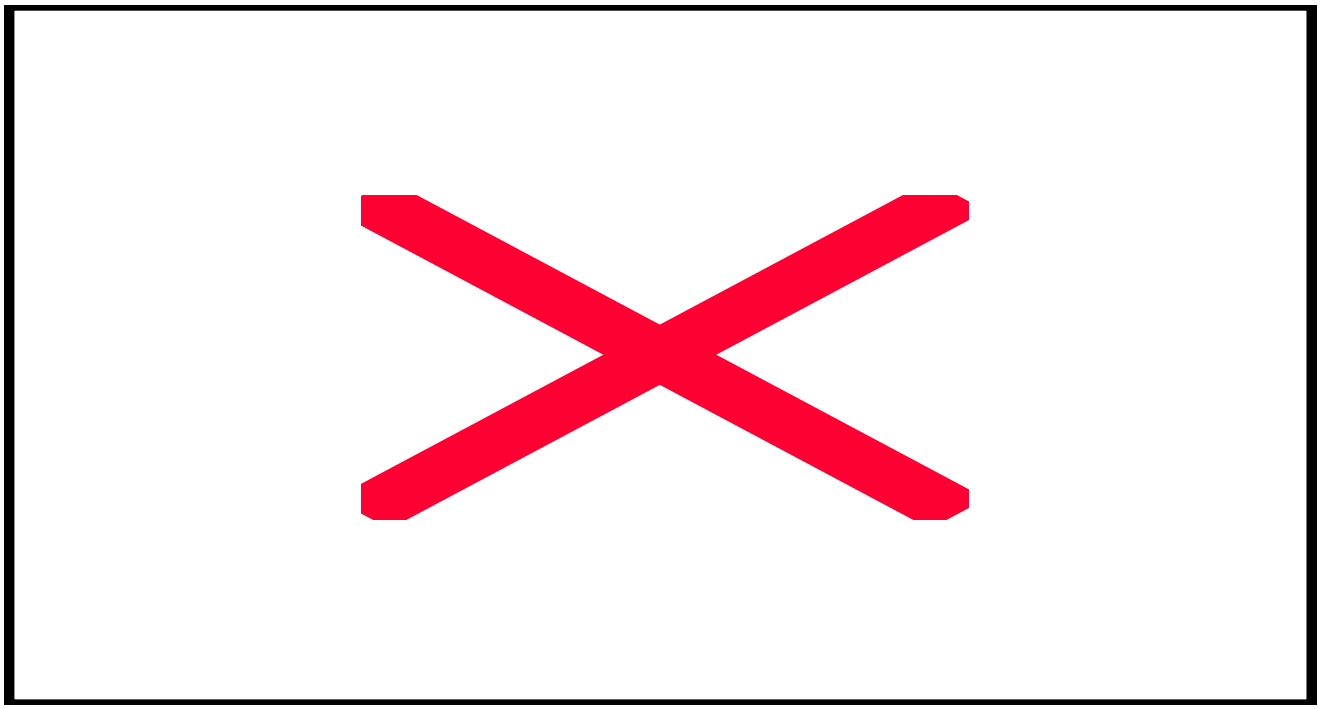


Sources: Kaiser Family Foundation, 2003: Bureau National Statistics: CMS

Per capita healthcare cost trends indicate spending on physician services has not increased at the same rate in recent years as hospital and pharmaceutical spending. Typically, cost trends are utilized to determine increases in health insurance premiums. However, between 2000 and 2003, health insurers have consistently raised annual premium prices above the rate of costs with premium yields at least 1.5 to 2.0 percentage points above cost trends since 2000 (Robinson, 2004).

Even though national health care costs declined during 2003 to 7.4 percent, the 13.9 percent increase in health plan premiums indicates health insurers are not experiencing vigorous price competition (Robinson, 2004) and that health insurers' administrative costs and profits have accelerated as benefit growth has decelerated (Grossman and Ginsburg, 2004). A study by the Center for Studying Health System Change (HSC) reported the four spending categories associated with total health care costs per privately insured person rose 7.4 percent in 2003. For the third consecutive year, spending on physician services was the slowest-growing category with a 5.1 percent increase, down from 6.5 percent in 2002. Total hospital spending increased by eight (8) percent, compared to 5.2 percent in 2002. The increase in hospital spending is indicative of favorable payment rate increases negotiated between hospitals and health insurers during 2002 and 2003. The New York Times reported that recent hospital mergers have created "powerful networks" that have "the upper hand in negotiations with health insurers." Figure V.4 illustrates the annual per capita percentage change in health care spending between 1994 and 2003.

Figure V.4. Annual Per Capita Changes in Healthcare Spending, 1994-2003.



