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

Dear Representative Gordon,

The Blue Cross Blue Shield Association (BCBSA) appreciates your willingness to talk with us regarding the "Model Act Ensuring Access to Eye Care Services and Materials for Patients Through Transparent and Fair Business Practices by Vision Benefit Plans" (the Model). We welcome the opportunity to comment on the draft Model and look forward to working with you on this language.

BCBSA is a national federation of independent, community-based and locally operated Blue Cross and Blue Shield companies (Plans) that collectively provide health care coverage for one in three Americans. Our Plans provide vision coverage to more than 21 million members, both through integrated medical/vision products and through standalone vision benefit arrangements administered on behalf of self-funded employers, giving us direct experience with the contracting and operational practices the Model seeks to regulate.

BCBSA is broadly supportive of efforts to bring greater transparency and fairness to this market. However, BCBSA has significant concerns about several provisions of the Model as currently drafted. In particular, BCBSA is concerned that the Model's definitions extend its requirements well beyond the standalone vision benefit market the Model is designed to address, and that its private right of action creates disproportionate litigation exposure. BCBSA urges the committee to consider the following amendments.

Section 2 — Definitions

Sections 2(G) and 2(K) define "Health benefit plan" and "Insurer" so broadly that the Model's requirements extend well beyond standalone vision benefit managers to the entire ACA-compliant individual, small group, and large group markets, and to self-funded employer plans

administered by third party administrators. Because pediatric vision is a mandatory Essential Health Benefit under the ACA, it is embedded in every fully insured medical policy — meaning every insurer offering ACA-compliant coverage would be subject to the Model's requirements and its private right of action upon adoption, regardless of whether their primary business involves standalone vision benefits.

Fully insured medical policies are already subject to comprehensive consumer protection requirements under the ACA and applicable state law. Extending the Model's requirements to these products would not meaningfully improve those protections, but would impose significant litigation costs on insurers with no standalone vision business. The "Insurer" definition also captures insurers that offer vision products administered by vision benefit managers under the insurer's own brand – arrangements where the insurer plays no direct role in the practices the Model is designed to address. This creates ambiguity about whether compliance obligations fall on the insurer, the vision benefit manager, or both.

Recommendation: BCBSA recommends that the definition of "Insurer" be narrowed and the definition of "Health benefit plan" be eliminated to focus the Model's requirements on standalone vision benefit managers and exclude third party administrators acting on behalf of self-funded ERISA plans and insurers offering integrated medical coverage.

Section 3 — Transparency and Disclosure Requirements

Section 3(D) requires 90 days advance notice for any amendment to provider agreements, fee schedules, or provider manuals, and renders any non-compliant amendment void and unenforceable as a matter of law. For insurers that update these documents on regular operational cycles — often to reflect regulatory changes, updated billing codes, or annual rate adjustments — even a minor timing shortfall could retroactively invalidate substantive contractual terms and trigger per-violation damages under Section 8 across the entire provider network. Many Plans also operate under existing provider agreements with notice periods shorter than 90 days that providers have contractually agreed to, which the 90-day requirement would automatically void.

Recommendation: BCBSA recommends that Section 3(D) be amended to replace the automatic void consequence with Insurance Commissioner enforcement, consistent with the Model's broader enforcement framework. If the committee is not prepared to adopt that approach, Section 3(D) should, at a minimum, include a cure period, limit any void remedy to amendments that materially prejudice providers, and replace the 90-day notice period with one that reflects standard industry practice and accommodates reasonable operational variation.

Section 4 — Covered and Non-Covered Services and Materials

Section 4 includes several provisions that would significantly disrupt standard contracting and claims administration practices. Sections 4(A), 4(F), and 4(G) prohibit conditioning network participation or covered service fee schedules on a provider's pricing for non-covered services,

effectively eliminating negotiated discount arrangements that directly benefit patients. Sections 4(B) and 4(H) prohibit reimbursement levels deemed “nominal,” as defined in Section 2(Q), which ties reimbursement floors to provider costs plus a reasonable profit, and references external fee schedules, including the CMS Physician Fee Schedule. In practice, this approach would effectively mandate Medicare-level reimbursement regardless of negotiated market rates.

Section 4(M) prohibits altering any code or modifier submitted by a provider if the change would reduce payment, eliminating key tools—such as coding edits, bundling logic, and modifier review—that plans rely on to detect and prevent fraudulent, wasteful, and abusive billing practices, including upcoding and duplicate billing.

