Introduced by Senator Mullin

Referred to Committee on Finance

Date: January 5, 2016

Subject: Health; health insurance; vision plans; optometrists

Statement of purpose of bill as introduced: This bill proposes to regulate vision insurance plans as health insurance. It would impose several requirements on vision care plans in their contracts with plan enrollees and in their financial arrangements with optometrists and ophthalmologists. It would also create a private right of action for anyone adversely affected by a violation of the provisions of the bill.

An act relating to the regulation of vision insurance plans

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 8 V.S.A. § 3301(a) is amended to read:

(a) Subject to the additional or varied requirements stated in this subchapter, a corporation may be formed pursuant to the general corporation law to do any and all insurance and reinsurance comprised in any one of the following numbered subdivisions:

Sec. 1.
(2) “Health insurance” which is insurance of human beings against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto. Health insurance does not include workers’ compensation coverages but does include vision care plans.

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Sec. 2. 8 V.S.A. § 4088j is amended to read:

§ 4088j. CHOICE OF PROVIDERS FOR VISION CARE AND MEDICAL EYE CARE SERVICES

(a) To the extent a health insurance plan provides coverage for vision care or medical eye care services, it shall cover those services whether provided by a licensed optometrist or by a licensed ophthalmologist, provided the health care professional is acting within his or her authorized scope of practice and participates in the plan’s network.

(b) A health insurance plan shall impose no greater co-payment, coinsurance, or other cost-sharing amount for services when provided by an optometrist than for the same service when provided by an ophthalmologist.

(c) A health insurance plan shall provide to a licensed health care professional acting within his or her scope of practice the same level of reimbursement or other compensation for providing vision care and medical eye care services that are within the lawful scope of practice of the professions
of medicine, optometry, and osteopathy, regardless of whether the health care professional is an optometrist or an ophthalmologist.

(d)(1) A health insurer shall permit a licensed optometrist to participate in plans or contracts providing for vision care or medical eye care to the same extent as it does an ophthalmologist.

(2) A health insurer shall not require a licensed optometrist or ophthalmologist to provide discounted materials benefits or to participate as a provider in another medical or vision care plan or contract as a condition or requirement for the optometrist’s or ophthalmologist’s participation as a provider in any medical or vision care plan or contract.

(e)(1) An agreement between a health insurer or an entity that writes vision insurance and an optometrist or ophthalmologist for the provision of vision services to plan members or subscribers in connection with coverage under a stand-alone vision plan or other health insurance plan shall not require that an optometrist or ophthalmologist provide services or materials at a fee limited or set by the plan or insurer unless the services or materials are reimbursed as covered services under the contract.

(2) An optometrist or ophthalmologist shall not charge more for services and materials that are noncovered services under a vision care plan than his or her usual and customary rate for those services and materials.
(2) Reimbursement paid by a vision plan for covered services and materials shall be reasonable and shall not provide nominal reimbursement in order to claim that services and materials are covered services.

(f) In addition to the enforcement authority available to the Commissioner of Financial Regulation under this title, any person adversely affected by a violation of this section may bring an action in Vermont Superior Court against the health insurer or vision care plan for injunctive relief and damages of up to $1,000.00 per day in violation, as well as reasonable costs and attorney’s fees.

(g) As used in this section:

(1) “Covered services” means services and materials for which reimbursement from a vision care plan or other health insurance plan is provided by a member’s or subscriber’s plan contract, or for which a reimbursement would be available but for application of the deductible, co-payment, or coinsurance requirements under the member’s or subscriber’s health insurance plan.

(2) “Health insurance plan” means any health insurance policy or health benefit plan offered by a health insurer or a subcontractor of a health insurer, as well as Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State. The term includes vision care plans but does not include policies or plans that provide benefits only under a contract between a vision_plan and a vision care plan.
plans providing coverage for a specified disease or other limited benefit
coverage.

(3) “Health insurer” shall have the same meaning as in 18 V.S.A. § 9402.

(4) “Materials” includes lenses, devices containing lenses, prisms, lens
treatments and coatings, contact lenses, and prosthetic devices to correct,
relieve, or treat defects or abnormal conditions of the human eye or its adnexa.