Source: Center for Studying Health System Change, June 2004

Per the Center for Medicare and Medicaid Services (CMS), spending for physicians' services during 2002 represented 22% of total health care expenditures while overall hospital spending represented 32% of total healthcare expenditures, an increase of eight (8) percent compared to 5.2 percent in 2001, indicative of better payment rates from health insurers due to greater negotiating leverage created from recent hospital mergers and consolidation.

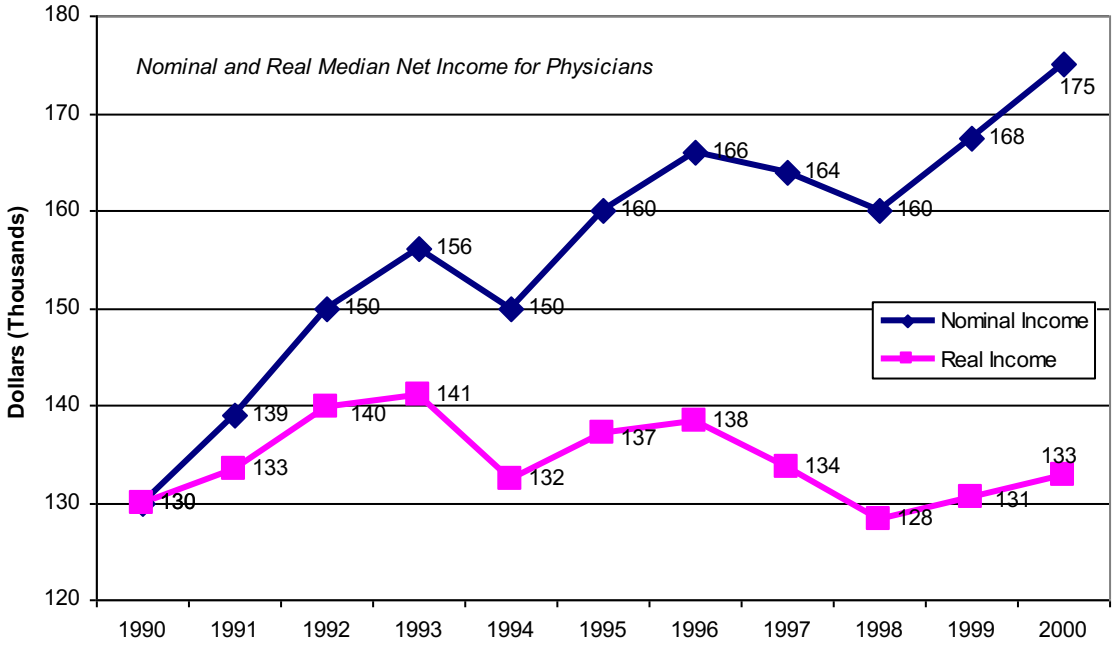
VI. Trend of Physician Income

While health plan premiums and health insurer profits continue to escalate, physician reimbursement has remained relatively flat or decreased. Physicians have received very little of the substantial resources generated by increased health plan premiums. "Real" practice revenues fell by 1.5% per year between 1998 and 2000 while health plan premiums increased by double-digits (AMA Patient Care Survey, 2001; The Lewin Group, June 2003). The median "real income" of all U.S. physicians increased an average of 0.2% per year from $130,000 in 1990 to $132,800 in 2000 (American Medical Association, 2003). Financial pressures from increasing professional liability insurance premiums has emerged as a crisis for many physician specialties including obstetrics/gynecology, orthopaedics, neuro-surgery, trauma, emergency medicine, etc., In order to offset reductions in Medicare and commercial reimbursements, many physicians are increasing their workloads while also dealing with increased administrative burdens related to health insurers and federal regulatory compliance. The combination of lower payments and rising costs are making it more difficult for physicians to cross-subsidize care provided to Medicaid and

uninsured patients, again jeopardizing access to care. Physicians are also seeking other ways to increase medical revenues to offset increasing practice costs (e.g., ambulatory surgical centers, professional service agreements with hospitals to subsidize the expense of providing care in the hospital setting, increased utilization of physician extenders, etc.).

A candid reminder of physicians' inability to negotiate appropriate reimbursement for professional services was found on The Medical Society of Virginia's website in January 2004, "Unlike other professions, we as physicians are not able to raise our prices to meet the increasing cost of delivering care to our patients…." The AMA's Report on Competition in Health Insurance (Second Edition: January 2003) validated that "physicians have little, if any, bargaining power with health plans." Figure VI.1 illustrates nominal and real median income for physicians between 1990 and 2000.

Figure VI.1. Nominal and Real Median Income for Physicians Between 1990 and 2000.