Finally, Sections 4(J) and 4(K) require payment upon eligibility verification and prohibit recovery of payments made on invalid eligibility, removing a critical safeguard against enrollment and identity fraud and shifting those costs onto legitimate enrollees. These provisions would ultimately increase premiums and out-of-pocket costs for patients and employers.

Recommendation: BCBSA recommends that Section 4 be revised to preserve the ability of insurers and vision benefit managers to negotiate pricing and discount arrangements for non-covered services, establish reimbursement levels through market-based contracting, and apply standard claims adjudication and payment integrity practices that protect patients from fraud and abusive billing. BCBSA further recommends revising the definition of “nominal” to reflect market-based reimbursement rather than external fee schedule benchmarks and clarifying that plans may recover payments made based on invalid eligibility information, including where eligibility errors result from retroactive changes in enrollment status, administrative data discrepancies, or other circumstances outside the plan's control at the time of service.

Section 5 — Network Participation and Reimbursement Requirements

Section 5 restricts standard contracting practices critical for designing efficient networks that are cost-effective for patients. Sections 5(A) and 5(B) restrict cross-product participation requirements, which may require plans offering multiple benefit variations to maintain duplicative networks, increasing administrative complexity without improving patients’ access to care or quality outcomes. Section 5(C) mandates identical reimbursement for optometrists and ophthalmologists regardless of differences in training, scope of practice, or cost structures, and provides no mechanism for determining which services are sufficiently equivalent to trigger the parity requirement leaving plans without clear compliance guidance and exposing them to unnecessary contracting disputes. Section 5(D) requires uniform participation terms regardless of provider credentials, limiting the flexibility to tailor networks to clinical and affordability objectives. Section 5(E) prohibits requiring providers to offer materials as a condition of participation, potentially preventing integrated delivery models that improve convenience and continuity of care for patients.

Recommendation: BCBSA recommends that Section 5 be revised to preserve market-based contracting flexibility, including the ability to set reimbursement levels that reflect legitimate

differences in provider training and cost structures, vary participation terms, and permit reasonable requirements related to the integrated delivery of services and materials.

Section 6 — Network Adequacy

Section 6 restricts and creates ambiguity regarding the use of aggregate provider counts, time and distance standards, or participation status in other plans — the primary tools by which insurers design cost-effective networks and comply with existing state network adequacy regulations. As drafted, Section 6 effectively converts vision networks into any-willing-provider arrangements and risks conflict with state network adequacy regulations that require or rely on insurers to apply the same time and distance criteria the Model would restrict.

Recommendation: BCBSA recommends that Section 6 be narrowed to prohibit discriminatory or pretextual exclusions while preserving insurers' ability to apply objective, actuarially sound network adequacy standards consistent with existing state law.

Section 7 — Lab and Supplier Choice

Section 7 prohibits any restriction on provider choice of optical laboratories or suppliers, which as drafted would invalidate existing preferred lab arrangements established to promote quality, efficiency, and cost-effectiveness for enrollees and render those arrangements immediately actionable under Section 8.

Recommendation: BCBSA recommends that Section 7 be clarified to prohibit coercive restrictions while permitting voluntary preferred supplier arrangements that lower costs and improve quality for patients.

Section 8 — Private Right of Action

Section 8 creates a private right of action for any provider "adversely affected" by a violation, with per-violation damages of up to \$10,000 plus attorneys' fees, with no requirement to show actual harm. In a networked environment, a single administrative error could generate thousands of simultaneous violations. This, combined with the automatic void consequence in Section 3(D), a routine timing failure could simultaneously void a contractual provision and trigger per-violation damages across an entire provider network. Section 8's exposure is further compounded by the Model's overbroad definitions, which extend liability to insurers offering ACA-compliant medical products — far beyond standalone vision benefit managers.

Recommendation: BCBSA recommends that Section 8 be deleted in its entirety. This approach is consistent with the NCOIL dental model, which relies on Insurance Commissioner and Attorney General enforcement rather than private litigation. If the committee is not prepared to delete Section 8 entirely, BCBSA recommends that it be amended to require a showing of actual harm, provide a cure period for inadvertent violations, and cap aggregate liability for systemic operational violations.

