616 Fifth Avenue, Unit 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Will Melofchik

National Council for Insurance Legislators (NCOIL)

Model Act Ensuring Access to Eye Care Services and Materials for Patients Through Transparent and Fair Business Practices by Vision Benefit Plans

Sponsored by Rep. Deanna Gordon (KY)

Draft as of March 18, 2026. To be introduced and discussed during the Health Insurance & Long Term Issues Committee on April 17, 2026.

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Section 1. Title

This Act shall be known as the [State] Access to Eye Care Services and Materials for Patients Through Transparent and Fair Business Practices by Vision Benefit Plans Act.

Section 2. Definitions

As used in this Act, the following terms shall have the following meanings:

A. "Contractual discount" means a percentage reduction from a provider's usual and customary rate for covered services and covered materials required under a participating provider agreement.

B. “Materials” means ophthalmic devices including but not limited to lenses, devices containing lenses, artificial intraocular lenses, ophthalmic frames and other lens mounting apparatus, prisms, lens treatments and coatings, contact lenses, low vision devices, vision therapy devices, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa, or any material allowed to be utilized by the [state]’s Board of Optometry and Practice Act.

C. "Covered services" means the professional work performed by an eye care provider for which reimbursement from an insurer, vision benefit manager, or subcontractor is provided to an eye care provider by an enrollee's plan contract, or for which a reimbursement would be available but for the application of the enrollee's contractual plan limitations of deductibles, copayments, or coinsurance, regardless of how the services are listed or described in an enrollee’s benefit plan’s definition of benefits.

D. “Covered materials” means materials for which reimbursement from an insurer, vision benefit manager, or subcontractor is provided to an eye care provider by an enrollee’s plan contract, or for which a reimbursement would be available but for the application of the enrollee’s contractual limitations of deductibles, copayments, or coinsurance, regardless of how the materials are listed or described in an enrollee’s benefit plan’s definition of benefits.

E. “Eye care provider” means a licensed doctor of optometry practicing under the authority of [statutory reference] or a licensed medical or osteopathic doctor practicing under the authority of [statutory reference].

F. *“*Participating eye care provider” means an eye care provider that has entered into a contractual agreement or other business relationship with an insurer, vision benefit manager, third party administrator, or subcontractor to provide covered services or covered materials.

G. “Health benefit plan” means a policy, contract, or agreement offered by an insurer, third party administrator, or subcontractor to an enrollee to pay for, reimburse, discount, or offset health care costs.

H. “Vision benefit plan” means a policy, contract, or agreement offered by an insurer or vision benefit manager to an enrollee to pay for, reimburse, or offset health and vision care costs.

I. “Vision benefit discount plan” means a policy, contract, or agreement offered by an insurer or vision benefit manager to an enrollee that solely provides for a discount for vision care services or materials.

J. “Vision Benefit Manager” means an individual, company, organization, group, or other entity, including but not limited to insurers, third party administrators, and subcontractors, that creates, promotes, sells, provides, advertises or administers, an integrated or stand-alone vision benefit plan, vision benefit discount plan, or other insurance policy or contract which provides vision benefits or discounts to an enrollee pertaining to the provision of covered services or covered materials.

K. “Insurer” means, for the purposes of this [Chapter/Title/etc.] an individual, corporation, partnership, company, organization, group, HMO, captive, risk-retention group, self-insurance group, optometric service and indemnity corporation or other entity, whether organized for profit or not-for-profit, whether foreign or domestic, that conducts business in this state and that offers a vision benefit plan or provides coverage for vision-related services or vision-related materials to enrollees. For avoidance of doubt, an entity is considered an Insurer for purposes of this Act irrespective of:

(i) its corporate form or category of licensure, if applicable, including whether it is otherwise subject to insurance regulations or any other regulations;

(ii) whether it, either directly or indirectly reimburses, indemnifies, pays, or discounts the costs of vision services or vision materials; or

(iii) whether it delegates, assigns, or contracts performance of any function regulated by this Act to an affiliate, subsidiary, contractor, intermediary, or network leasing entity.

L. “Third party administrator” means an individual, company, organization, group, or other entity that provides services including but not limited to administrative, operational, regulatory, human resource, compliance, and claim adjudication services for an insurer, vision benefit manager, individual, company, organization, group, or other entity under a contract or agreement.

