SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

Date: April 16, 1998 Revised: 04/20/98

Subject: Dental Insurance Coverage

	Analyst	Staff Director	Reference	Action
1.	Johnson	Deffenbaugh	BI	Favorable/CS
2.	Williams	Wilson	HC	Fav/2 amendments
3.			WM	
4.				
5.				

I. Summary:

Committee Substitute for Senate Bill 792 requires each individual health insurance policy, group (including out-of-state group) health insurance policy, and health maintenance organization contract to provide coverage for charges for general anesthesia or hospitalization for dental care provided to a covered person who: 1) is 8 years of age or less and is determined by a licensed dentist in consultation with the child's physician licensed under chapter 458 or 459, F.S., to require necessary dental treatment in a hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or 2) has one or more medical conditions that would create significant undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center. Dental treatment or surgery would be considered necessary when the dental condition is likely to result in a medical condition if left untreated.

All terms and conditions of the covered person's health insurance policy or contract would apply to such services and the provisions of this bill would not require coverage for the diagnosis or treatment of dental disease. The bill provides that the insurer or HMO may require prior authorization for hospitalization for dental care procedures in the same manner that the insurer requires prior authorization for hospitalization for other covered diseases or conditions.

This bill creates sections 627.4295 and 627.65755; amends sections 627.6515 and 641.31, Florida Statutes; and creates one undesignated section of law.

II. Present Situation:

Current Florida law does not require that health insurance policies or health maintenance organization contracts provide coverage for dental care. However, s. 627.419(2), F.S., provides that the word "physician" or "medical doctor," when used in any health insurance policy or other contract providing for the payment of surgical procedures which are specified in the policy or contract or are performed in an accredited hospital in consultation with a licensed physician and are within the scope of a dentist's professional license, shall be construed to include a dentist who performs such specified procedures. Otherwise, individual or group health care insurance policies and HMO contracts do not typically cover dental care, which is more typically provided under a separate dental policy or contract. Dental policies may cover dental care ranging from general maintenance of teeth, to more extensive coverage, including dentures, oral surgery, or other types of care to the mouth and teeth.

According to the Florida Dental Association, the vast majority of dental care can be done in the dental office setting. However, routine approaches may not be appropriate or effective for certain patients. The patients for whom routine approaches are inappropriate may include the young, the severely disabled, or a person with a special medical condition. Health insurance plans and HMO contracts may deny hospitalization and general anesthesia benefits claiming that the procedures are dental, and therefore excluded from the plan.

III. Effect of Proposed Changes:

The bill requires each individual health insurance policy (Section 1), group, including out-of-state group, health insurance policy (Sections 2 and 3), and health maintenance organization contract (Section 4) to provide coverage for charges for general anesthesia or hospitalization for dental care provided to a covered person who: 1) is 8 years of age or less and is determined by a licensed dentist in consultation with the child's physician licensed under chapter 458 or 459, F.S., to require necessary dental treatment in a hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or 2) has one or more medical conditions that would create significant undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center. Dental treatment or surgery would be considered necessary when the dental condition is likely to result in a medical condition if left untreated.

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The requirements of this bill would not apply to a Medicare supplement, long-term care, disability, limited benefit, or specified disease policy.

The bill provides that the provisions of this act fulfill an important state interest in that they promote the relief, alleviation, and prevention of health, dental, or medical problems associated with inadequate dental care.

The bill takes effect October 1, 1998, and shall apply to any policy issued, written, renewed, or contract entered into on or after such date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Inasmuch as this bill may require the state and local governments to incur expenses, that is, to pay additional employee health insurance costs, the bill falls within the purview of Art. VII, s. 18 of the State Constitution, which provides that cities and counties are not bound by general laws requiring them to spend funds or to take an action which requires the expenditure of funds unless certain specified exemptions or exceptions are met. The law is binding on counties and municipalities if the Legislature determines that the law fulfills an important state interest. The bill requires similarly situated persons (private employee health care coverage) to comply with the provisions of the bill and, in section 5, states that the act fulfills an important state interest.

B. Public Records/Open Meetings Issues:

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

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Individuals would be able to obtain coverage for general anesthesia or hospitalization for dental care that might not otherwise be covered by a health insurance policy or HMO contract.

According to the Department of Insurance, the provisions in the bill may represent a significant increase in costs to insurers and HMOs. Claims costs from hospitalization and anesthesia could significantly increase as a result of these added benefits and would be passed through in the form of increased premiums.

The report submitted to the committee by the Florida Dental Association estimates that the cost for coverage, per covered family, is $2.19 per year. (See Related Issues, below.)

C. Government Sector Impact:

Presently, the State Plan (indemnity coverage for state employees) excludes coverage for services and supplies for dental work, treatment, and examinations unless it is the result of a covered accident. However, the plan will pay for non-physician services provided by a hospital, ambulatory surgical center, outpatient health care facility, or skilled nursing facility in connection with dental work, treatment, or examinations when ordered by a physician and deemed medically necessary for the treatment of the participant as a result of a covered accident, illness, condition, or mental or nervous disorder.

The state HMO contracts do not currently require coverage for dental services unless the service is the treatment of a non-dental injury to teeth, including an accident or injury occurring while, and as a result of, biting and chewing. If the HMOs are required to provide such services, there would be a fiscal impact (Information provided by the Division of State Group Insurance).

VI. Technical Deficiencies:

None.

VII. Related Issues:

Pursuant to s. 624.215, F.S., every individual seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage is required to submit to the Agency for Health Care Administration and the legislative committee having jurisdiction a report which assesses the social and financial impacts of the proposed coverage. Such a report was submitted to the Committee. The report estimated that the cost for coverage, per covered family, is $2.19 per year.

VIII. Amendments:

#1 by Health Care:
Changes the treating physicians's role from that of a "consultant" to that of issuing a "joint determination" with the treating dentist.

#2 by Health Care:
Specifies that the provisions of the bill do not apply to "accident-only" policies.