Section 9 — Relationship to Other Laws

Section 9's savings clause acknowledges federal preemption but does not resolve the conflict created by the Model's definitions, which extend its requirements to third party administrators of self-funded employer plans governed by ERISA. The savings clause merely shifts the burden of establishing preemption to individual insurers and administrators on a state-by-state basis. An explicit carve-out for self-funded ERISA plans would also serve the Model's own interests — a Model that clearly limits itself to the fully insured market is less likely to face federal preemption challenges that could delay or invalidate its adoption.

Recommendation: BCBSA recommends clarifying that the Model applies to fully insured vision benefit arrangements and does not apply to self-funded employer health plans governed by ERISA.

Section 12 — Effective Date

Section 12(B)'s "earlier of" construct effectively makes "January 1, 202x" the controlling effective date regardless of when the Model is enacted, potentially leaving insurers and vision benefit managers with weeks or days to implement sweeping new requirements.

Recommendation: BCBSA recommends replacing "earlier of" with "later of" to ensure regulated entities have sufficient time to implement the Model's requirements following enactment.

BCBSA and its member Plans support the Model's core objectives of transparency, fair dealing, and meaningful patient access to eye care. The concerns raised above are not about avoiding oversight — they are about ensuring the Model regulates the market it was designed to address, without creating unintended consequences for the broader health insurance market or generating litigation burdens that ultimately harm patients and providers alike. We welcome the opportunity to work with the committee and other stakeholders to address these concerns and look forward to continued engagement as the Model develops. If you have questions, please contact Randi Chapman at Randi.Chapman@bcbsa.com.

With best regards,



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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.G.~~ “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.

~~H.H.~~ “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.

~~H.I.~~ “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.

Commented [RM1]: BCBSA recommends deleting the definition of 'Health benefit plan.' Standalone vision benefits, like standalone dental benefits, are excepted benefits under HIPAA that operate in a distinct market from comprehensive medical coverage. The NCOIL dental model reflects this distinction — it focuses on the standalone dental benefit market and does not define or regulate health benefit plans. The vision model should follow the same approach. The operative provisions have been revised throughout to reference 'vision benefit plan' and 'vision benefit discount plan' only. See BCBSA Comments, Section 2.

Commented [RM2]: Consistent with the NCOIL dental model, BCBSA recommends removing "third party administrators" from the Vision Benefit Manager definition. TPAs administering self-funded employer vision benefits should not be captured as Vision Benefit Managers. See BCBSA Comments, Section 2.

~~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:~~

~~L.~~—

~~M.~~— its corporate form or category of licensure, if applicable, including whether it is otherwise subject to insurance regulations or any other regulations;

~~N.~~—

~~O.~~— whether it, either directly or indirectly reimburses, indemnifies, pays, or discounts the costs of vision services or vision materials; or

~~P.~~—

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

~~R.K.~~ “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.

~~S.L.~~ “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.

~~T.M.~~ “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.

~~U.N.~~ “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.

~~V.O.~~ “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.

~~W.P.~~ “Nominal” means ~~an amount that does not reflect reasonable compensation to the~~

Commented [RM3]: BCBSA recommends deleting subsections (i)–(iii). The anti-circumvention language sweeps in insurers offering integrated medical/vision coverage who are not the primary focus of the Model's regulatory concerns. A narrower definition focused on standalone vision benefit administration better targets the Model's requirements. See BCBSA Comments, Section 2.

~~vision care provider rendering the covered service or covered materials, as established through market-based contracting between the Insurer or Vision Benefit Manager and the eye care provider, 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.~~

~~X-Q.~~ "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.

Commented [RM4]: BCBSA recommends replacing the Medicare PFS and Medicaid fee schedule floors with a market-based standard. Tying reimbursement floors to government fee schedules effectively mandates Medicare-level reimbursement for vision services regardless of negotiated market rates. The revised definition preserves the prohibition on nominal reimbursement while allowing market-based contracting to establish appropriate rates. See BCBSA Comments, Section 4.

- 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 subject to enforcement by the Commissioner pursuant to Section 10~~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.

Commented [RM5]: BCBSA recommends replacing the automatic void-and-unenforceable consequence with Commissioner enforcement. The void consequence is a disproportionate remedy for what may be a procedural or administrative timing failure. Commissioner enforcement preserves the notice requirement’s purpose while ensuring the remedy is proportionate. See BCBSA Comments, Section 3. If the committee is not prepared to replace the void-and-unenforceable consequence entirely, BCBSA would alternatively recommend adding a cure period before the void consequence attaches, or harmonizing the 90-day notice period with standard industry practice to reduce the risk of inadvertent violations. See BCBSA Comments, Section 3.

