HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 337 Vision Care Plans
SPONSOR(S): Peters and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 340

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	11 Y, 0 N	Langston	Poche
2) Insurance & Banking Subcommittee	11 Y, 0 N	Peterson	Luczynski
3) Health & Human Services Committee	15 Y, 0 N	Langston	Calamas

SUMMARY ANALYSIS

Ophthalmologists, optometrists, and opticians are health care practitioners, as defined in s. 456.001(4), F.S. They are regulated by their respective boards within the Division of Medical Quality Assurance and are overseen by the Department of Health (DOH).

An optician designs, verifies, fits, and dispenses eyeglasses, contact lenses, and other optical devices upon the written prescription of a licensed ophthalmologist or optometrist; an optician does not diagnose or treat eye diseases. In addition to being able to dispense eyeglasses and contact lenses, an optometrist performs eye exams and vision tests to detect certain eye abnormalities, prescribes eyeglasses and contact lenses, and prescribes medications for eye diseases. An optometrist is not a medical doctor and is not authorized within the scope of practice to perform surgery or other invasive procedures. An ophthalmologist is an allopathic or osteopathic physician; therefore, in addition to being able to perform the duties of an optometrist, the ophthalmologist is licensed to perform eye surgeries.

Ophthalmologists, optometrists, and opticians routinely contract with health insurers, prepaid limited health services organizations (PLHSOs), and health maintenance organizations (HMOs) for the provision of vision care services. HMOs are required to have a system for verification and examination of the credentials of each of its providers. Credentialing is also a required element for health plan accreditation by the National Commission for Quality Assurance. Some plans contract for credentialing services through a third-party vendor. However, credentialing is not required for health insurers and PLHSOs.

HB 337 prohibits health insurers, PLHSOs, and HMOs from requiring an 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. The bill also prohibits health insurers, PLHSOs, and HMOs from restricting an ophthalmologist, optometrist, or optician to specific suppliers of materials or optical laboratories. Additionally, the bill requires health insurers, PLHSOs, and HMOs to update their online vision care network provider directories on a monthly basis to reflect current participating providers.

The bill makes a violation of these prohibitions an unfair insurance trade practice.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides for an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Regulation of Ophthalmologists, Optometrists, and Opticians

Ophthalmologists, optometrists, and opticians are health care practitioners, as defined in s. 456.001(4), F.S., and are regulated by their respective boards within the Division of Medical Quality Assurance[1] within the Department of Health (DOH).[2] Ophthalmologists are governed by the practice act in Chapter 458 or 459, F.S.; optometrists are governed by the practice act in Chapter 463, F.S.; opticians are governed by the practice act in Chapter 484, Part I, F.S.

Ophthalmologists

Ophthalmology is a branch of medicine specializing in the anatomy, function, and diseases of the eye. Ophthalmologists provide a full spectrum of eye care. They perform functions of optometrists, such as annual eye exams and prescribing glasses and contact lenses. In addition, they are authorized within their scope of practice to perform delicate eye surgery. Ophthalmologists are either Medical Doctors (MDs) or Doctors of Osteopathic Medicine (DOs). They are regulated by the Board of Medicine and the Board of Osteopathic Medicine, respectively.

Optometrists

Optometrists, licensed by the Board of Optometry, are the primary health providers for normal vision care, including yearly checkups. They are licensed to practice optometry, which involves performing eye exams and vision tests, prescribing and dispensing glasses and contact lenses, detecting certain eye abnormalities, and prescribing medications for certain eye diseases.[3] Optometrists, or Doctors of Optometry, are not medical doctors and are not authorized within their scope of practice to perform surgery or other invasive techniques.[4]

Opticians

Opticians, licensed by Board of Opticianry, are technicians trained to design, verify and fit eyeglass lenses and frames, contact lenses, and other devices to correct eyesight.[5] Opticians are not permitted to test vision, diagnose or treat eye diseases, or write prescriptions for visual correction. Opticians rely on prescriptions supplied by ophthalmologists or optometrists to provide services.

Third-Party Reimbursement for Vision Care Services

According to a 2012 survey, approximately 48 percent of insured U.S. adults are enrolled in vision plans.[6] Nationwide, vision care is approximately a $36 billion industry comprised of services and sale of corrective eye glasses and lenses with expected growth of approximately one to two percent annually.[7]

Health Insurer Contracts

[1] s. 456.001, F.S.
[2] s. 456.004, F.S.
[3] AMERICAN ASSOCIATION FOR PEDIATRIC OPHTHALMOLOGY AND STRABISMUS, *Differences between Ophthalmologist, Optometrist and Optician*, http://www.aapos.org/terms/conditions/132 (last visited Jan. 24, 2016).
[4] s. 463.0055(1)(a), F.S.
[5] *Supra* note 3.
[6] AMERICAN OPTOMETRIC ASSOCIATION, *An Action-Oriented Analysis of the State of the Optometric Profession: 2013,* at 14, *available at* https://www.aoa.org/Documents/news/state_of_optometry.pdf (last visited Jan. 24, 2016).
[7] HARRIS WILLIAMS & CO., *Vision Industry Overview,* Feb. 2015, at 1, *available at* http://www.harriswilliams.com/sites/default/files/content/hwco_hcls_vision_industry_updatev2.pdf (last visited Jan. 24, 2016).

