IN THE SUPREME COURT OF FLORIDA
TALLAHASSEE, FLORIDA

ALLSTATE INSURANCE COMPANY

Petitioner

v.

HOLY CROSS HOSPITAL, INC.

Respondent

APPEAL FROM THE DISTRICT COURT OF APPEAL
FOR THE FOURTH DISTRICT
WEST PALM BEACH, FLORIDA

AMENDED BRIEF OF *AMICUS CURIAE* FLORIDA CONSUMER ACTION NETWORK In Support Of Respondent Holy Cross Hospital, Inc.

CASE NO. SC05-435 (Consolidated)
CASE NO. SC05-545 (Consolidated)

LEE & AMTZIS, P.L.
Attorneys for *amicus curiae*
5550 Glades Road, Suite 401
Boca Raton, Florida 33431
(561) 981-9988
(561) 981-9980 (fax)

KOPELMAN & BLANKMAN
350 E. Las Olas Blvd., Ste. 980
Ft. Lauderdale, FL 33301
(954) 462-6855
(954) 462-6899 (fax)

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IDENTITY AND INTEREST OF *AMICUS CURIAE*

Amicus the Florida Consumer Action Network ("FCAN"), is a not-for-profit, grassroots consumer and environmental advocacy organization with more than 40,000 members reaching from Key West to Tallahassee. Its purpose is to organize individuals along with allied organizations to win change on issues which affect the average Floridian's quality of life. FCAN was incorporated in Florida on December 27, 1984 and is recognized by the Internal Revenue Service as a tax-exempt organization. In addition, FCAN has complied with the registration requirements of the Florida Division of Consumer Services under Chapter 496.

FCAN is vitally interested in the outcome of this appeal. At the center of the dispute is the operation of "Silent PPOs" in Florida by Petitioner Allstate Insurance Company ("ALLSTATE") and other automobile insurance companies. Through the operation of a Silent PPO in the Florida automobile insurance arena, ALLSTATE and other auto insurers have been wrongfully and secretly taking preferred provider organization ("PPO") discounts from thousands of healthcare providers and applying these discounts to automobile insurance Personal Injury Protection ("PIP") claims. This practice forces managed care policies on consumers who pay for indemnity policies without providing consumers with the benefit of reduced premiums.

These "Silent PPO" practices both in Florida and nationally, cost healthcare

providers and consumers millions of dollars through the improper taking of discounts. FCAN believes that an understanding of the structure and operation of Silent PPOs and how they damage consumers and how they detrimentally affect the delivery of healthcare to consumers will assist the Court in analyzing the issues raised on appeal. For these reasons, FCAN respectfully submits this *Amicus Curiae* brief in support of Respondent HOLY CROSS HOSPITAL, INC., ("HOLY CROSS").

STATEMENT OF THE CASE AND FACTS

FCAN accepts and adopts the Statement of the Case and Facts as outlined by HOLY CROSS in its Answer/Cross – Initial Brief on the Merits.

SUMMARY OF THE ARGUMENT

Reversal of the Fourth District Court of Appeal's decision in this appeal will assist medical care providers and consumers in fighting unlawful "Silent PPO' practices that are being operated by auto insurers in Florida which are costing healthcare providers and Florida consumers millions of dollars annually. Despite the auto insurance companies' arguments to the contrary, the only parties benefiting from Silent PPO practices in Florida are the auto insurers and the PPO networks that are leasing their preferred provider lists and discounts. The auto insurers reap the improper benefits from making lower discounted PIP payments to medical providers, while at the same time collecting higher auto insurance

premiums from their consumers to whom they are not offering PPO auto insurance policies in compliance with Florida statutory law. The PPO networks receive either fixed fees or fees based on percentages of savings for leasing or selling their preferred provider lists to the auto insurers.

