HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 367 Health Care Provider Contracts
SPONSOR(S): Hooper and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 546

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee	13 Y, 1 N	Poche	Calamas
2) Insurance & Banking Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

House Bill 367 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 health insurer, prepaid limited health service organization or health maintenance organization unless the services are covered under the applicable subscriber agreement. The bill defines “covered services” and specifies what services are not considered “covered services”.

The bill does not appear to have a fiscal impact.

The bill provides an effective date of July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

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[1], exclusive provider organizations[2], or provider contracts[3], except for a practitioner in a group practice[4] 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.[5]

Prepaid Limited Health Service Organization (PLHSO) Provider Arrangements

PLHSOs 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;

[1] S. 627.6471, F.S.
[2] S. 627.6472, F.S.
[3] S. 641.315, F.S.
[4] A group practice is a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association such that services are provided through the joint use of shared office space, facilities, equipment, and personnel; services are billed in the name of the group and amounts received are treated as receipts of the group; and overhead expenses and income is distributed by methods determined by the group. See s. 456.053(h), F.S.
[5] S. 627.6474, F.S.

- podiatric care services; and
- pharmaceutical services.

AHCA currently has two types of PLHSOs- a prepaid dental health plan (PDHP), as authorized in s. 409.912(43), F.S., and a 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.

As of March 2011, approximately 253,739 beneficiaries are enrolled in the PDHP program and 648,730 beneficiaries are enrolled in the PMHP program.[6]

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 insurers which may not require a health care practitioner to accept the terms of other health care practitioner contracts with an insurer, prepaid limited health service organization, or HMO. The bill 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.

The bill amends s. 636.035, F.S., to prohibit provider contracts between a PLHSO and a dentist from containing any provision that requires dentists to provide services at a fee set by the PLHSO unless the services are covered services under the applicable subscriber agreement.

Also, the bill amends s. 641.315, F.S., to prohibit provider contracts between a HMO and a dentist from containing provisions that require the dentist 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.

The bill defines "covered services" as those services that are reimbursable under an applicable contract, subject to contractual limitations on benefits. The bill specifically exempts from the definition of "covered services" any dental services provided by a dentist to a covered individual who has met or exceeded the periodic maximum amount of benefits allowed by the individual's health insurance plan or policy. Also, 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 policy are not considered covered services.

The bill applies to all contracts entered into or renewed on or after July 1, 2011.

B. SECTION DIRECTORY:

[6] Email correspondence from AHCA staff dated March 11, 2011, providing total enrolled beneficiaries in the PDHP and PMHP programs for March 2011, on file with Health and Human Services Quality Subcommittee.

Section 1: Amends s. 627.6474, F.S., relating to provider contracts and health care practitioners
Section 2: Amends s. 636.035, F.S., relating to provider arrangements and prepaid limited health service organizations
Section 3: Amends s. 641.315, F.S., relating to provider contracts and health maintenance organizations
Section 4: Provides an effective date of July 1, 2011

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 insurance company. There may be an increase in the cost of dental insurance coverage to pay for services that are not "covered services" and for which insurers may not contract with dentists.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES