House File 2249 - Introduced

HOUSE FILE 2249
BY BOSSMAN

A BILL FOR

An Act relating to vision benefit plans, vision benefit managers, vision care providers, and vision care provider contracts and including civil penalties and effective date and applicability provisions.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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Section 1. NEW SECTION. **514M.1 Definitions.**

As used in this chapter, unless the context otherwise requires:

1. *"Chargeback"* means a dollar amount, fee, surcharge, rebate, or item of value that reduces, modifies, or offsets all or part of the covered person's responsibility, provider reimbursement, allowed amount, or fee schedule for a covered service or covered material.

2. *"Cost sharing"* means any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirement.

3. *"Covered material"* means a material for which reimbursement from a vision benefit manager or subcontractor is provided to a vision care provider by a covered person's plan contract, or for which a reimbursement would be available but for the application of the covered person's cost sharing, regardless of how the materials are listed or described in a covered person's benefit plan's definition of benefits.

4. *"Covered person"* means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan, vision benefit plan, or vision benefit discount plan that provides for third-party payment or prepayment of covered services or covered materials.

5. *"Covered service"* means a service performed by a vision care provider for which reimbursement from a vision benefit manager or subcontractor is provided to a vision care provider by a covered person's plan contract, or for which a reimbursement would be available but for the application of the covered person's cost sharing, regardless of how the services are listed or described in a covered person's benefit plan's definition of benefits.

6. *"Health benefit plan"* means a policy, contract, certificate, or agreement offered or issued by a third-party administrator or a subcontractor to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care

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services.

7. *"Material"* 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 Iowa board of optometry.

8. *"Participating vision care provider"* means a vision care provider that has entered into a contractual agreement or other business relationship with a vision benefit manager or subcontractor to provide covered services or covered materials.

9. *"Subcontractor"* means a person, including but not limited to the person's agents, servants, brokers, wholesalers, distributors, partially 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, vision care provider, or covered person to execute or fulfill the health benefit plan, vision benefit plan, or vision benefit discount plan of a vision benefit manager.

10. *"Third-party administrator"* means a person that provides services including but not limited to administrative, operational, regulatory, human resource, compliance, and claim adjudication services for a vision benefit manager, individual, company, organization, group, or other entity under a contract or agreement.

11. *"Vision benefit discount plan"* means a policy, contract, or plan offered by a vision benefit manager to a covered person that exclusively provides for a discount for vision care services or materials.

12. *"Vision benefit manager"* means a person, including but not limited to a third-party administrator or a subcontractor, that creates, promotes, sells, provides, advertises, or administers an integrated or stand-alone vision benefit plan,

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vision benefit discount plan, or other insurance policy or contract which provides vision benefits or discounts pertaining to the provision of covered services or covered materials to a covered person.

13. *"Vision benefit plan"* means a policy, contract, or plan offered or issued by a vision benefit manager to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services and vision care materials and services.

14. *"Vision care provider"* means an optometrist licensed under chapter 154, or a person engaged in the practice of medicine and surgery or osteopathic medicine and surgery licensed under chapter 148.

Sec. 2. NEW SECTION. **514M.2 Standards of conduct —— vision benefit managers.**

1. A reimbursement paid by a vision benefit manager for a covered service or covered material must meet all of the following requirements:

a. Be clearly and individually listed on a reimbursement schedule made available to the vision care provider.

b. Use the Medicare health care procedure coding system and current procedural terminology codes.

c. Not be less than the calendar year Medicare physician fee schedule for a covered service or covered material in effect at the time of either of the following:

(1) On the date that a contract is offered to the vision care provider by a vision benefit manager.

(2) Within five business days from the date a participating vision care provider requests to execute a contract with the vision benefit manager.

2. Reimbursement rate fee schedules for vision care providers shall be increased annually to adjust for inflation and, to the extent data is available, the rate of inflation for office practice expenses for the relevant vision care provider category.

3. The period of time prescribed by a contract executed by a vision care provider and a vision benefit manager for the

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vision benefit manager to recover a reimbursement amount from the vision care provider shall be the same period of time allowed or required for a vision benefit manager to remit the applicable reimbursement following a vision care provider's submission of a clean claim for services rendered or materials furnished. This subsection shall not be construed to limit a vision benefit manager's ability to conduct an audit of claims, in accordance with the vision benefit plan manager's written policies and applicable law, if the vision benefit manager has a reasonable belief that the vision care provider has engaged in fraud, waste, or abuse.

4. The time frame for an audit of a claim or collection of a claim shall be equal for a vision benefit manager and a vision care provider. The time frame for audit of a claim shall be extended for the vision care provider if the submission and claim correspondence is ongoing.