In contrast, physicians, hospitals, physical therapists, chiropractors and other healthcare providers, as well as covered patients, are all victimized by the Silent PPO scheme. Medical providers lose revenue and even lose the benefit of their originally contracted bargain for joining a PPO network, which is supposed to be increased patient volume. Covered patients may receive a bill for the balance of the claim and lower benefit levels for the originally contracted services. Consumers also pay premiums for indemnity policies, while receiving only managed care reimbursement.

ARGUMENT

I. THE PURPOSE OF SECTION 627.736 IS TO BENEFIT INSUREDS, NOT INSURANCE COMPANIES.

In addition to its stated purpose of providing medical benefits without regard to fault (Fla. Stat. § 627.731), the legislature mandated the required security pursuant to this act be provided by an insurance policy providing the benefits and exceptions contained in Sections 627.730-627.7405, Florida Statutes ("No Fault Act") and that any policy of insurance represented or sold as providing the security required shall be deemed to provide insurance for the payment of the required

benefits (Fla. Stat. § 627.733). The legislature did not, nor has it ever authorized insurers to sell policies and provide benefits in any manner other than provided for under the No Fault Act.

Contrary to ALLSTATE's position that it could establish its own auto managed care plan in derogation of the No Fault Act is the simple fact that there is no authority allowing it to do so. In 1991, the legislature voted to add subsection (10) to Section 627.736, Florida Statutes ("Section 627.736(10)"). Critical to the analysis of whether an auto insurer may create its own managed care arrangement outside the confines of subsection(10) and without the knowledge of its insureds is an examination of the language used by the legislature when the law was originally enacted in 1991 and the subsequent amendment to the statute in 1992. As originally enacted in 1991, the law read as follows:

> <<+(10) An insurer may negotiate and enter into contracts with licensed health care providers for the benefits described in this section, referred to in this section as "preferred providers" which shall include health care providers licensed under chapters 458, 459, 460, 461, and 463. The insurer may provide an option to an insured to use a preferred provider at the time that medical services are sought by the insured for the benefits described in this section. If the insured elects to use a provider who is not a preferred provider, the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider who is a preferred provider, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. The insurer may not require a policyholder or applicant to make any election in this regard at the time of purchase of the policy or at any time other than at the time that medical services are sought. The insurer shall provide each

> policyholder with a current roster of preferred providers and shall make such list available for public inspection during regular business hours at the principal office of the insurer within the state.

Laws 1991, c. 91-106 § 7. (emphasis added).

Accordingly, an insurer could, if it chose, enter into contracts with health care providers, otherwise referred to as preferred providers, and provide an option to its insureds to use these preferred providers only when the medical services were sought by the insured. The auto insurer was given permission to set up this type of managed care arrangement by complying with the law which conferred upon them that authority. The legislature never authorized auto insurers to establish their own managed care arrangements outside of subsection(10), for if they had there would be absolutely no reason to have enacted subsection(10) and there would be no laws or regulations governing their conduct since they were not preferred provider organizations regulated under the PPO Act.

In 1992, merely one year after subsection(10) was enacted, the legislature amended this subsection, which exists to this day and governs the conduct of auto insurers like ALLSTATE. The amendment is as follows:

> (10) An insurer may negotiate and enter into contracts with licensed health care providers for the benefits described in this section, referred to in this section as "preferred providers," which shall include health care providers licensed under chapters 458, 459, 460, 461, and 463. The insurer may provide an option to an insured to use a preferred provider at the time <<+of purchase of the policy for personal injury protection benefits, if the requirements of this subsection are met+>> <<-that medical services are sought by the insured for the benefits

> described in this section->>. If the insured elects to use a provider who is not a preferred provider, <<+whether the insured purchased a preferred provider policy or a nonpreferred provider policy+>> the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider who is a preferred provider, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. <<+If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy.+>> <<-The insurer may not require a policyholder or applicant to make any election in this regard at the time of purchase of the policy or at any time other than at the time that medical services are sought.->> The insurer shall provide each policyholder with a current roster of preferred providers <<+in the county in which the insured resides at the time of purchase of such policy,+>> and shall make such list available for public inspection during regular business hours at the principal office of the insurer within the state.

