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 Committee on Rules

BILL: CS/CS/SB 1016

INTRODUCER: Judiciary Committee; Health Policy Committee; and Senator Hays

SUBJECT: Sovereign Immunity for Dentists and Dental Hygienist

DATE: April 12, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	McElheney	Stovall	HP	**Fav/CS**
2.	Munroe	Cibula	JU	**Fav/CS**
3.	McElheney	Phelps	RC	**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:

CS/CS/SB 1016 prohibits an insurer, health maintenance organization (HMO), 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, HMO, or prepaid limited health services organization from requiring that a contracted dentist participate in a discount medical plan. The bill also 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 authorizes a dentist, who is a government contracted health care provider under the Access to Health Care Act, to allow a patient, or a parent or guardian of a patient to voluntarily contribute a fee to cover costs of dental laboratory work. The contribution may not exceed the actual cost of the laboratory fee. When the voluntary contribution is accepted from the patient for dental laboratory fees, it is not considered compensation for services so that sovereign immunity protection is not lost.

This bill creates one undesignated section of law.

This bill substantially amends the following sections of the Florida Statutes: 627.6474, 636.035, 641.315, and 766.1115.

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 another 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. Before being prohibited by the 2001 Legislature, these clauses 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 services to enrollees through an exclusive panel of providers in exchange for a prepayment, and are authorized in ch. 636, 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.[1] Provider arrangements for prepaid limited health service organizations are authorized in s. 636.035, F.S., and must comply with the requirements in that section.

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.[2] 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

[1] Section 636.003(5), F.S.
[2] Section 641.19(12), F.S.

payment of benefits for the out-of-network services rendered to the member. Section 641.315, F.S., specifies requirements for the HMO provider contracts with providers of health care services.

Discount Medical Plan Organizations

Discount medical plan organizations (DMPOs)[3] 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.

The 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.[4] As a condition of licensure, each DMPO must maintain a net worth requirement of $150,000.[5] 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.[6] All forms used by the organization must be filed with and approved by OIR.

Access to Health Care Act

Section 766.1115, F.S., is entitled "The Access to Health Care Act" (the Act). The Act was enacted in 1992 to encourage health care providers to provide care to low-income persons.[7] This section extends sovereign immunity to health care providers who execute a contract with a governmental contractor and who provide volunteer, uncompensated health care services to low-income individuals as an agent of the state. These health care providers are considered agents of the state under s. 768.28(9), F.S., for purposes of extending sovereign immunity while acting within the scope of duties required under the Act.

Health care providers under the Act include:[8]

- A birth center licensed under ch. 383, F.S.[9]

[3] Section 636.202(2), F.S.
[4] Section 636.204, F.S.
[5] Section 636.220, F.S.
[6] Section 636.216(1), F.S.
[7] Low-income persons are defined in the Act as a person who is Medicaid-eligible, a person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level, or any eligible client of the Department of Health who voluntarily chooses to participate in a program offered or approved by the department.
[8] Section 766.1115(3)(d), F.S.
[9] Section 766.1115(3)(d)1., F.S.

- An ambulatory surgical center licensed under ch. 395, F.S.[10]
- A hospital licensed under ch. 395, F.S.[11]
- A physician or physician assistant licensed under ch. 458, F.S.[12]
- An osteopathic physician or osteopathic physician assistant licensed under ch. 459, F.S.[13]
- A chiropractic physician licensed under ch. 460, F.S.[14]
- A podiatric physician licensed under ch. 461, F.S.[15]
- A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of ch. 464, F.S., or any facility which employs nurses licensed or registered under part I of ch. 464, F.S., to supply all or part of the care delivered under this section.[16]
- A dentist or dental hygienist licensed under ch. 466, F.S.[17]
- A midwife licensed under ch. 467, F.S.[18]
- A health maintenance organization certificated under part I of ch. 641, F.S.[19]
- A health care professional association and its employees or a corporate medical group and its employees.[20]
- Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.[21]
- A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.[22]
- Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in subparagraphs 766.1115(3)(d)4-9, F.S.[23]
- Any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by the listed licensed professionals, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

[10] Section 766.1115(3)(d)2., F.S.
[11] Section 766.1115(3)(d)3., F.S.
[12] Section 766.1115(3)(d)4., F.S.
[13] Section 766.1115(3)(d)5., F.S.
[14] Section 766.1115(3)(d)6., F.S.
[15] Section 766.1115(3)(d)7., F.S.
[16] Section 766.1115(3)(d)8., F.S.
[17] Section 766.1115(3)(d)9., F.S.
[18] Section 766.1115(3)(d)10., F.S.
[19] Section 766.1115(3)(d)11., F.S.
[20] Section 766.1115(3)(d)12., F.S.
[21] Section 766.1115(3)(d)13., F.S.
[22] Section 766.1115(3)(d)14., F.S.
[23] Section 766.1115(3)(d)15., F.S.

