BILL ANALYSIS

C.S.H.B. 1696
By: Buckley
Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

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 judgement, 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. C.S.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.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 1696 amends the Insurance Code to revise provisions regarding access to optometrists and therapeutic optometrists used under a managed care plan. The bill expands the definition of "managed care plan" for purposes of those provisions to include a plan under which a vision benefit plan issuer, vision benefit plan administrator, or other organization provides or arranges for vision benefits to plan participants and requires or encourages plan participants to use health care practitioners the plan designates.

C.S.H.B. 1696 revises provisions establishing certain prohibitions and requirements for a managed care plan with respect to the use of optometrists, therapeutic optometrists, or ophthalmologists under the plan by removing ophthalmologists from the applicability of those prohibitions and requirements. The bill expands the list of prohibitions to additionally prohibit a managed care plan from doing the following:

- creating, offering, or using a contractual fee schedule that reimburses an optometrist or therapeutic optometrist differently from another optometrist or therapeutic optometrist;

- identifying a participating optometrist or therapeutic optometrist differently from another optometrist or therapeutic optometrist based on the following:
    - a discount or incentive offered on a medical or vision care product or service that is not a covered product or service by the optometrist or therapeutic optometrist;
    - the dollar amount, volume amount, or percent usage amount of any product or good purchased by the optometrist or therapeutic optometrist; or
    - the brand, source, manufacturer, or supplier of a medical or vision care product or service utilized by the optometrist or therapeutic optometrist to practice optometry; and
- incentivizing, recommending, encouraging, persuading, or attempting to persuade an enrollee to obtain covered or uncovered products or services in the following manner:
    - at any particular participating optometrist or therapeutic optometrist instead of another participating optometrist or therapeutic optometrist; or
    - at a retail establishment, or an Internet or virtual provider or retailer, that is owned by, partially owned by, contracted with, or otherwise affiliated with the plan instead of a different participating optometrist or therapeutic optometrist.

C.S.H.B. 1696 establishes additional requirements regarding the use of optometrists and therapeutic optometrists under a managed care plan. A managed care plan must do the following:

- 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;
- 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;
- allow an optometrist or 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
- allow an optometrist or therapeutic optometrist to receive reimbursement through an electronic funds transfer.

The bill removes the requirement for a therapeutic optometrist who is included in a managed care plan's medical panels to comply with the requirements of the controlled substances registration program operated by the Department of Public Safety.

C.S.H.B. 1696 includes a medical care product or service among the products or services for which reimbursement is available, as a product or service provided within the scope of practice of optometry or therapeutic optometry, under an enrollee's managed care plan contract or subject to a contractual limitation specified by statute. The bill establishes, for the purposes of state law governing contracts between a managed care plan and an optometrist or therapeutic optometrist, that a product or service reimbursed to an optometrist or therapeutic optometrist at a nominal or de minimis rate or solely by an enrollee is not a covered product or service. The bill prohibits a contract between a managed care plan and an optometrist or therapeutic optometrist from containing the following:

- a provision authorizing a chargeback to the patient, optometrist, or therapeutic optometrist if the chargeback is for a covered product or service that the plan does not incur the cost to produce, deliver, or provide to the patient, optometrist, or therapeutic optometrist;
- 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 services, products, or affiliations as specified in the bill;
- a provision requiring the optometrist or therapeutic optometrist to provide a covered product at a loss; or

- 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 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.

The bill prohibits a managed care plan from changing a contract between the plan and an optometrist or therapeutic optometrist, including terms, reimbursements, or fee schedules, unless the 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. The bill defines "chargeback" as a dollar amount, fee, surcharge, or item of value that reduces, modifies, or offsets all or part of the patient responsibility, provider reimbursement, or fee schedule for a covered product or service.

C.S.H.B. 1696 prohibits a managed care plan from directly or indirectly doing the following:

- reimbursing an optometrist or therapeutic optometrist a different amount for a covered product or service because of the optometrist's or therapeutic optometrist's choice of services, products, or affiliations as specified in the bill;
- influencing an optometrist's or therapeutic optometrist's choice of sources or suppliers of services or materials;
- restricting, limiting, or influencing an optometrist's or therapeutic optometrist's choice of electronic health record software, electronic medical record software, practice management software, third-party claim-filing service, billing service, or electronic data interchange clearinghouse company;
- restricting or limiting an optometrist's or therapeutic optometrist's access to a patient's complete plan coverage information, including in-patient and out-of-network details;
- applying a chargeback 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;
- requiring an optometrist or therapeutic optometrist to provide a covered product at a loss;
- 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;
- 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;
- 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; or
- 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.

C.S.H.B. 1696 prohibits a vision care plan from using extrapolation to complete an audit of a participating optometrist or therapeutic optometrist. Any additional payment due to a participating optometrist or therapeutic optometrist or any refund due to the vision care plan must be based on the actual overpayment or underpayment and may not be based on an extrapolation. The bill defines "extrapolation" as a mathematical process or technique used by a vision care plan in the audit of an optometrist or therapeutic optometrist to estimate audit results or findings for a larger batch or group of claims not reviewed by the plan and defines "vision care plan" for purposes of these provisions as a limited-scope policy, agreement,

contract, or evidence of coverage that provides coverage for eye care expenses but does not provide comprehensive medical coverage.

