

## **BILL ANALYSIS**

Senate Research Center

H.B. 1696  
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Engrossed

### **AUTHOR'S / SPONSOR'S STATEMENT OF INTENT**

Certain managed care plan issuers, including vision care plan issuers, compete directly with their own in-network providers in a variety of ways. Specifically, vision plan companies own brick-and-mortar optometry practices, e-commerce retail internet sites, eyeglass production laboratories, glasses frame brands, electronic medical records companies, and claim filing service companies. These companies may differentiate between in-network providers by attempting to steer patients to doctors at locations where their owned-products are being sold, and financially control doctors by incentivizing or disincentivizing plan benefits and reimbursements to prefer the products and services they own.

In 2015, S.B. 684 addressed these marketplace concerns by broadly preventing managed care plans from directly or indirectly controlling or attempting to control the professional judgment, manner of practice, or practice of an optometrist. However, since the passage of that legislation, managed care plans have continued to use controlling tactics as business practices and as contractual term requirements.

H.B. 1696 seeks to add transparency for patients for in-network and out-of-network benefits and promote local competition and patient choice through fair business practices by establishing prohibitions against certain business practices and contractual terms to specify the ways in which managed care plans are not allowed to control optometrists and their practices.

H.B. 1696 amends current law relating to the relationship between managed care plans and optometrists and therapeutic optometrists.

### **RULEMAKING AUTHORITY**

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

### **SECTION BY SECTION ANALYSIS**

SECTION 1. Amends the heading to Subchapter D, Chapter 1451, Insurance Code, to read as follows:

#### **SUBCHAPTER D. ACCESS TO OPTOMETRISTS USED UNDER MANAGED CARE PLAN**

SECTION 2. Amends Section 1451.151, Insurance Code, as follows:

Sec. 1451.151. New heading: DEFINITION. Redefines "managed care plan." Deletes existing definition of "ophthalmologist."

SECTION 3. Amends Section 1451.153, Insurance Code, as follows:

Sec. 1451.153. New heading. USE OF OPTOMETRIST OR THERAPEUTIC OPTOMETRIST. (a) Prohibits a managed care plan from:

(1) discriminating against a health care practitioner because the practitioner is an optometrist or a therapeutic optometrist, rather than an optometrist, therapeutic optometrist, or ophthalmologist;

(2)-(3) makes conforming changes to these subdivisions;

(4) identifying a participating optometrist or therapeutic optometrist differently from another optometrist or therapeutic optometrist based on:

(A) a discount or incentive offered on a medical or vision care product or service, as defined by Section 1451.155 (Contracts With Optometrists or Therapeutic Optometrists), that is not a covered product or service, as defined by Section 1451.155, by the optometrist or therapeutic optometrist;

(B) the dollar amount, volume amount, or percent usage amount of any product or good purchased by the optometrist or therapeutic optometrist; or

(C) the brand, source, manufacturer, or supplier of a medical or vision care product or service, as defined by Section 1451.155, utilized by the optometrist or therapeutic optometrist to practice optometry;

(5) incentivizing, recommending, encouraging, persuading, or attempting to persuade an enrollee to obtain covered or uncovered products or services:

(A) at any particular participating optometrist or therapeutic optometrist instead of another participating optometrist or therapeutic optometrist;

(B) at a retail establishment owned by, partially owned by, contracted with, or otherwise affiliated with the managed care plan instead of a different participating optometrist or therapeutic optometrist; or

(C) at any Internet or virtual provider or retailer owned by, partially owned by, contracted with, or otherwise affiliated with the managed care plan instead of a different participating optometrist or therapeutic optometrist;

(6) makes conforming changes to this subdivision; or

(7) redesignates existing Subdivision (5) as Subdivision (7) and makes conforming changes.

(b) Requires that a managed care plan:

(1)-(2) makes conforming changes to these subdivisions;

(3) provide directly to an optometrist, therapeutic optometrist, or plan enrollee immediate access by electronic means to an enrollee's complete plan coverage information, including in-network and out-of-network coverage details;

(4) publish complete plan information, including in-network and out-of-network coverage details, with any marketing materials that describe the plan benefits, including any summary plan description;

(5) allow an optometrist or a therapeutic optometrist to utilize any third-party claim-filing service, billing service, or electronic data interchange clearinghouse company that uses the standardized claim submission protocol of the National Uniform Claim Committee and that allows the optometrist or therapeutic optometrist to submit details for both services and vision care products to facilitate the authorization, submission, and reimbursement of claims; and

(6) allow an optometrist or a therapeutic optometrist to receive reimbursement through an electronic funds transfer.