(5) “Ophthalmologist” means a physician licensed pursuant to 26 V.S.A.
chapter 23 or an osteopathic physician licensed pursuant to 26 V.S.A.
chapter 33 who has had special training in the field of ophthalmology.

(6) “Optometrist” means a person licensed pursuant to 26 V.S.A.
chapter 30.

(7) “Vision care plan” means an integrated or stand-alone plan, policy,
or contract providing vision benefits to enrollees with respect to covered
services or covered materials, or both.

Sec. 3. 8 V.S.A. § 4088k is added to read:

§ 4088k. VISION CARE PLANS

(a) Definitions. As used in this section:

(1) “Covered services” means services and materials for which
reimbursement from a vision care plan or other health insurance plan is
provided by a member’s or subscriber’s plan contract, or for which a
reimbursement would be available but for application of the deductible, co-payment, or coinsurance requirements under the member’s or subscriber’s health insurance plan.

(2) “Enrollee” means a person covered by a vision care plan or health insurance plan.

(3) “Health insurance plan” means any health insurance policy or health benefit plan offered by a health insurer or a subcontractor of a health insurer, as well as Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State. The term includes vision care plans but does not include policies or plans providing coverage for a specified disease or other limited benefit coverage.

(4) “Health insurer” shall have the same meaning as in 18 V.S.A. § 9402.

(5) “Materials” includes lenses, devices containing lenses, prisms, lens treatments and coatings, contact lenses, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa.

(6) “Ophthalmologist” means a physician licensed pursuant to 26 V.S.A. chapter 23 or an osteopathic physician licensed pursuant to 26 V.S.A. chapter 33 who has had special training in the field of ophthalmology.
(7) “Optometrist” means a person licensed pursuant to 26 V.S.A. chapter 30.

(8) “Vision care plan” means an integrated or stand-alone plan, policy, or contract providing vision benefits to enrollees with respect to covered services or covered materials, or both.

(9) “Vision care provider” or “provider” means an ophthalmologist or optometrist.

(b) Vision care plan requirements with respect to providers. A health insurer or vision care plan shall:

(1) Reimburse covered services and materials at a reasonable amount and shall not provide nominal reimbursement in order to claim that services and materials are covered services.

(2) Provide a vision care provider with a new contract at least once in a 24-month period.

(3) Treat all providers equally in a print or online directory. Printed directories shall list all providers according to geographic location. Online directories shall allow enrollees to prioritize search results based on the enrollee’s input address. The directory shall provide an accurate listing of a provider’s services available at each location.
(c) Vision care plan prohibitions with respect to providers. A health

insurance or vision care plan shall not:

(1) Require a licensed optometrist or ophthalmologist to provide
discounted materials benefits or to participate as a provider in another medical
or vision care plan or contract as a condition or requirement for the
optometrist’s or ophthalmologist’s participation as a provider in any medical or
vision care plan or contract.

(2) Require that an optometrist or ophthalmologist provide services or
materials at a fee limited or set by the plan unless the services or materials are
reimbursed as covered services under the contract.

(3) Make any amendments, including changes to discounts, fee
schedules, or provider reimbursement rates, to the contract, provider manual,
or other document governing the relationship between a vision care plan and a
vision care provider without providing at least 90 days’ written notice to the
provider and obtaining a signed acknowledgment from the provider accepting
the changes.

(4)(A) Restrict, penalize, coerce, compel, threaten, undermine, or
otherwise limit, directly or indirectly, a vision care provider’s choice of and
relationship with sources and suppliers of services or materials or use of
optical laboratories. The plan shall not impose any penalty or fee on providers
for using a supplier, optical laboratory, product, service, or material of the
provider’s choice.

(B) Restrict, penalize, coerce, compel, threaten, undermine, or
otherwise limit, directly or indirectly, a contracted optical laboratory’s choice
of and relationship with providers and with sources and suppliers of services or
materials. The plan shall not require a contracted optical laboratory to
maintain a specific product or material in the laboratory’s inventory at all times
if the laboratory cannot, despite good faith efforts, obtain the product in time to
meet production schedule specified in the contract.

