



September 3, 2026

The Honorable Deanna Gordon
Kentucky House of Representatives
702 Capitol Avenue Annex Room 367
Frankfort, KY 40601

RE: NCOIL 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,

On behalf of the American Academy of Ophthalmology (Academy), thank you for the opportunity to comment on the National Conference of Insurance Legislators' (NCOIL) draft of the *Model Act Ensuring Access to Eye Care Services and Materials for Patients Through Transparent and Fair Business Practices by Vision Benefit Plans*.

The Academy supports efforts to promote transparency, fairness, and patient access within vision benefit plans. We also recognize and value the important role optometrists play in delivering primary vision care, including performing eye examinations and vision testing, prescribing eyeglasses and contact lenses, and detecting or managing certain eye conditions

The model act as currently drafted could have consequences extending beyond those objectives. We respectfully outline some of our concerns and request several suggested revisions or amendments including the following:

- **Section 2(B): Definition of "Materials."** The definition of "materials" includes "artificial intraocular lenses" and concludes with a reference to "any material allowed to be utilized by the [state]'s Board of Optometry and Practice Act."

A model insurance law should define clearly and directly the products subject to its reimbursement, fee-schedule, supplier-choice, chargeback, and contracting provisions. As written, the final clause could allow the meaning of "materials" to change based on later regulations, interpretations, or administrative decisions by a state Board of Optometry, without any corresponding amendment to the insurance statute.

Our concern is not with the Board of Optometry's authority to regulate optometric practice. Rather, professional licensing laws and insurance laws serve two completely different purposes. A licensing board determines what a professional may lawfully use or provide. The legislature should determine which products are governed by the insurance requirements of this model act.

Leaving the definition dependent on varying state laws and board interpretations could also produce inconsistent results among states adopting the model legislation. The same product could be considered a regulated "material" in one state but not in another, and the definition could change without legislative review of the implications of the insurance-policy.

Prosthetic intraocular lenses raise an additional concern. An intraocular lens is a surgically implanted medical device furnished as part of an intraocular procedure. Its selection and use involve surgical judgment, facility procurement, medical-benefit reimbursement, postoperative care, and management of complications. Including intraocular lenses within the same definition as frames, contact lenses, coatings, and other optical materials could unintentionally apply vision-benefit contracting provisions to surgical implants and facility-based medical care.

We therefore recommend that NCOIL:

- Define “materials” directly through neutral, product-based language;
- Delete the reference to “materials allowed by the Board of Optometry and practice act;”
- Exclude prosthetic intraocular lenses and other implanted devices and tissues; and
- Make clear that the act does not alter any profession’s legal scope of practice.

The following language would address these concerns:

- “Materials” does not include a prosthetic intraocular lens, other surgically or otherwise implanted devices or tissue, or a product or supply furnished as an integral part of a medical or surgical procedure.

A separate construction provision should state:

- Nothing in this Act shall be construed to expand, restrict, or otherwise alter the scope of practice of any healthcare professional licensed under state law.

- **Section 2(E)—Remove the Definition of “Eye care provider.”** The model language groups medical doctors and optometrists under a newly created statutory term of “eye care provider.” When distinct professions are intended to be covered by model legislation, they should be expressly identified rather than grouped under a single umbrella definition. While optometrists and ophthalmologists each play important roles in patient care, they are subject to different educational pathways, clinical training, licensure requirements, and scopes of practice.

An ophthalmologist is a physician—a medical or osteopathic doctor (MD or DO)—who specializes in diagnosing, treating, preventing, and surgically managing eye and vision disorders. After college, four year of medical school and extensive specialty training (4-6+ years), ophthalmologists are qualified to provide comprehensive eye care, including eye examinations, vision correction prescriptions, treatment of eye diseases and injuries, and ocular surgery. They are also trained to identify and manage eye conditions associated with systemic health issues.

