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 Appropriations

BILL:	SB 924
INTRODUCER:	Senator Latvala
SUBJECT:	Dentists
DATE:	April 19, 2013
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Favorable**
2.	Burgess	Burgess	BI	**Favorable**
3.	Betta	Hansen	AP	**Favorable**
4.			RC	
5.				
6.				

I. Summary:

SB 924 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.

According to the Office of Insurance Regulation (OIR), there is no fiscal impact to implement the provisions of the bill.

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 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, 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 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 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.

[1] S. 636.003(5), F.S.
[2] S. 641.19(12), F.S.
[3] S. 636.202(2), F.S.

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.

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 those services that are listed as a benefit that the 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 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.

[4] S. 636.204, F.S.
[5] S. 636.220, F.S.
[6] S. 636.216(1), F.S.

The bill also addresses the criminal penalty specified in s. 624.15, F.S.,[7,8] 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).

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.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 924 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.

[7] 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.

[8] 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.

The bill may have a positive fiscal impact on dentists who may be able to benefit from increased payments from insurers, HMOs, and PLHSOs due to the contract restrictions in this bill.

C. Government Sector Impact:

According to an OIR analysis on a 2011 similar bill,[9] implementing the provisions of this bill will have no fiscal impact. In addition, there 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.

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.)

None.

B. Amendments:

None.

[9] SB 546