(5) Compel, discriminate, or threaten a provider to engage a vision care
benefit when engagement of a medical health insurance benefit is most
appropriate. The health insurance or vision care plan shall allow the vision
care provider to determine which benefit is appropriate and shall not represent
to enrollees prospectively which benefit will be engaged for a particular
service.

(6) Require a provider to accept multiple fee schedules, plans, or
sub-plans as a condition or requirement of the provider’s participation in any
health insurance or vision care plan or contract.

(7) Unless otherwise required by law, communicate with an enrollee in a
manner that interferes with or contravenes any State or federal requirement or
provider-patient relationship in existence at the time of the communication.
(8) Prohibit a provider from selling contact lenses, prescription lenses, eyewear, or other materials that the plan also sells, or contractually control or mandate a discount on a provider’s price for contact lenses, prescription lenses, eyewear, or other materials when the plan competes with the provider by also selling those products.

(d) Vision care plan requirements with respect to enrollees. A health insurer or vision care plan shall:

(1) On or before March 1 of each year, provide each enrollee with an annual summary of the premium amounts paid to the plan by the enrollee personally or on the enrollee’s behalf by his or her employer during the previous calendar year, as well as an annual summary of all payments made by the plan on the enrollee’s behalf for services and materials rendered to the enrollee during the previous calendar year. For employer-sponsored plans, the plan shall also provide each employer with an annual summary of all premium amounts paid to the plan by the employer and its employees, as well as the total amount of payments made by the plan on behalf of the employer’s employees for services and materials rendered to the employees during the previous calendar year.

(2) Participate in the coordination of benefits between a health insurer and a vision care plan when the services provided to an enrollee are both medical and vision-related in nature. Each health insurer or vision care plan...
shall pay the provider the contracted amount for its respective services, provided that the total amount paid by all plans for the specific patient encounter shall not exceed the provider’s usual and customary charges for all of the services provided.

(3) Provide enrollees with out-of-network benefits, which shall comprise at least 50 percent of the plan’s in-network benefit for the same services and materials. The plan shall provide full disclosure of its policies and procedures for out-of-network benefits to enrollees and providers.

(4) Provide a fixed material benefit for enrollees, which shall be described as a dollar amount and which the enrollee may use toward any materials covered by the plan.

(5) Allow material benefits to be independent, and not require enrollees to purchase certain materials in order to use their plan benefit toward other materials.

(e) Enforcement. In addition to the enforcement authority available to the Commissioner of Financial Regulation under this title, any person adversely affected by a violation of this section may bring an action in Vermont Superior Court against the health insurer or vision care plan for injunctive relief and damages of up to $1,000.00 per day in violation, as well as reasonable costs and attorney’s fees.
Sec. 4. EFFECTIVE DATE

This act shall take effect on July 1, 2016 and shall apply to all health insurance and vision care plans on such date as a health insurer or other insurance provider issues, offers, or renews the plan, but in no event later than July 1, 2017. The act shall apply to all new and renewal provider contracts entered into on or after July 1, 2016.

Sec. 1. 8 V.S.A. § 4088j is amended to read:

§ 4088j. CHOICE OF PROVIDERS FOR VISION CARE AND MEDICAL EYE CARE SERVICES

* * *

(e)(1) An agreement between a health insurer or an entity that writes vision insurance and an optometrist or ophthalmologist for the provision of vision services to plan members or subscribers in connection with coverage under a stand-alone vision care plan or other health insurance plan shall not require that an optometrist or ophthalmologist provide services or materials at a fee limited or set by the plan or insurer unless the services or materials are reimbursed as covered services under the contract.

(2) An optometrist or ophthalmologist shall not charge more for services and materials that are noncovered services under a vision care plan than his or her usual and customary rate for those services and materials.

(3) Reimbursement paid by a vision care plan for covered services and materials shall be reasonable and shall not provide nominal reimbursement in order to claim that services and materials are covered services.

(4) A vision care plan shall not limit an optometrist’s or ophthalmologist’s choice of or relationship with optical laboratories or sources and suppliers of services or materials if the source, supplier, or laboratory selected by the optometrist or ophthalmologist offers the services or materials at a lower cost to the consumer than the source, supplier, or laboratory selected by the vision care plan.