M. “Subcontractor” means an individual, company, organization, group or other entity including but not limited to agents, servants, brokers, wholesalers, distributors, indirectly-owned, partially-owned or wholly-owned subsidiaries, and controlled organizations that is contracted by the vision benefit manager to supply services or materials to another vision benefit manager, eye care provider, or enrollee to execute or fulfill the health benefit plan, vision benefit plan, or vision benefit discount plan of a vision benefit manager.

N. “Enrollee” means any individual participating in a health benefit plan, vision benefit plan or vision benefit discount plan that is purchased by an individual or provided to an individual by an Insurer, company, organization, group, employer, government assistance program, or any other entity that purchases or supplies coverage for a health benefit plan, vision care benefit plan or vision benefit discount plan.

O. “Chargeback” means a dollar amount, fee, surcharge, rebate, or item of value that reduces, modifies, or offsets all or part of the patient responsibility, provider reimbursement, allowed amount, or fee schedule for a covered service or covered material.

P. “Fee Schedule” means the document or system that lists the predetermined payment rates or allowed amounts for covered services and/or covered materials and determines how much eye care providers are reimbursed by the insurer or vision benefit manager and how much patients are charged by the insurer, vision benefit manager, or eye care provider.

Q. "Nominal" means, when there is no corresponding reimbursement in the current year's published Physician Fee Schedule (PFS) released annually by the Centers for Medicare & Medicaid Services (CMS) or in the current year's published state Medicaid fee schedule, an amount less than the reasonable compensation to the vision care provider rendering the covered service or covered materials, taking into account the provider's direct and indirect costs, i.e., the actual acquisition costs and actual pro rata overhead costs, and reasonable profit.

R. "De Minimis" means equal to zero or an otherwise negligible amount.

Section 3. Transparency and Disclosure Requirements for Insurers and Vision Benefit Managers

A. An Insurer or Vision Benefit Manager shall disclose the following information publicly on its internet website and with all documents and document packages including but not limited to proposals, responses to requests for proposals, sales documents, enrollment documents, benefit plan documents, purchaser contracts, enrollee contracts, and provider agreements that are presented to purchasers, potential purchasers, enrollees, potential enrollees, participating eye care providers, potential participating providers, and state agencies with jurisdictional, regulatory, or enforcement authority over its business:

1. its legal name and entity type;

2. its legal address and state in which the legal entity is formed or organized;

3. the physical address, mailing address, electronic mail address, and phone number of its operational headquarters;

4. the agencies, departments, committees, commissions, and other bodies that have jurisdictional, regulatory, or enforcement authority over the business;

5. a statement that no jurisdictional, regulatory, or enforcement authority exists over its business, if none exists;

6. the names, physical addresses, mailing addresses, electronic mail addresses, and phone numbers of all parent companies, related holding companies, wholly-owned subsidiary companies, and partially-owned subsidiary companies;

7. All federal and state litigation in which the company is, or has been, a party to in the current year and during the preceding five (5) years.

8. All [state department of insurance] formal complaints against the company in the current year and during the preceding five (5) years by purchasers, enrollees, or eye care providers.

B. All information required to be disclosed by an Insurer or Vision Benefit Manager in subsection (1) shall be conveyed in plain language and typed with a minimum of ten (10) point font size and prominently displayed:

1. on the Insurer's or Vision Benefit Manager's website in a publicly accessible section titled "Required Transparency Information for Patients, Doctors, and Purchasers"; and

2. in a separately created document titled "Required Transparency Information for Patients, Doctors, and Purchasers" that shall be included with all documents and document packages including but not limited to proposals, responses to requests for proposals, benefit plan documents, sales documents, enrollment documents, purchaser contracts, enrollee contracts, and provider agreements.

C. An Insurer or Vision Benefit Manager shall provide notice to each participating eye care provider of any proposed amendments to existing provider agreements, fee schedules, provider handbooks, provider manuals, or related policy documents via electronic mail.

D. A participating eye care provider shall be provided with a minimum of ninety (90) calendar days from the time of distribution to review changes and respond, if necessary, to any proposed amendments from an insurer or vision benefit manager to existing provider agreements, fee schedules, provider handbooks, provider manuals, or related policy documents. Any such proposed amendments proffered by the Insurer or Vision Benefit Manager in violation of the foregoing shall be void and unenforceable as a matter of law.

