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October 29, 2026

Representative Deanna Gordon
702 Capital Ave Annex Room 367
Frankfort, KY 40601

Re: Proposed NCOIL Model Act "Ensuring Access to Eye Care Services and Materials for Patients Through Transparent and Fair Business Practices" and NCOIL Annual Meeting 30-Day Materials

Dear Rep. Gordon,

On behalf of AHIP and our members, we appreciate the opportunity to provide additional input on the proposed vision insurance model (Proposed Model) as circulated in the NCOIL Annual Meeting 30-day materials on October 21.

As we stated in our letter on September 23,[1] AHIP is concerned that the Proposed Model would increase the cost of vision insurance and reduce access to vision care, and the amendments presented in the most recent version of the model have not substantively addressed these concerns. The Proposed Model would still establish price floors, limit patient discounts, prohibit coding accuracy initiatives, and apply other requirements beyond the scope of typical NCOIL approaches.

As currently drafted, AHIP respectfully asks that you not consider the proposed model at the National Meeting, and oppose it should there be a vote on the language.

Changes to the Model

AHIP maintains that its primary concerns on price floors, patient discounts, coding accuracy, any willing provider, and scope discussed in our September 23 letter must be addressed to preserve the affordability of vision coverage and care. As currently drafted, these issues remain unresolved. The most recent version of the model makes changes in several sections from the version discussed at the Summer Meeting, including:

- Amending "Vision Benefit Manager" to "Vision Benefit Organization" and the related definition throughout the model;
- Altering the scope to include only optometrists;
- Amending the word "nominal" to remove reference to a requirement that reimbursement from vision insurance be profitable for optometrists; and
- Removing certain reporting requirements in Section 3, including publication of documents, RFIs, complaints, and lawsuits.

Below we discuss how these amendments do not make substantive changes to alleviate the potential impacts of the model on the affordability of vision coverage, while also creating new concerns.

Definitions
Like "vision benefit manager," "vision benefit organization" as defined in the Proposed Model does not align with regulatory structures in most states for vision insurance. AHIP is concerned the impacts of using "vision benefit organization" in the Proposed Model would expand beyond the standalone vision market to include

[1] AHIP Letter to NCOIL, September 23, 2026

comprehensive medical insurance plans that cover pediatric vision care as an essential health benefit under the ACA, as well as employer sponsored coverage. If applied across different coverage types as currently drafted, the Proposed Model could conflict with existing federal and state regulations.

AHIP recommends that NCOIL review the language to remove ambiguity on its scope so that provisions of the Proposed Model are applied to only standalone vision coverage, which is typically defined under a state's insurance code as a limited scope benefit.

Scope of Applicability
The ambiguity around application of the model is further complicated by the change to apply the model only to relationships between "optometrists" and carriers. Other types of medical practitioners who may provide vision care services covered by limited scope vision insurance may operate, participate in, or own practices that are separate from optometrists. Additional revision is needed to clarify that the model intends to regulate only the relationship between a contracted provider and limited scope vision insurance, not providers' scope of practice for vision care.

Price Floor and Non-covered Services
The Proposed Model also makes changes to the definition of "nominal" reimbursement, retaining the price floors associated with Medicaid and Medicare reimbursement but removing reference to provider costs. We reiterate that the structure proposed in the model for mandatory price floors, in conjunction with the limits on discounts for services and materials, would raise costs for patients. Evidence from the major medical market indicates that establishing payment benchmarks tied to Medicare rates increases costs more quickly than under normal circumstances. For every dollar increase in Medicare rates, costs for care in the commercial market rise by $1.16.[2] This means that even for patients enrolled in coverage not subject to the Proposed Model's requirements (e.g., employer plans governed by ERISA), costs will continue to grow because of a price floor requirement. Since Medicare fees tend to rise consistently with inflation, the proposed model will create an ever-increasing price spiral for consumers, which will impact their premiums for vision insurance and out of pocket costs. Annual price increases on services would be particularly harmful under the model's limitations on discounts for non-covered services, which give patients access to discounts on care and materials when paying out of pocket. **67% of surveyed patients with vision insurance stated that the discounts provided by their plan made them more likely to seek care**.[3]

Reporting
Finally, the Proposed Model's amended reporting requirements for vision insurance carriers remain substantial and require further revision. Many vision insurance carriers have significant numbers of subsidiaries that are unrelated to vision care, and publication of the information required by the proposed model could result in hundreds of pages of contact information and disclosures irrelevant to the relationship between the carrier, patient, and provider. Furthermore, under the new language requiring the same disclosures by providers, if a carrier operates its own vision care practices, this information would be duplicated across the reporting requirements by multiple entities creating additional confusion.

Again, AHIP appreciates the opportunity to share our concerns and requests that the committee not consider the model as currently drafted. Please contact me with any questions or concerns.

Sincerely,

Miranda Motter
AHIP Senior Vice President of State Affairs and Policy

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[2] Clemens J, Gottlieb JD. 2017. *In the Shadow of a Giant: Medicare's Influence on Private Physician Payments*. Journal of Political Economy. doi: 10.1086/689772.
[3] GSG Report on Behalf of AHIP, 2024.

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cc: Members, NCOIL Health Insurance & Long Term Care Issues Committee
Will Melofchik, NCOIL CEO
Christa Rapoport, NCOIL General Counsel

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