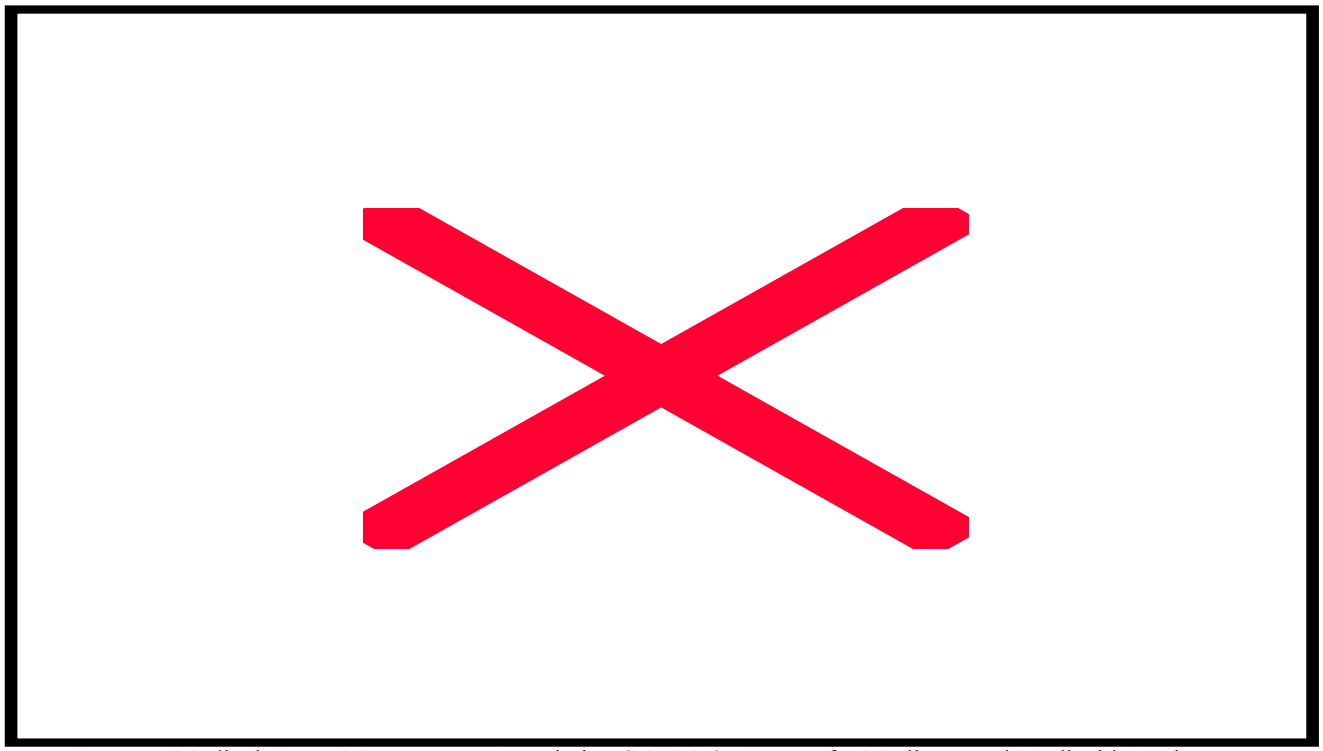


Sources: 1991-1999 AMA Physician Socioeconomic Statistics, 2001 AMA Patient Care Survey and Income Adjusted using Bureau of Labor Statistics CPI for all urban consumers (not seasonally adjusted).

Medicare's Fee Schedule (MFS) for physicians fell 14% behind practice cost inflation from 1991 through 2003 (AMA letter to Congress, June 2003). Based upon data provided by the Medical Group Management Association (MGMA), medical practice costs have outpaced Medicare reimbursement by an average of 2.7 percent annually during the last ten years, with practice costs increasing by more than 3.8 percent per year while Medicare reimbursements increased by only 1.1 percent. Since most national health insurers benchmark their fee schedules according to

Medicare reimbursement, healthcare services for non-Medicare populations are also being negatively impacted. Physician practices are struggling to offset rising costs and declining reimbursement through staff reductions, postponement of technology investments, and limited expansion of their practices—all indicators of declining access to care. Figure VI.2 compares medical practice costs, the Medicare Economic Index and Medicare Updates.

Figure VI.2. Comparison of MGMA Practice Costs, the Medicare Economic Index and Medicare Updates:



Sources: Medical Group Management Association (MGMA), Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and Medicare Payment Advisory Commission (MedPAC). Estimates for 2003-2006 operating costs and 2005-2005\6 MEI are 5-year average.