An optometrist earns an OD degree, generally after college and four years of optometry school. Optometrists are important members of the eye-care team and provide a wide range of vision and health services, including examinations, refractions, corrective-lens prescriptions, and the detection and management of certain eye conditions. Their authorized scope of practice is established by each state’s government. Although optometrists and ophthalmologists often work collaboratively to serve patients, the two professions follow significantly different educational and clinical training pathways. Optometric care is important to patients and essential to the eye-care delivery system, but optometry education and training are not interchangeable with the medical education and clinical training of ophthalmologists.

Respecting these distinctions does not diminish the contributions of optometrists to eye care. To the contrary, accurately identifying each profession helps patients, policymakers, and insurers understand the qualifications and responsibilities of the professionals involved in eye care. The model should therefore address optometric providers on their own terms rather than equating or combining optometrists (ODs) with physicians (MDs and DOs).

While ophthalmologists account for the vast majority of physician (MD/DO) participation in vision benefit plans, state laws generally do not limit physician-participation exclusively to ophthalmologists. Depending on the services provided and the terms of a particular plan, other licensed medical or osteopathic physicians may be eligible to participate. Accordingly, model legislation should avoid a single statutory definition of “eye care provider” and instead maintain separate definitions for physicians and optometrists. This approach promotes transparency for patients, maintains consistency with existing state practice acts, and avoids ambiguity in the interpretation of vision care insurance statutes, provider network requirements, reimbursement policies, and other provisions that may depend on professional qualifications and authorities.

Model legislation should rely on state-recognized professional classifications and specifically identify physicians and optometrists whenever both professions are intended to be covered.

Therefore, we request that Section 2(E) be deleted as a definition and replaced with a new 2(E) and 2(F) as follows:

- 2(E) “Optometrist” means a licensed doctor of optometry practicing under the authority of [statutory reference].
- 2(F) Physician” means a licensed medical or osteopathic doctor practicing under the authority of [statutory reference].

All previous and subsequent references to “eye care provider” in the model language should be deleted and replaced with “optometrist or physician.”

- **Section 5(C) – Mandatory Reimbursement Parity.** This subsection requires optometrists to receive the same reimbursement as physicians or osteopathic physicians for services within their scope of practice. The Academy supports fair contracting and opposes reimbursement decisions based solely on professional licensure. However, Section 5(C) goes beyond nondiscrimination by mandating identical payment rates. A nondiscrimination standard addresses *why* reimbursement differs; payment parity dictates the reimbursement outcome regardless of other relevant factors, such as contractual obligations, quality arrangements, service capabilities, geographic considerations, value-based payment models, or negotiated terms.

The provision also does not specify which physician reimbursement rate applies when rates vary among physicians or physician groups, nor does it ensure higher reimbursement for optometrists, as plans could comply by lowering physician rates. More fundamentally, Section 5(C) regulates payment levels rather than access to care. Before adopting a payment parity mandate, states should evaluate whether a documented access problem exists and consider potential impacts on premiums, benefit design, provider contracting decisions, and regulatory flexibility.

The Academy encourages NCOIL to replace mandatory payment parity with a targeted prohibition on reimbursement discrimination based solely on professional licensure. We propose striking the existing language of this subsection and amending it so that it reads as follows:

- An insurer or vision benefit manager shall not establish reimbursement for a covered service or covered material based solely on whether the participating provider is licensed as an optometrist or licensed as a physician to practice medicine or osteopathy. Nothing in this subsection shall prohibit reimbursement differences based on reasonable and objectively applied factors, including contractual responsibilities, quality measures, service capabilities, site of service, geographic conditions, value-based payment arrangements, or individually negotiated terms.

This approach would address arbitrary discrimination without imposing a rigid statutory price mandate.

- **Section 5(D) – Identical Participation Terms.** This subsection requires insurers and vision benefit managers to apply the same participation terms and conditions to all eye care providers, regardless of educational training, so long as the provider is acting within state scope-of-practice laws. The Academy supports fair treatment of all licensed providers but is concerned that this provision could be interpreted to require identical participation standards for providers who deliver different services or assume different clinical and contractual responsibilities.

While scope-of-practice laws define the services a provider may perform in a state, health plans also rely on objective factors such as service capabilities, quality measures, facility resources, reporting requirements, referral arrangements, and network responsibilities when establishing participation standards. Because the phrase “*same terms and conditions*” is broad, it could limit insurance plans’ ability to maintain standards tailored to the services provided and responsibilities assumed on behalf of their covered beneficiaries.

Rather than requiring identical participation standards, NCOIL should prohibit discrimination based solely on professional licensure while preserving reasonable, objective, transparent, and consistently applied network and credentialing criteria.

To that end, we propose striking the existing language of this subsection and amending it so that it reads as follows:

- *An insurer or vision benefit manager shall not deny participation to, or impose less favorable participation terms on, a provider solely on the basis of the provider's professional license. Nothing in this subsection shall prohibit reasonable and objectively applied standards based on the services the provider seeks to furnish, qualifications relevant to those services, quality measures, service capabilities, site of service, contractual responsibilities, or other legitimate, nondiscriminatory factors.*

Equal access should mean equitable treatment of providers furnishing comparable services and assuming comparable responsibilities, while allowing plans to apply reasonable standards that reflect meaningful differences in the services furnished and responsibilities assumed.

- **Section 6(A)(1) and (2): Network Capacity and Access.** These sections prohibit plans from limiting provider participation based on existing network size or measures such as time, distance, and appointment availability. The Academy supports strong network-adequacy standards and timely access to eye care. However, these provisions appear to prevent plans from considering whether a network already provides adequate access when determining whether additional providers are needed. The same factors barred from consideration here are commonly used to assess network adequacy, creating a potential inconsistency.

While the language does not guarantee participation for every applicant, it could effectively create an open-panel or "any willing-provider" requirement even after access standards have been met. This may expand network size without improving patient access to appropriate care. This concern is particularly significant for medical, surgical, referral, and subspecialty eye-care networks, which should be structured around clinical capacity, continuity of care, timely referrals, and access to appropriate levels of treatment.

The Academy recommends preserving robust network-adequacy requirements while allowing plans to close panels when they can demonstrate to regulators and the public sufficient geographic access, appointment availability, clinical capacity, and access to all necessary levels of eye care. Therefore, we propose striking the existing language and replacing it with the following:

- *PROHIBITED BASES FOR DENIAL OF PARTICIPATION. An insurer or vision benefit manager shall not deny an optometrist or physician participation in a network of a health benefit plan, vision benefit plan, or vision benefit discount plan solely because of:*
 - *the professional designation, except as permitted under subsection (c);*
 - *the optometrist or physician's independent practice affiliation; or*
 - *the optometrist or physician's participation status in another health benefit plan, vision benefit plan, or vision benefit discount plan.*
- *LIMITATION ON PARTICIPATION.*
 - *Nothing in this section shall be construed to require an insurer or vision benefit manager to accept every applicant as a participating optometrist or physician.*
 - *An insurer or vision benefit manager may decline or limit additional optometrist or physician participation based on the size, geographic distribution, accessibility, or capacity of an existing network, tier, service-specific panel, specialty panel, or provider category when the insurer or vision benefit manager can demonstrate, based on objective and verifiable information consistent with applicable network-adequacy requirements, that covered persons have timely and reasonable access to the services for which the network, tier, panel, or provider category is established, taking into account:*

- the number and geographic distribution of participating optometrists or physicians;
 - applicable time and distance standards;
 - appointment availability;
 - the clinical capacity of participating optometrists or physicians to furnish covered services; and
 - access to the appropriate levels of eye care required by covered persons.
- The basis for a determination under paragraph (2) shall be documented and made available to the applicable state regulatory authority and, upon request, to an optometrist or physician denied participation on that basis.
- **Section 6(A)(3): Clinically Defined Networks and Panels.** This may be intended only to prohibit arbitrary exclusion based on professional designation. The Academy supports that objective. The model bill's provision, however, is susceptible to a broader interpretation because it prohibits excluding a provider not only from applying, but also from "becoming" a participating provider because of professional designation. It could therefore be read to call into question ophthalmologist-specific medical-eye-care networks, surgical panels, referral panels, specialty tiers, or ophthalmic subspecialty networks.

