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 Committee on Judiciary

BILL: CS/SB 856

INTRODUCER: Banking and Insurance Committee and Senator Latvala

SUBJECT: Vision Insurance

DATE: March 23, 2015 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Davis	Cibula	JU	**Favorable**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 856 prohibits an insurer, prepaid limited health service organization (PLHSO), health maintenance organization (HMO), or a third-party administrator (TPA) from requiring a licensed ophthalmologist or optometrist to provide vision care services as a condition of participating as a provider of any other type of service to an insured. The bill also prohibits those entities from requiring a licensed ophthalmologist or optometrist to purchase a material or service used by the ophthalmologist or optometrist from another entity in which the insurer, PLHSO or HMO or its TPA has a financial interest. The bill also provides the same prohibition relating to the purchase of materials by opticians. The bill provides that a violation of one of these provisions constitutes an unfair insurance trade practice under s. 626.9541, F.S.

II. Present Situation:

Regulation of Insurance

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations, and other risk-bearing entities. The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency pursuant to part III of ch. 641, F.S.

Prepaid Limited Health Service Organizations Contracts

Prepaid limited health service organizations (PLHSO) provide limited health services to enrollees through an exclusive panel of providers in exchange for a prepayment authorized under ch. 636, F.S. Limited health services include ambulance, dental, vision, mental health, substance abuse, chiropractic, podiatric, and pharmaceutical.[1] Provider arrangements for prepaid limited health service organizations are authorized in s. 636.035, F.S., and must comply with the requirements in that section.

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 providers.

Third Party Administrators

Third party administrators are regulated under part VII of ch. 626, F.S. An administrator is any person who directly or indirectly solicits or effects coverage of, collects charges or premiums from, or adjusts or settles claims on residents of this state in connection with authorized commercial self-insurance funds or with insured or self-insured programs which provide life or health insurance coverage or coverage of any other expenses described in s. 624.33(1), F.S., or any person who, through a contract as defined in s. 641.234, F.S., with an insurer or HMO, provides billing and collection services to health insurers and HMO on behalf of health care providers.[2]

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, exclusive provider organization, or preferred 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.

State Group Insurance Program

Under the authority of s. 110.123, F.S., the Department of Management Services (department), through the Division of State Group Insurance, administers the State Group Insurance Program providing employee benefits under a cafeteria plan consistent with Section 125, Internal Revenue Code. The Division of State Group Insurance offers a fully-insured vision insurance plan to eligible employees and their eligible dependents.

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[1] Section 636.003(5), F.S.

[2] Section 626.88(1), F.S.

Unfair Insurance Trade Practices

Part IX of ch. 626, F.S., regulates practices relating to the business of insurance by defining practices that constitute unfair methods of competition or unfair or deceptive acts or practices and prohibits those activities. Section 626.9541(1)(d), F.S., provides that the following acts are an unfair insurance trade practice:

> Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in, or tending to result in, unreasonable restraint of, or monopoly in, the business of insurance.

Section 626.9521, F.S., provides administrative fines and criminal penalties for violations under s. 626.9541, F.S. Further, the OIR is authorized to issue cease and desist orders and suspend or revoke an entity's certificate of authority for engaging in unfair insurance trade practices.[3]

Credentialing

Section 641.495(6), F.S., provides that each HMO must have a system for verification and examination of the credentials of each of its providers. If the organization has delegated the credentialing process to a contracted provider or entity, it must verify that the policies and procedures of the delegated provider or entity are consistent with the policies and procedures of the organization and there is evidence of oversight activities of the organization to determine that required standards are met and maintained.[4]

Credentialing is a process for the collection and verification of a provider's professional qualifications. The qualifications that are reviewed and verified include, but are not limited to, relevant training, licensure, certification and/or registration to practice in a health care field, experience, and academic background. A credentialing process is used by: healthcare facilities as part of its process to allow practitioners to provide services at its facilities; health plans to allow providers to participate in its network (provider enrollment); medical group when hiring new providers; and other healthcare entities that have a need to hire or otherwise engage providers.