A governmental contractor is defined in the Act as the Department of Health (DOH or department), a county health department, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity.[24]

The definition of contract under the Act provides that the contract must be for volunteer, uncompensated services. For services to qualify as volunteer, uncompensated services the health care provider must receive no compensation from the governmental contractor for any services provided under the contract and must not bill or accept compensation from the recipient, or any public or private third-party payor, for the specific services provided to the low-income recipients covered by the contract.[25]

The Act further specifies contract requirements. The contract must provide that:

- The governmental contractor retains the right of dismissal or termination of any health care provider delivering services under the contract.
- The governmental contractor has access to the patient records of any health care provider delivering services under the contract.
- The health care provider must report adverse incidents and information on treatment outcomes.
- The governmental contractor must make patient selection and initial referrals.
- The health care provider must accept all referred patients; however, the contract may specify limits on the number of patients to be referred.
- Patient care, including any follow-up or hospital care is subject to approval by the governmental contractor.
- The health care provider is subject to supervision and regular inspection by the governmental contractor.

The governmental contractor must provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing, that the provider is covered under s. 768.28, F.S., for purposes of actions related to medical negligence.

The individual accepting services through this contracted provider must not have medical or dental care coverage for the illness, injury, or condition in which medical or dental care is sought.[26] The services not covered under this program include experimental procedures and clinically unproven procedures. The governmental contractor shall determine whether or not a procedure is covered.

The health care provider may not subcontract for the provision of services under this chapter.[27]

Currently, s. 766.1115, F.S., is interpreted differently across the state. In certain parts of the state one medical director interprets this law to mean that as long as there is transparency and clear proof that the volunteer provider is providing services, without receiving personal compensation,

[24] Section 766.1115(3)(c), F.S.
[25] Section 766.1115(3)(a), F.S.
[26] Rule 64I-2.002, F.A.C.
[27] *Id.*

then the patient can pay a nominal amount per visit to assist in covering laboratory fees. In other parts of the state, a medical director suggests that if any monetary amount is accepted then sovereign immunity is lost. Patients sometimes offer to pay a nominal contribution to cover some of the cost of laboratory fees that the provider incurs to pay outside providers for items such as dentures for the patient. In many areas, the dentist is paying the cost of these fees from his or her own resources.[28]

Sovereign Immunity

The term "sovereign immunity" originally referred to the English common law concept that the government may not be sued because "the King can do no wrong." Sovereign immunity bars lawsuits against the state or its political subdivisions for the torts of officers, employees, or agents of such governments unless the immunity is expressly waived.

Article X, s. 13, of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the right to waive such immunity in part or in full by general law. Section 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state.

Under this statute, officers, employees, and agents of the state will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

Instead, the state steps in as the party litigant and defends against the claim. Subsection (5) limits the recovery of any one person to $200,000 for one incidence and limits all recovery related to one incidence to a total of $300,000. The sovereign immunity recovery caps do not prevent a plaintiff from obtaining a judgment in excess of the caps, but the plaintiff cannot recover the excess damages without action by the Legislature.[29]

Whether sovereign immunity applies turns on the degree of control of the agent of the state retained by the state.[30] In *Stoll v. Noel*, the Florida Supreme Court explained that independent contractor physicians may be agents of the state for purposes of sovereign immunity:

> One who contracts on behalf of another and subject to the other's control except with respect to his physical conduct is an agent and also independent contractor.31

The court examined the employment contract between the physicians and the state to determine whether the state's right to control was sufficient to create an agency relationship and held that it did.[32] The court explained:

[28] Staff of Committee on Health Policy's discussion with representatives from the Florida Dental Association on March 8, 2013.
[29] Section 768.28(5), F.S.
[30] *Stoll v. Noel*, 694 So. 2d 701, 703(Fla. 1997).
[31] *Id.* (quoting The Restatement of Agency).
[32] *Stoll v. Noel*, 694 So. 2d 701 at 703.