Professional designation is not an arbitrary label. In some circumstances, it is directly related to the type and range of services a network or panel is intended to provide. Patients, referring providers, and purchasers rely on network categories to identify whether participating providers furnish routine vision care, medical eye care, surgery, or subspecialty services. Preventing the maintenance of clinically meaningful provider categories could make directories less useful, complicate referral pathways, and delay patients' access to the appropriate level of care.

We recommend **revising the provision to prohibit exclusion solely because of professional designation** while expressly preserving clinically defined networks, tiers, referral panels, and provider categories based on the services, qualifications, and capabilities required for participation. We propose striking the current language and amending this subsection so that it reads:

- **CLINICALLY DEFINED NETWORKS AND PANELS.**
 - Nothing in this section shall be construed to prohibit an insurer or vision benefit manager from establishing or maintaining distinct networks, tiers, service-specific panels, specialty panels, or provider categories for routine vision care, medical eye care, surgical care, emergency eye care, ophthalmology, or ophthalmic subspecialty services, as applicable to the benefits or services covered or administered under the plan.
 - Participation criteria for a network, tier, service-specific panel, specialty panel, or provider category described in paragraph (1) shall be:
 - Reasonably related to the services furnished through the network, tier, panel, or provider category;
 - Based on relevant professional designation, qualifications, and clinical capabilities;
 - Consistently applied to optometrists or physicians furnishing comparable services and assuming comparable responsibilities; and
 - Disclosed to optometrists or physicians seeking participation, participating optometrists or physicians, and the applicable state regulatory authority in a manner sufficient to understand the basis for the criteria and how the criteria are applied.
- An insurer or vision benefit manager shall make available to covered persons and prospective enrollees information sufficient to identify the types and levels of eye care available through each network, tier, service-specific panel, specialty panel, or provider category.

In conclusion, the Academy's concerns with model provisions outlined above reflect a common principle: policies governing eye care should promote patient access while recognizing the distinct education, training, and clinical responsibilities of different provider types. Preserving those distinctions helps ensure that patients receive the appropriate level of care while maintaining flexibility for states to develop sound regulatory frameworks.

Ophthalmologists and optometrists both make important contributions to patient care, and they frequently work together to help patients obtain appropriate services for the best possible outcome. That collaborative relationship is strengthened, not weakened, when statutes accurately reflect their different training, qualifications, and professional responsibilities.

Thank you for considering the Academy's comments. We would welcome the opportunity to work with NCOIL on revisions that recognize the important role of optometrists while maintaining the necessary distinction between optometry and the medical and surgical practice of ophthalmology.

Sincerely,



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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 ~~June 30~~ ~~March 18~~, 2026. To be ~~introduced and~~ discussed during the Health Insurance & Long Term Issues Committee on July 17 ~~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.~~ "Materials" does not include a prosthetic intraocular lens, other surgically or otherwise implanted devices or tissue, or a product or supply furnished as an integral part of a medical or surgical procedure. Nothing in this Act shall be construed to expand, restrict, or otherwise alter the scope of practice of any healthcare professional licensed under state law.
- C. "Covered services" means the professional work performed by an optometrist or physician ~~eye care provider~~ for which reimbursement from an insurer, vision benefit manager, or subcontractor is provided to an optometrist or physician ~~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 optometrist or physician ~~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"~~ Optometrist 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. Physician" means a licensed medical or osteopathic doctor practicing under the authority of [statutory reference].
- G. "Participating ~~eye care provider~~ optometrist or physician" means an optometrist or physician ~~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.
- H. "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.