III. Effect of Proposed Changes:

Sections 1, 2, and 3 amend ss. 627.6474, 636.035, and 641.315, F.S., to prohibit insurers, PLHSO, HMOs, respectively, or their third-party administrators from requiring a licensed ophthalmologist or optometrist to provide vision care services as a condition of participating as a provider of any other type of service to an insured. The bill also prohibits these entities from requiring an ophthalmologist or optometrist to purchase certain materials or services from an entity in which the insurer, PLHSO, the HMO, or the entity's third-party administrators has a direct or indirect ownership, financial, or controlling interest. The bill also provides the same prohibition relating to the purchase of materials by opticians.

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[3] Section 626.9581, F.S.

[4] Agency for Health Care Administration, *Interpretive Guidelines for Initial Health Care Provider Certificates for Health Maintenance Organizations and Prepaid Health Clinics*, (2010).

The bill provides that a violation of one of these provisions constitutes an unfair insurance trade practice under s. 626.9541 (1)(d), F.S., which relates to any act of boycott, coercion, or intimidation resulting in, or tending to result in, unreasonable restraint of, or monopoly in, the business of insurance.

Potential fines under the Unfair Insurance Trade Practices Act include an amount not greater than:

- $5,000 for each nonwillful violation;
- $40,000 for each willful violation;
- An aggregate amount of $20,000 for all nonwillful violations arising out of the same action; or
- An aggregate amount of $200,000 for all willful violations arising out of the same action.

The fines may be imposed in addition to any other applicable penalty.[5]

The bill takes effect July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

This bill does not appear to have an impact on cities or counties and as such, does not appear to be a mandate for constitutional purposes.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

This bill takes effect upon becoming a law. The general rule of law is that legislation applies prospectively and not retrospectively. In other words, this bill will not apply retroactively to impair the effectiveness of contracts already in existence on the date this legislation becomes effective. It will apply only to contracts signed on or after the effective date of the bill.

The State Constitution provides that "No…. law impairing the obligation of contracts shall be passed."[6] The Florida Supreme Court[7] has noted that "Virtually no degree of contract impairment has been tolerated in this state" and strongly favors the sanctity of

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[5] Section 626.9521(2), F.S.
[6] FLA. CONST. art. I, s. 10.
[7] *Yamaha Part Distributors Inc., et al, v. Ehrman et al.,* 316 So. 2d 557, 559 (Fla 1975).

contracts. Accordingly, contracts already in existence on the date this bill becomes effective will remain in effect between the parties to the contracts, regardless of the language in this bill. However, to avoid confusion, the Legislature may wish to expressly state in the bill that it does not apply to existing contracts.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Ophthalmologists or optometrists contracting with insurers, PLHSOs, HMOs, and third-party administrators would not be required to purchase materials and services from an entity in which the insurer, PLHSO, or HMO has a direct or indirect financial ownership or financial interest. Opticians would not be required to purchase materials from those entities under similar circumstances. This gives the provider flexibility in the provision of those materials or services.

Further, the entities specified above could not require an ophthalmologist or optometrist with whom they contract to provide vision care services as a condition of participating as a provider of any other type of service to an insured. According to advocates of the bill, insurers and HMOs outsource credentialing to third parties. As a condition of that credentialing, a third party, such as a vision plan, may require the optometrist to join the vision plan network as a provider as a condition for being credentialed and participating on a panel with another health insurer, HMO, or PLHSO. This would not be allowed under the bill.

According to proponents of the bill, consumers access a wide variety of specialty care through limited benefit plans, such as vision care plans. Vision care plans contract with preferred providers and build supplier and laboratory networks to provide efficient networks that reduce consumer costs. They also assert that limiting business models flattens competition and provides fewer options to consumers and employers.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill amends sections 627.6474, 636.035, and 641.315 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Banking and Insurance on March 17, 2015

The CS amends the Insurance Code rather than ch. 501, F.S. The CS also provides that violations under the bill constitute an unfair insurance trade practice under part IX of ch. 626, F.S., of the Insurance Code rather than a violation of the Florida Deceptive and Unfair Trade Practices Act, under part II of ch. 501, F.S.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.