House File 656 - Introduced

HOUSE FILE 656
BY BOSSMAN

A BILL FOR

An Act relating to vision benefit plans, the regulation of insurers and vision benefit managers, vision care providers, and vision care provider contracts and including effective date and applicability provisions.

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

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 an insurer, 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 an insurer, 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 an insurer, a third-party administrator, or a subcontractor to provide, deliver, arrange for, pay for, or reimburse any of the costs of

health care services.

7. "*Insurer*" means an individual, company, organization, managed care organization, group, or other entity that operates a health benefit plan.

8. "*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.

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

10. "*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.

11. "*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 an insurer, vision benefit manager, individual, company, organization, group, or other entity under a contract or agreement.

12. "*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.

13. "*Vision benefit manager*" means a person, including

but not limited to an insurer, a third-party administrator, or a subcontractor, 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 pertaining to the provision of covered services or covered materials to a covered person.

14. *"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.

15. *"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 —— insurers and vision benefit managers.**

1. A reimbursement paid by an insurer or vision benefit manager for a covered service or covered material shall be clearly and individually listed on a reimbursement schedule made available to the vision care provider, and shall not discriminate in the amount of reimbursement between physicians, as that term is defined under section 135.1, as follows:

a. At the time a contract is offered to the vision care provider by an insurer or vision benefit manager.

b. Within five business days from the date a contract is requested of the insurer or vision benefit manager by the participating vision care provider.

2. An insurer and vision benefit manager shall calculate an annual adjustment using the increase, if any, in the consumer price index for all urban consumers for the most recent available five-year period published by the United States department of labor, bureau of labor statistics, and shall ensure that all contractually allowed amounts and reimbursement rates reflect such increase.

3. The period of time, prescribed by a contract between a vision care provider and either an insurer or vision benefit manager, for the insurer or vision benefit manager to recover a reimbursement amount from a vision care provider shall be the same period of time allowed or required for an insurer or 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 an insurer's or vision benefit manager's ability to conduct an audit of claims, in accordance with the insurer's or vision benefit plan manager's written policies and applicable law, if the insurer or 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 an insurer, 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. An insurer or 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 by the vision care provider through customary verification methods of the insurer or vision benefit manager to receive the covered service or covered material on the date of service.

6. An insurer or vision benefit manager shall identify participating vision care providers in a neutral manner, which 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 insurer or 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 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 —— insurers and vision benefit managers.**

1. *a.* An insurer or 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 insurer's or 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. An insurer or 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 insurer's or vision benefit manager's property or assets, including assets pertaining to the insurer's or vision benefit manager's practice, in an amount equal to an amount owed to an insurer or 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 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. An insurer or 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. An insurer or 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. An insurer or 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.

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. An insurer or 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. An insurer or 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 insurer or 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. An insurer or 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. An insurer or 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.

10. *a.* An insurer or 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, an insurer and vision benefit manager shall submit all information regarding alleged savings and discounts offered by affiliates of the insurer or vision benefit manager.

b. An insurer or 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. An insurer or 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. An insurer or 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 insurer or 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 an insurer or 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. An insurer or vision benefit manager shall not construe 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 insurer or vision benefit manager.

3. An insurer or 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 an insurer or 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 an insurer or 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. An insurer or vision benefit manager shall not change or alter a contract, including any terms, reimbursements, or fee schedules contained in the contract, entered into with a participating vision care provider unless the insurer or 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 insurer or 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 insurer or 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 an insurer or vision benefit manager seeks to make three or more material changes to an existing contract, the insurer or vision benefit manager shall enter into a new contract with the vision care provider.

e. A proposed amendment to an existing contract between an insurer or 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, an insurer or vision benefit manager shall not terminate a contract with a vision care provider prior to the expiration of the contract.

b. If an insurer or vision benefit manager believes that a

vision care provider has breached a contract between either the insurer or vision benefit manager and the vision care provider, the insurer or 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 insurer or vision benefit manager within thirty calendar days of receipt of the written notice, the insurer or vision benefit manager may terminate the contract with the vision care provider.

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

1. An insurer and 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 Insurers or vision benefit managers —— merger or acquisition.**

For an acquisition or merger of an insurer and 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 shall be well defined and shall provide for a minimum of six months notice to vision care providers prior to the activation of a new plan by the prevailing entity 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 either an insurer or a vision benefit manager.

3. The prevailing entity 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 an insurer or vision benefit manager may bring an action in a court of competent jurisdiction for injunctive relief against the insurer or vision benefit manager.

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

3. If a vision care provider prevails in an action under 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 an insurer or 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 an insurer or 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 2025, is amended by adding the following new paragraph:

NEW PARAGRAPH. *h.* 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, the regulation of

insurers and vision benefit managers, vision care providers, and vision care provider contracts.

The bill details the standards of conduct for insurers and vision benefit managers (managers), including the requirements for a reimbursement paid by an insurer or manager to a vision care provider (provider), the calculation of an annual adjustment, the period of time for an insurer or manager to recover a reimbursement amount from a provider, the auditing time frame for an audit 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", "insurer", "vision benefit manager", and "vision care provider" are defined in the bill.

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

An insurer and 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 insurers and managers, the parties to the acquisition or merger shall provide for a reenrollment period for providers. The reenrollment process and details shall be well defined and shall provide for a minimum of six months notice to providers prior to the activation of a new plan by the prevailing entity 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 entity 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 an insurer or manager may bring an action in a court of

competent jurisdiction for injunctive relief against the insurer or 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 an insurer or manager.

The bill applies to policies, contracts, and plans between an insurer or manager and a provider delivered, issued for delivery, continued, or renewed in this state on or after the effective date of the bill. The bill also applies to an affiliate or subcontractor used by an insurer or 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.