

1-1 By: Buckley, et al. (Senate Sponsor - Hughes) H.B. No. 1696
 1-2 (In the Senate - Received from the House May 9, 2023;
 1-3 May 11, 2023, read first time and referred to Committee on State
 1-4 Affairs; May 21, 2023, reported favorably by the following vote:
 1-5 Yeas 10, Nays 0; May 21, 2023, sent to printer.)

1-6 COMMITTEE VOTE

	Yea	Nay	Absent	PNV
1-7				
1-8	X			
1-9	X			
1-10	X			
1-11	X			
1-12	X			
1-13	X			
1-14	X			
1-15	X			
1-16	X			
1-17	X			
1-18			X	

1-19 A BILL TO BE ENTITLED
 1-20 AN ACT

1-21 relating to the relationship between managed care plans and
 1-22 optometrists and therapeutic optometrists.

1-23 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

1-24 SECTION 1. The heading to Subchapter D, Chapter 1451,
 1-25 Insurance Code, is amended to read as follows:

1-26 SUBCHAPTER D. ACCESS TO OPTOMETRISTS [~~AND OPHTHALMOLOGISTS~~] USED
 1-27 UNDER MANAGED CARE PLAN

1-28 SECTION 2. Section 1451.151, Insurance Code, is amended to
 1-29 read as follows:

1-30 Sec. 1451.151. DEFINITION [~~DEFINITIONS~~]. In this
 1-31 subchapter, ~~[+]~~

1-32 [~~(1)~~] "managed [~~Managed~~] care plan" means a plan under
 1-33 which a health maintenance organization, preferred provider
 1-34 benefit plan issuer, vision benefit plan issuer, vision benefit
 1-35 plan administrator, or other organization provides or arranges for
 1-36 health care benefits or vision benefits to plan participants and
 1-37 requires or encourages plan participants to use health care
 1-38 practitioners the plan designates.

1-39 [~~(2)~~] "~~Ophthalmologist~~" ~~means a physician who~~
 1-40 ~~specializes in ophthalmology.~~

1-41 SECTION 3. Section 1451.153, Insurance Code, is amended to
 1-42 read as follows:

1-43 Sec. 1451.153. USE OF OPTOMETRIST OR[~~OR~~] THERAPEUTIC
 1-44 OPTOMETRIST[~~, OR OPHTHALMOLOGIST~~]. (a) A managed care plan may
 1-45 not:

1-46 (1) discriminate against a health care practitioner
 1-47 because the practitioner is an optometrist or a[~~or~~] therapeutic
 1-48 optometrist[~~, or ophthalmologist~~];

1-49 (2) restrict or discourage a plan participant from
 1-50 obtaining covered vision or medical eye care services or procedures
 1-51 from a participating optometrist or[~~or~~] therapeutic optometrist[~~or~~
 1-52 ~~or ophthalmologist~~] solely because the practitioner is an
 1-53 optometrist or[~~or~~] therapeutic optometrist[~~, or ophthalmologist~~];

1-54 (3) exclude an optometrist or a[~~or~~] therapeutic
 1-55 optometrist[~~, or ophthalmologist~~] as a participating practitioner
 1-56 in the plan because the optometrist or[~~or~~] therapeutic optometrist[~~or~~
 1-57 ~~or ophthalmologist~~] does not have medical staff privileges at a
 1-58 hospital or at a particular hospital;

1-59 (4) identify a participating optometrist or
 1-60 therapeutic optometrist differently from another optometrist or
 1-61 therapeutic optometrist based on:

2-1 (A) a discount or incentive offered on a medical
2-2 or vision care product or service, as defined by Section 1451.155,
2-3 that is not a covered product or service, as defined by Section
2-4 1451.155, by the optometrist or therapeutic optometrist;

2-5 (B) the dollar amount, volume amount, or percent
2-6 usage amount of any product or good purchased by the optometrist or
2-7 therapeutic optometrist; or

2-8 (C) the brand, source, manufacturer, or supplier
2-9 of a medical or vision care product or service, as defined by
2-10 Section 1451.155, utilized by the optometrist or therapeutic
2-11 optometrist to practice optometry;

2-12 (5) incentivize, recommend, encourage, persuade, or
2-13 attempt to persuade an enrollee to obtain covered or uncovered
2-14 products or services:

