IN THE SUPREME COURT OF FLORIDA

ALLSTATE INSURANCE COMPANY. CASE NO: SC05-435
ALLSTATE INDEMNITY COMPANY,
Petitioners,

(Consolidated)

vs.

Respondent.
_____/
HOLY CROSS HOSPITAL, INC. CASE NO.: SC05-545
Cross-Petitioner,

vs.

ALLSTATE INSURANCE COMPANY,
ALLSTATE INDEMNITY COMPANY
Cross-Respondents.
_____/

AMENDED BRIEF OF AMICUS CURIAE OF THE FLORIDA HOSPITAL ASSOCIATION AND THE FLORIDA ORTHOPAEDIC SOCIETY IN SUPPORT OF RESPONDENT / CROSS-PETITIONER, HOLY CROSS HOSPITAL, INC.

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IDENTITY AND INTEREST OF *AMICUS CURIAE*

Amicus The Florida Hospital Association (AFHA@) is a not-for-profit association representing all types of hospitals throughout the state. Through advocacy, education, research, representation, and service, the FHA carries out its mission to promote the ability of member hospitals and healthcare systems to effectively and efficiently serve the healthcare needs of their communities. The FHA is the primary organization of hospitals in Florida, with a membership of approximately 230 hospitals that range in size from 32 beds to over 1,000 beds. The FHA=s membership is representative of the various types, locations, and forms of ownership that currently exist in the hospital field. The FHA=s principal corporate objective is to enhance its members= ability to provide comprehensive, efficient, and high quality medical care to their patients, consistent with financial and civic responsibilities.

Amicus The Florida Orthopaedic Society (AFOS@) is a not-for-profit association which was founded in 1947 to raise standards of orthopaedic practices by providing ongoing education, networking, recognition, and certification. The FOS is a statewide organization comprised of over 900 orthopaedic surgeons licensed to practice in the State of Florida. The FOS=s principal objective is to enhance its members= ability to provide comprehensive, efficient, and high quality medical care to their patients, consistent with financial and civic responsibilities.

The FHA and FOS are vitally interested in the outcome of this appeal. At the center of

the dispute is the operation of ASilent PPOs@ in Florida by Petitioners Allstate Insurance Company, Allstate Indemnity Company (AALLSTATE@) 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 (APPO@) discounts from thousands of healthcare providers and applying these discounts to automobile insurance Personal Injury Protection (APIP@) claims.

Health care providers are losing revenues due to the undisclosed/unauthorized selling of PPO provider lists and rates. Payers can access preferred provider discounts without the providers knowledge when PPOs make their lists of preferred providers and contract rates available to other payers and brokers for a fee. This practice is referred to as a ASilent PPO@.

In traditional PPOs, providers offer discounted fees to payers in exchange for preferred provider designations that attract more patients. With silent PPOs, payers access the PPO payment discounts without a contract and without obligation for directing patients to preferred providers. In the case of a silent PPO, the PPO *wins* by gaining a fee for use of the discount. The payer *wins* by paying less for services. The provider *loses* by receiving discounted payments for non-directed patient volume. The patient *loses* by paying higher premiums for freedom of provider choice and higher deductibles and coinsurance based on provider charges, thereby not sharing in insurer savings. The FHA and FOS believe that an understanding of the structure and operation of Silent PPOs and how they damage health care providers 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, the FHA and FOS respectfully submit this *Amicus Curiae* brief in support of Respondent / Cross-Petitioner HOLY CROSS HOSPITAL, INC., (AHOLY CROSS@).

SUMMARY OF THE ARGUMENT

Allstate=s scheme of reducing Health Care Providers (AHCP@) bills to the Preferred Provider amounts, without contracting ***directly*** with the HCP, without selling a PPO policy and without complying with the dictates of F.S. 627.736 (10), is an attempt to create their own third

party administered PIP Managed Care System, not authorized by Florida Law. Without the statutory authority to create a PIP Managed Care System to treat injured motorists which allows insurers to contract ***indirectly*** with health care networks like Health Maintenance Organizations (HMO=s) or Preferred Provider Organizations (PPO=s), Allstate cannot rely on the alleged Beech Street contract at bar to reduce the patient=s bills to PPO rates. The No-Fault statute permits only one type of PPO plan, that is, an arrangement wherein the insurer contracts ***directly*** with the HCP, and does not permit the use of ***indirect*** contracts with third parties.

