

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			

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).

The key difference between ophthalmologists, optometrists, and opticians is the scope of their practice. 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 a medical doctor or an 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. In a study commissioned by the American Optometric Association, optometrists reported in 2011 that two-thirds of revenue comes from third-party payers. A separate survey indicated that 48 percent of U.S. adults were enrolled in vision plans during 2012. Nationwide, vision care is approximately a \$36 billion industry.

Credentialing is a process for the collection and verification of a provider's professional qualifications. An HMO is required by law 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.

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 Assurance¹ 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

In a study commissioned by the American Optometric Association, optometrists reported in 2011 that two-thirds of revenue comes from third-party payers. Reimbursements from vision insurance plans accounted for 31 percent of revenues; reimbursements from private medical insurers accounted for 17 percent of revenue; and government reimbursements accounted for 17 percent of revenue. A separate survey indicated that 48 percent of U.S. adults were enrolled in vision plans during 2012.⁶ Nationwide, vision care is approximately a \$36 billion industry comprised of services (\$15 billion) and sale of

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. 4, 2016).

⁴ s. 463.0055(1)(a), F.S.

⁵ *Supra* note 3.

⁶ AMERICAN OPTOMETRIC ASSOCIATION, *AOA Excel and Jobson Medical Information present, An action-oriented analysis of The State of the Optometric Profession: 2013*, at 14, available at https://www.google.com/?gws_rd=ssl#q=the+state+of+the+optometric+profession.

corrective eye glasses and lenses (\$21 billion) with expected growth of approximately 1 percent to 2 percent.⁷

Health Insurer Contracts

Health insurer provider contracts are regulated by the Office of Insurance Regulation (OIR) under part VI of ch. 627, F.S.

There are certain limitations placed on health insurer contracts. Section 627.6474(1), F.S., provides that a health insurer may not require that a health care practitioner 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. Additionally, s. 627.6474(2), F.S., provides that a contract between a health insurer and a dentist for the provision of dental services may not require 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. There are also no statutes that require health insurers to update network provider directories monthly or to make such directories available in an online version.

Prepaid Limited Health Service Organization 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. Provider agreements for PLHSOs are authorized in s. 636.035, F.S., and must comply with the requirements in that section.

There are other 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.” Like insurance contracts, a PLHSO contract provision that violates this prohibition is void.⁸ Again, 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. Additionally, s. 636.035(13), F.S., provides that a contract between a health insurer 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.

Section 636.035, F.S., 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. There are also no statutes that require PLHSOs to update network provider directories monthly or to make such directories available in an online version.

⁷ HARRIS WILLIAMS & CO., *Vision Industry Overview*, Feb. 2015, at 1, available at http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKewjig4e08tPJAhXG4SYKHcYeDOUQFggcMAA&url=http%3A%2F%2Fwww.harriswilliams.com%2Fsites%2Fdefault%2Ffiles%2Fcontent%2Fhwco_hcls_vision_industry_updatev2.pdf&usq=AFQjCNFg6oUP4KjPv6GxudQ9ms4iotr-Q&sig2=cTEzESQqV0e0yflyIhJLQ&bvm=bv.109395566.d.eWE.

⁸ s. 636.035(12), F.S.

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 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., limits the provisions that may be in an HMO provider contract. Section 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. Additionally, s. 641.315(11), F.S., provides 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.

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. There are also no statutes that require 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. 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.⁹

Fines may be imposed in addition to any other applicable penalty.¹⁰ Additionally, the OIR is authorized to conduct hearings,¹¹ issue cease and desist orders,¹² 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.¹³

Current law expressly exempts PLHSOs and HMOs from the Insurance Code.¹⁴ Thus, they are not subject to the Act. Instead, s. 641.3903, F.S., sets forth unfair methods of competition and unfair or deceptive acts or practices applicable to HMOs. Section 636.059, F.S., makes those provisions applicable to PLHSOs, as well. The provisions in s. 641.3903, F.S., are not identical to those set forth in the Act.

Credentialing

⁹ s. 626.9521(2), F.S.

¹⁰ See s. 626.9631, F.S., the penalties under the insurance code are in addition to any other civil or administrative penalties.

¹¹ s. 626.9571, F.S.

¹² s. 626.9581, F.S.

¹³ s. 626.6901, F.S.

¹⁴ See ss. 636.004, 636.029, 641.18(4)(b), 641.201, 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.¹⁵ Credentialing is a required element for health plan accreditation by the National Commission for Quality Assurance.¹⁶

Historically, practitioners who wished to be credentialed by an entity were required to submit original documentation to the entity which, in turn, would independently verify the documentation. This resulted in a significant administrative burden for practitioners who, because they participated with multiple insurance plans or had admitting privileges to multiple hospitals, were required to submit the same documentation over and over again. As a result, various organizations and companies have emerged to provide centralized credentialing services. In centralized credentialing, a practitioner submits the required documentation one time and entities that wish to credential the practitioner access the necessary information from the central database.¹⁷

Florida law only addresses credentialing for HMOs. 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 an HMO delegates 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 HMO and that there is evidence of oversight activities to determine that required standards are maintained.¹⁸ Florida law does not expressly require credentialing for other types of health plans.

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.¹⁹ The violator is then subject to civil and administrative penalties under the Unfair Insurance Trade Practices Act.

¹⁵ 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 Dec. 10, 2015); FLORIDA BLUE, *Manual for Physicians and Providers*, (2015), at 14, available at <https://www.floridablue.com/docview/provider-manual-2015/> (last visited Jan. 5, 2016); UNITEDHEALTHCARE, *Physician Credentialing and Recredentialing Frequently Asked Questions*, available at https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Protocols/Credentialing_FAQ.pdf (last visited Jan. 5, 2016).

¹⁶ NCQA, *CR Standards & Guidelines*, <http://www.ncqa.org/tabid/404/Default.aspx> (last visited Jan. 5, 2016).

¹⁷ See, e.g., CAQH, *About CAQH ProView, A CAQH Solution*, available at <http://www.caqh.org/about/press-kit> (last visited Jan. 5, 2016); Subcomm. on Health Care Approps., The Florida House of Representatives, *CS/HB 817* (April 2, 2013), at 2–3, available at <http://myfloridahouse.gov/Sections/Bills/bills.aspx>.

¹⁸ 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. 5, 2016).

¹⁹ 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.

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

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:

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 such materials and services provided to consumers. This would also enable the provider to deliver these services in-house if the provider has the service capability. 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.

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:

The general rule of law is that legislation applies prospectively only. The Florida Constitution prohibits laws that retroactively impair the obligation of contracts already in existence.²⁰ To clarify its application, the bill may specify that the provisions only apply to contracts entered into or renewed on or after July 1, 2016.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill requires insurers, PLHSOs, and HMOs to update their online directory monthly. While industry practice may be to offer an online directory, current law does not require it. Thus, it is unclear whether the intent of the bill is to require monthly updating only if the insurer, PLHSO, or HMO maintains an online directory, or to impose both a requirement for an online directory and monthly updating.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

²⁰ FLA. CONST. art I, s. 10.