2-15 (A) at any particular participating optometrist
2-16 or therapeutic optometrist instead of another participating
2-17 optometrist or therapeutic optometrist;

2-18 (B) at a retail establishment owned by, partially
2-19 owned by, contracted with, or otherwise affiliated with the managed
2-20 care plan instead of a different participating optometrist or
2-21 therapeutic optometrist; or

2-22 (C) at any Internet or virtual provider or
2-23 retailer owned by, partially owned by, contracted with, or
2-24 otherwise affiliated with the managed care plan instead of a
2-25 different participating optometrist or therapeutic optometrist;

2-26 (6) exclude an optometrist or a ~~[]~~ therapeutic
2-27 optometrist ~~[, or ophthalmologist]~~ as a participating practitioner
2-28 in the plan because the services or procedures provided by the
2-29 optometrist or ~~[]~~ therapeutic optometrist ~~[, or ophthalmologist]~~
2-30 may be provided by another type of health care practitioner; or

2-31 (7) ~~[(5)]~~ as a condition for a therapeutic optometrist
2-32 ~~[or ophthalmologist]~~ to be included in one or more of the plan's
2-33 medical panels, require the therapeutic optometrist ~~[or~~
2-34 ~~ophthalmologist]~~ to be included in, or to accept the terms of
2-35 payment under or for, a particular vision panel in which the
2-36 therapeutic optometrist ~~[or ophthalmologist]~~ does not otherwise
2-37 wish to be included.

2-38 (b) A managed care plan shall:

2-39 (1) include optometrists and ~~[]~~ therapeutic
2-40 optometrists ~~[, and ophthalmologists]~~ as participating health care
2-41 practitioners in the plan; ~~[and]~~

2-42 (2) include the name of a participating optometrist
2-43 or ~~[]~~ therapeutic optometrist ~~[, or ophthalmologist]~~ in any list of
2-44 participating health care practitioners and give equal prominence
2-45 to each name;

2-46 (3) provide directly to an optometrist, therapeutic
2-47 optometrist, or plan enrollee immediate access by electronic means
2-48 to an enrollee's complete plan coverage information, including
2-49 in-network and out-of-network coverage details;

2-50 (4) publish complete plan information, including
2-51 in-network and out-of-network coverage details, with any marketing
2-52 materials that describe the plan benefits, including any summary
2-53 plan description;

2-54 (5) allow an optometrist or a therapeutic optometrist
2-55 to utilize any third-party claim-filing service, billing service,
2-56 or electronic data interchange clearinghouse company that uses the
2-57 standardized claim submission protocol of the National Uniform
2-58 Claim Committee and that allows the optometrist or therapeutic
2-59 optometrist to submit details for both services and vision care
2-60 products to facilitate the authorization, submission, and
2-61 reimbursement of claims; and

2-62 (6) allow an optometrist or a therapeutic optometrist
2-63 to receive reimbursement through an electronic funds transfer.

2-64 (c) For the purposes of Subsection (a)(7) ~~[(a)(5)]~~,
2-65 "medical panel" and "vision panel" have the meanings assigned by
2-66 Section 1451.154(a).

2-67 SECTION 4. Section 1451.154(a)(2), Insurance Code, is
2-68 amended to read as follows:

2-69 (2) "Vision panel" means the optometrists and ~~[]~~

3-1 therapeutic optometrists [~~and ophthalmologists~~] who are listed as
3-2 participating providers for routine eye examinations under a
3-3 managed care plan or who a patient seeking a routine eye examination
3-4 is encouraged or required to use under a managed care plan.

3-5 SECTION 5. Section 1451.154(c), Insurance Code, is amended
3-6 to read as follows:

3-7 (c) A therapeutic optometrist who is included in a managed
3-8 care plan's medical panels under Subsection (b) must:

3-9 (1) abide by the terms and conditions of the managed
3-10 care plan;

3-11 (2) satisfy the managed care plan's credentialing
3-12 standards for therapeutic optometrists; and

3-13 (3) provide proof that the Texas Optometry Board
3-14 considers the therapeutic optometrist's license to practice
3-15 therapeutic optometry to be in good standing [~~and~~

3-16 [~~(4) comply with the requirements of the Controlled
3-17 Substances Registration Program operated by the Department of
3-18 Public Safety~~].