Beech Street is neither insurer, nor third party administrator and acts without any oversight or regulation by the Florida Department of Insurance. The insureds in these consolidated cases were not informed of a PPO plan at the time they purchased their private passenger automobile policy, were never given a list of health care providers from which to choose, never made an election to choose one health care provider over another, and did not receive a reduced premium. There is *no* increase in patient volume for the HCP. There is *no* benefit to the insured or the HCP . There is *no* rationale for an HCP to discount its fees in return for nothing. AGiven what is usual and customary in the managed care industry, we cannot imagine that even a poorly represented entity would promise to discount its fees in return for nothing.@ *HCA Health Services of Georgia, Inc. V. Employers Health Insurance Company,* 240 F.3d 982, 999 (11th Cir. 2001), FN33. To merely allow Allstate to reference a 1-800 telephone number or permit a claims adjuster to recommend an HCP, allows Allstate to illegally manipulate the system, withhold information from the insured, and direct the insured to those providers

which the insurer favors. This in turn usurps the insured=s right to choose their physician.

F.S. 627.736 (10) was enacted for the sole purpose of allowing motor vehicle insurers to offer PIP coverage under a preferred provider policy. Once a PPO PIP policy is offered by an insurer, the option to choose a PPO policy or the standard indemnity policy belongs to the insured. F.S. 627.736(10). Specifically, the requirements of subsection 10 give the option to the insured to use a preferred provider. The option does not belong to the insurance company. The obvious reason for giving the insured this option at the time of the purchase of the policy is to pay a reduced premium or have the insurer pay medical benefits in excess of 80% as stated in subsection 10. Each and every Allstate policyholder purchased a NON-PREFERRED provider policy at the premium amount structured for non-preferred provider policies, yet everyone was treated as though they had purchased a PREFERRED PROVIDER policy. This also includes the vast majority of insureds who never had accidents, paid for non-preferred provider policies, yet would have been treated the same way. Why did Allstate conceal this from the insureds? Obviously, so they could keep the savings to themselves without reducing premiums. This whole scheme goes way beyond non compliance with a statute. This is an illegal act of patient brokering being perpetrated against insureds and medical providers by the auto insurance industry. Florida Statutes Section 817.505 specifically outlaws these type of arrangements without any exception for Casualty Insurers providing No Fault PIP benefits.

ARGUMENT

I. THE COURT SHOULD QUASH THE DECISION OF THE FOURTH DISTRICT

AND DETERMINE THAT ALLSTATE COULD NOT REDUCE PIP BENEFITS USING PREFERRED PROVIDER RATES WITHOUT OFFERING A PREFERRED PROVIDER POLICY OF INSURANCE AND WITHOUT COMPLYING WITH THE REQUIREMENTS OF FLORIDA STATUTES, SECTION 627.736 (10)

A. ALLSTATE HAS CREATED ITS OWN PIP MANAGED CARE SYSTEM NOT AUTHORIZED BY FLORIDA LAW.

Allstate=s legal position combined with its conduct in these consolidated cases, presents nothing short of an artful - but unsuccessful, effort to circumvent established bodies of Florida regulatory law. Allstate=s scheme of reducing Health Care Providers (AHCP@) bills to the Preferred Provider amounts, without contracting directly with the HCP, without selling a PPO policy and without complying with the dictates of F.S. 627.736 (10), is an attempt to create their own third party administered PIP Managed Care System, not authorized by Florida Law. Without the statutory authority to create a PIP Managed Care System to treat injured motorists which allows insurers to contract ***indirectly*** with health care networks like Health Maintenance Organizations (HMO=s) or Preferred Provider Organizations (PPO=s), Allstate cannot rely on the alleged Beech Street contract at bar to reduce the patient=s bills to PPO rates.

Nowhere does the legislation allow insurers to unilaterally develop a new type or form of No-Fault benefits. Insurance companies cannot retroactively re-write legislation through private contracts.[1] See *Christian v. Colonial Penn Ins. Co.*, 537 So. 2d 623, 625 (Fla. 4th DCA 1988)

[1]The statute, as originally enacted, allowed the insured to utilize a preferred provider system if such election was made at the time of the claim. See '627.736(10), Fla. Stat. (1991). However, the statute was amended in 1992 to only allow a preferred provider system to be utilized if the option was purchased at the time

(explaining that an insurer may not contract around or alter statutorily mandated insurance coverage, and any contract seeking to do so is void); *Kaufman v. Mutual of Omaha Ins. Co.*, 681 So.2d 747, 749 (Fla. 3d DCA 1996).

The regulatory scheme surrounding insurance has a long history and is widely recognized.

> . . .regulation of the insurance industry is necessary. As the United States Supreme Court has long recognized, insurance is a business coupled with a public interest. Consumers invest substantial sums in insurance coverage in advance, but the value of the insurance lies in the future performance of the various contingent obligations. Because the interests protected are so important - including an individual=s future ability to provide for dependents in case of death or injury, to retire, to obtain necessary medical treatment, to replace damaged or destroyed property - regulation of the industry furthers public welfare. Related reasons for insurance regulation center on the complexity of insurance and consumers= inability to obtain and understand information about insurance. Consumers are ill-equipped to assess a company=s future solvency, to compare the coverage of various policies, or to evaluate a company=s claim service. Theoretically, government regulation of insurance eliminates these problems. Regulation can ensure solvency and the insurer=s ability to pay claims in the future, standardize policy coverage, require minimum coverage and require fair claims processing.

Susan Randall, *Article: Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners.* 26 Fla. St. U.L. Rev. 625, 627 (1999) (footnotes omitted).

The federal government recognizes that states must regulate the insurance industry. According to the McCarran-Ferguson Act, the business of insurance will be subject to state law:

> . . .Congress hereby declares that the continued regulation and taxation by the several States of the Business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

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of the policy issuance.

15 U.S.C. ' 1011.

Thus, Allstate=s argument that they can freely contract with whomever they choose, without any over site or compliance with Florida Statutes, must fail.

Notably and as set forth below, past attempts by insurers to pass legislation which would allow insurers to contract with third party administered Managed Care Networks to provide care for injured motorists have failed.[2] While third party administered managed care networks are statutorily authorized and regulated for health insurance and workers compensation contracts, these networks are plainly not authorized by the No-Fault law. Furthermore, Allstate=s assertion that PPO=s like Beech Street are somehow regulated under the Florida Insurance Code is completely inaccurate, curiously without citation and totally misleading. Contrary to Allstate=s assertions, on January 6, 2003, the Department of Insurance dismissed a Petition for Declaratory Statement seeking an interpretation of Section 627.736 (10) and determining whether the use of the Network Program by a Florida insurer complies with all pertinent Florida Statues. *In the matter of: ADP Integrated Medical Solutions, Inc.*, Case No. 63528, The Treasurer of the State of Florida, Department of Insurance, Order Dismissing Petition for Declaratory Statement (January 6, 2003). Moreover, as evidenced by the certificates issued by the Department of Insurance and the list of Third Party Administrators published by the Department, Beech Street

[2] See Proposed Senate Bill 1326 (March 4, 1997) and Senate Staff Analysis and Economic Impact Statement, S.B. 1326 (March 23, 1997) & P.C.S./S.B. 1326 (March 24, 1997).

is neither insurer nor third party administrator. In short, Allstate cannot skirt the regulatory mandates of both Florida=s PIP and Health Care laws, but reap the benefits of their non-compliance.

