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 Rules

BILL:	CS/CS/SB 856
INTRODUCER:	Rules Committee, Banking and Insurance Committee and Senator Latvala
SUBJECT:	Vision Care Plans
DATE:	April 3, 2015 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 856 prohibits an insurer, prepaid limited health service organization (PLHSO), or a health maintenance organization (HMO) from requiring a licensed ophthalmologist or optometrist to join a network solely for the purpose of credentialing the licensee for another insurer's, PLHSO's, or HMO's vision network, respectively. The bill provides that this provision would not prevent an insurer, PLHSO, or HMO from entering into a contract with another insurer's, PLHSO's, or HMO's vision care plan to use the vision network. The bill also prohibits these plans from limiting or restricting a licensed ophthalmologist, optometrist, or optician to specific suppliers of material or optical laboratories. The bill provides that this provision does not limit or restrict an insurer, PLHSO, or HMO in determining specific amounts of coverage or reimbursement for the use of network or out-of-network suppliers or laboratories.

The bill provides that a knowing violation of either of these provision described above constitutes an unfair insurance trade practice under s. 626.9541(1)(d), F.S.

The bill requires insurers, PLHSOs, and HMOs to update their online vision care network directory monthly to reflect currently participating providers in their respective network.

II. Present Situation:

State 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.

Prohibition against "All Products" Clauses in Health Care Provider Contracts

Section 627.6474(1), 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.

[1] Section 636.003(5), 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. Generally, the potential fines[2] under the Unfair Insurance Trade Practices Act include an amount not greater than $5,000 for each nonwillful violation and not greater than $40,000 for each willful violation. Such fines imposed against an insurer may not exceed 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.[3] The fines may be imposed in addition to any other applicable penalty.[4] 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.[5]

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.[6] Preferred provider organizations also subject providers to credentialing.

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.

[2] Section 626.9521(2), F.S.
[3] Section 626.9521(3), F.S., provides exceptions to these caps.
[4] Section 626.9521(2), F.S.
[5] Section 626.9581, F.S.
[6] Agency for Health Care Administration, *Interpretive Guidelines for Initial Health Care Provider Certificates for Health Maintenance Organizations and Prepaid Health Clinics*, (2010).

III. Effect of Proposed Changes:

Sections 1, 2, and 3 amend ss. 627.6474, 636.035, and 641.315, F.S., to prohibit an insurer, PLHSO, and HMO from requiring a licensed ophthalmologist or optometrist to join a network solely for the purpose of credentialing the licensee for another insurer's, PLHSO's, or HMO's network, respectively. The bill provides that this provision would not prevent an insurer, PLHSO, or HMO from entering into a contract with another insurer's, PLHSO's, or HMO's vision care plan to use the vision network.

Further, the bill prohibits these plans from limiting or restricting a licensed ophthalmologist, optometrist, or optician to specific suppliers of material or optical laboratories. The bill provides that this provision does not limit or restrict an insurer, PLHSO, or HMO in determining specific amounts of coverage or reimbursement for the use of network or out-of-network suppliers or laboratories.

The bill provides that a knowing violation of either of these provision described above 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.

The bill requires an insurer, PLHSO, or a HMO to update their online vision care network directory monthly to reflect currently participating providers in their respective network.

Section 4 provides the bill is effective January 1, 2016.

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:

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."[7] The Florida Supreme Court[8] has noted that "Virtually no degree of contract impairment has been tolerated in this state" and strongly favors the sanctity of 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:

A licensed ophthalmologist, optometrist or optician contracting with an insurer, PLHSO, or HMO would not be required to purchase materials and services from specific suppliers or optical laboratories. This gives the network provider flexibility in the acquisition and provision of those materials or services.

Further, a health plan could not require a licensed ophthalmologist or optometrist to join a network solely for credentialing the licensee for another plan's vision network.

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.)

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

CS/CS by Rules on April 2, 2015:
The CS/CS prohibits an insurer, PLHSO, and HMO from restricting or limiting a licensed ophthalmologist, optometrist, or an optician to specific suppliers of materials or optical laboratories. The prior CS prohibited a health plan from requiring a licensee from purchasing material or service from an entity that had a direct or indirect ownership, financial, or controlling interest with an insurer, PLHSO, or HMO.

The CS clarifies that an insurer, PLHSO, and HMO may not require a licensed ophthalmologist or optometrist to join a network solely for credentialing the licensee for another plan's network.

A knowing violation of either of these provisions described above constitutes a violation under s. 626.9541(1)(d), F.S.

The CS requires an insurer, PLHSO, and HMO to update their respective online, vision care network directory on a monthly basis.

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.