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HOUSE OF REPRESENTATIVES
COMMITTEE ON
CHILDREN & FAMILIES
ANALYSIS

BILL #: HB 657

RELATING TO: Dental Coverage/Kidcare Program

SPONSOR(S): Representatives Goodlette, Co-sponsors: Peaden, Goode, Sanderson, Bloom, Cosgrove, Wasserman- Schultz, C. Green, Wiles, Farkas, L. Miller, Dennis, Hafner, Gottlieb, Chestnut, Frankel, Villalobos, Sobel, Wilson, Murman, Casey, Brummer, Jones, Effman, A. Greene, Flanagan, Ritchie, Maygarden, Jacobs, Barreiro, Lynn, Fasano

COMPANION BILL(S): SB 1414

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) CHILDREN & FAMILIES YEAS 8 NAYS 0
(2) FINANCE & TAXATION
(3) HEALTH & HUMAN SERVICES APPROPRIATIONS
(4)
(5)

I. SUMMARY:

This bill amends the Florida Kidcare Act to include dental services for children that are not covered under Medicaid or Medikids. The bill would either provide for services covered under the Medicaid Children's Dental Program or services specified by the Department of Health. A schedule of benefits and a fee schedule would also be developed but it is unclear which agency would be responsible. The bill allows for reimbursement to individual dental providers on a capitated or noncapitated basis.

The fiscal impact depends on the fee schedule and range of services to be provided.

The Committee on Children and Families adopted an amendment to substantially change the bill. Under the amendment all children's dental services would be carved out of KidCare, administered by the Agency for Health Care Administration, and offered to all the children of families under 200% of poverty. The program would provide Medicaid dental services as specified in s. 409.906 (6) F.S. and would be reimbursed at 'Medicaid fee for service rates. The program would be eligible for 70% federal funding. The state share would be $1.7 million in the first year and $3 million in the second year.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Tooth decay is one of the most prevalent chronic diseases of childhood. Because it is a chronic, progressive bacterial infection, routine, periodic professional intervention is needed to prevent and control the disease. Children from low-income families have the least access to dental care and, thus, the greatest unmet need. Eighty percent of tooth decay on permanent teeth occurs in only 25 percent of children, mostly children from low-income families. These children suffer unnecessary pain, difficulty in eating, distraction from learning, and diminished self-esteem resulting from unattractive appearances. Studies have shown that twice as many parents indicate unmet dental need for their children than unmet medical need. Low-income parents rank dental care as a top issue. The 1987 National Medical Expenditure Household Survey reported that expenditures for dental care for children aged 3-12 accounted for 22 percent of their health expenditures, and for children aged 13-18, 30 percent. However, less than 5 percent of public child health expenditures are spent on dental care for low-income children. Only 17 percent of the children in Florida with family incomes below 200 percent of the federal poverty level receive an annual dental visit through publicly funded programs, their main source of care.

The 1998 Kidcare Act provided dental benefits for children up to age 5 with family incomes below 200 percent of the federal poverty level under Medikids, and it expanded Medicaid benefits to cover children up to age 19 below 100 percent of the federal poverty level. No dental benefits were provided for children aged 5 with family incomes above 133 percent of the federal poverty level and for children aged 6 to 19 with family incomes above 100 percent of the federal poverty level. Dental benefits under the Healthy Kids program are provided at local option and if included, only cover cleanings and x-rays.

Low Medicaid reimbursement rates hinder provider participation. The majority of private dental practitioners do not support capitated programs and, thus, will not participate in a capitated reimbursement program. Adding to the overall problem for children is the low reimbursement rates for the Medicaid program. Only around 10 percent of all dentists are significant Medicaid providers and the annual utilization rate for children is only 31 percent to 37 percent. As a result, two-thirds of Medicaid eligible children do not receive the periodic early diagnostic/preventive/restorative care necessary to improve and maintain good oral health. This is also a problem nationally.

STRUCTURE

In addition to the state and federal government, the Kidcare program is financed through optional county participation and through full cost purchase by families above 200 percent of poverty.

B. EFFECT OF PROPOSED CHANGES:

This bill will extend basic diagnostic, preventive, restorative, and surgical services to all children up to age 19 with family incomes below 200 percent of the federal poverty level that are enrolled in the Healthy Kids/private insurance programs.

The third-party administrator option provides for payment to a third-party administrator on a capitated basis who then reimburses providers on a non-capitated basis, fee for service basis. The geographic scope of contracts are not specified so they may be on a county, regional, or state basis.

The bill would provide for either services covered under the Medicaid Children's Dental Program or services specified by the Department of Health. A schedule of benefits and a fee schedule would also be developed, but it is unclear which agency would be responsible for this. The bill allows for reimbursement to individual dental providers on a capitated or noncapitated basis. The fiscal impact depends on the fee schedule and range of services to be provided. The bill does not specify the agency responsible for developing the fee schedule.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

N/A

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

The Department of Health would administer the program.

(3) any entitlement to a government service or benefit?

The KidCare program is not an entitlement.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

The bill provides for two different coverage options. If prepaid per capita payments are selected, then there would be a slight workload increase for staff of the Agency for Health Care Administration; however, no new FTEs would be required. If option 2 is selected, then Florida Healthy Kids would contract with third-party administrators to develop, implement, and oversee the KidCare dental services program for children age 5 through 18 whose family income is between 100 and 200 percent of the federal poverty level.

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

N/A

b. Does the bill require or authorize an increase in any fees?

N/A

c. Does the bill reduce total taxes, both rates and revenues?

N/A

d. Does the bill reduce total fees, both rates and revenues?

N/A

e. Does the bill authorize any fee or tax increase by any local government?

N/A

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No. The bill expands dental coverage to include children in families under 200 percent of poverty who are currently not covered for dental benefits.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

Some families purchase KidCare, basically as an insurance policy. For these families the increased mandatory benefits would result in a cost increase.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

N/A

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

N/A

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

The family member(s) and their dental health care provider.

(2) Who makes the decisions?

The family member(s) and their dental health care provider.

(3) Are private alternatives permitted?

Yes.

(4) Are families required to participate in a program?

No.

(5) Are families penalized for not participating in a program?

No.

b. Does the bill directly affect the legal rights and obligations between family members?

N/A

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

Parents or guardians would have input regarding decisions concerning dental treatment.

(2) service providers?

Yes.

(3) government employees/agencies?

The Department of Health would define the services. It is not clear how reimbursement rates would be decided.

D. STATUTE(S) AFFECTED:

s. 409.815 F.S.

E. SECTION-BY-SECTION ANALYSIS:

See effect of proposed changes.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

Indeterminate, see fiscal comments.

2. Recurring Effects:

Indeterminate, see fiscal comments.

3. Long Run Effects Other Than Normal Growth:

N/A

4. Total Revenues and Expenditures:

Indeterminate, see fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

N/A

2. Recurring Effects:

Adding this benefit increases the cost of purchasing the benefits to families with incomes above 200 percent of poverty. Some of these families will no longer be able to afford the program unless counties increase their voluntary financing to offset this cost increase.

3. Long Run Effects Other Than Normal Growth:

   N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   Some families purchase KidCare, basically as an insurance policy. For these families the increased mandatory benefits would result in a cost increase. It is conceivable that some families would be priced out of the program.

2. Direct Private Sector Benefits:

   N/A

3. Effects on Competition, Private Enterprise and Employment Markets:

   N/A

D. FISCAL COMMENTS:

The total fiscal impact of the bill as drafted appears to be discretionary on the part of the Department of Health. The Department of Health is given the authority to define the range of services to be covered. It is unclear who develops the reimbursement schedules, but the implication appears to be the Department of Health.

