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 Budget Subcommittee on General Government Appropriations

BILL:	CS/SB 546
INTRODUCER:	Health Regulation Committee and Senator Hays and others
SUBJECT:	Dentists
DATE:	April 13, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	**Favorable**
2.	Brown	Stovall	HR	**Fav/CS**
3.	Frederick	DeLoach	BGA	**Favorable**
4.				
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:

The bill prohibits an insurer, health maintenance organization (HMOs), or prepaid limited health service organization from contracting with a licensed dentist to provide services to an insured or subscriber at a specified fee unless such services are "covered services" under the applicable contract. The bill prohibits an insurer from requiring that a contracted health care provider accept the terms of other practitioner contracts with a prepaid limited health service organization that is under common management and control with the contracting insurer. The bill also prohibits an insurer, HMO, or prepaid limited health services organization from requiring that a contracted dentist participate in a discount medical plan.

This bill substantially amends the following sections of the Florida Statutes: 627.6474, 636.035, and 641.315.

II. Present Situation:

Prohibition Against "All Products" Clauses in Health Care Provider Contracts

Section 627.6474, F.S., prohibits a health insurer from requiring that a contracted health care practitioner accept the terms of other practitioner contracts (including Medicare and Medicaid practitioner contracts) with the insurer or with an insurer, HMO, preferred provider organization, or exclusive provider organization that is under common management and control with the contracting insurer. The statute exempts practitioners in group practices who must accept the contract terms negotiated by the group. These contractual provisions are referred to as "all products" clauses, and, before being prohibited by the 2001 Legislature, typically required the health care provider, as a condition of participating in any of the health plan products, to participate in *all* of the health plan's current or future health plan products. The 2001 Legislature outlawed "all products" clauses after concerns were raised by physicians that the clauses: may force providers to render services at below market rates; harm consumers through suppressed market competition; may require physicians to accept future contracts with unknown and unpredictable business risk; and may unfairly keep competing health plans out of the marketplace.

Prepaid Limited Health Service Organizations Contracts

Prepaid limited health service organizations (PLHSO) provide limited health service to enrollees through an exclusive panel of providers in exchange for a prepayment, and are authorized in s. 636.003, F.S. Limited health services are: ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services.

Provider arrangements for prepaid limited health service organizations are authorized in s. 636.035, F.S., and are subject to the following statutory requirements:

- The provider contract must be in writing.
- The subscriber is not liable to providers for services rendered except for deductibles and copayments.
- If the PLHSO cannot meet its obligations to a provider, the subscriber is not liable for providing payment.
- The provider or PLHSO cancelling the provider contract must provide notice as detailed in statute.
- Prohibition against limiting the provider's ability to inform patients about medical treatment options.
- Prohibition against limiting the provider from contracting with other PLHSOs.
- Prohibition against "all products" clauses.

Health Maintenance Organization Provider Contracts

An HMO is an organization that provides a wide range of health care services, including emergency care, inpatient hospital care, physician care, ambulatory diagnostic treatment and preventive health care pursuant to contractual arrangements with preferred providers in a

designated service area. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. The use of a health care provider outside the HMO's network generally results in the HMO limiting or denying the payment of benefits for out-of-network services rendered to the member.

Section 641.315, F.S., specifies requirements for the HMO provider contracts with "health care practitioners" as defined in s. 456.001(4), F.S. The requirements include provisions related to:

- Notice of the insurer or provider cancelling the provider contract.
- Procedures for billing and reimbursement.
- Prohibition against limiting the provider's ability to inform patients about medical treatment options.
- Prohibitions against limiting the provider or HMO from contracting with other parties.
- Procedures for authorizing the utilization of health care services.
- Prohibition against preventing providers from rendering services that are medically necessary and covered in a contracting hospital.
- Prohibition against "all products" clauses.

Discount Medical Plan Organizations

Discount medical plan organizations (DMPOs) offer a variety of health care services to consumers at a discounted rate. These plans are not health insurance and therefore do not pay for services on behalf of members; instead, the plans offer members access to specific health care products and services at a discounted fee. These health products and services may include, but are not limited to, dental services, emergency services, mental health services, vision care, chiropractic services, and hearing care. Generally, a DMPO has a contract with a provider network under which the individual providers render the medical services at a discount.

DMPOs are regulated by the Office of Insurance Regulation (OIR) under part II of ch. 636, F.S. That statute establishes licensure requirements, annual reporting, minimum capital requirements, authority for examinations and investigations, marketing restrictions, prohibited activities, and criminal penalties, among other regulations.

Before transacting business in Florida, a DMPO must be incorporated and possess a license as a DMPO.[1] As a condition of licensure, each DMPO must maintain a net worth requirement of $150,000. All charges to members of such plans must be filed with OIR and any charge to members greater than $30 per month or $360 per year must be approved by OIR before the charges can be used by the plan. All forms used by the organization must be filed with and approved by OIR.

[1] Section 636.204, F.S.

III. Effect of Proposed Changes:

Inclusion of PLHSOs In Prohibition Against "All Products" Health Care Provider Contracts

Under current law, a health insurer cannot require that a contracted health care practitioner accept the terms of other practitioner contracts (including Medicare and Medicaid practitioner contracts) with the insurer or with an insurer, HMO, preferred provider organization, or exclusive provider organization that is under common management and control with the contracting insurer. The bill adds to that list by prohibiting the insurer from requiring that a contracted health care provider accept the terms of other practitioner contracts with a PLHSO that is under common management and control with the contracting insurer.

Dentist Provider Contracts: Prohibition Against Specifying Fees for Non-Covered Services

The bill prohibits insurers, HMOs, and PLHSOs from executing a contract with a licensed dentist that requires the dentist to provide services to an insured or subscriber at a specified fee unless such services are "covered services" under the applicable contract. "Covered services" are defined as services reimbursable under the applicable contract at not less than 50 percent of the usual, customary, and reasonable fee of similar providers in the zip code area where the services are provided, subject to such contractual limitations on benefits, such as deductibles, coinsurance, and copayments, as may apply. Covered services do not include dental services that are provided by a dentist to an insured or subscriber not listed as a benefit that the insured or subscriber is entitled to receive under the contract. This will prevent contracts between dentists and insurers, HMOs, or PLHSOs from containing provisions that subject non-covered services to negotiated payment rates.

The bill prohibits contracts between dentists and insurers, HMOs, or PLHSOs from containing provisions that prevent the dentist from billing a patient the difference between the amount reimbursed by the insurer, HMO, or PLHSO and the dentist's normal rate for the services if the services are not covered services as defined in the bill.

The bill prohibits insurers, HMOs, and PLHSOs from requiring that a contracted dentist participate in a discount medical plan under part II of ch. 636, F.S., which regulates DMPOs.

The bill also addresses the criminal penalty specified in s. 624.15, F.S.[2,3] by limiting the exemption from the criminal penalty currently contained in s. 627.6474, F.S., to subsection (1) of s. 627.6474, F.S. The provisions of subsection (2) of s. 627.6474, F.S., as created by the bill, are not specifically exempted from the criminal penalty. This leaves the current-law exemption in

[2] Section 624.15, F.S., provides that, unless a greater specific penalty is provided by another provision of the Insurance Code or other applicable law or rule of the state, each willful violation of the Insurance Code is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, F.S., and that each instance of such violation shall be considered a separate offense.

[3] Section 775.082, F.S., provides that a person convicted of a misdemeanor of the second degree may be sentenced to a term of imprisonment not exceeding 60 days. Section 775.083, F.S., provides that a person convicted of a misdemeanor of the second degree may be sentenced to pay a fine not exceeding $500 plus court costs.

place for the amended statutory provisions to which it currently applies, without applying the exemption to the bill's new provisions in subsection (2).

The bill provides an effective July 1, 2011, and the provisions in the bill apply to contracts entered into on or after that date.

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:

Representatives of health insurers, HMOs, and PLHSOs assert that their policyholders and subscribers will pay higher costs for dental care if the Legislature prohibits these entities from contracting with dentists to provide services that are not covered at a negotiated fee. These representatives also assert that the bill unduly interferes with the freedom of two private entities to agree to their own contract terms.

Representatives of dentists assert that the Legislature should prohibit health insurers, HMOs, and PLHSOs from negotiating fees with dentists for services that are not covered because these provisions unfairly shift health care costs to dentists and potentially imperil the financial stability of dental practices. These representatives indicate that 18 other states have passed similar legislation.

C. Government Sector Impact:

According to the Office of Insurance Regulation, implementing the provisions of this bill will have no fiscal impact on the office, nor is there a direct impact on the costs that the state incurs for the state employees' Preferred Provider Organization, (PPO) or the HMO Plans. However, members of the state dental coverage plans, could be affected if dentists have the ability to bill and charge amounts above contracted rates when members are financially responsible for the service in question.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill defines covered services as "services reimbursable under the applicable contract at not less than 50 percent of the usual, customary, and reasonable fee of similar providers in the zip code area where the services are provided, subject to such contractual limitations on benefits, such as deductibles, coinsurance, and copayments, as may apply." The bill does not specify how the usual, customary, and reasonable fee of similar providers in the zip code area must be calculated, which will leave that determination to the parties in the contract and to other provisions of the Insurance Code that might apply to the calculation of usual, customary, and reasonable fees.[4]

The bill supplements the definition of covered services with the following provision: "However, covered services do not include *dental services that are provided by a dentist to an insured for dental services* that are not listed as a benefit that the insured is entitled to receive under the contract." [emphasis added] It might be clearer to word this provision as follows: "However, covered services do not include *dental services provided by a dentist to an insured which* are not listed as a benefit that the insured is entitled to receive under the contract." [emphasis added]

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 the Committee on Health Regulation on March 28, 2011:
The CS makes the following changes to the bill as filed:

- The bill as filed applied the exemption from criminal penalties in s. 627.6474, F.S., to the new subsection (2) of that statute created by the bill. The CS limits that exemption to the amended provisions of existing law in subsection (1) of s. 627.6474, F.S.
- The bill as filed specified that covered services do not include dental services that are provided by a dentist to an insured who has already met or exceeded the annual or other periodic payment maximum established by the contract. The CS does not contain this provision.
- The CS defines covered services, in part, as services reimbursable under the applicable contract at not less than 50 percent of the usual, customary, and reasonable fee of similar providers in the zip code area where the services are provided. The bill as filed did not contain this provision.
- The CS prohibits contracts between dentists and insurers, HMOs, or PLHSOs from containing provisions that prevent the dentist from billing a patient the difference between the amount reimbursed by the insurer, HMO, or PLHSO and the dentist's normal rate for the services if the services are not covered services. The bill as filed did not contain this provision.

[4] Three sections of statute in the Insurance Code use all three terms – usual, customary, and reasonable – when placing conditions on provider fees or charges. *See* ss. 627.6044(1), 627.736(5)(a)1., and 641.51(5)(c), F.S.

- The CS prohibits insurers, HMOs, and PLHSOs from requiring that a contracted dentist participate in a discount medical plan under part II of ch. 636, F.S. The bill as filed did not contain this provision.

B. Amendments:

None.