E. Any proposed amendments to existing provider agreements, fee schedules, provider handbooks, provider manuals, or related policy documents by an Insurer or Vision Benefit Manager delivered to a participating eye care provider shall be:

1. enumerated in a cover letter;

2. marked with highlights or in tracked changes within the applicable agreements and/or documents to clearly display all changes over the previous version(s);

3. structured to include implications of agreeance or non-agreeance by the participating eye care provider.

F. An Insurer or Vision Benefit Manager shall maintain:

1. a phone number to company representatives to receive questions and communications from participating eye care providers at all times during standard business hours;

2. the ability for an eye care provider to leave voice messages at all times; and

3. the ability for an eye care provider to have a live phone discussion with a company representative within (24) hours of an initial phone call or a voice message left with the Insurer or Vision Benefit Manager.

G. An Insurer or Vision Benefit Manager shall maintain a physical mailing address and an electronic mail address to company representatives to receive questions, disputes, and communications from participating eye care providers about all matters, at all times, including but not limited to proposed amendments to existing provider agreements, fee schedules, provider handbooks, provider manuals, and related policy documents, and will publish instructions for mail submission and electronic mail submission of questions, disputes, and communications in a place visible to participating eye care providers including on its website and in any provider agreements, provider handbooks, provider manuals, or related policy documents.

H. An Insurer or Vision Benefit Manager shall acknowledge receipt of an electronic mail message within one (1) hour by use of a return electronic mail message with a communication tracking number, and shall respond to the substantive questions or communications of the electronic mail message within seventy-two (72) hours in writing by use of a return electronic mail message.

I. An Insurer or Vision Benefit Manager shall, at all times, make available to the eye care provider the most up-to-date provider agreements, fee schedules, provider handbooks, provider manuals, and related policy documents via website access.

J. Insurers or Vision Benefit Managers shall not engage in marketing or advertising activities that are misleading or deceptive to the public. Such acts are considered deceptive trade practices and subject to penalty under [state's deceptive trade practice statute].

K. Upon request by a state agency with jurisdictional, regulatory, or enforcement authority over its business, Insurers and Vision Benefit Managers shall submit all information related to a health benefit plan, vision benefit plan, or vision benefit discount plan, including but not limited to proposals, responses to requests for proposals, benefit plan documents, sales documents, enrollment documents, purchaser contracts, enrollee contracts, provider agreements, and marketing and advertising activities for review.

Section 4. Covered and Non-Covered Services and Materials Provisions

A. No agreement or contract between an Insurer or Vision Benefit Manager and an eye care provider may seek to or require that an eye care provider provide services or materials at a fee limited or set by the Insurer or Vision Benefit Manager unless the services or materials are defined and reimbursed as covered services or covered materials under the agreement or contract.

B. All fee schedules in an agreement between an Insurer or Vision Benefit Manager and an eye care provider and all reimbursements paid by an Insurer or Vision Benefit Manager to an eye care provider for all covered services and covered materials shall not be Nominal or De Minimis. There shall be no limitation on the ability of an individual eye care provider or a group of eye care providers who practice under a single Employer Identification Number (EIN) or Tax Identification Number (TIN) to engage in direct negotiations with the Insurer or Vision Benefit Manager regarding reimbursement fee schedules, and ultimately agreeing to a different fee schedule than the fee schedule provided by the Insurer or Vision Benefit

Manager to other participating providers or groups.

C. A contract between an Insurer or Vision Benefit Manager and an eye care provider shall include a fee schedule that includes and individually identifies each covered service and covered material and its corresponding allowed amount, reimbursement amount paid to the eye care provider, and any form of a cost-sharing amount paid by the enrollee to the eye care provider.

D. Insurers or Vision Benefit Managers shall not advertise, claim, or represent to purchasers or enrollees that services and materials provided by a participating eye care provider are covered, included, or covered with an additional deductible, copay, or coinsurance, if the Insurer or Vision Benefit Manager does not remit an actual payment to the participating eye care provider as full or partial reimbursement for the service or material.