5. A vision benefit manager shall reimburse a vision care provider the contracted amount for a covered service or covered material provided to a covered person if the covered person was verified to be eligible to receive the covered service or covered material on the date of service by the vision care provider through the customary verification methods of the vision benefit manager.

6. A vision benefit manager shall identify participating vision care providers in a neutral manner that does not distinguish between participating vision care providers based on any of the following characteristics:

a. A discount or incentive offered by the vision care provider on services and materials that are not covered by the vision benefit manager.

b. The dollar amount, volume amount, or percent usage amount of any material purchased by the vision care provider.

c. The brand, source, manufacturer, or supplier of a covered service or covered material utilized by the vision care provider.

7. *a.* A vision benefit manager shall be licensed to conduct

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the business of insurance in this state, and shall submit an application for licensure to the commissioner of insurance as prescribed by the commissioner by rule.

b. A vision benefit manager shall comply with all applicable current procedural terminology code requirements.

Sec. 3. NEW SECTION. **514M.3 Prohibited conduct —— vision benefit managers.**

1. *a.* A vision benefit manager that offers multiple vision benefit plans or vision benefit discount plans shall not require a vision care provider, as a condition of participation in a vision benefit plan or vision benefit discount plan, to participate in the vision benefit manager's other vision benefit plans or vision benefit discount plans.

b. In addition to any penalties provided under this chapter, a violation of this subsection shall constitute a prohibited practice or act under section 714H.3.

c. A contract in violation of this subsection shall be void as a matter of law.

2. A vision benefit manager shall not require a vision care provider to do any of the following:

a. Establish a security interest in all or part of the vision benefit manager's property or assets, including assets pertaining to the vision benefit manager's practice, in an amount equal to an amount owed to a vision benefit manager upon termination of a contract.

b. Disclose a covered person's confidential or protected health information unless the disclosure is expressly authorized by the covered person, or permitted without authorization under the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, including amendments thereto and regulations promulgated thereunder.

c. Disclose or report a medical history or diagnosis as a condition to file a claim, adjudicate a claim, or receive reimbursement for a covered service.

d. Disclose or report a covered person's glasses

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prescription, contact lens prescription, ophthalmic device measurements, facial photograph, or unique anatomical measurements as a condition to file a claim, adjudicate a claim, or receive reimbursement for a claim, unless the information is necessary for the vision benefit manager to manufacture, or cause to be manufactured, a covered material that is submitted on the applicable claim.

e. Disclose a covered person's information, other than information identified in the most recent version of the national uniform claim committee health insurance claim form, as a condition to file a claim, adjudicate a claim, or receive reimbursement for a claim unless the information is necessary for the vision benefit manager to manufacture, or cause to be manufactured, a covered material that is submitted on the applicable claim.

3. A vision benefit manager shall not, directly or indirectly, control or attempt to control the professional judgment, manner of practice, or practice of a vision care provider.

4. A vision benefit manager shall not, directly or indirectly, withhold or recoup payment to a vision care provider for a covered service or covered material provided for a covered person if the covered person was shown to be eligible on the date that the covered service or covered material was provided.

5. A vision benefit manager shall not reimburse a vision care provider a different amount for a covered service or covered material because of the vision care provider's choice of any of the following:

a. Optical laboratory.

b. Source or supplier of contact lenses, ophthalmic lenses, ophthalmic glasses frames or covered or noncovered services or materials.

c. Equipment used for patient care.

d. Retail optical affiliation.

e. Vision support organization.

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f. Group purchasing organization.

g. Doctor alliance.

h. Professional trade association membership.

i. Electronic health record software, electronic medical record software, or practice management software.

j. Third-party claim filing service, billing service, or electronic data interchange clearinghouse company.

6. A vision benefit manager shall not, directly or indirectly, restrict, limit, or influence any of the following:

a. A vision care provider's choice of electronic health record software, electronic medical record software, or practice management software.

b. A vision care provider's choice of third-party claim filing service, billing service, or electronic data interchange clearinghouse company.

c. A vision care provider's access to a covered person's complete plan coverage information, including in-network and out-of-network coverage details.

7. A vision benefit manager shall not apply a chargeback to a covered person or vision care provider if the chargeback is for a covered service or covered material for which the vision benefit manager does not incur the cost to produce, deliver, or provide the covered service or covered material to the covered person or vision care provider.

8. A vision benefit manager shall not require or request a vision care provider to opt in or opt out, or waive by contract, the requirements of this section and section 514M.4.