3-19 SECTION 6. Section 1451.155, Insurance Code, is amended to
3-20 read as follows:

3-21 Sec. 1451.155. CONTRACTS WITH OPTOMETRISTS OR THERAPEUTIC
3-22 OPTOMETRISTS. (a) In this section:

3-23 (1) "Chargeback" means a dollar amount, fee,
3-24 surcharge, or item of value that reduces, modifies, or offsets all
3-25 or part of the patient responsibility, provider reimbursement, or
3-26 fee schedule for a covered product or service.

3-27 (2) "Covered product or service" means a medical or
3-28 vision care product or service for which reimbursement is available
3-29 under an enrollee's managed care plan contract or for which
3-30 reimbursement is available subject to a contractual limitation,
3-31 including:

- 3-32 (A) a deductible;
- 3-33 (B) a copayment;
- 3-34 (C) coinsurance;
- 3-35 (D) a waiting period;
- 3-36 (E) an annual or lifetime maximum limit;
- 3-37 (F) a frequency limitation; or
- 3-38 (G) an alternative benefit payment.

3-39 (3) [~~(2)~~] "Medical or vision [~~Vision~~] care product or
3-40 service" means a product or service provided within the scope of the
3-41 practice of optometry or therapeutic optometry under Chapter 351,
3-42 Occupations Code.

3-43 (a-1) For the purposes of this section, a product or service
3-44 reimbursed to an optometrist or therapeutic optometrist at a
3-45 nominal or de minimis rate is not a covered product or service.

3-46 (a-2) For the purposes of this section, a product or service
3-47 reimbursed to an optometrist or therapeutic optometrist solely by
3-48 the enrollee is not a covered product or service.

3-49 (b) A contract between a managed care plan [~~an insurer~~] and
3-50 an optometrist or therapeutic optometrist may not limit the fee the
3-51 optometrist or therapeutic optometrist may charge for a product or
3-52 service that is not a covered product or service.

3-53 (c) A contract between a managed care plan [~~an insurer~~] and
3-54 an optometrist or therapeutic optometrist may not require a
3-55 discount on a product or service that is not a covered product or
3-56 service.

3-57 (d) A contract between a managed care plan and an
3-58 optometrist or therapeutic optometrist may not contain a provision
3-59 authorizing a chargeback to the patient, optometrist, or
3-60 therapeutic optometrist if the chargeback is for a covered product
3-61 or service that the managed care plan does not incur the cost to
3-62 produce, deliver, or provide to the patient, optometrist, or
3-63 therapeutic optometrist.

3-64 (e) A contract between a managed care plan and an
3-65 optometrist or therapeutic optometrist may not contain a provision
3-66 authorizing a reimbursement fee schedule for a covered product or
3-67 service that is different from the fee schedule applicable to
3-68 another optometrist or therapeutic optometrist because of the
3-69 optometrist's or therapeutic optometrist's choice of:

