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 Health Regulation Committee

BILL:	SB 546
INTRODUCER:	Senator Hays
SUBJECT:	Dentists
DATE:	March 24, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	**Favorable**
2.	Brown	Stovall	HR	**Pre-meeting**
3.			BC	
4.				
5.				
6.				

I. Summary:

Senate Bill 546 prohibits an insurer, health maintenance organization (HMO), and 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 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.

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 co-payments.
- 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.

III. Effect of Proposed Changes:

Sections 1-3.

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. A "covered service" is defined as a reimbursable service under the contract between the dentist and insurer, HMO, or PLHSO that may be subject to deductibles, coinsurance, and copayments. A "covered service" does not include services rendered to an insured or subscriber who has reached the periodic payment maximum established by the contract or dental services that are not listed as benefits under the contract. This will prevent such non-covered services from being subject to negotiated payment rates established by contract.

Section 4. The act is effective July 1, 2011, and applies to contracts entered into on or after that date.

Other Potential Implications:

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

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, especially since the bill classifies as non-covered services those services that are typically covered by the policy but for which benefit payments will no longer be made if the policyholder or subscriber has reached the periodic payment maximum. 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 note that sixteen other states have passed similar legislation.

C. Government Sector Impact:

This bill does not appear to have a direct impact on the cost that the state incurs for the state employees' PPO Plan or the HMO plans. Members of the state dental coverage plans, however, 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.