(c) Makes a conforming change to this subsection.

SECTION 4. Amends Section 1451.154(a)(2), Insurance Code, to redefine "vision panel."

SECTION 5. Amends Section 1451.154(c), Insurance Code, to delete existing text requiring a therapeutic optometrist who is included in a managed care plan's medical panels under Subsection (b) (relating to requiring that a managed care plan allow a therapeutic optometrist who is on one or more of the plan's vision panels to be a fully participating provider on the plan's medical panels to the full extent of the therapeutic optometrist's license to practice therapeutic optometry) to comply with the requirements of the Controlled Substances Registration Program operated by the Department of Public Safety of the State of Texas.

SECTION 6. Amends Section 1451.155, Insurance Code, as follows:

Sec. 1451.155. **CONTRACTS WITH OPTOMETRISTS OR THERAPEUTIC OPTOMETRISTS.** (a) Defines "chargeback" and "medical or vision care product or service" and redefines "covered product or service." Deletes existing definition of "vision care product or service."

(a-1) Provides that a product or service reimbursed to an optometrist or therapeutic optometrist at a nominal or de minimis rate, for the purposes of this section, is not a covered product or service.

(a-2) Provides that, for the purposes of this section, a product or service reimbursed to an optometrist or therapeutic optometrist solely by the enrollee is not a covered product or service.

(b) Prohibits a contract between a managed care plan, rather than an insurer, and an optometrist or therapeutic optometrist from limiting the fee the optometrist or therapeutic optometrist is authorized to charge for a product or service that is not a covered product or service.

(c) Makes a conforming change to this subsection.

(d) Prohibits a contract between a managed care plan and an optometrist or therapeutic optometrist from containing a provision authorizing a chargeback to the patient, optometrist, or therapeutic optometrist if the chargeback is for a covered product or service that the managed care plan does not incur the cost to produce, deliver, or provide to the patient, optometrist, or therapeutic optometrist.

(e) Prohibits a contract between a managed care plan and an optometrist or therapeutic optometrist from containing a provision authorizing a reimbursement fee schedule for a covered product or service that is different from the fee schedule applicable to another optometrist or therapeutic optometrist because of the optometrist's or therapeutic optometrist's choice of:

(1) optical laboratory;

(2) source or supplier of:

- (A) contact lenses;
  - (B) ophthalmic lenses;
  - (C) ophthalmic glasses frames; or
  - (D) covered or uncovered products or services;
- (3) equipment used for patient care;
  - (4) retail optical affiliation;
  - (5) vision support organization;
  - (6) group purchasing organization;
  - (7) doctor alliance;
  - (8) professional trade association membership;
  - (9) affiliation with an arrangement defined as a franchise by 16 C.F.R. Part 436;
  - (10) electronic health record software, electronic medical record software, or practice management software; or
  - (11) third-party claim-filing service, billing service, or electronic data interchange clearinghouse company.

(f) Prohibits a managed care plan from changing a contract between a managed care plan and an optometrist or therapeutic optometrist, including terms, reimbursements, or fee schedules, unless the managed care plan provides written notice of the change to the optometrist or therapeutic optometrist at least 90 days before the date the proposed change takes effect.

(g) Prohibits a contract between a managed care plan and an optometrist or therapeutic optometrist from containing a provision requiring the optometrist or therapeutic optometrist to provide a covered product at a loss.

(h) Prohibits a contract between a managed care plan and an optometrist or therapeutic optometrist from containing a provision requiring the optometrist or therapeutic optometrist to accept a reimbursement payment in the form of a virtual credit card or any other payment method where a processing fee, administrative fee, percentage amount, or dollar amount is assessed to receive the reimbursement payment, except in the case of a nominal fee assessed by the optometrist's or therapeutic optometrist's bank to receive an electronic funds transfer.

SECTION 7. Amends the heading to Section 1451.156, Insurance Code, to read as follows:

Sec. 1451.156. CERTAIN CONDUCT PROHIBITED.