(f) The Department of Financial Regulation shall enforce the provisions of this section.

(a) As used in this section:
(1) “Covered services” means services and materials for which reimbursement from a vision care plan or other health insurance plan is provided by a member’s or subscriber’s plan contract, or for which a reimbursement would be available but for application of the deductible, co-payment, or coinsurance requirements under the member’s or subscriber’s health insurance plan.

(2) “Health insurance plan” means any health insurance policy or health benefit plan offered by a health insurer or a subcontractor of a health insurer, as well as Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State. The term includes vision care plans but does not include policies or plans providing coverage for a specified disease or other limited benefit coverage.

(7) “Vision care plan” means an integrated or stand-alone plan, policy, or contract providing vision benefits to enrollees with respect to covered services or covered materials, or both.

Sec. 2. EFFECTIVE DATE

This act shall take effect on July 1, 2016.

Sec. 1. 8 V.S.A. § 4088j is amended to read:

§ 4088j. CHOICE OF PROVIDERS FOR VISION CARE AND MEDICAL EYE CARE SERVICES

(e)(1) An agreement between a health insurer or an entity that writes vision insurance and an optometrist or ophthalmologist for the provision of vision services to plan members or subscribers in connection with coverage under a stand-alone vision care plan or other health insurance plan shall not require that an optometrist or ophthalmologist provide services or materials at a fee limited or set by the plan or insurer unless the services or materials are reimbursed as covered services under the contract.

(2) An optometrist or ophthalmologist shall not charge more for services and materials that are noncovered services under a vision care plan or other health insurance plan than his or her usual and customary rate for those services and materials.

(3) Reimbursement paid by a vision care plan or other health insurance plan for covered services and materials shall be reasonable and shall not provide nominal reimbursement in order to claim that services and materials are covered services.
(4)(A) A vision care plan or other health insurance plan shall not restrict or otherwise limit, directly or indirectly, an optometrist’s, ophthalmologist’s, or independent optician’s choice of or relationship with sources and suppliers of products, services, or materials or use of optical laboratories if the optometrist, ophthalmologist, or optician determines that the source, supplier, or laboratory he or she has selected offers the products, services, or materials in a manner that is more beneficial to the consumer, including with respect to cost, quality, timing, or selection, than the source, supplier, or laboratory selected by the vision care plan or other health insurance plan. The plan shall not impose any penalty or fee on an optometrist, ophthalmologist, or independent optician for using any supplier, optical laboratory, product, service, or material.

(B) The optometrist, ophthalmologist, or optician shall notify the consumer of any additional costs the consumer may incur as the result of procuring the products, services, or materials from the source, supplier, or laboratory selected by the optometrist, ophthalmologist, or optician instead of from the source, supplier, or laboratory selected by the vision care plan or other health insurance plan.

(C) Nothing in this subdivision (4) shall be construed to prevent a vision care plan or other health insurance plan from informing its policyholders of the benefits available under the plan or from conducting an audit of an optometrist’s, ophthalmologist’s, or optician’s use of alternative sources, suppliers, or laboratories.

(D) The provisions of this subdivision (4) shall not apply to Medicaid.

(f) The Department of Financial Regulation shall enforce the provisions of this section as they relate to health insurance plans and vision care plans other than Medicaid.

(g) As used in this section:

(1) “Covered services” means services and materials for which reimbursement from a vision care plan or other health insurance plan is provided by a member’s or subscriber’s plan contract, or for which a reimbursement would be available but for application of the deductible, co-payment, or coinsurance requirements under the member’s or subscriber’s health insurance plan.

(2) “Health insurance plan” means any health insurance policy or health benefit plan offered by a health insurer or a subcontractor of a health insurer, as well as Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or
instrumentality of the State. The term includes vision care plans but does not include policies or plans providing coverage for a specified disease or other limited benefit coverage.

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(7) “Optician” means a person licensed pursuant to 26 V.S.A. chapter 47.

(8) “Vision care plan” means an integrated or stand-alone plan, policy, or contract providing vision benefits to enrollees with respect to covered services or covered materials, or both.

Sec. 2. EFFECTIVE DATE

This act shall take effect on July 1, 2016.