- 4-1 (1) optical laboratory;
 4-2 (2) source or supplier of:
 4-3 (A) contact lenses;
 4-4 (B) ophthalmic lenses;
 4-5 (C) ophthalmic glasses frames; or
 4-6 (D) covered or uncovered products or services;
 4-7 (3) equipment used for patient care;
 4-8 (4) retail optical affiliation;
 4-9 (5) vision support organization;
 4-10 (6) group purchasing organization;
 4-11 (7) doctor alliance;
 4-12 (8) professional trade association membership;
 4-13 (9) affiliation with an arrangement defined as a
 4-14 franchise by 16 C.F.R. Part 436;
 4-15 (10) electronic health record software, electronic
 4-16 medical record software, or practice management software; or
 4-17 (11) third-party claim-filing service, billing
 4-18 service, or electronic data interchange clearinghouse company.
 4-19 (f) A managed care plan may not change a contract between a
 4-20 managed care plan and an optometrist or therapeutic optometrist,
 4-21 including terms, reimbursements, or fee schedules, unless the
 4-22 managed care plan provides written notice of the change to the
 4-23 optometrist or therapeutic optometrist at least 90 days before the
 4-24 date the proposed change takes effect.
 4-25 (g) A contract between a managed care plan and an
 4-26 optometrist or therapeutic optometrist may not contain a provision
 4-27 requiring the optometrist or therapeutic optometrist to provide a
 4-28 covered product at a loss.
 4-29 (h) A contract between a managed care plan and an
 4-30 optometrist or therapeutic optometrist may not contain a provision
 4-31 requiring the optometrist or therapeutic optometrist to accept a
 4-32 reimbursement payment in the form of a virtual credit card or any
 4-33 other payment method where a processing fee, administrative fee,
 4-34 percentage amount, or dollar amount is assessed to receive the
 4-35 reimbursement payment, except in the case of a nominal fee assessed
 4-36 by the optometrist's or therapeutic optometrist's bank to receive
 4-37 an electronic funds transfer.
 4-38 SECTION 7. The heading to Section 1451.156, Insurance Code,
 4-39 is amended to read as follows:
 4-40 Sec. 1451.156. CERTAIN CONDUCT PROHIBITED [~~CONDUCT~~].
 4-41 SECTION 8. Section 1451.156(a), Insurance Code, is amended
 4-42 to read as follows:
 4-43 (a) A managed care plan, as described by Section
 4-44 1451.152(a), may not directly or indirectly:
 4-45 (1) control or attempt to control the professional
 4-46 judgment, manner of practice, or practice of an optometrist or
 4-47 therapeutic optometrist;
 4-48 (2) employ an optometrist or therapeutic optometrist
 4-49 to provide a vision care product or service as defined by Section
 4-50 1451.155;
 4-51 (3) pay an optometrist or therapeutic optometrist for
 4-52 a service not provided;
 4-53 (4) reimburse an optometrist or therapeutic
 4-54 optometrist a different amount for a covered product or service as
 4-55 defined by Section 1451.155 because of the optometrist's or
 4-56 therapeutic optometrist's choice of:
 4-57 (A) optical laboratory;
 4-58 (B) source or supplier of:
 4-59 (i) contact lenses;
 4-60 (ii) ophthalmic lenses;
 4-61 (iii) ophthalmic glasses frames; or
 4-62 (iv) covered or uncovered products or
 4-63 services;
 4-64 (C) equipment used for patient care;
 4-65 (D) retail optical affiliation;
 4-66 (E) vision support organization;
 4-67 (F) group purchasing organization;
 4-68 (G) doctor alliance;
 4-69 (H) professional trade association membership;