- 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 covered services or covered 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. Nothing in this subsection shall be construed to prohibit an Insurer or Vision Benefit Manager from negotiating pricing or discount arrangements with eye care providers for non-covered services or materials.

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

Commented [RM6]: BCBSA recommends narrowing this provision to covered services and covered materials only, and adding a savings clause for non-covered service pricing. Provisions restricting discounts and pricing for non-covered services eliminate negotiated savings that directly benefit consumers. See BCBSA Comments, Section 4.

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 subject to enforcement by the Commissioner pursuant to Section 10 ~~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 subject to enforcement by the Commissioner pursuant to Section 10 ~~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 subject to enforcement by the Commissioner pursuant to Section 10. Nothing in this subsection shall be construed to prohibit reimbursement

Commented [RM7]: BCBSA recommends replacing the void-and-unenforceable consequence with Commissioner enforcement, consistent with the approach taken in Section 3(D). See BCBSA Comments, Section 4.

Commented [RM8]: BCBSA recommends replacing the void-and-unenforceable consequence with Commissioner enforcement, consistent with the approach taken in Section 3(D). See BCBSA Comments, Section 4.

rates established through voluntary arms-length negotiation where the eye care provider has affirmatively agreed to the applicable fee schedule~~void and unenforceable as a matter of law.~~

Commented [RM9]: BCBSA recommends replacing the void-and-unenforceable consequence with Commissioner enforcement and adding a savings clause for voluntarily negotiated fee schedules. Prohibiting reimbursement arrangements that providers have affirmatively agreed to removes a key mechanism for controlling vision benefit costs. When Plans cannot negotiate market-based rates, those costs are ultimately passed on to enrollees through higher premiums and out-of-pocket expenses — undermining the affordability objectives the Model is designed to support. See BCBSA Comments, Section 4.

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. Nothing in this subsection shall be construed to prohibit an Insurer or Vision Benefit Manager from recovering payments made based on fraudulent misrepresentation of eligibility by the enrollee or a third party, or where the enrollee was determined to be ineligible due to a retroactive change in enrollment status, administrative data error, or system discrepancy that was not reflected in the Insurer's or Vision Benefit Manager's eligibility records at the time of verification.

Commented [RM10]: BCBSA recommends adding a fraud exception to preserve the ability to recover payments made based on fraudulent misrepresentation of eligibility. As drafted, the prohibition on retroactive reversal removes a critical safeguard against enrollment and identity fraud. BCBSA further recommends expanding the carve-out to address eligibility errors outside the plan's control, including retroactive changes in enrollment status, administrative data errors, and system discrepancies not reflected in eligibility records at the time of verification. See BCBSA Comments, Section 4.

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. Nothing in this subsection shall be construed to prohibit an Insurer or Vision Benefit Manager from recovering payments made based on fraudulent misrepresentation of eligibility by the enrollee or a third party, or where the enrollee was determined to be ineligible due to a retroactive change in enrollment status, administrative data error, or system discrepancy that was not reflected in the Insurer's or Vision Benefit Manager's eligibility records at the time of verification.

Commented [RM11]: BCBSA recommends adding a fraud exception to preserve the ability to recover payments made based on fraudulent misrepresentation of eligibility. As drafted, the prohibition on retroactive reversal removes a critical safeguard against enrollment and identity fraud. BCBSA further recommends expanding the carve-out to address eligibility errors outside the plan's control, including retroactive changes in enrollment status, administrative data errors, and system discrepancies not reflected in eligibility records at the time of verification. See BCBSA Comments, Section 4.

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. Nothing in this subsection shall be construed to prohibit the application of nationally recognized coding guidelines, clinically appropriate bundling edits, or payment integrity practices consistent with industry standards, provided such practices are applied consistently and in good faith.

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 coercively require, through financial penalties, network termination threats, or similar means, 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-vision benefit plan provider network of the Insurer or Vision Benefit Manager to provide covered services or covered materials to the enrollees of the health-vision benefit plan.