- I. “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.
- J. “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.
- K. “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.
- L. “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 visionrelated 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.
- M. “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.
- N. “Subcontractor” means an individual, company, organization, group or other entity including but not limited to agents, servants, brokers, wholesalers, distributors, indirectlyowned, 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, optometrist or physician 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.

- O. “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.
- P. “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.
- Q. “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 optometrists or physicians ~~eye care providers~~ are reimbursed by the insurer or vision benefit manager and how much patients are charged by the insurer, vision benefit manager, optometrist, or physician. ~~or eye care provider.~~
- R. “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 optometrist or physician ~~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.
- S. “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~~ optometrists or physicians, potential participating optometrists or physicians ~~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~~ optometrists, or physicians.
- 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 ~~optometrist or physician 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 ~~optometrist or physician 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 ~~optometrist or physician 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 agreement or non-agreement by the participating optometrist or physician. ~~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~~ optometrists or physicians at all times during standard business hours;
2. the ability for an optometrist or physician ~~eye-care provider~~ to leave voice messages at all times; and
3. the ability for an optometrist or physician ~~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~~ optometrists or physicians 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~~ optometrists or physicians 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~~ optometrist or physician 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-optometrist or physician~~ may seek to or require that an ~~eye-care provider-optometrist or physician~~ 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-optometrist or physician~~ and all reimbursements paid by an Insurer or Vision Benefit Manager to an ~~eye-care provider-optometrist or physician~~ 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-optometrist or physician~~ or a group of ~~eye-care providers optometrists or physicians~~ 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 ~~optometrists or physicians providers~~ or groups.

C. A contract between an Insurer or Vision Benefit Manager and an eye care ~~provider~~ optometrist or physician 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, optometrist or physician~~, and any form of a cost-sharing amount paid by the enrollee to the ~~eye-care provider optometrist or physician~~.

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~~ optometrist or physician 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-optometrist or physician~~ as full or partial reimbursement for the service or material.

E. A service or material provided by a participating ~~eye-care provider-optometrist or physician~~ 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~~ optometrist or physician is only comprised of an enrollee's payment to the participating ~~eye care provider, optometrist or physician~~.

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 optometrist or~~ -based physician based on the ~~eye-care provider's optometrist or physician'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~~ optometrist or physician 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~~ optometrist or physician'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~~ optometrist or physician shall not contain a provision, fee schedule, or reimbursement amount in which the ~~eye care provider~~ optometrist or physician, 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~~ optometrist or physician 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~~ optometrist or physician 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~~ optometrists or physicians are allowed, but not required, to offer an enrollee the opportunity to pay the participating ~~eye care provider~~ optometrist or physician 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~~ optometrist or physician for a covered service or covered material, alter, delete, substitute, or otherwise change any code or modifier submitted by the ~~eye care provider, optometrist or physician,~~ -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, optometrist or physician;~~ and “bundling” means to combine, substitute, or treat two or more distinct services, supplied, or materials reported on the same claim or date of 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~~ optometrist or physician 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~~ optometrist or physician 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~~ optometrist or physician shall require that an ~~eye care provider~~ optometrist or physician 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~~ optometrist or physician shall require that an ~~eye care provider~~ optometrist or physician 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. An insurer or vision benefit manager shall not establish reimbursement for a covered service or covered material based solely on whether the participating provider is licensed as an optometrist or licensed as a physician to practice medicine or osteopathy. Nothing in this subsection shall prohibit reimbursement differences based on reasonable and objectively applied factors, including contractual responsibilities, quality measures, service capabilities, site of service, geographic conditions, value-based payment arrangements, or individually negotiated terms.~~

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.~~

An insurer or vision benefit manager shall not deny participation to, or impose less favorable participation terms on, an optometrist or physician solely on the basis of the provider's professional license. Nothing in this subsection shall prohibit reasonable and objectively applied standards based on the services the provider seeks to furnish, qualifications relevant to those services, quality measures, service capabilities, site of service, contractual responsibilities, or other legitimate, nondiscriminatory factors.