SECTION 8. Amends Section 1451.156(a), Insurance Code, as follows:

(a) Prohibits a managed care plan, as described by Section 1451.152(a) (relating to a managed care plan that provides or arranges for benefits for vision or medical eye care services or procedures that are within the scope of an optometrist's or therapeutic optometrist's license), from directly or indirectly:

(1)-(3) makes no changes to these subdivisions;

(4) reimbursing an optometrist or therapeutic optometrist a different amount for a covered product or service as defined by Section 1451.155 because of the optometrist's or therapeutic optometrist's choice of:

(A) optical laboratory;

(B) source or supplier of:

(i) contact lenses;

(ii) ophthalmic lenses;

(iii) ophthalmic glasses frames; or

(iv) covered or uncovered products or services;

(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) affiliation with an arrangement defined as a franchise by 16 C.F.R. Part 436;

(J) electronic health record software, electronic medical record software, or practice management software; or

(K) third-party claim-filing service, billing service, or electronic data interchange clearinghouse company;

(5) restricting, limiting, or influencing an optometrist's or therapeutic optometrist's choice of sources or suppliers of services or materials, including optical laboratories used by the optometrist or therapeutic optometrist to provide services or materials to a patient;

(6) restricting, limiting, or influencing an optometrist's or therapeutic optometrist's choice of electronic health record software, electronic medical record software, or practice management software;

(7) restricting, limiting, or influencing an optometrist's or therapeutic optometrist's choice of third-party claim-filing service, billing service, or electronic data interchange clearinghouse company;

(8) restricting or limiting an optometrist's or therapeutic optometrist's access to a patient's complete plan coverage information, including in-network and out-of-network coverage details;

(9) applying a chargeback, as defined by Section 1451.155, to a patient, optometrist, or therapeutic optometrist if the chargeback is for a covered product or service that the managed care plan does not incur the cost to produce, deliver, or provide to the patient, optometrist, or therapeutic optometrist;

(10) requiring an optometrist or therapeutic optometrist to provide a covered product at a loss;

(11) redesignates existing Subdivision (5) as Subdivision (11);

(12) requiring an optometrist or therapeutic optometrist to disclose or report a medical history or diagnosis as a condition to file a claim, adjudicate a claim, or receive reimbursement for a routine or wellness vision eye exam;

(13) requiring an optometrist or therapeutic optometrist to disclose or report a patient'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 needed for the managed care plan to manufacture or cause to be manufactured a covered product that is submitted on the claim;

(14) requiring an optometrist or therapeutic optometrist to disclose any patient information, other than information identified on the version of the Health Insurance Claim Form approved by the National Uniform Claim Committee as of March 1, 2023, as a condition to file a claim, adjudicate a claim, or receive reimbursement for a claim unless the information is needed for the managed care plan to manufacture or cause to be manufactured a covered product that is submitted on the claim; or

(15) requiring an optometrist or therapeutic optometrist to accept a reimbursement payment in the form of a virtual credit card or any other payment method where a processing fee, administrative fee, percentage amount, or dollar amount is assessed to receive the reimbursement payment, except in the case of a nominal fee assessed by the optometrist's or therapeutic optometrist's bank to receive an electronic funds transfer.

SECTION 9. Amends Subchapter D, Chapter 1451, Insurance Code, by adding Sections 1451.157 and 1451.158, as follows:

Sec. 1451.157. EXTRAPOLATION PROHIBITED. (a) Defines "extrapolation" and "vision care plan."

(b) Prohibits a vision care plan from using extrapolation to complete an audit of a participating optometrist or therapeutic optometrist. Requires that any additional payment due to a participating optometrist or therapeutic optometrist or any refund due to the vision care plan be based on the actual overpayment or underpayment and is prohibited from being based on an extrapolation.

Sec. 1451.158. ENFORCEMENT OF SUBCHAPTER. (a) Provides that a violation of this subchapter by a managed care plan is subject to an administrative penalty under Chapter 84 (Administrative Penalties).

(b) Requires the commissioner of insurance to take all reasonable actions to ensure compliance with this subchapter, including issuing orders to enforce this subchapter.

SECTION 10. Repealers: Sections 1451.154(d) (relating to authorizing a managed care plan to charge a participating therapeutic optometrist certain fees) and 1451.156(d) (relating to a restriction or limit a managed care plan's determination of specific amounts of coverage or reimbursement for the use of network or out-of-network suppliers or laboratories), Insurance Code.

SECTION 11. Makes application of this Act prospective to January 1, 2024.

SECTION 12. Effective date: September 1, 2023.