Laws 1992, c. 92-318 § 84. (emphasis added).

Once again insurers were given permission to participate in this managed care arrangement if they followed subsection (10). However, there is no statutory authority for an insurer to act on their own and create a managed care scheme outside of the provisions of Section 627.736(10). Significantly, the 1992 amendment, while still requiring insurers to negotiate and enter into contracts with health care providers, which ALLSTATE did <u>not</u> do, now required insurers, if they provided this option to their insureds, to provide such option <u>at the time of the purchase of the policy</u>. It also required insurers to offer non-preferred as well as preferred provider policies and give each policyholder rosters of preferred

providers in the county in which the insured resided at the time of the purchase of the policy.

ALLSTATE admits that it did not follow any of the requirements of Section 627.736(10). Instead, ALLSTATE contends that it was allowed to utilize PPO rates by virtue of its arrangement with a middle man preferred provider network known as CCN. By side-stepping the prescribed statutory mandate, ALLSTATE has enriched its own pockets by saving millions of dollars in medical benefits otherwise payable to medical providers and their patients while failing to pass any of the savings dollars on to its insureds. ALLSTATE does not offer reduced premiums for preferred provider policies or pay benefits in excess of the statutorily required by Section 627.736(1)(a). ALLSTATE fails to even give its insureds an option to purchase a preferred provider policy and has instead created its own "silent PPO" in which it collects full premiums but pays only discounted amounts to providers.

Despite not even offering its insureds an option to purchase a preferred provider policy, ALLSTATE treated all of its PIP insureds as though they had purchased preferred provider policies and passed none of the savings along to them in the form of reduced premiums. While this case deals with ALLSTATE's alleged entitlement to act outside the No Fault Act and create its own managed care scheme, this Court should be mindful of the insureds who unwittingly purchased

non-preferred policies and were treated like PPO patients by overworked and under-reimbursed medical providers. In addition, the vast majority of ALLSTATE insureds paid full premium dollars for non-preferred policies, which would have paid benefits at PPO rates, yet never made claims. Quite simply, they did not get what they paid for, a traditional non-preferred provider PIP policy.

Why didn't ALLSTATE comply with subsection (10) and why do they go to such great lengths to argue that they don't have to comply? Why was it that in 2002, after years of litigating this issue in County Courts across this state, ALLSTATE and other insurance companies ceased this illicit managed care scheme? The answers are simple. Had they complied with subsection (10), they would have had to actually enter into direct contracts with medical providers, they would have had to give their insureds an option to purchase preferred provider policies, and they would have had to provide their insureds lists and directories of preferred providers. All this would have severely cut into the millions of dollars that ALLSTATE saved as a result of its scheme.

In addition to the potential animosity between patient and physician which may arise in a legitimate managed care arrangement, this secret arrangement has created other risks for insureds. Although ALLSTATE would like this Court to believe that creating this scheme benefits its insureds, what ALLSTATE conveniently ignores is the fact that insureds remain responsible for amounts not

paid by the insurance company.[1] ALLSTATE's silent PPO scheme eventually became the problem of insureds and an already overburdened court system clogged with PIP suits. While in most instances medical providers with assignments of benefits sue to recover benefits wrongfully denied them, there is no doubt that the insured is the ultimate responsible party.

This Court should also not lose sight of the fact that although ALLSTATE contends that its insureds benefit by being placed in its self-created managed care scheme, in traditional managed care arrangements, legitimate PPO's do not have the contractual right to force their insureds to submit to compulsory IME's and cut off their benefits. ALLSTATE not only maintained this discretion, but exercised it whenever it deemed it necessary. Therefore, not only were benefits reduced by being paid at preferred provider rates, but in many instances were cut off completely.