E. An Insurer or Vision Benefit Manager shall not require an ~~eye care provider~~ optometrist or physician 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~~ optometrist or physician 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. Provider Participation 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.~~

A. PROHIBITED BASES FOR DENIAL OF PARTICIPATION. An insurer or vision benefit manager shall not deny an optometrist or physician participation in a network of a health benefit plan, vision benefit plan, or vision benefit discount plan solely because of:

1. the professional designation, except as permitted under subsection (c);

2. the optometrist or physician's independent practice affiliation; or

3. the optometrist or physician's participation status in another health benefit plan, vision benefit plan, or vision benefit discount plan.

B. LIMITATION ON PARTICIPATION.

1. Nothing in this section shall be construed to require an insurer or vision benefit manager to accept every applicant as a participating optometrist or physician.

2. An insurer or vision benefit manager may decline or limit additional optometrist or physician participation based on the size, geographic distribution, accessibility, or capacity of an existing network, tier, service-specific panel, specialty panel, or provider category when the insurer or vision benefit manager can demonstrate, based on objective and verifiable information and consistent with applicable network-adequacy requirements, that covered persons have timely and reasonable access to the services for which the network, tier, panel, or provider category is established, taking into account:

i. the number and geographic distribution of participating optometrists or physicians;

ii. applicable time and distance standards;

iii. appointment availability;

iv. the clinical capacity of participating optometrists or physicians to furnish covered services; and

v. access to the appropriate levels of eye care required by covered persons.

3. The basis for a determination under paragraph (2) shall be documented and made available to the applicable state regulatory authority and, upon request, to an optometrist or physician denied participation on that basis.

C. CLINICALLY DEFINED NETWORKS AND PANELS.

1. Nothing in this section shall be construed to prohibit an insurer or vision benefit manager from establishing or maintaining distinct networks, tiers, service-specific panels, specialty panels, or provider categories for routine vision care, medical eye care, surgical care, emergency eye care, ophthalmology, or ophthalmic subspecialty services, as applicable to the benefits or services covered or administered under the plan.
2. Participation criteria for a network, tier, service-specific panel, specialty panel, or provider category described in paragraph (1) shall be:
 - i. Reasonably related to the services furnished through the network, tier, panel, or provider category;
 - ii. Based on relevant professional designation, qualifications, and clinical capabilities;
 - iii. Consistently applied to similarly situated optometrists or physicians; and
 - iv. Disclosed to optometrists or physicians seeking participation, participating optometrists or physicians, and the applicable state regulatory authority in a manner sufficient to understand the basis for the criteria and how the criteria are applied.
3. An insurer or vision benefit manager shall make available to covered persons and prospective enrollees information sufficient to identify the types and levels of eye care available through each network, tier, service-specific panel, specialty panel, or provider category.

Section 7. Permitting ~~Eye-Care Providers~~Optometrists or Physicians to Use any Lab or Supplier

A. No agreement between an Insurer or Vision Benefit Manager and an ~~eye-care provider~~optometrist or physician shall restrict or limit, either directly or indirectly, the ~~eye-care provider~~optometrist or physician'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~~optometrist or physician 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~~optometrist or physician 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 89. 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~~ optometrists or physicians, 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 94. 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~~ optometrists or physicians 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 ~~1041~~: 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 ~~1142~~: 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 recontracting with a participating eye care ~~provider~~ optometrist or physician. A provider agreement must be a distinctly separate document from any credentialing materials and must be signed by the ~~eye care provider~~ optometrist or physician 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 optometrist or physician eye care provider or upon any amendment of an existing provider agreement with an optometrist or physician eye care provider; or
3. January 1, 202x.