The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Banking and Insurance Committee

BILL:	CS/SB 0302
INTRODUCER:	Banking and Insurance Committee and Senator Jones
SUBJECT:	Dentists
DATE:	April 14, 2010
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Messer	Burgess	BI	**Fav/CS**
2.			CM	
3.			HR	
4.			SPSC	
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

This committee substitute amends ss. 627.6474, 636.035 and 641.315, F.S., to prohibit certain health insurance provider contracts from containing provisions requiring dentists to provide services at a fee set by the prepaid limited health service organization unless the services are covered under the applicable subscriber agreement. This could allow some dentists to charge a higher fee for certain services than they are currently able to charge. The bill also clarifies the definition of "covered services" under this section.

This committee substitute provides an effective date of July 1, 2010.

This committee substitute substantially amends sections 627.6474, 636.035, and 641.315 of the Florida Statutes.

II. Present Situation:

Health Insurer Provider Arrangements

Health insurer provider contracts are regulated by the Office of Insurance Regulation (OIR). Currently, Florida Statutes do not prohibit provider contracts between health insurers and dentists from containing provisions that require the practitioner to provide services to the health insurer subscribers at a fee set by the health insurer unless the services are covered services under the applicable subscriber agreement.

Prepaid Limited Health Service Organizations Provider Arrangements

Prepaid limited health service organizations are authorized in s. 636.003, F.S. This section defines "limited health service" to include the following: ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services. The AHCA currently has two types of prepaid limited health service organizations: prepaid dental health plan (PDHP) as authorized in s. 409.912(43), F.S., and prepaid mental health plan (PMHP) as authorized in s. 409.912(4)(b), F.S. These prepaid limited health service organizations are administered under contract with AHCA and reimbursed on a capitated basis.[1]

As of November 2009, approximately 214,291 beneficiaries were enrolled in the PDHP program and 693,596 beneficiaries were enrolled in the PMHP program.[2]

Provider arrangements for prepaid limited health service organizations are authorized in s. 636.035, F.S. Currently, Florida Statutes do not prohibit provider contracts between prepaid limited health service organizations and dentists from containing provisions that require dentists to provide non-covered services[3] to the prepaid limited health service organization subscribers at a fee set by the prepaid limited health service organization.

Health Maintenance Organization Provider Contracts

Section 641.315, F.S., specifies requirements for the health maintenance organization (HMO) provider contracts with "health care practitioners" as defined in s. 456.001(4), F.S. Section 641.315, F.S., does not currently prohibit provider contracts between health maintenance organizations and dentists from containing provisions that require the practitioner to provide services to the HMO subscribers at a fee set by the HMO unless the services are covered services under the applicable subscriber agreement.

Health Care Practitioners

Health care practitioners, as defined in s. 456.001(4), F.S., include, but are not limited to, physicians, osteopathic physicians, chiropractors, podiatrists, nurses, pharmacists, dentists,

[1] Id.
[2] Id.
[3] Meaning services that are not covered under the applicable subscriber agreement.

midwives, optometrists, speech pathologists, occupational therapists, orthotic providers, massage therapists, clinical laboratory personnel, and psychologists.

III. Effect of Proposed Changes:

Section 1: Amends s. 627.6474, F.S., to make a non-substantive clerical change and amend subsection (1) regarding provider arrangements. This section adds prepaid limited health service organization provider arrangement contracts, authorized under s. 636.035, F.S., to the list of contracts for which this section applies.

This section also amends s. 627.6474(2), F.S., to prohibit contracts between health insurers and dentists from containing provisions that require dentists to provide services to the health insurer subscribers at a fee set by the insurer unless the services are covered services under the applicable subscriber agreement.

This section also defines the term "covered services" as "services reimbursable under the applicable subscriber agreement, subject to such contractual limitations on subscriber benefits as may apply."

This section is applicable to contracts entered into or renewed after July 1, 2010. This section does not have a fiscal impact on AHCA[4].

Section 2: Amends s. 636.035, F.S., to add new subsection (13) regarding prepaid limited health service organization provider arrangements. Subsection (13) prohibits provider contracts between a prepaid limited health service organization and dentists from containing any provision that requires dentists to provide services at a fee set by the prepaid limited health service organization unless the services are covered services under the applicable subscriber agreement.

This section defines covered services as "services reimbursable under the applicable subscriber agreement, subject to such contractual limitations on subscriber benefits as may apply."

These provisions would apply to contracts entered into or renewed on or after July 1, 2010. This section does not have a fiscal impact on AHCA.

Section 3: Amends s. 641.315, F.S., to add subsection (11), prohibiting provider contracts between a HMO and dentists from containing provisions that require dentists to provide services to the HMO subscribers at a fee set by the HMO unless the services are covered services under the applicable subscriber agreement.

This section (11) defines covered services as "services reimbursable under the applicable subscriber agreement, subject to such contractual limitations on subscriber benefits as may apply."

[4] Analysis submitted by the Agency for Health Care Administration, on file with the Senate Committee on Banking and Insurance.

These provisions would apply to the HMO contracts entered into or renewed on or after July 1, 2010. However, new subsection (11) would require the AHCA to modify the definition of covered services in its contracts with HMOs authorized under ch. 641, F.S., entered into or renewed after July 1, 2010. The AHCA's existing contracts with HMOs entered into or renewed prior to July 1, 2010, would not be required to comply with proposed subsection (11) of s. 641.315, F.S., until renewed.

This section does not have a fiscal impact on AHCA.

Section 4: This section provides for an effective date of July 1, 2010.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

This bill may increase healthcare costs for non-covered services.

C. Government Sector Impact:

This bill does not appear to have a direct impact on the State Employees' PPO Plan or the HMO plans. Members could be effected if the legislation is interpreted or applied to allow providers the ability to bill and charge amounts above contracted rates whenever members are financially responsible.[5]

VI. Technical Deficiencies:

None.

[5] Analysis submitted by the Department of Management Services, on file with the Senate Committee on Banking and Insurance.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Banking and Insurance on April 13, 2010:
This committee substitute limits the application of the original bill to only apply to dentists as opposed to all health care providers.

B. Amendments:

None.