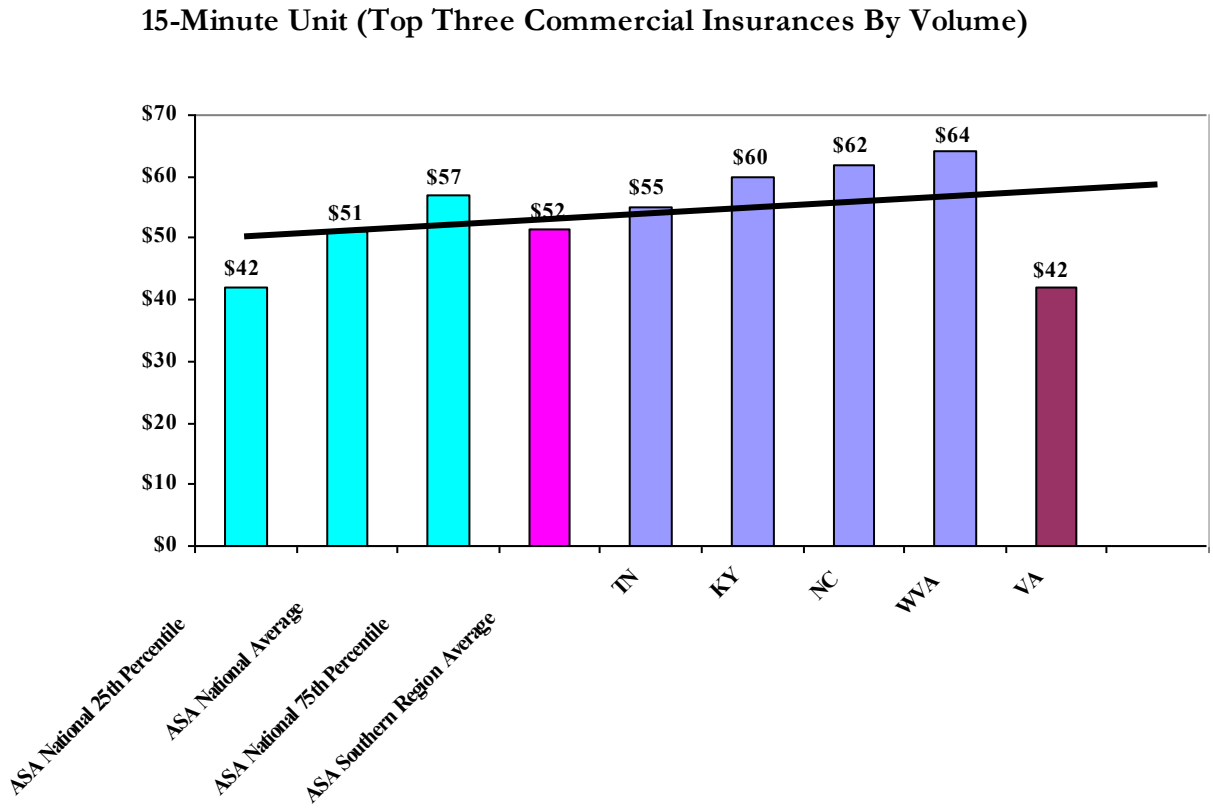
Through consolidation, health plan insurers have secured significant leverage in determining the delivery of healthcare services in this country. Only ten health insurers now cover over one-half of commercially insured Americans. The primary obligation of publicly traded health insurers is to their shareholders, not to patients enrolled in their plans. With the recent finalized merger of Wellpoint and Anthem, it is reasonable to assume that issues specific to healthcare delivery and physician shortages in Virginia will not be driving Wellpoint/Anthem's corporate policies.

In a letter to the Federal Trade Commission from the Congress of the United States, Representative Pete Stark expressed: "Dominant health insurers, particularly those that are for-profit have the potential, if not the incentive, to use their market power to establish highly favorable bargaining positions with providers, increase premiums to employers and individuals, and generate higher profits."

As Virginia's dominant health insurer, Anthem is one of the most influential forces in the state's health care economy and plays a considerable role in the political community and public policy arenas. Per a comment from the Milbank Quarterly report (2003), "Before Anthem's acquisition of Trigon, BCBS was very conscious of how it was viewed from a political standpoint by the public, the press, and the regulators, and that this constrained its behavior to some extent. Several people thought that BCBS was still trying to craft workable solutions to public policy and regulatory issues in Virginia"….."But due to Anthem's dominance, two cynics maintained that BCBS in Virginia did not really care what people think because they don't have to," …."BCBS liked to be perceived as caring about the community but the feeling was not genuine."

An example of low reimbursement rates paid to physicians by health insurers in Virginia is illustrated in Figure VI.3, which compares anesthesia rates nationally and in surrounding states. Other categories of medical practices (e.g., emergency medicine, general surgery, obstetrics, orthopaedic surgery, thoracic surgery, etc.) are also experiencing lower reimbursement rates than neighboring states.