E. A service or material provided by a participating eye care provider cannot be designated as a covered service or covered material by the Insurer or Vision Benefit Manager in the design of a health benefit plan, vision benefit plan, or vision benefit discount plan if the reimbursement amount to the participating eye care provider is only comprised of an enrollee's payment to the participating eye care provider.

F. Insurers or Vision Benefit Managers shall not condition application to or network participation in a health benefit plan, vision benefit plan, or vision benefit discount plan by an eye care provider based on the eye care provider's usual and customary pricing or discounts on usual and customary pricing for services or materials that are not covered services or not covered materials. Any such contractual language, policies, or procedures set by the Insurer or Vision Benefit Manager in violation of the foregoing shall be void and unenforceable as a matter of law.

G. Insurers or Vision Benefit Managers shall not make conditional a fee schedule proposed or made to an eye care provider of a health benefit plan, vision benefit plan, or vision benefit discount plan for covered services or covered materials based on the eye care provider's usual and customary pricing or discounts on usual and customary pricing for services or materials that are not covered services or not covered materials. Any such contractual language, policies, or procedures set by the Insurer or Vision Benefit Manager in violation of the foregoing shall be void and unenforceable as a matter of law.

H. A contract between an Insurer or Vision Benefit Manager and an eye care provider shall not contain a provision, fee schedule, or reimbursement amount in which the eye care provider, with consideration of any applicable deductibles, copays, coinsurances, discounts, rebates, or chargebacks, to provide covered services or covered materials to an enrollee at a financial loss. Any such contractual language, policies or procedures set by the Insurer or Vision Benefit Manager in violation of the foregoing shall be void and unenforceable as a matter of law.

I. An Insurer or Vision Benefit Manager shall not promote or use in any marketing or advertising for a health benefit plan, vision benefit plan, or vision benefit discount plan that a covered service or covered material is "free" or "no charge" or "complimentary" or any

materially similar language to induce a client, group, employer, purchaser, company, enrollee or prospective enrollee to purchase services, materials, supplies, or plans from the Insurer, Vision Benefit Manager, or affiliate of the Insurer or Vision Benefit Manager.

J. Insurers or Vision Benefit Managers shall remit to the participating eye care provider the contracted reimbursement amount from the fee schedule for a covered service or covered material provided to an enrollee if the enrollee is verified to be eligible by the participating eye care provider through customary verification methods of the Insurer or Vision Benefit Manager to receive the covered service or covered material on the date of service.

K. Insurers or Vision Benefit Managers shall not retroactively reverse a reimbursement or withhold a future reimbursement to a participating eye care provider who relied in good faith on an individual's presented coverage credentials and the customary verification methods of the Insurer or Vision Benefit Manager, if the Vision Benefit Manager later determines that the enrollee was ineligible to receive covered services or covered materials on the date of service.

L. Participating eye care providers are allowed, but not required, to offer an enrollee the opportunity to pay the participating eye care provider directly for covered services and covered materials if such direct payment would be less costly to the enrollee than the total out-of-pocket cost required under the terms of a health benefit plan or vision benefit plan. A provider may not be subject to an audit, removed from participation in the network, or otherwise penalized or discriminated against in any manner for offering an enrollee the opportunity to pay the participating provider directly under the conditions of this provision.

M. Insurers or Vision Benefit Managers shall not, in the course of adjudicating a claim for reimbursement by a participating eye care provider for a covered service or covered material, alter, delete, substitute, or otherwise change any code or modifier submitted by the eye care provider, including by downcoding, bundling or reassigning to a different code, if such change would reduce payment or otherwise adversely affect the provider and/or enrollee. For purposes of this section, "downcoding" means to alter, delete, substitute or assign a code that results in a lower level of service, a lower-valued code, or a reduced reimbursement amount relative of the code(s) submitted by the eye care provider; and "bundling" means to combine, substitute, or treat two or more distinct services, supplied, or materials reported on the same claim or date or service as included within a single code, package, or global service, and denying, reducing, or disallowing separate reimbursement for one or more of these codes.

N. All provisions in this chapter shall apply to all affiliates, parent companies, third party administrators, and subcontractors that are used by an Insurer or Vision Benefit Manager to supply covered services or covered materials to an eye care provider or enrollee and be subject to all applicable penalties as referenced in this [chapter] or [section].

