HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 31 Dentists
SPONSOR(S): Insurance & Banking Subcommittee; Health Innovation Subcommittee; Renuart and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 86

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	11 Y, 0 N, As CS	Poche	Shaw
2) Insurance & Banking Subcommittee	12 Y, 0 N, As CS	Cooper	Cooper
3) Health & Human Services Committee	18 Y, 0 N	Poche	Calamas

SUMMARY ANALYSIS

CS/CS/HB 31 prohibits health insurance provider contracts from containing provisions requiring dentists to provide services at a fee set by the health insurer, prepaid limited health service organization or health maintenance organization unless the services are covered under the contract or subscriber agreement. The bill defines "covered services" as those services for which reimbursement is available under a plan or contract or those services for which reimbursement would be available but for contractual limitations such as deductibles, yearly or lifetime maximums, alternative payment benefits, or any other limitation in the plan or contract.

The bill also adds prepaid limited health service organization (PLHSO) provider arrangement contracts to the list of insurers which may not require a health care practitioner to accept the terms of other health care practitioner contracts with an insurer, PLHSO, or health maintenance organization as a condition of continuing or renewing a contract.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of July 1, 2014, and applies to contracts entered into or renewed on or after that date.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Regulation of Health Insurers and Health Maintenance Organizations (HMOs)

The Office of Insurance Regulation (OIR) regulates health insurance policies and rates under Part VI of Chapter 627, F.S. OIR also regulates HMO contracts and rates under Part I of Chapter 641, F.S. The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under Part III of Chapter 641, F.S.

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

Health Insurer Provider Arrangements

Health insurer provider contracts are regulated by the OIR. Current Florida law does not prohibit provider contracts between health insurers and dentists from containing provisions that require the dentist to provide services to the subscribers to a health insurance plan or policy at a fee set by the health insurer, regardless of whether or not the services are covered under the health insurance plan or policy.

Section 627.6474, F.S., provides that a health insurer cannot require a contracted health care practitioner to accept the terms of other health care practitioner contracts with the insurer, or any other insurer or HMO under common management and control with the insurer, including Medicare and Medicaid practitioner contracts, preferred provider, exclusive provider organizations, or provider contracts, except for a practitioner in a group practice who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Any contract provision that violates this provision is considered void.

OIR must approve any charge to members greater than $30 per month or $360 per year before the charges can be used by the plan.[1] All forms used by the organization must be filed with and approved by the OIR.[2]

Prepaid Limited Health Service Organization (PLHSO) Provider Arrangements

PLHSOs are authorized in s. 636.003, F.S. The statute 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

[1] S. 636.216(1), F.S.
[2] S. 636.216(3), F.S.

- pharmaceutical services.

Provider arrangements for PLHSOs are authorized in s. 636.035, F.S. Current law does not prohibit provider contracts between PLHSOs and dentists from containing provisions that require dentists to provide non-covered services to the PLHSO subscribers at a fee set by the PLHSO.

HMO Provider Contracts

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. 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.

Effect of Proposed Changes

The bill amends s. 627.6474, F.S., to add PLHSO provider arrangement contracts, authorized under s. 636.035, F.S., to the list of contracts under which a health insurer may not require a health care practitioner to accept the terms of other health care practitioner contracts with an insurer, PLHSO, or HMO.

The bill also amends ss. 627.6474, 636.035, and 641.315, F.S., to prohibit a contract between a health insurer, a PLHSO, or an HMO and a dentist from containing provisions that require the dentist to provide a service to the insured or subscriber at a fee set by the insurer, PLHSO, or HMO, unless the service is a covered service under the applicable policy or subscriber agreement. The bill defines a "covered service" as a service for which reimbursement is available under a plan or contract or a service for which reimbursement would be available but for contractual limitations such as deductibles, yearly or lifetime maximums, alternative payment benefits, or any other limitation in the plan or contract. Services that are not listed in an individual's health insurance plan or policy as a benefit to which the individual is entitled under the plan or agreement are not considered covered services.

The bill applies to all contracts entered into or renewed on or after July 1, 2014.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6474, F.S., relating to provider contracts.
Section 2: Amends s. 636.035, F.S., relating to provider arrangements.
Section 3: Amends s. 641.315, F.S., relating to provider contracts.
Section 4: Provides for application to contracts entered into or renewed on or after July 1, 2014.
Section 5: Provides an effective date of July 1, 2014.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may allow dentists to charge higher fees to patients for services that are not considered "covered services" under a contract with a PLHSO, HMO, or health insurer.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The title of the bill, an act relating to dentists, is narrower than the substance of the bill. For instance, section 1 of the bill concerns provider contracts between health insurers and health care providers. Because the bill, in part, applies to health care providers other than dentists, it is recommended that the title of the bill be amended to a more general "act relating to" clause. An appropriate title is, "An act relating to health care provider contracts."

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 5, 2014, the Health Innovation Subcommittee adopted a strike-all amendment to House Bill 31. The amendment made the following changes to the bill:

- Removed the requirement that fees for covered services be set in good faith.
- Removed the prohibition against insurers, PLHSOs, and HMOs setting nominal or de minimis fees for covered services as a way of avoiding the provisions of the bill.
- Defined "covered services" to mean those services for which reimbursement is available under a plan or contract or those services for which reimbursement would be available but for contractual limitations such as deductibles, yearly or lifetime maximums, alternative payment benefits, or any other limitation in the plan or contract.

On March 25, 2014, the Insurance & Banking Subcommittee considered CS/HB 31 and adopted three amendments. The amendments removed the provisions that health insurers, PHLSOs or HMOs may not require as a condition of the contract that dentists participate in a discount medical plan.

The bill was reported favorably as a committee substitute. The analysis reflects the committee substitute.