If the option that provides a third-party administrator is adopted, reimbursement to the administrator would be at a capitated rate. The administrator would then reimburse providers at a non-capitated rate, fee for service.

Current participation rates of the Medicaid Children's Dental Program for very low income families are suppressed by the low reimbursement rate. The impact of the program established by this bill would depend on its attractiveness relative to the existing Medicaid program and whether or not the program expands the number of providers. The new program could be more attractive than the existing program for the most poor children, if the rates are higher. If the new program is more attractive to providers, but not sufficiently attractive to expand the pool of providers, then one impact could be to reduce access for children currently receiving the program.

The estimated costs of adding dental benefits have covered a large range. Last year actuarial estimates were from a low of $3.78 per member per month to a high of $11.10 pmpm. The American Academy of Pediatrics in their promotion to include comprehensive dental benefits in a comprehensive health package estimated dental costs at $21.35 pmpm nationally with a total health cost $101.47 pmpm. For Florida urban areas, the AAP estimated dental costs at $26.09 pmpm (total health cost of $104.01 pmpm) and for rural areas, $15.98 pmpm (total health cost of $87.34 pmpm).

Based on 1997 Medicaid utilization data using the Medicaid benefits package and the current fee schedule, the Medicaid cost is estimated at $6.63 pmpm. This does not include HMO administrative costs.

The Statewide Dental Coordinating Council has developed a schedule of benefits and a fee schedule to contract with third-party administrators on a prepaid per capita basis or on a prepaid aggregate fixed sum basis. The third-party administrators will reimburse providers on a noncapitated basis and will purchase stop-loss insurance to protect against higher than expected utilization rates. Based on the 1997 Medicaid utilization data, the cost of the Statewide Dental Coordinating Council plan is estimated at $7.74 pmpm. An actuarial estimate for this plan paid for by the Florida Dental Association came to $4.85 pmpm. Based on the analysis above it is difficult to see how this rate could support the option of using a non-capitated rate. The association estimates the administrative and stop-loss insurance coverage costs for third-party administrators are at $2 pmpm.

Currently 162,330 children are estimated to be covered at age 5 from 134% - 200% FPL and ages 6 to 19 from 101% - 200% FPL under the Healthy Kids/private insurance program components. The Governor's budget recommendation indicated an additional 95,114 children to be covered.

There is no limit in the bill on the total cost of the program. As a result any costs above that assumed in the appropriation for this program would come from funds available for current coverage and, in turn, reduce the number of children to be served through KidCare program.

Some families purchase KidCare, basically as an insurance policy. For these families the increased mandatory benefits would result in a cost increase. It is conceivable that some families would be priced out of the program.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

No, however see section B.2.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

N/A

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

N/A

V. COMMENTS:

The bill would create new coverage for the KidCare program that would appear to be administered in a manner different from the rest of the KidCare program.

- All of the other benefits under the KidCare program are part of a comprehensive insurance package and: bid as one package of benefits. The dental benefits would appear to be bid separately.
- Healthy Kids and Employer Sponsored plans are required in KidCare to deliver services only through licensed insurers or health plans. Use of a third-party administrator (TPA) to pay providers appears to conflict with this requirement.
- The Department of Health is consulted on this benefit and given the authority to set the benefit levels when all other benefits are set forward in the KidCare Act.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

The Committee on Children & Families adopted an amendment to substantially change the bill. Under the amendment all children's dental services would be carved out of KidCare, administered by the Agency for Health Care Administration, and offered to all the children of families under 200 percent of poverty. The program would provide Medicaid dental services as specified in s. 409.906 (6) F.S., and would be reimbursed at Medicaid fee for service rates. The program would be eligible for 70 percent federal funding. The state share would be $1.7 million in the first year and $3 million in the second year.

VII. SIGNATURES:

COMMITTEE ON CHILDREN AND FAMILIES:

Prepared by: Staff Director:

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