O. An Insurer or Vision Benefit Manager shall not require nor request an eye care provider to opt-in or opt-out of the provisions set forth in this [chapter] or [section].

Section 5: Prohibiting Coercive Tactics by Insurers and Vision Benefit Managers; Providing Reimbursement Parity for Optometrists and Ophthalmologists; Requiring Affiliates to Comply with Statute

A. No agreement between an Insurer or Vision Benefit Manager and an eye care provider shall require that an eye care provider must participate with, be credentialed by, or enter into an agreement with any specific vision benefit plan or vision benefit discount plan as a condition for participation in the health benefit plan provider network of the Insurer or Vision Benefit Manager to provide covered services or covered materials to the enrollees of the health benefit plan.

B. No agreement between an Insurer or Vision Benefit Manager and an eye care provider shall require that an eye care provider must participate with, be credentialed by, or enter into an agreement with any specific health benefit plan as a condition for participation in the vision benefit plan or vision benefit discount plan provider network of the Insurer or Vision Benefit Manager to provide covered services or covered materials to the enrollees of the vision benefit plan or vision benefit discount plan.

C. Any Insurer or Vision Benefit Manager issuing or renewing a health benefit plan, vision benefit plan or vision benefit discount plan which provides benefits for covered services or covered materials rendered by a physician or osteopath duly licensed under [statutory reference] that are within the scope of practice of an optometrist duly licensed under the provisions of [statutory reference] shall provide the same reimbursement for covered services or covered materials to optometrists as allowed for those covered services or covered materials rendered by physicians or osteopaths.

D. An Insurer or Vision Benefit Manager shall apply the same terms and conditions of participation for all eye care providers, irrespective of their educational credentials, i.e., MD, DO, OD, subject to the permitted scope of practice for the licensee under applicable state law.

E. An Insurer or Vision Benefit Manager shall not require an eye care provider to possess, offer, procure, or sell materials or covered materials in their office as a condition of participation in the provider network of health benefit plan, vision benefit plan, or vision benefit discount plan. Any such contractual language, policies or procedures set by the Insurer or Vision Benefit Manager in violation of the foregoing shall be void and unenforceable as a matter of law.

F. If an eye care provider enters into any subcontract agreement with another provider to provide his or her licensed health care services to an enrollee or a covered dependent of an enrollee of a health benefit plan, vision benefit plan, or vision benefit discount plan where the subcontracted provider will seek reimbursement from the plan or enrollee for the subcontracted services, the subcontract agreement must meet all requirements of this [chapter]or[act].

G. The provisions of this subsection shall also apply to any agreements an Insurer or Vision Benefit Manager enters into with another entity to provide an enrollee with covered services or covered materials.

Section 6. Acceptance as Participating Eye Care Provider

A. An Insurer or Vision Benefit Manager shall not exclude an eye care provider from applying to, or becoming a participating provider in, the network of a health benefit plan, vision benefit plan, or vision benefit discount plan because of:

1. the aggregate number of eye care providers in a state, county, city, zip code, or other geographically defined service area;

2. the time, distance, or appointment availability for an enrollee to access a participating eye care provider;

3. the provider's professional designation, independent practice affiliation, or participation status in other health benefit plans, vision benefit plans, or vision benefit discount plans.

Section 7. Permitting Eye Care Providers to Use any Lab or Supplier

A. No agreement between an Insurer or Vision Benefit Manager and an eye care provider shall restrict or limit, either directly or indirectly, the eye care provider's choice or use of sources and suppliers of covered or uncovered services or materials, including the choice or use of optical laboratories, provided by the eye care provider to an enrollee. Any such contractual language, policies or procedures set by the Insurer or Vision Benefit Manager in violation of the foregoing shall be void and unenforceable as a matter of law.

B. An Insurer or Vision Benefit Manager shall not directly or indirectly apply a chargeback to an enrollee or eye care provider if the chargeback is for a covered product or service for which the insurer or vision benefit manager does not incur the cost to produce, deliver, or provide to the enrollee or eye care provider.

