OHIO LEGISLATIVE SERVICE COMMISSION

Bill Analysis Nick Thomas

Sub. H.B. 156*

132nd General Assembly
(As Reported by S. Insurance and Financial Institutions)

Reps. Schuring, Retherford, Anielski, Boyd, Dever, Henne, Holmes, Landis, Lanese, Lepore-Hagan, Manning, Miller. Patton, Pelanda, Reineke, Rogers, Ryan, Schaffer, Scherer, Slaby, K. Smith, West

BILL SUMMARY

- Prohibits specified terms from being included in health care contracts between a vision care provider and a contracting entity (any person that has the primary business purpose of contracting with participating providers for the delivery of health care services).
- Prohibits a contracting entity from requiring that a vision care provider accept a payment amount set by the contracting entity for vision care services or materials unless those services or materials are covered services.
- Imposes disclosure requirements on health insurers regarding vision care services and materials that are not covered services.
- Makes a violation of the above provisions an unfair and deceptive act in the business of insurance.
- Imposes disclosure requirements on vision care providers regarding vision care materials and services that not covered or are out-of-network.
- Subjects providers who violate the above disclosure requirements to professional discipline.

* This analysis was prepared before the report of the Senate Insurance and Financial Committee appeared in the Senate Journal. Note that the list of co-sponsors and the legislative history may be incomplete.

CONTENT AND OPERATION

Choice of vision care providers and suppliers of vision care materials

The bill regulates the coverage of vision care services and vision care materials in health care contracts and the provision of those services and materials in provider agreements between insurers and vision care providers (licensed optometrists and physicians). "**Vision care materials**" include lenses, devices containing lenses, prisms, lens treatments and coatings, contact lenses, orthopics, vision training, and any prosthetic device necessary to correct, relieve, or treat any defect or abnormal condition of the human eye or its adnexa (appendages or accessory organs). "**Covered vision services**" are vision care services and vision care materials for which reimbursement is generally available under the health care contract.[1]

The bill imposes disclosure requirements on any health care policy, contract, agreement, or plan of a (1) health insuring corporation, (2) sickness and accident insurer, (3) multiple employer welfare arrangement, or (4) public employee benefit plan (collectively, health insurer) regarding vision care services and vision care materials. A health insurer must provide all of the following information to an enrollee in a conspicuous, easily accessible form:

- The following statement:

  IMPORTANT: If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request.

- A disclosure of any business interests the insurer has in a source or supplier of vision care materials.

- An explanation that the enrollee may incur out-of-pocket expenses as a result of the purchase of vision care services or vision care materials that are not covered vision care services. The explanation must be communicated in a manner similar to how the health insurer provides an

[1] R.C. 3963.01(C), (T), and (U), with a conforming change in R.C. 3963.03; The Free Dictionary, *Adnexa*, http://medical-dictionary.thefreedictionary.com/adnexa (accessed April 17, 2018).

enrollee with information on coverage levels and out-of-pocket expenses that may be incurred by the enrollee when purchasing out-of-network vision care services or vision care materials.[2]

Unfair and deceptive act in the practice of insurance

Under the bill, a pattern of continuous or repeated violations of the above requirements is an unfair or deceptive practice in the business of insurance.[3] Under continuing law, a person who is found to have committed an unfair and deceptive practice in the business of insurance is subject to any or all of the following sanctions:

- Suspension or revocation of the person's license to engage in the business of insurance;
- Prohibition on an insurance company or insurance agency employing the person or permitting the person to serve the company or agency in any capacity for a period of time;
- Return of any payments received by the person as a result of the violation;
- Fees for attorneys and other costs of any investigation into the violations committed by the person.[4]

Health Contract Law prohibitions

Provider contract terms

The bill also prohibits specified terms from being included in health care contracts between a vision care provider and a contracting entity (any person that has the primary business purpose of contracting with participating providers for the delivery of health care services).

The bill prohibits a contract between a contracting entity and a vision care provider from doing any of the following:

- Requiring that a vision care provider accept as payment an amount set by the contracting entity for vision care services or vision care materials unless the services or materials in question are "**covered vision services**" (those services or materials for which reimbursement is available under a

[2] R.C. 1739.05, 1751.85(B), and 3923.86(B).

[3] R.C. 1751.85(C) and 3923.86(C).

[4] R.C. 3901.22, not in the bill.

health care contract or would be available but for the application of contractual limitations such as deductibles, copayments, waiting periods, annual or lifetime maximums, or any other limitation). In other words, the contracting entity cannot require the vision care provider to charge a certain rate for vision care services or materials that are not covered services.