5-1 (I) affiliation with an arrangement defined as a
 5-2 franchise by 16 C.F.R. Part 436;
 5-3 (J) electronic health record software,
 5-4 electronic medical record software, or practice management
 5-5 software; or
 5-6 (K) third-party claim-filing service, billing
 5-7 service, or electronic data interchange clearinghouse company;
 5-8 (5) restrict, ~~or~~ limit, or influence an
 5-9 optometrist's or therapeutic optometrist's choice of sources or
 5-10 suppliers of services or materials, including optical laboratories
 5-11 used by the optometrist or therapeutic optometrist to provide
 5-12 services or materials to a patient;
 5-13 (6) restrict, limit, or influence an optometrist's or
 5-14 therapeutic optometrist's choice of electronic health record
 5-15 software, electronic medical record software, or practice
 5-16 management software;
 5-17 (7) restrict, limit, or influence an optometrist's or
 5-18 therapeutic optometrist's choice of third-party claim-filing
 5-19 service, billing service, or electronic data interchange
 5-20 clearinghouse company;
 5-21 (8) restrict or limit an optometrist's or therapeutic
 5-22 optometrist's access to a patient's complete plan coverage
 5-23 information, including in-network and out-of-network coverage
 5-24 details;
 5-25 (9) apply a chargeback, as defined by Section
 5-26 1451.155, to a patient, optometrist, or therapeutic optometrist if
 5-27 the chargeback is for a covered product or service that the managed
 5-28 care plan does not incur the cost to produce, deliver, or provide to
 5-29 the patient, optometrist, or therapeutic optometrist;
 5-30 (10) require an optometrist or therapeutic
 5-31 optometrist to provide a covered product at a loss; ~~or~~
 5-32 (11) ~~(45)~~ require an optometrist or therapeutic
 5-33 optometrist to disclose a patient's confidential or protected
 5-34 health information unless the disclosure is authorized by the
 5-35 patient or permitted without authorization under the Health
 5-36 Insurance Portability and Accountability Act of 1996 (42 U.S.C.
 5-37 Section 1320d et seq.) or under Section 602.053;
 5-38 (12) require an optometrist or therapeutic
 5-39 optometrist to disclose or report a medical history or diagnosis as
 5-40 a condition to file a claim, adjudicate a claim, or receive
 5-41 reimbursement for a routine or wellness vision eye exam;
 5-42 (13) require an optometrist or therapeutic
 5-43 optometrist to disclose or report a patient's glasses prescription,
 5-44 contact lens prescription, ophthalmic device measurements, facial
 5-45 photograph, or unique anatomical measurements as a condition to
 5-46 file a claim, adjudicate a claim, or receive reimbursement for a
 5-47 claim unless the information is needed for the managed care plan to
 5-48 manufacture or cause to be manufactured a covered product that is
 5-49 submitted on the claim;
 5-50 (14) require an optometrist or therapeutic
 5-51 optometrist to disclose any patient information, other than
 5-52 information identified on the version of the Health Insurance Claim
 5-53 Form approved by the National Uniform Claim Committee as of March 1,
 5-54 2023, as a condition to file a claim, adjudicate a claim, or receive
 5-55 reimbursement for a claim unless the information is needed for the
 5-56 managed care plan to manufacture or cause to be manufactured a
 5-57 covered product that is submitted on the claim; or
 5-58 (15) require an optometrist or therapeutic
 5-59 optometrist to accept a reimbursement payment in the form of a
 5-60 virtual credit card or any other payment method where a processing
 5-61 fee, administrative fee, percentage amount, or dollar amount is
 5-62 assessed to receive the reimbursement payment, except in the case
 5-63 of a nominal fee assessed by the optometrist's or therapeutic
 5-64 optometrist's bank to receive an electronic funds transfer.
 5-65 SECTION 9. Subchapter D, Chapter 1451, Insurance Code, is
 5-66 amended by adding Sections 1451.157 and 1451.158 to read as
 5-67 follows:
 5-68 Sec. 1451.157. EXTRAPOLATION PROHIBITED. (a) In this
 5-69 section:

6-1 (1) "Extrapolation" means a mathematical process or
6-2 technique used by a vision care plan in the audit of an optometrist
6-3 or therapeutic optometrist to estimate audit results or findings
6-4 for a larger batch or group of claims not reviewed by the plan.

6-5 (2) "Vision care plan" means a limited-scope policy,
6-6 agreement, contract, or evidence of coverage that provides coverage
6-7 for eye care expenses but does not provide comprehensive medical
6-8 coverage.

6-9 (b) A vision care plan may not use extrapolation to complete
6-10 an audit of a participating optometrist or therapeutic optometrist.
6-11 Any additional payment due to a participating optometrist or
6-12 therapeutic optometrist or any refund due to the vision care plan
6-13 must be based on the actual overpayment or underpayment and may not
6-14 be based on an extrapolation.

6-15 Sec. 1451.158. ENFORCEMENT OF SUBCHAPTER. (a) A violation
6-16 of this subchapter by a managed care plan is subject to an
6-17 administrative penalty under Chapter 84.

6-18 (b) The commissioner shall take all reasonable actions to
6-19 ensure compliance with this subchapter, including issuing orders to
6-20 enforce this subchapter.

6-21 SECTION 10. Sections 1451.154(d) and 1451.156(d),
6-22 Insurance Code, are repealed.

6-23 SECTION 11. The changes in law made by this Act apply only
6-24 to a contract between a managed care plan or vision care plan and an
6-25 optometrist or a therapeutic optometrist entered into or renewed,
6-26 or a managed care plan or vision care plan delivered, issued for
6-27 delivery, or renewed, on or after January 1, 2024. A contract
6-28 entered into or renewed, or a managed care plan or vision care plan
6-29 delivered, issued for delivery, or renewed, before January 1, 2024,
6-30 is governed by the law as it existed immediately before the
6-31 effective date of this Act, and that law is continued in effect for
6-32 that purpose.

6-33 SECTION 12. This Act takes effect September 1, 2023.

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