C.S.H.B. 1696 establishes that a violation by a vision care plan of provisions regarding access to optometrists and therapeutic optometrists used under a managed care plan is subject to an administrative penalty. The bill requires the commissioner of insurance to take all reasonable actions to ensure compliance with such provisions, including issuing orders to enforce the provisions.

C.S.H.B. 1696 repeals the following provisions of the Insurance Code:

- Section 1451.154(d), which authorizes a managed care plan to charge a participating therapeutic optometrist any reasonable credentialing costs associated with inclusion of the therapeutic optometrist in the plan's medical panel and a one-time administrative fee not to exceed $200 for expenses incurred in adding the therapeutic optometrist to the panel; and
- Section 1451.156(d), which establishes that the prohibition against a managed care plan directly or indirectly restricting or limiting 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, does not restrict or limit the plan's determination of specific amounts of coverage or reimbursement for the use of network or out-of-network suppliers or laboratories.

C.S.H.B. 1696 applies only to a contract between a managed care plan and an optometrist or therapeutic optometrist entered into or renewed, or a managed care plan delivered, issued for delivery, or renewed, on or after January 1, 2024.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 1696 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute revises provisions that establish prohibitions and requirements for managed care plans with respect to the use of optometrists, therapeutic optometrists, and ophthalmologists under the plan by removing ophthalmologists from the applicability of those prohibitions and requirements, whereas the introduced did not do so. Accordingly, the substitute does not include ophthalmologists in the scope of the new prohibitions and requirements established by the bill relating to such use, unlike the introduced which did include them.

The substitute does not include the following provisions present in the introduced:

- a prohibition against a managed care plan denying participation of an optometrist, therapeutic optometrist, or ophthalmologist as a participating practitioner in the plan if the optometrist, therapeutic optometrist, or ophthalmologist meets the plan's credentialing requirements and agrees to the plan's contractual terms;
- a provision that conditioned the authority of a managed care plan to change a contract between the plan and an optometrist or therapeutic optometrist on the optometrist or therapeutic optometrist affirmatively agreeing in writing to the change;
- prohibitions against a managed care plan or an applicable contract provision requiring a patient, optometrist, or therapeutic optometrist to obtain precertification or prior authorization for a covered service provided by the optometrist or therapeutic optometrist; and

- prohibitions against a managed care plan or an applicable contract provision requiring an optometrist or therapeutic optometrist to provide a covered service at a loss.

Both versions include a prohibition against a managed care plan creating, offering, or using a contractual fee schedule that reimburses an optometrist or therapeutic optometrist differently from another optometrist or therapeutic optometrist, but the introduced prohibited schedules that provide different reimbursement based on professional degree held, whereas the substitute prohibits any schedule that provides for different reimbursement.

Whereas the introduced prohibited a managed care plan from identifying a participating optometrist or therapeutic optometrist differently from other participating health care practitioners based on any characteristic other than professional degree held, the substitute prohibits a managed care plan from identifying a participating optometrist or therapeutic optometrist differently from another optometrist or therapeutic optometrist based on the following specific characteristics:

- a discount or incentive offered on a medical or vision care product or service that is not a covered product or service;
- the dollar amount, volume amount, or percent usage amount of any product or good purchased; or
- the brand, source, manufacturer, or supplier of a medical or vision care product or service utilized.

The introduced required a managed care plan to allow an optometrist or therapeutic optometrist to utilize a 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 to facilitate the authorization, submission, and reimbursement of claims. The substitute requires the plan to allow utilization of such a service or company that uses the standard claim submission protocol 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.

The introduced prohibited a managed care plan from applying a chargeback to a patient, optometrist, or therapeutic optometrist if the chargeback is for a covered product or service that the plan does not produce, deliver, or provide and prohibited contract provisions authorizing such a chargeback. The substitute revises those prohibitions instead to prohibit chargebacks for a covered service or product that the plan does not incur the cost to produce, deliver, or provide to the patient, optometrist, or therapeutic optometrist.

Whereas the introduced prohibited a managed care plan from using extrapolation to complete an audit of a participating optometrist or therapeutic optometrist, the substitute prohibits a vision care plan from doing so. Accordingly, the substitute includes a definition of "vision care plan" for purposes of the extrapolation prohibition, which did not appear in the introduced.

Both versions provide for the enforcement of provisions regarding access to optometrists and therapeutic optometrists used under a managed care plan, but their provisions differ as follows:

- the substitute establishes that a violation of those provisions by a vision care provider is subject to an administrative penalty, whereas the introduced established that a violation of those provisions by a managed care plan is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance and is subject to enforcement as such; and
- the substitute includes a requirement absent from the introduced for the commissioner of insurance to take all reasonable actions to ensure compliance with those provisions, including issuing enforcement orders.