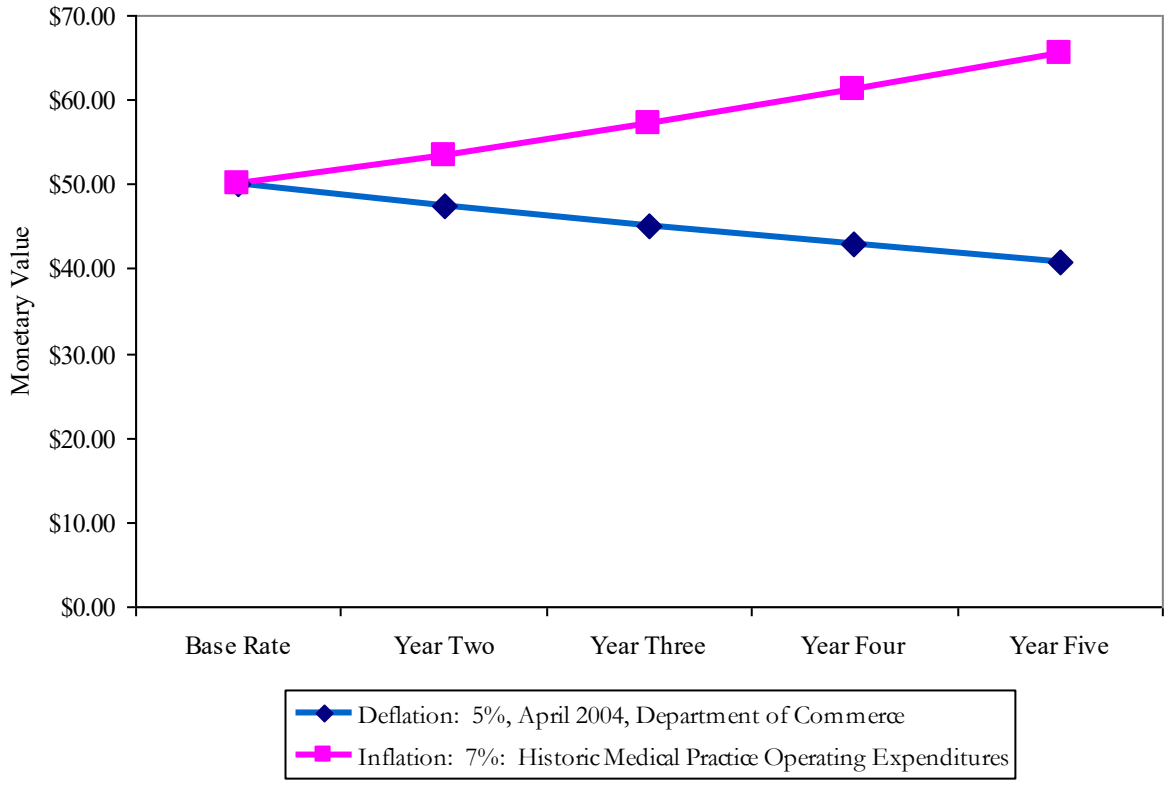
Figure VI.3. Comparison of Anesthesia Reimbursement Rates in Virginia



Based on the 2003 ASA survey, average commercial reimbursement per 15-minute anesthesia unit in Virginia is $42.00, which places it in the nation's lowest 25th percentile for anesthesia reimbursement. Reimbursement rates are higher in the states surrounding Virginia, making it

more difficult to recruit anesthesiologists to the Commonwealth. In addition, some health insurers are presenting contractual agreements to anesthesia practices with a five-year flat fee. Figure VI.3 presents the inflationary and deflationary value associated with a flat fee and medical practice inflation.

Figure VI.3: Anesthesia Reimbursement: Monetary Value of Flat Fee for Five Years.



The AMA met with the Federal Trade Commission (FTC) and members of Congress to address the inability of physicians to negotiate appropriate reimbursement from health insurers while the health insurers continue to consolidate and command extraordinary market power and report record profits. The AMA's position on collective bargaining for physicians includes the following:

- AMA: H-160.966 Market Forces on Medical Practice. "The ratcheting down of physician payment rates will not produce appreciable reductions in the rate of health care cost increases, since payment for physicians' services constitutes only about 1/5 of spending for health care: however; it may well reduce access to care as more physicians leave the area, retire, or in other ways change their practices."

- Collective Bargaining/Antitrust Relief: "Self-employed MDs lack the ability to negotiate with managed care plans or be involved in key decisions that affect the well being of their patients and the quality of care of their professional practices or training institutions. There have been several recent examples of unprofessional and egregious health plan tactics in contract negotiations and employment issues."
- H-385.976 Physician Collective Negotiations—"the AMA will seek amendments to the National Labor Relations Act and other appropriate federal antitrust to allow physicians to negotiate collectively with payors who have market power. "(Res. 95, A-90; Reaffirmed by BOT Rep. 33, A-96; Reaffirmation A-97).

VII. Largest Publicly Traded Health Insurers' Financial Performance

Weiss Ratings, Inc. reported the nation's HMOs experienced a $3 billion profit for the first quarter of 2004, which was a 33 percent increase of $742 million over the same period during 2003. The HMOS nearly doubled their profits to $10.2 billion during 2003, an 86% increase over the $5.5 billion profit reported for 2002, which represented an 81% increase from the $3 billion profit reported in 2001. The gains have been attributed to ongoing double-digit premium increases and cost-cutting measures, including decreased reimbursement to providers. Regarding the earnings, Melissa Gannon, a Weiss Rating, Inc. vice president, commented "The industry's soaring profits continue to irk both consumers and businesses who are shouldering skyrocketing healthcare costs without any perceived improvement in benefits."