The Office of Insurance Regulation (OIR) regulates health insurer provider contracts under part VI of ch. 627, F.S.

Florida law imposes limitations on health insurer contracts. For example, 627.6474(1), F.S., prohibits a health insurer from requiring a health care practitioner to accept the terms of other health care practitioner contracts with any other insurer or health maintenance organization (HMO) that is under common management and control of the insurer. This includes contracts for Medicare and Medicaid services, and services provided by a preferred provider organization, an exclusive provider organization, or a prepaid limited health service organization (PLHSO). This type of provision is typically referred to as an "all products clause." A contract provision that violates this prohibition is void. The only exception is 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. Another example is s. 627.6474(2), F.S., which prohibits a contract between a health insurer and a dentist for the provision of dental services from requiring the dentist to provide services to the insured under such contract at a fee set by the health insurer unless such services are covered services under the applicable contract.

Current Florida law does not prohibit health insurer provider contracts from requiring a licensed ophthalmologist or optometrist to join a network or restricting an ophthalmologist, optometrist, or optician to specific suppliers of materials or optical laboratories. No statute requires health insurers to update network provider directories monthly or to make such directories available in an online version.

Prepaid Limited Health Service Organization (PLHSO) Arrangements

PLHSOs provide limited health services to enrollees through an exclusive panel of providers in exchange for a prepayment, and are authorized in part I of ch. 636, F.S. Limited health services are ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services.[8] Provider agreements for PLHSOs are authorized in s. 636.035, F.S., and must comply with the requirements in that section.

Florida law imposes limitations on PLHSO provider agreements. Like insurance contracts, PLHSO provider agreements may not, as a condition of continuation or renewal of a contract, require compliance with an "all products clause." A PLHSO contract provision that violates this prohibition is void.[9] Like insurance contracts, there is an exception to this limitation 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. Another example of a limitation on provider agreements is that, like insurance contracts, a contract between a PLHSO and a dentist for dental services may not contain a provision that requires the dentist to provide services to the subscriber of the PLHSO at a fee set by the PLHSO unless such services are covered services under the applicable contract.[10]

Current Florida law does not prohibit PLHSO provider agreements from requiring a licensed ophthalmologist or optometrist to join a network or restricting an ophthalmologist, optometrist, or optician to specific suppliers of materials or optical laboratories. No statute requires that require PLHSOs to update network provider directories monthly or to make such directories available in an online version.

Health Maintenance Organization (HMO) Contracts

The OIR regulates HMO contracts and rates under part I of ch. 641, F.S. The Agency for Health Care Administration regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Section

[8] s. 636.035(5), F.S.
[9] s. 636.035(12), F.S.
[10] s. 636.035(13), F.S.,

641.315, F.S., authorizes provider contracts with HMOs, and specifies the requirements for HMO provider contracts with "health care practitioners" as defined in s. 465.001(4), F.S.

Part I of ch. 641, F.S., prohibits certain provider contract provisions. For example, s. 641.315(9), F.S., provides that a contract between an HMO and a contracted primary care or admitting physician may not contain any provision that prohibits the physician from providing inpatient services in a contracted hospital to a subscriber if such services are determined by the HMO to be medically necessary and covered services under the HMO's contract with the contracted physician. As with insurance contracts and PLHSO agreements, an HMO provider contract may not contain an "all products clause" that requires a contracted health care practitioner to accept the terms of another practitioner contract. A contract provision that violates the statute is void, except in cases where the practitioner is in a group practice and must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Another example of a prohibited contract provision is that a contract for dental services may not contain a provision that requires the dentist to provide services to the subscriber of the HMO at a fee set by the HMO unless such services are covered services under the applicable contract.[11]

Section 641.315, F.S., does not prohibit HMO provider contracts from requiring a licensed ophthalmologist or optometrist to join a network or restricting an ophthalmologist, optometrist, or optician to specific suppliers of materials or optical laboratories. No statute requires HMOs to update network provider directories monthly or to make such directories available in an online version.

Unfair Insurance Trade Practices

Part IX of ch. 626, F.S., regulates insurance by defining practices that constitute unfair methods of competition or unfair or deceptive acts or practices and prohibits those activities. [12] Potential penalties under the Unfair Insurance Trade Practices Act (the 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.
- An aggregate amount of $200,000 for all willful violations arising out of the same action.[13]

Fines may be imposed in addition to any other applicable penalty.[14] Additionally, the OIR is authorized to conduct hearings,[15] issue cease and desist orders,[16] and assess a penalty of up to $50,000 and suspend or revoke an entity's certificate of authority for engaging in an unfair insurance trade practice.[17]

The Act applies to health insurance policies;[18] however, PLHSOs and HMOs are not subject to the Act.[19] Section 641.3903, F.S., sets forth unfair methods of competition and unfair or deceptive acts or practices applicable to HMOs that are similar, but not identical to, the content of the Act. Section 636.059, F.S., applies the provisions of s. 641.3903, F.S., to PLHSOs by cross-reference.