9. A vision benefit manager shall not do any of the following:

a. Mandate, or otherwise condition, a reimbursement or participation on a price term for a service or material that is not a covered service or covered material.

b. Direct or limit a covered person's choice of vision care provider for a service or material that is not a covered service or covered material.

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10. *a.* A vision benefit manager shall not engage in marketing or advertising activities that may be misleading or deceptive to the public. Upon request by an enforcement agency, a vision benefit manager shall submit all information regarding alleged savings and discounts offered by affiliates of the vision benefit manager.

b. A vision benefit manager shall not promote or use in any marketing or advertising that a covered service or covered material is "free", "no charge", or "complimentary", or any materially similar language, to a client, purchaser, company, covered person or prospective covered person.

11. A vision benefit manager shall not offer a covered person varying cost sharing, coverage amounts, rebates, gift cards, or other incentives to obtain covered or noncovered materials or services at any of the following:

a. A particular participating vision care provider.

b. A retail establishment owned by, partially owned by, contracted with, or otherwise affiliated with the vision benefit manager.

c. An internet or virtual vision care provider or retailer owned by, partially owned by, contracted with, or otherwise affiliated with the vision benefit manager.

12. A vision benefit manager shall not retroactively reverse reimbursement to a vision care provider who relied in good faith on a covered person's presented coverage credentials and the customary verification methods of the vision benefits manager if the vision benefit manager later determines that the covered person was ineligible to receive covered services or covered materials on the date of service.

Sec. 4. NEW SECTION. **514M.4 Prohibited conduct —— contracts.**

1. A contract between a vision benefit manager and a vision care provider shall not exceed a term of two years from the date that the contract is fully executed.

2. A vision benefit manager shall not construe

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re-credentialing as renewing a contract with a participating vision care provider. A vision care provider contract shall be a distinct and separate document from any credentialing materials, and shall be signed by the vision care provider and the vision benefit manager.

3. A vision benefit manager shall include a copy of a current plan provider manual referred to in a vision care provider contract at the time the contract is delivered to a vision care provider or prospective vision care provider.

4. A contract entered into by a vision benefit manager with a vision care provider shall not require a vision care provider to do any of the following:

a. Provide services or materials at a fee limited or set by the vision benefit manager, unless the service or material is reimbursed as a covered service or covered material under the contract.

b. Consider applicable discounts and chargebacks to provide a covered service or covered material to a covered person at a financial loss.

c. Accept a reimbursement payment in the form of a virtual credit card or any other payment method wherein a processing fee, administrative fee, percentage amount, or dollar amount is assessed for the vision care provider to receive the reimbursement payment.

d. Equally share the expenses of arbitration. Each party shall bear the party's own arbitration costs, contingent upon a fee-shifting provision that grants prevailing party status.

5. A contract entered into by a vision benefit manager with a vision care provider shall not restrict or limit, either directly or indirectly, the vision care provider's choice of, or use of, a source or supplier of covered or uncovered services or materials provided to a covered person, including the choice or use of an optical laboratory.

6. A vision benefit manager shall not change or alter a contract, including any terms, reimbursements, or fee schedules

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contained in the contract, entered into with a participating vision care provider unless the vision benefit manager, at least ninety calendar days prior to the effective date of the proposed change, does all of the following:

a. Delivers a certified letter, or an electronic communication requiring an electronic signature proving receipt, to the vision care provider detailing the proposed change.

b. Upon request by a vision care provider, the vision benefit manager meets face-to-face or virtually, to discuss the proposed change with the vision care provider.

c. Receives a written agreement from the vision care provider approving the proposed change. If the vision care provider does not agree in writing to the proposed change, the current contract shall continue and the vision benefit manager shall not remove the vision care provider from a network panel or plan as retaliation for not accepting the proposed change.

d. If a vision benefit manager seeks to make three or more material changes to an existing contract, the vision benefit manager shall enter into a new contract with the vision care provider.

e. A proposed amendment to an existing contract between a vision benefit manager and a vision care provider shall be delivered to the vision care provider for the provider's review. The proposed amendment shall be enumerated in a cover letter and clearly marked within the body of the applicable contract.

7. *a.* Except as provided in this subsection, a vision benefit manager shall not terminate a contract with a vision care provider prior to the expiration of the contract.

b. If a vision benefit manager believes that a vision care provider has breached a contract between the vision benefit manager and the vision care provider, the vision benefit manager shall provide written notice specifying the alleged breach to the vision care provider. If the vision care provider fails to remedy the breach to the satisfaction of the vision benefit manager within thirty calendar days of receipt of the written

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notice, the vision benefit manager may terminate the contract with the vision care provider.

Sec. 5. NEW SECTION. **514M.5 Coordination of benefits.**

1. A vision benefit manager shall comply with the national association of insurance commissioners coordination of benefits regulations.

2. Coordination of benefits shall allow for a covered person to apply all the covered person's benefits to the cost of a covered service and covered material.

Sec. 6. NEW SECTION. **514M.6 Vision benefit managers —— merger or acquisition.**

For an acquisition or merger of a vision benefit manager, all parties to the acquisition or merger shall provide for all of the following:

1. A reenrollment period for vision care providers. The reenrollment process and details must be well defined and provide for a minimum of six months notice to vision care providers prior to the activation of a new plan by the prevailing vision benefit manager after the merger or acquisition.

2. During the merger or acquisition, a vision care provider shall be entitled to opt out of reenrollment without penalty or obligation as provided in the vision care provider's current contract with a vision benefit manager.

3. The prevailing vision benefit manager to the merger or acquisition shall enter into updated contracts with all vision benefit providers who choose to reenroll.

Sec. 7. NEW SECTION. **514M.7 Penalties.**

1. A vision care provider adversely affected by a violation of this chapter by a vision benefit manager may bring an action in a court of competent jurisdiction for injunctive relief against the vision benefit manager.

2. The attorney general may bring an action on behalf of a vision care provider for injunctive relief against a vision benefit manager.

3. If a vision care provider prevails in an action under

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subsection 1, in addition to injunctive relief, the vision care provider shall be entitled to recover all of the following:

a. Monetary damages, including but not limited to direct, indirect, special, and punitive damages.

b. A penalty of no more than ten thousand dollars for each violation.

c. Attorney fees and costs.

Sec. 8. NEW SECTION. **514M.8 Applicability.**

1. This chapter shall apply to policies, contracts, and plans between a vision benefit manager and a vision care provider delivered, issued for delivery, continued, or renewed in this state on or after the effective date of this Act.

2. This chapter shall apply to an affiliate or subcontractor used by a vision benefit manager to supply covered services or covered materials to a vision care provider or a covered person.

Sec. 9. NEW SECTION. **514M.9 Rules.**

The commissioner of insurance may adopt rules pursuant to chapter 17A to administer this chapter.

Sec. 10. Section 714H.3, subsection 2, Code 2026, is amended by adding the following new paragraph:

NEW PARAGRAPH. *i.* Section 514M.3, subsection 1.

Sec. 11. EFFECTIVE DATE. This Act, being deemed of immediate importance, takes effect upon enactment.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill relates to vision benefit plans, vision benefit managers, vision care providers, and vision care provider contracts.

The bill details the standards of conduct for vision benefit managers (managers), including the requirements for a reimbursement paid by a manager to a vision care provider (provider), annual increases in reimbursement rate fee schedules, the period of time for a manager to recover a reimbursement amount from a provider, the auditing time frame for an audit

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of a claim or a collection of a claim, a reimbursement for a covered service or covered material provided to a covered person, the identification of participating providers, and the licensure requirements for managers. "Covered person", "vision benefit manager", and "vision care provider" are defined in the bill.

A manager shall not engage in any of the conduct prohibited by the bill. A contract between a manager and a provider shall not violate the provisions of the bill.

A manager shall comply with the national association of insurance commissioners coordination of benefits regulations, and the coordination of benefits shall allow for a covered person to apply all benefits to the cost of a covered service and covered material.

Under the bill, for the acquisition or merger of managers, the parties to the acquisition or merger shall provide for a reenrollment period for providers. The reenrollment process and details must be well defined and provide for a minimum of six months notice to providers prior to the activation of a new plan by the prevailing manager after the merger or acquisition. During the merger or acquisition, a provider shall be entitled to opt out of reenrollment without penalty or obligation to the previous contract. The prevailing manager to the merger or acquisition shall enter into updated contracts with all providers who choose to reenroll.

A provider adversely affected by a violation of the bill by a manager may bring an action in a court of competent jurisdiction for injunctive relief against the manager. If a provider prevails in such action, in addition to injunctive relief, the provider shall be entitled to recover monetary damages, penalties not to exceed $10,000 for each violation, and attorney fees and costs. The attorney general may bring an action on behalf of a provider for injunctive relief against a manager.

The bill applies to policies, contracts, and plans between a manager and a provider delivered, issued for delivery, continued, or renewed in this state on or after the effective date of the

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bill. The bill also applies to an affiliate or subcontractor used by a manager to supply covered services or covered materials to a provider or a covered person.

The commissioner of insurance may adopt rules to administer the bill.

The bill makes a conforming change to Code section 714H.3(2).

The bill takes effect upon enactment.

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