Section 8. A Private Right of Action for Eye Care Providers

Any eye care provider adversely affected by a violation of this subchapter may bring an action in a court of competent jurisdiction for injunctive relief against the Insurer or Vision Benefit Manager and, upon prevailing, in addition to such injunctive relief, shall recover monetary damages, including but not limited to direct, indirect, special and punitive damages, and penalties, of no more than $10,000 for each violation, plus attorney's fees and costs.

Section 9. Relationship to Other Laws

The requirements of this Act are in addition to, and do not limit, any other requirement applicable to an Insurer under State law. In the event of a conflict between this Act and another provision of State law applicable to Insurers, the provision that affords greater protection to Eye Care Providers or plan enrollees shall control. Notwithstanding any other provision of State law, including any law that purports to be the sole body of law governing the Insurer, an Insurer shall comply with this Act, to the extent not preempted by Federal law.

Section 10. Enforcement

A. The [Commissioner/Department] has jurisdiction to administer and enforce this Act with respect to any Insurer, as such term is defined herein. The [Commissioner/Department] may: (i) bring an action, issue orders, and impose remedies authorized by this Act against any Insurer; (ii) adopt rules to identify activities that constitute the administration, management, or control of vision benefits or materials; and (iii) coordinate enforcement with other State agencies that regulate Insurers under other applicable law. The Attorney General has concurrent enforcement authority for violations constituting unfair or deceptive acts or practices.

B. The Insurance Commissioner shall:

1. Provide a mechanism for aggrieved individuals, whether actively or formerly enrolled with a particular vision care plan, to submit complaints to the Insurance Commissioner for review, investigation, and as appropriate, discipline under applicable law.

2. Enforce the state's insurance laws and this provision using powers granted to the commissioner in the (Name of State) Insurance Code (Code citation);

3. Ensure that Insurers and Vision Benefit Managers comply with the requirement of this act; and

4. Be entitled to seek an injunction against an Insurer or Vision Benefit Manager in a court of competent jurisdiction if the Insurer or Vision Benefit Manager:

i. issues a coverage policy that does not comply with the requirement of this Act, uses fraudulent, coercive or dishonest practices, or demonstrates incompetence, untrustworthiness, or financial irresponsibility in the conduct of business;

ii. fails to deal equitably with any eye care providers or other persons of facilities which offer services or materials covered within a contract or policy issued pursuant to this Act; or

iii. fails to substantially comply with the insurance laws of this state or violates any regulation, rule, subpoena or order of the Commissioner

C. The Attorney General shall:

1. Enforce the state's laws and this Act’s provisions, using powers granted to the Attorney General in the (Name of State) Insurance Code (Code citation) and/or the state’s consumer protection statutes; and

2. Be entitled to seek an injunction against an Insurer or Vision Benefit Manager in a court of competent jurisdiction.

3. The penalties and remedies provided in this chapter for violation of this provision: (i) are cumulative, and in addition to any other penalties and remedies available under state law; and (ii) shall not waive, limit, or otherwise affect the applicability of the state's [Unfair Trade Practices Act/Consumer Protection Act/Deceptive Trade Practices Act], or any other law providing for civil or criminal penalties or remedies for unfair, deceptive, or unlawful business practices.

Section 11: Severability Clause

If any provision of this Act or the application thereof to any person or circumstance is held invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 12: Rules

A. The requirements of this section apply to Insurer or Vision Benefit Manager policies, contracts, addenda and certificates executed, delivered, issued for delivery, continued or renewed in (State).

1. No Insurer or Vision Benefit Manager shall construe re-credentialing as re-contracting with a participating eye care provider. A provider agreement must be a distinctly separate document from any credentialing materials and must be signed by the eye care provider and the Insurer or Vision Benefit Manager.

2. An Insurer or Vision Benefit Manager must include a copy of the current plan provider manual referred to in a provider agreement at the time an agreement is sent to any provider and prospective provider, as well as any policies referenced in the provider agreement, e.g. dispute resolution policies.

B. This law shall go into effect immediately upon passage and shall apply to all Insurers and Vision Benefit Managers upon the earlier of:

1. the renewal of enrollee's current benefit plan or upon issue of a new benefit plan to any enrollee;

2. the initiation of a new provider agreement with an eye care provider or upon any amendment of an existing provider agreement with an eye care provider; or

3. January 1, 202x.