SUBJECT: Regulating dental provider organizations

COMMITTEE: Insurance — committee substitute recommended

VOTE: 6 ayes — Smithee, Averitt, De La Garza, Dutton, G. Lewis, Shields

2 nays — Counts, Driver

1 absent — Duncan

WITNESSES: For — L. Dean Cobb, Hector DeLeon, Dr. W. David Jenkins, Thomas P. Washburn, Texas Dental Plans, Inc; Hank Gonzales, Hispanic American Republicans of Texas

Against — Gary Downey, Texas HMO Association, American Dental Corporation; Dennis B. Martinez, Safeguard Health Plans, Inc; Vincent Contorno, Prudential

On — Rhonda Myron, Texas Department of Insurance

DIGEST: CSHB 1194 would regulate dental provider plans and organizations under the Insurance Code by creating a new act. A *dental provider plan* would be defined as a plan under which a person arranges the availability of dental care services from one or more participating dentists on a fee-for-service basis according to predetermined or discounted fees. A dental provider plan would not include a plan in which dental care is arranged or provided for on a pre-paid basis through insurance or indemnification. A *dental provider organization* would refer to a person or business who arranges for or provides a dental provider plan to enrolled members for a fee or other consideration.

A dental provider organization could not operate, sell, offer to sell or solicit offers to purchase or receive consideration without a valid certificate of authority. A foreign corporation registered to do business in this state under the Texas Business Corporation Act could obtain a certificate of authority in accordance with the bill.

Dental provider plans and organizations would be exempted from all other Texas insurance laws unless dental provider plans are expressly designated.

Certificate application procedures. An applicant would be required to submit an application to the commissioner of insurance accompanied by a nonrefundable application fee. The application would also be required to be verified by the applicant or applicant's designee and include:

• copies of the applicant's basic organizational documents, if any;
• copies of the bylaws, rules or similar documents regulating the conduct of the applicant's internal affairs, if any;
• a list of the names, addresses and official positions of persons responsible for the conduct of the applicant's affairs;
• a sample copy of the form of a contract made or to be made between a dentist, other provider, marketing representative and the organization,
• a copy of the fee schedule form to be issued;
• a current, audited financial statement;
• a description of the geographical service area;
• a description of complaint resolution procedures;
• a copy of the organization's surety bond and
• other information deemed necessary by the commissioner.

The commissioner would be required to review applications, promptly notify the applicants of any deficiencies and allow the applicant 60 days to correct any deficiencies. The commissioner would be required to issue the certificate or deny the application not later than the 60th day after the receipt of the application, unless applicant needed more time to correct deficiencies. The commissioner would be required to notify the applicant of a denial and reasons for the denial.

The commissioner would be required to issue the certificate if each application item appeared satisfactory, each person responsible for the conduct of the applicant's affairs was competent, trustworthy and of good reputation, the dental provider organization would effectively provide or arrange for dental services, the organization was fully responsible and could reasonably be expected to meet its obligations and the proposed method of operation was not against state law.

Certificate renewal. A certificate of authority would expire annually on April 1. Renewal applications would be required to be accompanied by a nonrefundable renewal fee and include any modifications or amendments of the information required under the original application. A modification or amendment would be considered approved unless the commissioner specifically disapproved of a change not later than the 30th day after the receipt of information. The commissioner could postpone action on a modification for an additional 30 days if necessary.

A dental provider organization would also be required to file an annual financial report for the preceding year. An independent certified public accountant would have to attest to the annual report, which would have to include a balance sheet, statement of income and retained earnings and statement of cash flow.

Notification of change. A change in ownership or control would be subject to the prior approval of the commissioner.

Dental provider organization powers. A dental provider organization could arrange for the availability of services on a fee-for-service basis using predetermined and/or discounted rates with dentists or groups of dentists under contract.

A dental provider plan could not pay or prepay a dentist for services rendered to a member or employ or contract with a dentist in a manner prohibited by state law.

A dental provider organization could contract for the performance of marketing, enrollment and administration on its behalf.

Prohibited practices. An organization could not cause or knowingly permit the use of advertising, solicitations or schedules that are untrue, misleading or deceptive. The Deceptive Trade Practices-Consumer Protection Act would apply to a dental provider organization, its fee schedules and the sale of a dental plan.

A dental provider organization would not be permitted to practice dentistry.

Fee schedules. A dental provider organization would be required to give each member a schedule of dental care services fees and a list of participating dentists. The fee schedule could not contain statements that are unfair, misleading, deceptive or encourages misrepresentation. At a minimum a fee schedule would be required to contain two clear and complete statements: one statement describing available services from participating dentists and any limitations or exclusions and another explaining that the plan would not constitute dental insurance or a health maintenance organization and would not reimburse dentists or indemnify members.

A fee schedule could not be issued without first being filed with the commissioner. An appropriately certified fee schedule could be immediately used by the dental provider organization until it had been disapproved by the commissioner. The commissioner could disapprove any schedule that violated the act or related rule and would be required to specify the reason for the disapproval.

Solvency. An organization would be required to maintain a minimum surplus of not less than $100,000. The commissioner would be required to take appropriate action to protect members in the continued operation of the dental plan if compliance with the surplus requirement was not met. The commissioner could suspend, revoke or fail to renew a certificate for noncompliance.

Penalties. The commissioner could suspend, revoke or fail to renew a certificate of authority if the organization:

- operated in a manner contrary to its basic organizational documents;
- used a fee schedule not in compliance with this act;
- could not meet its obligations to its members;
- failed to implement or maintain the complaint resolution system;
- marketed its plan in an untrue, misleading or deceptive manner;
- failed to substantially comply with this act or
- operated in a manner that would be hazardous to members.

An organization with a suspended certificate could not enroll additional members or engage in advertising or solicitation. An organization whose

certificate was revoked or not renewed could not conduct further business except to conclude affairs or engage in further advertising or solicitation.

An organization could appeal a commissioner rule or decision using procedures prescribed in Insurance Code art. 1.04.

Fees. Fees could not exceed: $4,000 for the original application, $3,000 for annual renewal, $500 for annual report filing, $100 for each fee schedule. The Department of Insurance would be required to set required fees.

Effective dates. The bill would take effect September 1, 1995. Organizations would be required to submit applications for certificates of authority not later than December 1, 1995, but could continue to operate until the applications are acted on.

SUPPORTERS SAY:

CSHB 1194 is needed to regulate the relatively new, unregulated health care service of dental provider plans. In 1990 Attorney General Jim Mattox ruled that because dental referral plans were not indemnification plans or pre-paid service plans, they were beyond the jurisdiction of the Texas Department of Insurance (JM-1167). CSHB 1194 would fill a regulatory void by defining dental provider plans and authorizing the regulation of those plans in a manner that would protect both consumers and dental provider organizations.

Dental provider plans provide a valuable legitimate service to consumers by arranging for discounted services among participating providers. One Texas dental provider plan has over 300,000 members. Enrollees paying monthly fees to a dental provider organization are eligible to receive available services at discounted rates without experiencing the impediments of preexisting condition exclusions or other limitations often placed on health insurance policies.

Regulation of dental provider plans would help clear up consumer confusion among dental provider plans, dental insurance and health maintenance organization (HMO) dental plans. CSHB 1194 would specifically require all dental provider plan fee schedules to clearly state that the plan is not an HMO or an indemnification policy and will not reimburse members or dentists for services provided.

Dental provider plans are not HMO plans or indemnity health insurance plans. Dental provider plans need regulation separate and distinct from HMO and insurance regulations because they do not represent to offer reimbursement or pre-paid coverage for dental care services. Proposals to regulate dental provider plans similar to HMO dental plans are anti-competitive and anti-business. Distinct regulations for dental provider plans would encourage healthy competition in the marketplace.

Unlike HMOs and health insurance policies, dental provider plans have no financial incentives to decrease or limit patient utilization of services. Dentists receive reimbursement, though reduced, for each service provided, and patients are free to utilize the affordable services as necessary.

Dental provider plans offer members freedom-of-choice in the selection of providers and services. They also offer a dental benefit that can stay with employees during job changes or loss. Monthly membership rates are market driven and would remain as low as competitively possible. Fee schedules would be monitored by the Department of Insurance and could not be used without commissioner's approval. Members could choose not to participate in a plan if they find monthly rates or dentist fees unreasonable.

CSHB 1194 would strengthen consumer protections. Annual renewal of certificates of authority would require dental provider organizations to prove competency and quality. In contrast, indemnification policies and HMO plans are only reviewed upon the filing of a complaint. Participating dentists would be regulated by the Board of Dental Examiners under the Dental Practice Act.