The Hartford Courant reported the S&P Managed Health Index for 2004 increased 43% and is ranked eighth-best among 132 industry groups in the Standard & Poors (S&P) 500 index, as health insurers' profits surged due to a continuing decrease in medical costs (12/02/04). While health insurance premiums increased an average of 11.2% in 2004 (Kaiser Family Foundation), it is expected that medical costs will have increased approximately 8% at year-end (Strunk and Ginsburg). From an investor perspective, Robinson reported the health industry has remained extremely attractive during the last four years. With the exception of Aetna and CIGNA, which both endured setbacks and loss of market share (mainly to BCBS plans), Wellpoint, Anthem and United share prices consistently appreciated by double-digits, compared to the S & P 500 index for the broader market, which declined 10.1% in 2000, 13.0% in 2001, and 23.4% in 2002, followed by an increase of 26.4% in 2003.

An illustration of health plan profitability in a state with mandated assignment of benefits to healthcare providers is Georgia. Wellpoint reported a 28% increase in profits during the 3rd quarter 2004—revenue increased 16% to $5.85 billion from $5.05 billion a year earlier, attributed to a 15% climb in premium revenue. The recently completed $16.4 billion merger of Wellpoint Health Networks by Anthem will provide Georgia with approximately $126.5 million for health care programs as well as a promise to not increase premiums for Georgia's 3.2 million BCBS members. Even though California does not have mandated assignment of benefits to health care providers, the new Wellpoint Inc. will also provide California with $265 million to fund health care programs and guarantees that expenditures on patient care will increase but premiums for the 7 million BCBS members in California will not increase to help finance the merger. It is expected that 293 Wellpoint executives will receive as much as $356 million in compensation, which does not include millions of dollars in stock options.

The profitability of the largest health insurers does not indicate an industry in crisis, quite a contrast to the practice environment many physicians are currently dealing with in Virginia and throughout the country. Additional information on various financial performance indicators for some national publicly traded health insurers doing business in Virginia includes the following:

•**The Blue Cross and Blue Shield Association** reported the combined earnings of its 41 independent Blue Cross Blue Shield affiliates increased 32% to $3.7 billion for the 2nd quarter of 2004, compared to $2.7 billion for the same period last year. The increase comes after a 53% increase in 2003 profits to $6.1 billion, compared to a 43% increase to $4.0 billion profit reported for 2002 and the $2.8 billion profit reported for 2001. At year-end 2003, the 41 plans held a combined $31.9 billion in reserves, up 30% from $24.5 billion from 2002. Total enrollment in the plans climbed 4% in 2003 to 88.8 million members, the highest level in 23 years.

•**Anthem** reported record results for 1st quarter 2004, which increased 54% to $295.6 million, compared to a $191.7 million profit for the same period last year. Anthem's chairman, president and chief executive commented, "We remain confident in our ability to continue this momentum, and look forward to the additional opportunities that our pending merger with WellPoint Health Networks will bring."

Anthem's annual net income during 2003 increased 41% to $774 million while enrollment increased by 8% to 874,000 members. Second-quarter earnings during 2003 represented a 67% increase due to Anthem's acquisition of Richmond, VA.based Trigon Healthcare during 2002. Anthem's medical cost ratio decreased from 84.8% in 2000 to 80.8 percent in 2003. Anthem experienced the same rate of profitability between 2000 and 2002 when its annual performance goal was projected at only 15 percent. The press reported in 2001 that Wall Street's expectations had been exceeded by Trigon every quarter since it's conversion to for-profit status (Milbank Quarterly, 2003). Per a Securities and Exchange Commission filing, Anthem's rapid growth between 2000 and 2002 earned Larry Glasscock, Anthem's Chairman, an incentive bonus of $42.5 million. During 2003, Glasscock's combined salary and bonus was $3.3 million. Anthem's four other top executives were also rewarded for the company's substantial three-year performance. The executive vice president and chief legal and administrative officer, David R. Frick, received $1.3 million in compensation and bonus plus a $16.1 million performance award; executive vice president and chief financial and accounting officer, Michael L. Smith, received $1.4 million in compensation and bonus plus a $16.1 million performance award; the president of Anthem Midwest, Keith R. Faller, received $1.45 million in compensation and bonus plus a $11.9 million award; and the president of Anthem Southeast, Thomas G. Snead, Jr. received $4.8 million in compensation and bonus plus a $4.4 million award. The executives, including Glasscock, must stay with Anthem until 2005 to fully collect on the performance awards, which will be equally comprised of cash and stock. William J. Ryan, a Maine banker who chairs Anthem's Board of Directors compensation committee commented, "the company has performed in an extraordinary way, and it would be unfair for the executives not to be paid in an extraordinary way."

