S.215 - proposed language from Reps. Poirier, Patt, and Gage

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

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

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(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 **restrict or otherwise** limit**, directly or indirectly,** an optometrist's or ophthalmologist's choice of or relationship with ~~**optical laboratories or**~~ sources and suppliers of services or materials **or use of optical laboratories** ~~**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~~. The plan shall not impose any penalty or fee on an optometrist or ophthalmologist for using any supplier, optical laboratory, product, service, or material.

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

(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) "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.