> Whether the [Children's Medical Services(CMS)] physician consultants are agents of the state turns on the degree of control retained or exercised by CMS. This Court has held that the right to control depends upon the terms of the employment contract. *National Sur. Corp. v. Windham*, 74 So. 2d 549, 550 (Fla. 1954) ("The [principal's] right to control depends upon the terms of the contract of employment…") The CMS requires each consultant, as a condition of participating in the CMS program, to agree to abide by the terms published in its HRS[33] Manual and CMS Consultants Guide which contain CMS policies and rules governing its relationship with the consultants. The Consultant's Guide states that all services provided to CMS patients must be authorized in advance by the clinic medical director. The language of the HRS Manual ascribes to CMS responsibility to supervise and direct the medical care of all CMS patients and supervisory authority over all personnel. The manual also grants to the CMS medical director absolute authority over payment for treatments proposed by consultants. The HRS Manual and the Consultant's Guide demonstrate that CMS has final authority over all care and treatment provided to CMS patients, and it can refuse to allow a physician consultant's recommended course of treatment of any CMS patient for either medical or budgetary reasons.
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> Our conclusion is buttressed by HRS's acknowledgement that the manual creates an agency relationship between CMS and its physician consultants, and despite its potential liability in this case, HRS has acknowledged full financial responsibility for the physicians' actions. HRS's interpretation of its manual is entitled to judicial deference and great weight.[34]

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 which 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 those services that are listed as a benefit that the subscriber is entitled to receive under

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[33] Florida Department of Health and Rehabilitative Services.
[34] *Stoll v. Noel*, 694 So. 2d 701, 703(Fla. 1997).

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 also prohibits insurers, HMOs, and PLHSOs from providing merely de minimis reimbursement or coverage to avoid the requirements of the bill. The bill requires that fees for covered services must be set in good faith and cannot be nominal.

The bill prohibits insurers, HMOs, and PLHSOs from requiring that a contracted dentist participate in a DMPO.

The bill also addresses the criminal penalty specified in s. 624.15, F.S.,[35,36] 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 place for the amended statutory provisions to which it currently applies, without applying the exemption to the bill's new provisions in subsection (2).

Access to Health Care Act

The bill authorizes a dentist, who is a government contracted health care provider under the Access to Health Care Act, to allow a patient, or a parent or guardian of a patient to voluntarily contribute a fee to cover costs of dental laboratory work. The contribution may not exceed the actual cost of the laboratory fee. When the voluntary contribution is accepted from the patient for dental laboratory fees it is not considered compensation for services so that sovereign immunity protection is not lost.

The bill provides an effective date of July 1, 2013, and the provisions in the bill apply to contracts entered into or renewed on or after that date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

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[35] 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.

[36] 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.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Insurance

The bill may have a negative fiscal impact on health insurer, HMO, and PLHSO policyholders and subscribers who may 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.

Access to Health Care Act

The fiscal impact of the bill's provisions relating to a patient's voluntary contribution of a fee to cover costs of dental laboratory work is expected to be minimal since many areas in the state already allow voluntary contributions.[37]

C. Government Sector Impact:

Insurance

According to the Office of Insurance Regulation writing on a similar 2011 Senate bill,[38] implementing the provisions of this bill relating to insurance plans will have no fiscal impact on the office. There also should be no 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.

Access to Health Care Act

Additional documentation and billing may be required to avoid the appearance that voluntary contributions are compensation to the practitioner. It could be unclear whether the activities of the dentist's staff to coordinate lab services may be characterized as paid work to the extent a fee or partial fee was provided for these services. This can be

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[37] *See* Department of Health Bill Analysis for SB 1016 (dated March 11, 2013) on file with the Senate Health Policy Committee and notes from telephone call with staff on March 12, 2013.
[38] SB 546

problematic if the dentist is volunteering through a professional association. Mistakes could result in litigation on the issue of compensation to the health care provider.[39]

VI. Technical Deficiencies:

None.

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/CS by Judiciary on April 9, 2013:
The committee substitute makes the following changes to the underlying committee substitute to prohibit:

- An insurer, health maintenance organization (HMO), 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.
- An insurer, HMO, or prepaid limited health services organization from requiring that a contracted dentist participate in a discount medical plan.
- 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.

CS by Health Policy on March 14, 2013:
The CS removes the definition for the term "uncompensated services." The CS authorizes a dentist, who is a government contracted health care provider, to allow a patient, parent, or guardian to voluntarily contribute a fee to cover costs of dental laboratory work.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

[39] *See* Department of Health Bill Analysis for SB 1016(dated March 11, 2013) on file with the Senate Health Policy Committee.