•**WellPoint** reported 2004 first-quarter profit rose 53% to $295.2 million, up from $193.1 million for the same period last year. Overall, all of 2003 net income increased 33% to $935.2 million, up from $703.10 million during 2002. Wellpoint's medical cost ratio remained consistent between 2000 and 2003, ranging between 81.5% and 80.5%. Per filings with the Securities and

Exchange Commission, WellPoint's Chairman and CEO, Leonard Schaeffer, stands to receive a total of $335 million when the WellPoint/Anthem merger is completed. Based on annual cash compensation only, Schaeffer was also one of the ten highest paid CEOs of S&P 500 companies in 2002 (i.e., $7,077,413). Schaeffer explained the pressure created by having to keep Wellpoint's investors happy: 'there is no question that the pressure for economic performance and thus accountability to investors is very real….Stock analysts who follow companies want them to perform to their calculated profit estimates every quarter. Having said that, though…there was almost no change in how we behaved [following conversion]. We were [already] one of the most profitable plans in the United States. However, when we became publicly held, and listed on the stock exchange, for the first time ever there were incredible pressures for achieving our goals for quarterly earnings." (Iglehart, p.135).

•**Aetna,** the country's third largest proprietary health insurer with membership of 13.6 million enrollees, posted a steep rise in profit for 3rd quarter 2004, up from $215.9 million for the same period last year to $1.29 billion. For all of 2003, Aetna reported net income of $933.8 million. Aetna's medical cost ratio decreased from 89.8% in 2001 to 78.3% in 2003. Aetna's CEO, John W. Rowe received $10.6 million in compensation during 2003, which does not include $7.6 million in gains made from stock options.

•**CIGNA**, the country's fourth largest proprietary health insurer by membership—approximately 9.9 million enrollees at the end of 3rd quarter 2004, has projected 2004 consolidated income will be between $580 million to $610 million for its healthcare operations. CIGNA's net income for 3rd quarter 2004 was $320 million, up 64% from $195 million for the same period last year. CIGNA's medical cost ratio has remained fairly consistent at approximately 87% during the last four years.

•**Coventry Health Care** reported a 72% increase ($69.7 million) in net earnings for 2003, compared to 2002, due to higher premiums and increased membership. Its medical loss ratio decreased from 86.99% in 1998 to 80.9% in 2003. It is expected Coventry will become the country's eighth-largest health insurer with approximately 4 million enrollees if its acquisition of First Health Group Corp. receives regulatory approval during the first quarter of 2005.

•**UnitedHealth Group, Inc**., now the second largest proprietary health insurer with 22 million enrollees behind the newly created Wellpoint, Inc with approximately 28 million enrollees, posted a 37% increase in first-quarter net income for 2004. During 2003, United Health Group had $28.8 billion in revenue and record earnings of $2.9 billion. United's medical loss ratio decreased from 84.9% in 2000 to 80.0% in 2003. UnitedHealth Group Inc.'s Chairman and CEO, Dr. William McGuire, was the highest paid corporate executive in Minnesota last year. He received $94.2 million in compensation, ten times higher than his 2002 compensation. UnitedHealth's proxy statement also reported the compensation packages of the four other highest-paid executives in the company. The president and chief operating officer of UnitedHealth Group Inc. received $39.2 million, the CEO of UnitedHealthcare $10.7 million, the CEO of Uniprise, $9.3 million, and general counsel, $7.5 million.

Conclusion

At this time, we have not been able to establish any empirical evidence or data to support Anthem's claims that direct assignment of benefits to healthcare providers has a negative impact on insured consumer expenditures or access to quality care. Health plans' claims that mandated assignment of benefits will "cause harm" to consumers have not been substantiated. Health plans' abilities to provide adequate cost-effective networks have not been weakened. Managed care networks have not deteriorated due to an exodus of providers electing non-participatory status. A correlation between assignment of benefits and increased health insurance premiums and overall healthcare expenditures has not been established.

The practice environment in Virginia is making it more difficult to retain and recruit qualified physicians who are attracted to surrounding states with more favorable reimbursement. For many medical practices located in Virginia, the "cost of doing business" is no longer a viable option—increasing operating expenditures (i.e., medical malpractice premiums, health plan premiums, personnel, technology, regulatory mandates, etc.), are exceeding revenues even though physicians' work loads and the utilization of physician extenders have increased, prompting many physicians to exit the marketplace via early retirement, relocation or by reducing the types of services provided. The demand for many high-risk specialists (e.g., neurosurgery, obstetrics/gynecology, orthopedic surgery, thoracic surgery, emergency medicine, trauma, etc.) and lack of adequate physician coverage in numerous communities throughout the Commonwealth is causing delays in patients receiving treatment and increasing patient transfers between hospitals. Per a recent report from Virginia's Joint Legislative Audit and Review Commission, the most critical issue threatening access to trauma care in Virginia is inadequate physician coverage.