B. No agreement between an Insurer or Vision Benefit Manager and an eye care provider shall coercively require, through financial penalties, network termination threats, or similar means, that an eye care provider must participate with, be credentialed by, or enter into an agreement with any specific health-vision 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,

Commented [RM12]: BCBSA recommends adding a savings clause preserving nationally recognized coding guidelines and payment integrity practices. As drafted, this provision makes no distinction between manipulative payment practices and the legitimate application of coding standards, effectively immunizing fraudulent and abusive billing from correction. See BCBSA Comments, Section 4.

Commented [RM13]: BCBSA recommends removing “third party administrators” from the scope of this provision, consistent with the Section 9 ERISA carve-out and the removal of TPAs from the Vision Benefit Manager definition. TPAs acting solely in an administrative capacity on behalf of self-funded employer plans are governed by ERISA and should not be subject to this Act’s requirements and penalties.

Commented [RM14]: BCBSA recommends narrowing these provisions to prohibit coercive participation requirements only, rather than all cross-product participation conditions. Categorical restrictions on cross-product participation may necessitate multiple duplicative networks, increasing administrative complexity and costs without improving access or quality. See BCBSA Comments, Section 5.

Commented [RM15]: BCBSA recommends narrowing these provisions to prohibit coercive participation requirements only, rather than all cross-product participation conditions. Categorical restrictions on cross-product participation may necessitate multiple duplicative networks, increasing administrative complexity and costs without improving access or quality. See BCBSA Comments, Section 5.

Commented [RM16]: BCBSA supports the principle of fair reimbursement across provider types. However, Section 5(C) lacks a mechanism for determining which services are sufficiently equivalent to trigger the parity requirement. Optometrists and ophthalmologists have overlapping but distinct scopes of practice, and absent a clear equivalence standard, the provision would generate significant operational complexity and contracting disputes. BCBSA recommends adding an equivalence standard to provide compliance clarity. See BCBSA Comments, Section 5.

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 subject to enforcement by the Commissioner pursuant to Section 10~~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.

Nothing in this subsection shall be construed to prohibit an Insurer or Vision Benefit Manager from applying objective, actuarially sound network adequacy standards consistent with applicable state network adequacy regulations.

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 ~~coercively~~ restrict or limit, through financial penalties, network termination, or similar means 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. Nothing in this subsection shall be construed to prohibit voluntary preferred supplier arrangements that offer quality or cost benefits to enrollees

Commented [RM17]: BCBSA recommends adding a savings clause preserving objective, actuarially sound network adequacy standards. As drafted, Section 6 effectively eliminates standard network management criteria, converting vision networks into any-willing-provider arrangements with direct cost implications for enrollees. See BCBSA Comments, Section 6.

~~and that do not restrict providers' ability to use alternative suppliers when clinically appropriate. Any violation of this subsection shall be subject to enforcement by the Commissioner pursuant to Section 10 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. This Act does not apply to self-funded employee benefit plans governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 et seq., or to third party administrators acting solely in an administrative capacity on behalf of such plans.

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

Commented [RM18]: BCBSA recommends narrowing this provision to prohibit coercive restrictions on lab and supplier choice — such as financial penalties or network termination threats — while preserving voluntary preferred supplier arrangements. As drafted, Section 7 could invalidate existing preferred lab arrangements established to promote quality and cost-effectiveness for enrollees. See BCBSA Comments, Section 7.

Commented [RM19]: Consistent with the NCOIL dental model, BCBSA recommends deleting the private right of action. The \$10,000 per-violation exposure with no harm requirement, no cure period, and no aggregate cap is disproportionate and would generate litigation exposure for routine operational and administrative matters. Enforcement through the Commissioner and Attorney General under Section 10 provides meaningful oversight without the disproportionate litigation risk. See BCBSA Comments, Section 8.

Commented [RM20]: BCBSA recommends adding an explicit carve-out for self-funded employer plans governed by ERISA. The existing savings clause does not resolve the conflict — it shifts the burden of establishing preemption to individual Plans and administrators state by state. An explicit carve-out provides regulatory certainty and avoids costly preemption litigation. See BCBSA Comments, Section 9.

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~~ later 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.

Commented [RM21]: BCBSA recommends replacing "earlier of" with "later of" to ensure regulated entities have sufficient time to implement the Act's requirements following enactment. The breadth and complexity of the Model's requirements will require substantial operational changes. See BCBSA Comments, Section 12.