Dental provider plan members would not be subject to greater risk than any other dental services consumer. HMOs are more strictly regulated because of the financial incentive inherent in HMO plans to contain utilization. HMOs must be more closely monitored to ensure the quality of care provided.

Regulation of dental provider plans would also help prevent fraudulent practices by plan administrators, such as occurred in New York that prompted New York legislators to ban all dental referral plan operations.

OPPONENTS SAY:

Dental provider plans are a service of questionable value to the Texas health care delivery system and should be prohibited from operating or be more closely regulated. Dental provider plans add a layer of administrative costs to dental care benefits by profiting off of monthly rates — and there is no guarantee that service fees would be below normal market rates. Any fee reductions would end up being eventually passed onto other consumers or employers.

New York state banned the operation of for-profit dental provider services in July 1992, and the American Dental Association House of Delegates passed a resolution to encourage all states to make referral services illegal. According to the January 4, 1993 issue of *American Dental Association News*, the New York dental society found that for-profit referrals are, if not deceptive, inherently misleading. Legislation was introduced this session (SB 972 by Turner) would prohibit these kinds of plans in Texas.

Dental provider plans are confusing to many consumers because they mistake monthly fee payments to provider plans for payments to HMOs or health insurance policies that provide reimbursement or pre-paid coverage for dental care. Most of the dental provider plan brochures and services are identical to HMO dental plan brochures and services. Disclaimer requirements in the bill would not help to resolve confusion because most consumers fail to read all disclaimers.

CSHB 1194 would be giving plan members and consumers a false sense of security. Regulation by the department of insurance would confuse consumers in believing that dental provider plans are insurance. Dental provider plans are direct competitors of HMO dental plans yet under this bill they would be subject to less regulation and quality control than HMOs.

OTHER OPPONENTS SAY:

CSHB 1194 would not go far enough in regulating dental provider plans. This bill contains no provisions regulating monthly rates charged to consumers to ensure that rates charged would appropriately correspond to actual discounts received.

CSHB 1194 also would not regulate quality of care well enough. Members would tend to assume that a dentist participating in a plan specifically arranged by a particular organization is a qualified practitioner and would not enquire further about the dentist's qualifications or practice experiences. Many dentists who participate in provider plans could very well have problems establishing solid practices because of lack of competency and other problems. A license to practice does not guarantee the rendering of competent and appropriate services. This bill contains no provisions or requirements for dentist qualifications and practice procedures.

There also are no provisions guarding against the delivery of unneeded services and other fraudulent, criminal or misleading practices. CSHB 1194 complaint procedures system requirements are minimal. Dental provider plans should have to meet strict quality control requirements like HMOs to ensure that reduced charges for services does not lead to reduced quality or quantity of services. For example, if a complaint about an HMO is filed, the Texas Department of Health will investigate and audit HMO operations.

Regulation of contracts between the provider and the dental provider organization is needed to ensure that members do not enroll with the understanding that certain dentists participate in a plan only to discover later when services are needed that a dentist is no longer in the plan. Also, consumers generally prefer to maintain relationships with providers they know and trust and do not like having to switch providers. Solvency requirements in the bill should be set higher so as to prevent the establishment of "fly by night" operations.

NOTES: The committee substitute differs from the original version in that it:

• changed the name of the dental preferred provider plans and organizations to dental provider plans and organizations;
• gave dental plan applicants 60 days to correct filing deficiencies;
• made changes in ownership subject to prior approval of the commissioner of insurance;
• required provision of fee schedules and dentist lists to all members;

• allowed dental plans to use fee schedules pending commissioner approval or disapproval, with provisions requiring the discontinued use of a disapproved schedule;
• made marketing materials subject to approval of the dental provider organization and required to contain statements explaining the plan is not insurance or a HMO contract;
• made dental provider organizations and plans subject to the Insurance Code art. 21.21 (unfair competition and unfair practices provisions), art. 1.10 (department powers of authority) and art. 1.10A (cease and desist orders) and
• increased filing fee maximum amounts for initial application to $4,000 from $2,500, and for annual renewals to $3,000 from $2,500.

CSHB 1194 is very similar to legislation considered last session, HB 1880 by Berlanga, which passed the House and died in the Senate Economic Development Committee.