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

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January 9, 2012

Mr. R. Phillip Twogood, Coordinator
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Government Accountability
Claude Pepper Building Room 312
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Dear Mr. Twogood:

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

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

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

Sincerely,

John P. Miles
Secretary

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

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

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