Credentialing

[11] s. 641.315(11), F.S.
[12] s. 626.9541(1)(d), F.S., provides that 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 are an unfair insurance trade practices.
[13] s. 626.9521(2), F.S.
[14] *See* s. 626.9631, F.S., the penalties under the insurance code are in addition to any other civil or administrative penalties.
[15] s. 626.9571, F.S.
[16] s. 626.9581, F.S.
[17] s. 626.6901, F.S.
[18] s. 626.9511(2), F.S.
[19] Current law expressly exempts PLHSOs and HMOs from the Insurance Code. *See* ss. 636.004, 636.029, 641.18(4)(b), 641.201, and 641.30(2), F.S.

Credentialing is a process for the collection and verification of a provider's professional qualifications, including academic background, relevant training and experience, licensure, and certification or registration to practice in a particular health care field.[20] Credentialing is a required element for health plan accreditation by the National Commission for Quality Assurance.[21]

Florida law only addresses credentialing for HMOs. Section 641.495(6), F.S., requires each HMO to have a system to verify and examine the credentials of each of its providers. If an HMO delegates the credentialing process to a contracted provider or entity, the HMO must verify that the policies and procedures of the delegated provider or entity are consistent with the policies and procedures of the HMO and that the required standards are maintained.[22] Florida law does not require credentialing for health insurers or PLHSOs.

Effect of the Proposed Changes

HB 337 amends ss. 627.6474, 636.035, and 641.315, F.S., to prohibit health insurers, PLHSOs, and HMOs, respectively, from requiring a licensed ophthalmologist or optometrist to join a network solely for the purpose of credentialing the licensee for another insurer's or organization's network. However, the bill provides that this provision does not prevent a health insurer, PLHSO, or HMO from entering into a contract with another insurer's or organization's vision care plan to use their network.

The bill amends ss. 627.6474, 636.035, and 641.315, F.S., to prohibit health insurers, PLHSOs, and HMOs, respectively, from restricting a licensed ophthalmologist, optometrist, or optician to specific suppliers of material or optical laboratories. However, the bill provides that this provision does not restrict a health 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 specifies that any health insurer, PLHSO, or HMO who commits a knowing violation of either provision has committed an unfair insurance trade practice pursuant to s. 626.9541(1)(d), F.S.[23] The violator is then subject to civil and administrative penalties under the Act.

The bill also requires health insurers, PLHSOs, and HMOs to update their online vision care network provider directories on a monthly basis to accurately reflect the providers currently participating in their networks.

The bill provides an effective date of July 1, 2016.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6474, F.S., relating to provider contracts.
Section 2: Amends s. 636.035, F.S., relating to provider arrangements.
Section 3: Amends s. 641.315, F.S., relating to provider contracts.
Section 4: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

[20] *See, e.g.,* AETNA, *Health care professionals: Joining the Network FAQs*, https://www.aetna.com/faqs-health-insurance/health-care-professionals-join-network.html (last visited Jan. 24, 2016); FLORIDA BLUE, *Manual for Physicians and Providers*, (2015), at 14, *available at* https://www.floridablue.com/providers/tools-resources/provider-manual (last visited Jan. 5, 2016); UNITEDHEALTHCARE, *Physician Credentialing and Recredentialing Frequently Asked Questions*, *available at* https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/KS-Provider-Information/KS_Credentialing_FAQ.pdf (last visited Jan. 24, 2016).
[21] NCQA, *CR Standards & Guidelines,* http://www.ncqa.org/tabid/404/Default.aspx (last visited Jan. 5, 2016).
[22] BUREAU OF MANAGED HEALTH CARE, AGENCY FOR HEALTH CARE ADMINISTRATION, *Interpretive Guidelines for Initial Health Care Provider Certificates: Health Maintenance Organizations and Prepaid Health Clinics*, (2010), at 48, *available at* https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Commercial_Managed_Care/docs/CHMO/Initial-IGs-withProbesJune2010.pdf (last visited Jan. 24, 2016).
[23] s. 626.9541(1)(d), F.S., provides that 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 are an unfair insurance trade practices.

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:

Currently, the approved lab lists of some vision plans can be limited and may require a provider to send all orders to a plan-owned lab in another city or state, which may result in delays for the consumer in receiving their eyeglasses. The bill could offer providers the ability to be competitive and responsive to local market conditions regarding the cost and quality of such materials and services provided to consumers. However, by preventing health insurers, PLHSOs, and HMOs from designating a specific suppliers of material or optical laboratories, they may no longer be able to benefit from volume based pricing and other bulk discounts they could negotiate with a single supplier or laboratory.

Consumers will have online access to more timely and accurate network directories for vision care providers, which will assist them in evaluating plans or selecting network providers.

A health insurer, PLHSO, or HMO found to have violated the provisions of the bill is subject to civil and administrative fines under the Unfair Insurance Trade Practices Act.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES