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 Banking and Insurance

BILL:	SB 340
INTRODUCER:	Senator Latvala
SUBJECT:	Vision Care Plans
DATE:	October 20, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Favorable**
2.			HP	
3.			RC	

I. Summary:

SB 340 prohibits an insurer, a 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 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 restricting a licensed ophthalmologist, optometrist, or optician to specific suppliers of material or optical labs. The bill provides that this provision does not 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 labs. The bill provides that a knowing violation of either of these provision, as 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. 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, 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.

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 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. The fines may be imposed in addition to any other applicable penalty. Further, the OIR is authorized to issue cease and desist orders and suspend or revoke an entity's certificate of authority for engaging in an unfair insurance trade practice.

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 maintained. 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 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.

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. The program provides employee benefits under a cafeteria plan consistent with Section 125, Internal Revenue Code.[1] The Division of State Group Insurance offers a fully-insured vision insurance plan to eligible employees and their eligible dependents.

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 restricting a licensed ophthalmologist, optometrist, or optician to specific suppliers of material or optical laboratories. The bill provides that this provision does not 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 provisions 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.

[1] 26 U.S.C. s. 125. A cafeteria plan is a plan maintained by an employer under which all participants are employees, and all participants may choose among two or more benefits consisting of cash and qualified benefits. A qualified benefit is any benefit, which with the application of 26 U.S.C. s. 125(a), is not includable in the gross income of the employee with certain exceptions.

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 July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

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."[2] The Florida Supreme Court[3] 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:

The bill provides that a licensed ophthalmologist, optometrist or optician contracting with an insurer, PLHSO, or HMO is not required to purchase materials and services from specific suppliers or optical labs. This would give the provider the ability to be competitive and responsive to local market conditions regarding the cost and quality of

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

such materials and services provided to consumers. 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. If such a lab is performing poorly, this can cause additional delays and frustrations for consumers.

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

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.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

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

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.