Section 627.736(10) is a statute which afforded an opportunity to both insurers and insureds to participate in an auto managed care arrangement capable of financially benefiting the needs of insurers, insureds, and medical providers. Unfortunately, many insurance companies, like ALLSTATE, could not resist the

[1] In the HMO Act, Section 641.3154, Florida Statutes, precludes providers from balance billing HMO patents when an HMO accepts responsibility for payment. Thus, if an HMO does not pay the proper amount, the dispute is between the provider and the HMO. A similar provision does not exist under the No Fault Act. Providers who are not paid the correct amount by an automobile insurance company can seek the balance from the insured.

temptation to act outside the law and keep the vast majority of savings for itself at the expense of its insureds and medical providers. ALLSTATE is correct in stating that Section 627.736(10) is permissive and not mandatory. However, if an automobile insurance company decides to create a preferred provider insurance policy, the insurance company must comply with Section 627.736(10). A "preferred provider" as defined by subsection (10) is one who enters into a contract with an insurer for the benefits described in this section. Since ALLSTATE does not enter into contracts with licensed health care providers, none of the providers utilized by ALLSTATE insureds constitute preferred providers under Subsection 10. Since none of the providers are preferred providers as defined by Subsection 10, "the medical benefits provided by the insurer shall be as required by this section." It is only if an insured elects to use a preferred provider that the insurer may utilize PPO rates. Moreover, subsection (10) specifically contemplates that insurance companies would issue preferred provider policies and non-preferred provider policies and requires that insurers "provide each policyholder with a current roster of preferred providers . . ."

If ALLSTATE and the other insurance companies can create their own PPO networks without complying with subsection (10), then subsection (10) is meaningless. ALLSTATE cannot cite to any provision in the No-Fault Act which provides it with the ability to create a preferred provider network that does not

comply with subsection (10). An analogous situation, which this Court is quite familiar with, are the rules which give this Court discretionary review over only certain types of cases. Pursuant to Florida Rule of Appellate Procedure 9.030(a)(2), "The discretionary jurisdiction of the Supreme Court may be sought to review . . ." Rule 9.030(2) then sets forth the specific instances in which this Court may utilize its discretionary jurisdiction to review a matter. If a matter falls outside of these specific instances, this Court cannot exercise discretionary review, because such review is limited to only those instances set forth. Similarly, subsection (10) provides that an insurer may enter into preferred provider agreements and issue preferred provider insurance policies if it complies with the specific sections therein. Just because it is permissive does not mean that an insurance company can create its own PPO outside of the parameters of subsection (10). Just like this Court cannot exercise discretionary jurisdiction over matters not specifically set forth in Florida Rule of Appellate Procedure 9.030(2), insurance companies cannot create PPO networks that do not comply with subsection (10).

II. SILENT PPOs DEVASTATE THE EFFORTS OF LEGITIMATE PPOs TO PROMOTE QUALITY HEALTHCARE.

A "silent PPO" is a well-known abuse in the healthcare industry that involves the illegitimate sale of PPO discount rates to indemnity insurers, such as automobile insurers, who do not offer a PPO policy, whose insureds do not know of the existence of the PPO, whose insureds do not select to treat with a PPO

preferred provider, and who do not have appropriate mechanisms in place to encourage patients to use the services of a preferred provider. Thus, without the knowledge or approval of the healthcare provider, the PPO network, makes its preferred provider list available for a fee to other payors, including ALLSTATE and the other Florida automobile insurers in this case who did not enter into an agreement with the preferred provider entitling them to a discount. Typically, these illegitimate payors and brokers do not comply with the duties and responsibilities of the original PPO contract. They simply take the discount as if they were entitled to it, despite the fact that they have not provided the consideration for it.[2]

The American Association of Preferred Providers has denounced "Silent PPOs," and the American Medical Association has issued an "Action Alert Kit" to its members educating them about Silent PPO practices. Not only do Silent PPOs result in the "theft" of a medical provider's PPO discount, these underhanded practices effectively eliminate the promotion of quality healthcare services. For example, when a payor, such as ALLSTATE, purchases provider discounts from other PPO networks or brokers, without giving healthcare providers the requisite *quid pro quo* in the form of steerage, there exists a financial ramification that a

[2] And, in the case of ALLSTATE and the other Florida automobile insurers, they have taken the PPO discount in violation of Florida statutory law surrounding the creation of automobile insurance PPOs.

healthcare provider must face. Despite ALLSTATE's assertions to the contrary, over time this effect negatively impacts Florida consumers and the level of care that they can expect. In HCA Health Services of Ga., Inc. v. Empls. Health Ins. Co., 240 F.3d 982 (11th Cir. 2001), the Eleventh Circuit directly addressed the effect of silent PPOs on consumers. As the Eleventh Circuit found:

> . . .the level of service [a participant] receives out-of-network is also diminished as providers in PPOs . . . adjust for the failure to receive their usual and customary fee when treating Insurance Company A's [non-PPO] participants. When followed to its natural conclusion, EHI's plan interpretation in effect turns a discounted fee negotiated between a specific provider and specific insurance company into the usual and customary fee for the entire medical services industry. Because the level of service participants receive is directly related to this reduction in fees, participants' expectations continue to be unfulfilled.

HCA Health Servs. of Ga., 240 F.3d at 1008.

This is not to say that Florida healthcare providers will purposely provide less or worse medical care. See Id. at 1007 n. 54. The economic realities of the ALLSTATE Silent PPO scheme, however, logically force a healthcare provider to "take on more patients to offset the reduction in its fees." Id. The provider is then forced to take on more patients to offset the reductions, and more patients invariably results in more waiting time and less individual time with a patient's doctor. A provider can also compensate for the lower fees by cutting staff salaries or by hiring fewer staff. Id. "Lower salaries may mean a less educated or experienced staff, both of which would impact the level of service a patient

receives. Likewise, fewer staff necessarily means there will be less personnel available to attend to the patient which impacts the level of service a patient receives. . ." Id.

The expectations of consumers are also ignored by ALLSTATE. As the Eleventh Circuit succinctly explained:

> When Participant A breaks his other arm and returns to Provider B because he was pleased with the level of service he previously received, Provider B is unable to provide Participant A with the same level of service because he receives less compensation. The entire purpose of a PPO rather than an HMO is to afford participants the choice to receive out-of-network medical care. PPO Participants know their medical care will be less expensive if they receive such care from an in-network provider. They choose, nonetheless, to pay a higher premium for the freedom to have their medical expenses covered when they receive medical care elsewhere. A participant presumably believes the level of service *1007 he receives outside the network will be different from the level of service he receives inside the network; this is why he pays for the option of going outside the network. Implicit in the belief that the level of medical service differs outside the network is the participant's understanding that this level of service will cost more than in-network medical care. The participant's act of paying for his choice is evidence that participants value the ability to receive medical care outside the network. Presumably, this value is a different, if not better, level of medical service. We have no doubt this is a participant's contractual expectation when he opts for a PPO health insurance policy.
>
> . . .
>
> Because it is impossible to account for all possible altruistic or subjective motivations, this analysis necessarily presumes that the actors in this hypothetical scenario (insurance companies, providers, and participants) are motivated and act in a way consonant with their own economic self-interest. As such, we analyze this problem through the objective means available to us, namely economic

analysis.

. . .

> Importantly, it follows that this effect on providers will negatively impact participants. Consider that the level of service Participant A receives from an in-network provider reflects the further discounting of fees demanded by Insurance Company A to offset its lower premiums. Worse still, the level of service Participant A receives out-of-network is also diminished as providers in PPOs B and C adjust for the failure to receive their usual and customary fee when treating Insurance Company A's participants. When followed to its natural conclusion, EHI's plan interpretation in effect turns a discounted fee negotiated between a specific provider and specific insurance company into the usual and customary fee for the entire medical services industry. Because the level of service participants receive is directly related to this reduction in fees, participants' expectations continue to be unfulfilled.

Id. at 1007-1008 (footnotes omitted).

III. LEGITIMATE PPOs ARE DESIGNED TO PROMOTE QUALITY HEALTHCARE SERVICES AND TO CONTROL HEALTHCARE EXPENSES.

Generally, a PPO is a managed care organization through which hospitals, physicians, physical therapists, chiropractors and other healthcare providers contract with an insurer, employer or other payor sponsoring a health care plan to provide healthcare services to covered persons for discounted rates. PPOs have been traditionally described as "contractual agreement(s) between a health care provider and an employer. Pursuant to such an agreement, the health care provider offers services to the employer's employees at reduced rates. In turn, the employer encourages its employees, as participants of the plan, to use the preferred providers

designated by the PPO." Gavin North Sherwood Chiropractic Clinic, A.P.C. v. Brower, M.D., 838 F. Supp. 274, 275 (M.D. La. 1993). Encouragement comes from the creation of incentives for subscribers to use the services of the health care providers within the PPO network. Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc., 603 F.Supp. 1077, 1078 (S.D. Ind. 1985) (reasoning that two characteristics differentiate PPOs from other forms of health insurance: "(1) subscribers are given incentives to use a limited panel of providers, but retain freedom of choice to use other qualified providers, and (2) preferred providers are defined by specific health care cost containment characteristics, such as competitive charges and participation in utilization programs."); see also, Federal Trade Commission v. Tenet Healthcare Corporation, 186 F.3d 1045, 1049 n. 7 (8th Cir. 1998)(noting that PPOs provide participants with financial incentives such as lower deductibles or low co-payments to use "in-network" health providers).

PPO payors and plans typically encourage qualified plan participants to seek out the services of its preferred providers through various financial and educational means collectively known as "steerage." Financial encouragement results from reduced co-payments (i.e., $10 co-pays for office visits to "in-network" doctors versus $50.00 co-pays for visiting "out-of-network" doctors), smaller deductible amounts, and/or lower health insurance premiums in general. Educational steerage comes through communication efforts of the plan payors with its participants,

including providing participants with a list of preferred providers and identification cards designed to inform providers that a patient is a participant eligible for PPO discounts.

Steerage is at the heart, and is ultimately the success, of a legitimate PPO because it is the motivation for preferred providers to accept discounted rates for their medical services. Providers are willing to furnish their services at discounted rates because they expect to receive a larger volume of patients, i.e., participants in the welfare benefit plan offered by an employer or insurance company, through plan payors' incentive program. HCA Health Servs. of Ga., Inc., 240 F.3d at 987. Without the benefit of steerage, (which can result in increased patient volume) there is no reason for a medical care provider to agree to discount its fees. Id. at 997 n.9.

Unfortunately, some insurance companies, including ALLSTATE, and PPO networks, including Beech Street and CCN, are damaging the effectiveness of legitimate PPO practices in Florida through the operation of a "Silent PPO" which offers neither the promotion of quality healthcare services, the increase in patient volume, or reduced premiums for consumers.

IV. SILENT PPO SCHEMES LIKE THAT OPERATED BY ALLSTATE DIRECTLY INJURE FLORIDA CONSUMERS.

ALLSTATE took part in a Silent PPO scheme that has damaged HOLY CROSS and thousands of other Florida healthcare providers. ALLSTATE

admittedly did not offer preferred provider auto policies to its insureds, never provided its insureds with a list of preferred providers from which they could choose, and never offered its insureds the option of using a preferred provider plan at the time of the purchase (or renewal) of the insurance policy as required by Florida statute. There is also no evidence to demonstrate that ALLSTATE even entered into a contractual relationship with a PPO, such as CCN, to even utilize its PPO rates. Thus, ALLSTATE could not possibly provide any of the Appellees with the necessary "steerage" to support the application of the reductions at issue. Yet, ALLSTATE applied the PPO discounted rates to Florida PIP auto daims, despite the fact that it was not offering PPO auto policies.

As cited earlier, the Eleventh Circuit has condemned the same type of Silent PPO scheme that is being operated by ALLSTATE. In HCA Health Servs., the Eleventh Circuit referenced "shared savings agreements" intended to allow a third-party payor or insurance company to access discount fees from healthcare providers without providing requisite consideration for the provider. The agreements were between "middleman" MedView Services, Inc., Health Strategies, Inc. (a broker that permits insurance companies to access preferred provider discounts), and Employers Health, Inc., the insurance company that accessed the MedView PPO discount through the processing by Health Strategies, Inc. HCA Health Servs., 240 F.3d at 986-87.

Recognizing the lack of "steerage" in the Silent PPO scheme operated by MedView and Health Strategies, the Court of Appeals condemned this arrangement since the preferred provider never received contractual consideration in exchange for the provider's PPO discount. HCA Health Servs. of Ga., 240 F.3d at 1002. According to the Eleventh Circuit, an insurance company steers plan participants to in-network providers in their respective PPOs through the use of economic incentives. Id.

ALLSTATE's scheme lacks these fundamental forms of steerage that would permit it to validly apply discounts to PIP medical expenses. Instead, ALLSTATE and the other Florida automobile insurers attempt to camouflage their conduct under the guise of the "language and legislative history" of Section 627.736(10), Florida Statutes. Essentially, their argument is that neither the language, nor the legislative history provide the *exclusive* method by which an auto insurer may enter into auto insurance PPOs. Therefore, the insurers reason, ALLSTATE's conduct in accessing the discounts and applying them to HOLY CROSS' PIP medical expenses was not a violation of law.

What the auto insurers conveniently ignore is the undisputed fact that they provide absolutely no consideration - no steerage- in exchange for the discount that ALLSTATE applied to Appellees' bills. It is this very conduct which is the "black heart and soul" of the Silent PPO and which is the conduct that most directly

damages consumers and all Florida healthcare providers victimized by this conduct.

CONCLUSION

For the reasons set forth above, *Amicus Curiae*, the Florida Consumer Action Network respectfully requests that this Court reverse the Fourth District's decision.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by mail on March 8, 2006 upon all parties listed on the attached service list.

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing answered brief has been typed using Times New Roman 14 point font, and is in compliance with the requirements of Florida Rule of Appellate Procedure 9.210(a)(2).

Respectfully submitted,

LEE & AMTZIS, P.L.
Attorneys for *Amicus Curiae*
5550 Glades Rd., Suite 401
Boca Raton, FL 33431
(561) 981-9988
(561) 981-9980 Facsimile

By:_____
ERIC LEE
Florida Bar No. 961299

CO-COUNSEL

Kopelman & Blankman
Larry Kopelman, Esq.
350 E. Las Olas Blvd., Ste. 980
Ft. Lauderdale, FL 33301
(954) 462-6855
(954) 462-6899 Facsimile

SERVICE LIST

George A. Vaka, Esq.
Vaka, Larson & Johnson, P.L.
One Harbour Place
777 S. Harbour Island Blvd., Ste. 300
Tampa, FL 33602

Richard C. Godfrey, Esq.
Kirkland & Ellis, LLP
200 East Rudolph Drive
Chicago, IL 60601

Peter J. Valeta, Esq.
Meckler Bulger & Tilson LLP
123 N. Wacker Dr., Ste. 1800
Chicago, IL 60606

Jack Reiter, Esq.
Adorno & Yoss
2525 Ponce De Leon Blvd Ste 400
Miami Florida 33134-6044

Laura M. Watson, Esq.
Watson & Lentner
220 N. E. 51st Street
Ft. Lauderdale, FL 33334