During the last five years, health insurers have experienced unprecedented profitability due to double-digit premium increases and declining medical expense ratios. Three of the four major health insurers in this country—United Healthcare, Aetna and Cigna, representing approximately 46 million subscribers, have not experienced negative financial consequences due to honoring assignment of benefits to healthcare providers. Blue Cross Blue Shield plans, which provide health plan benefits to approximately 90 million subscribers, and are typically the dominant private insurer in most markets, are the only insurers to deny their subscribers the right to assign benefits as a matter of policy.

Assignment of benefits is a relatively simple and effective means to help restore some balance to the relationship between healthcare providers and insurers in the Commonwealth of Virginia. Providers would have the opportunity to negotiate more favorable terms with the insurers, allowing patients greater access to necessary services. Providers could choose not to participate in plans providing inadequate reimbursement without being financially disadvantaged or causing disruption to patient care. Assignment of benefits creates an environment where insurers have an incentive to recruit and retain providers in their networks.

References

American Medical Association, AMA, Chicago, Illinois

American Medical Association, *Competition in Health Insurance, Second Edition*, 2003.

American Medical Association, *Patient Care Survey, 2001*, Chicago, Illinois

American Medical Association, *Physician Socioeconomic Statistics, 2000-2002 edition,* (2001).

AHA Trendwatch: *The Changing Physician Environment*. (June 2003, Vol. 5, No. 1)

K. Bierstein, *Fees Paid for Anesthesia Services: 2003 Survey* Results (American Society of Anesthesiologists Newsletter, August 2003).

Bureau of Labor Statistics, Consumer Price Index, October 2004.

Centers for Medicare and Medicaid Services: *The CMS Health Care Industry Market Update, Managed Care,* March 24, 2003.

Centers for Medicare and Medicaid Services: U. S. Health Care Spending, 2003.

Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

G. Claxton, et.al., *Employer Health Benefits: 2004 Annual Survey,* (The Henry J. Kaiser Family Foundation and Health Research and Education Trust, September 2004).

Families USA*, Health Care: Are You Better Off Today Than You Were Four Years Ago?* Publication No. C4-04-100, September 2004.

S.E.Foreman, J.A. Wilson, and R.M. Scheffler, 1996: *Monopoloy, Monopsony and Contestability in Health Insurance: A Study of Blue Cross Plans.* (Economic Inquiry, 34: 662-77).

J. Gabel et al., *Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll on Coverage*, Health Affairs, 23, no. 5 (2004).

J. Grossman and P. Ginsburg, *As the Health Insurance Underwriting Cycle Turns: What Next?* Health Affairs, 24, no 7 (2004).

M.A.Hall and C. J. Conover, *The Impact of Blue Cross Conversions on Accessibility, Affordability, and the Public Interest* (The Milbank Quarterly, 81, no.4 (2003).

J. K. Iglehart, *Inside California's HMO Market: A conversation with Leonard D. Schaeffer* (Health Affairs, 14, no. 4, 131-42).

InterStudy Publications, *The InterStudy Competitive Edge 12.2, Part II: HMO Industry Report,* (October 2002, Figure 7, p. 51).

W. Jessee, Jr., *2004 Medicare Physician Fee Schedule*, Statement of the Medical Group Management Association to the Practicing Physician's Advisory Council, February 2003.

J. C. Robinson, *Consolidation and the Transformation of Competition in Health Insurance,* Health Affairs, 23, no. 6, (2004).

C. J. Schramm, 2001a. *Blue Cross Conversion: Policy Considerations Arising from a Sale of the Maryland Plan* (Baltimore: Abel Foundation, November 2001).

C. Smith, et.al, *Health Spending Growth Slows in 2003*, (Health Affairs, 23, no. 1, 2004)

State Legislative Health Care and Insurance Issues: 2001 Survey of Plans, (Blue Cross Blue Shield Association, December 2001).

B. C. Strunk and P.B. Ginsburg, *Tracking Health Care Costs: Trends Turn Downward in 2003,* (Center for Studying Health System Change, Data Bulletin No. 27, June 2004).

U. S. Department of Commerce, Economics and Statistics Administration, Washington, D.C. ,October 2004.

J. M. Wander and D. E. Freier, *The Potential Impact of State Mandatory Assignment Legislation on Consumers,* (Reden & Anders, Ltd., at the Request of the Blue Cross Blue Shield Association, September 2003.)

Weiss Ratings Inc. *HMO Profits Increase 33% in First Quarter 2004*, December 8, 2004.

Weiss Ratings, Inc. *HMO Profits Climb 81$ to $5.5 Billion in 200*3, December 10, 2003.

Weiss Ratings, Inc., *HMOs Earn $10.2 Billion in 2003, Nearly Doubling Profits*, August 30, 2004.