HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	CS/CS/HB 31	**FINAL HOUSE FLOOR ACTION:**	
SPONSOR(S):	Insurance & Banking Subcommittee; Health Innovation Subcommittee; Renuart and others	115 **Y's**	0 **N's**
COMPANION BILLS:	CS/SB 86; HB 869; SB 710	**GOVERNOR'S ACTION:**	Pending

SUMMARY ANALYSIS

CS/CS/HB 31 passed the House on April 28, 2014, as CS/SB 86 as amended.

The Senate concurred in the House amendments to the Senate bill and subsequently passed the bill as amended on May 1, 2014.

The bill 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.

Subject to the Governor's veto powers, the effective date of this bill is July 1, 2014, and applies to contracts entered into or renewed on or after that date.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF 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 does not appear to have a fiscal impact on state or local government.

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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.