In its Brief, Allstate states that neither Subsection 10 nor the Insurance Code limits Allstate=s ability to take advantage of these contractually agreed-upon rates. This is done in an attempt to justify their reductions and suggest that their PPO scheme is somehow regulated thereunder. This argument fails by statutory definition. Once a PPO PIP policy is offered by an insurer, the option to choose a PPO policy or the standard indemnity policy belongs to the insured. F.S. 627.736(10). Specifically, the requirements of subsection 10 give the option to the insured to use a preferred provider. The option does not belong to the insurance company. The obvious reason for giving the insured this option at the time of the purchase of the policy is to pay a reduced premium or have the insurer pay medical benefits in excess of 80% as stated in subsection 10. Each and every Allstate policyholder purchased a NON-PREFERRED provider policy at the premium amount structured for non-preferred provider policies, yet everyone was treated as though they had purchased a PREFERRED PROVIDER policy. This also includes the vast majority of insured who never had accidents, paid for non-preferred provider policies, yet would have been treated the same way. Why did Allstate conceal this from the insureds? Obviously, so they could keep the savings to themselves without reducing premiums. This whole scheme goes way beyond non compliance with a statute. This is an illegal act of patient brokering being perpetrated against insureds and medical providers by the auto insurance

industry. Florida Statutes, Section 817.505 specifically outlaws these types of arrangements without any exception for Casualty Insurers providing No Fault PIP benefits.

In 1997, Florida PIP insurers recognized that there was no lawful ability to create a PIP Managed Care Program by contracting with managed care networks to care for injured motorists. To address this issue two pieces of proposed legislation were introduced on behalf of Florida PIP insurers.[3] The proposed bills failed to pass the Florida Senate Banking and Insurance Committee. However, the bills as drafted were intended in many respects to mirror the highly regulated health care and worker=s compensation laws[4] and in accordance with these existing statutes, allow the insurer to access, for the first time, ***indirect*** contracts between the HCP and a managed care organization. Like the health care and worker=s compensation laws, the Proposed Bills required intense and stringent regulation of the PIP insurer=s managed care arrangement. These regulations included in part:

* approval of the plan by the Agency for Health Care Administration.

[3] See PCS/SB1326 (March 7, 1997).

[4] The Proposed Bills specifically adopted procedures and criteria referenced in the Workers Compensation Statute, Chapter 440, Florida Statutes. Similar subscriber protections are found in Florida Statutes, Section 641.85, 641.234, 641.27, 627.648, 627.6488 and 627.6492.

* full disclosure of the provisions, restrictions and limitations of the managed care arrangement to the insured.

* a $1,000.00 application fee by the insurer to offset the costs of the managed care arrangements.

* allowance of capitated contracts only with HCP=s that have approved exclusive provider organizations.

* the filing of a plan of operation which addresses such issues as adequacy of providers, description of grievance procedures, quality assurance programs, training in duties of managed care arrangements, provisions for a medical care coordinator, grievance and corrective procedures.

* provide an updated list of providers to the insured every six months.

* a requirement that an insurer make a rate filing to reflect anticipated reductions in loss costs and other anticipated savings attributable to the managed care option.

This attempt by insurers to pass such legislation demonstrates and acknowledges that there was, and still is, no statutory or administrative vehicle for them to reduce PIP bills pursuant to third party administered managed care networks. While managed care organizations are subject to licensing and reporting requirements, the principal object and purpose of health care plans is *service*, rather than indemnity. Beech Street is not a licensed insurer, do not indemnify the insureds, and have not obtained Acertificates of authority@ to act as an administrator of any Florida managed care plans. In short, they act without any oversight or regulation by the Florida

Department of Insurance.

Florida, either directly or through their HMO or PPO statutory acts, regulates ***the contracts*** between a licensed insurer and a Managed Care Organization. In the health care arena, the law requires that HMO=s and Exclusive PPO=s disclose the terms and conditions of their plans [5] and Non-Exclusive PPO=s must set forth any exceptions and reductions of indemnity in their policy of insurance.[6] The purpose of such disclosure is to protect the consumer, inform them of their benefits and provide them the ability to shop the competition. Like PIP, it is the policy of insurance, in compliance with the statutes that dictates and controls the insureds rights and methods of payment of benefits.

Allstate=s argument that their version of PIP PPO reductions actually broaden the insureds= benefits is specious. The health care PPO statute acknowledges that payment of different contract rates limits and reduces benefits. It requires that the policy provide schedules of payments for services provided by preferred providers that differ from the schedules of payments for services provided by nonpreferred providers. The health care PPO statute, like the PIP PPO statute, recognizes that the use of a Preferred Provider as compared to using a Non-Preferred Provider should result in a savings to the insured. These statutes set forth limitations of charging increased deductibles when a Preferred Provider is not chosen. F.S. 627.6471(3) (4) and 627.736 (10). Likewise, it is critical that the dictates of F.S.627.736(10) be followed for a

[5] Florida Statute, Section 641.31015.

[6] Florida Statute, Section 627.602(e).

Florida PIP insurer to take advantage of Florida PIP PPO arrangements and the savings are to be passed on to the insureds.

This is not Allstate=s first attempt to create a scheme of refusing to pay an insured=s medical bills. Previously, Allstate placed in their policy a clause which permitted Allstate to refuse to pay any medical bill they deemed to be unreasonable or unnecessary. In an effort to insulate themselves from suit over the unpaid medical bills, Allstate also placed an indemnification clause in their policy promising to pay the resulting defense costs and any judgment against the insured. On appeal Allstate argued that the policy language afforded the insureds more, not less protection consistent with the no-fault law. *Kaklamanos v. Allstate Insurance Company*, 796 So.2d 555 (Fla. 1st DCA 2001), FN2. This argument was flatly rejected. This Court found that the automobile Apolicy was a contract of indemnity against liability, not as an indemnity against loss.@ *Allstate Insurance Company v. Kaklamanos*, 843 So.2d 885, 896 (Fla. 2003). Thus a PIP policy in compliance with the code pays the insureds reasonable and necessary medical expenses and does not provide less coverage than required by statute. *Id.*

Like Allstate=s scheme in *Kaklamanos*, they seek to escape responsibility to the insured for unpaid medical bills. Allstate indemnifies against liability for PIP benefits and cannot legally diminish these benefits by the provisions of an alleged extra contractual arrangement with Beech Street. A reduction in the payment of medical services and in turn the losses per insured, would affect the rate structure and cost of the policy. Allstate increases its PIP policy benefits to

its insureds by either lowering its deductible, paying a higher percentage of benefits, or paying more than the required $10,000.00 in benefits. To properly effectuate and allow regulation of increases in PIP policy benefits to its insureds they must be part of the policy of insurance. Any other scheme results in a savings to the insurer which is *not* passed on to the insured.[7]

B. ALLSTATE=S SCHEME APPEARS COLLUSIVE AND IS A SHAM PPO.

Health care providers are losing revenues due to the undisclosed/unauthorized selling of PPO provider lists and rates. Payers can access preferred provider discounts without the provider=s knowledge when PPOs make their lists of preferred providers and contract rates available to other payers and brokers for a fee. This practice is referred to as a ASilent PPO.@

In traditional PPOs, providers offer discounted fees to payers in exchange for preferred provider designations that attract more patients. With silent PPOs, payers access the PPO payment discounts without a contract and without obligation for directing patients to preferred providers. In the case of a silent PPO, the PPO *wins* by gaining a fee for use of the discount. The payer *wins* by paying less for services. The provider *loses* by receiving discounted payments for non-directed patient volume. The patient *loses* by paying higher premiums for

[7]Insurers shall not deliver or issue a policy until a copy of any applicable classification of risks and premium rates have been filed with the Department of Insurance. The making and use of rates for motor vehicle insurance contemplate many factors, including the costs of medical services and trend factors such as actual losses per insured unit for the insurer making the filing. F.S. 627.0651 (2)(h) & (k).

freedom of provider choice and higher deductibles and coinsurance based on provider charges, thereby not sharing in insurer savings.

Silent PPOs are brokers that buy negotiated rates from PPOs, and then sell those rates to payers who are not participants in the PPO and have no obligation to direct or notify patients. Both traditional indemnity insurers and health benefit plans with out-of-network option may purchase the right to access the silent PPO discount, but do nothing to direct care to the providers in the PPO network. Beneficiaries are unaware of any PPO arrangement and access services from providers of their choice. The payer applies the PPO discount to the beneficiary=s claim when the provider submits the bill.

Beech Street meets the definition of a Silent PPO; i.e., an entity that does not use financial or educational mechanisms to steer patient volume to preferred providers. Moreover, it allows other insurers or self-insured plans access to PPO discounts AFTER services are provided, where a contract between the insurer/self-insurer and provider does not exist. Even if a contract of sorts does exist, the patient is not identified as covered by the arrangement.

These Networks lack any meaningful integration of activities. Unlike legitimate HMO=s and PPO=s, which are highly regulated by Florida Statutes, these sham arrangements are not regulated and fail to adequately inform prospective enrollees of the consequences of accepting their plan. Indeed, Allstate admits it does not offer a PPO policy and the insured is not informed of a PPO arrangement until after the injury has occurred and many times not until the HCP=s treatment has been rendered. Thus, the essential purpose of a PPO contract , i.e. in return for

directing patients to selected providers, the payor Allstate would receive a Apreferred@ or Areduced@ rate for services which are passed on to the insureds, does not exist under the Allstate scheme.

There is *no* increase in patient volume. There is *no* benefit to the insured or the HCP. There is *no* rationale for an HCP to discount its fees in return for nothing. As recently echoed by the Eleventh Circuit Court A[g]iven what is usual and customary in the managed care industry, we cannot imagine that even a poorly represented entity would promise to discount its fees in return for nothing.@ *HCA Health Services of Georgia, Inc. v. Employers Health Insurance Company*, 240 F.3d 982, 999 (11th Cir. 2001), FN33. To merely allow Allstate to reference a 1-800 telephone number or permit a claims adjuster to recommend an HCP, allows Allstate to illegally manipulate the system, withhold information from the insured, and direct the insured to those providers which the insurer favors. This in turn usurps the insured=s right to choose their physician.

Allstate argues, without any citation to the Florida Insurance Code (the ACode@), that the insurer should be able to take advantage of an indirect contract with third parties, like Beech Street, to alter or modify the required benefits. However, an insurer may not reduce statutorily fixed and prescribed protection under Florida=s No-Fault Benefits laws or Uninsured Motorist laws by inserting policy exclusions and exceptions which are not provided for in the statutes. *Salas v. Liberty Mutual Insurance Company*, 272 So. 2d 1, 5 (Fla.1972).

Once the method is detailed by statute, parties are not free to come up with alternative

methods not described by the statute. This is especially true where the legislature regulates the industry to the extent that forms of contracts and the rates charged for those contracts have to be approved by the Department of Insurance. F.S. 627.410 and F.S. 627.0651. Allstate argues that freedom of contract should allow an extra contractual relationship with an out of state corporation like Beech Street to alter or modify a Florida insureds= No-Fault Law benefits. However, all contracts of casualty insurance to be performed in this state shall be subject to the applicable provisions of the insurance code. F.S. 627.4135. And with regard to contents of policies, Aevery policy shall specify the conditions pertaining to the insurance.@ F.S. 627.413(1)(f). When insurance policies are written pursuant to a statutory scheme, there can be no policy exclusions which are contrary to the statute. *Mullis v. State Farm Mutual Auto. Ins. Co.*, 252 So.2d 229, 233 - 234 (Fla. 1971). Likewise, any extra contractual contract effecting the coverage under the insurance policy must not be contrary to the No-Fault Law, and any attempts by the insurance policy to limit or subtract from the statutory coverage results in a void provision. *American Indemnity Company v. Comeau*, 419 So.2d 670, 672 (Fla. 5th DCA 1982).

CONCLUSION

For the foregoing reasons, the FHA and FOS respectfully request this Court to quash the decision of the Fourth District, and hold that a PIP insurer who has not complied with ' 627.736(10), *Fla. Stat.* is required to pay benefits in accordance with the mandatory provisions

of 627.736(1), *Fla. Stat*.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been sent by U.S. Mail to the parties listed on the attached service list this _____ day of March, 2006.

CERTIFICATE OF COMPLIANCE

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

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