- The bill does, however, allow an entity to communicate to its enrollees which providers choose to accept an amount set by the entity for noncovered services. Any communication to this effect must treat providers equally in directories, locators, and other marketing materials as participating, in-network providers, annotated only as to their decision to accept such an amount.

- Being contingent on whether the provider has agreed to accept an amount set by the entity for noncovered services;

- Requiring a provider contract with a plan offering supplemental or specialty health care services as a condition of contracting with a plan offering basic health care services.

- Directly limiting a vision care provider's choice of sources and suppliers of vision care materials;

- Prohibiting a vision care provider from describing out-of-network options to an enrollee.[5]

The bill specifies that these provisions relating to provider contract terms will be effective for contracts entered into, amended, or renewed on or after January 1, 2019.[6]

Out-of-network and noncovered services

The bill also imposes requirements on vision care providers regarding vision care materials and services that are out-of-network or are not covered services.

First, if a provider recommends an out-of-network source of vision care materials to an enrollee, the provider must:

- Notify the enrollee in writing that the source is out-of-network;

[5] R.C. 3963.02(E)(1) and 3963.01(C) and (D), with a conforming change in R.C. 1753.09.

[6] R.C. 3963.02(E)(1).

- Inform the enrollee of the cost of those materials; and

- Disclose in writing to the enrollee any business interest the provider has in the recommended out-of-network source.

Second, if a provider does not accept as payment for vision care services or vision care materials that are not covered services an amount set by a contracting entity, the provider must, upon the enrollee's request, supply to the enrollee pricing and reimbursement information, including all of the following:

- The estimated fee or discounted price suggested by the contracting entity for the noncovered service or material;

- The estimated fee charged by the vision care provider for the noncovered service or material;

- The amount the vision care provider expects to be reimbursed by the contracting entity for the noncovered service or material;

- The estimated pricing and reimbursement information for any covered services or materials that are also expected to be provided during the enrollee's visit.

In addition to providing the above information, the provider must also post in a conspicuous location the following notice:

> IMPORTANT: This vision care provider does not accept the fee schedule set by your insurer for vision care services and vision care materials that are not covered benefits under your plan and instead charges his or her normal fee for those services and materials. This vision care provider will provide you with an estimate cost for each noncovered service or material upon your request.[7]

Contracting entities

The bill specifies that the above provisions do not:

- Restrict a contracting entity's determination of specific coverage or reimbursement amounts for network or out-of-network suppliers of vision care materials as set forth in a health benefit plan;

[7] R.C. 3963.02(E)(2) and (3).

- Restrict a contracting entity's ability to enter into an agreement with another contracting entity or an affiliate of another contracting entity.

- Restrict a health care plan's ability to enter into an agreement with a vision care plan to deliver routine vision care services that are covered under an enrollee's plan;

- Restrict a vision care plan network from acting as a network for a health care plan;

- Prohibit a contracting entity from requiring participating vision care providers to offer network sources or suppliers of vision care materials to enrollees;

- Prohibit an enrollee from utilizing a network source or supplier of vision care materials as set forth in an enrollee's plan;

- Prohibit a participating vision care provider from accepting as payment an amount that is the same as the amount set by the contracting entity for vision care services or materials that are not covered services.[8]

Enforcement

Health Care Contract Law

The prohibitions described above under "**Health Care Contract Law prohibitions**" would become part of Ohio's Health Care Contract Law.[9] Continuing law authorizes the Superintendent of Insurance to conduct a market investigation of any person regulated by the Department of Insurance under Ohio's Insurance Law[10] or Ohio's Corporation and Partnership Law[11] to determine whether any violation of the Health Care Contract Law has occurred. When conducting such an examination, the Superintendent can assess the costs of the examination against the person examined.

The Superintendent may enter into a consent agreement to impose any administrative assessment or fine for conduct discovered that may be a violation of the Health Care Contract Law. In addition, a series of violations of the Health Care Contract Law by any person regulated by the Department of Insurance that, taken together,

[8] R.C. 3963.02(E)(4).

[9] R.C. Chapter 3963.

[10] R.C. Title 39.

[11] R.C. Title 17.

constitute a pattern or practice of violating that Law may constitute an unfair and deceptive insurance practice.[12]

The bill also specifies that a violation of these prohibitions is an unfair or deceptive practice in the business of insurance (see "**Unfair and deceptive act in the practice of insurance**" above for a description of possible sanctions).[13]

Professional licensing law

In addition, the bill subjects a vision care provider who engages in a pattern of continuous or repeated violations of the disclosure, pricing, and notice requirements detailed in "**Out-of-network and noncovered services**" above. Discipline may include suspension or revocation of license to practice optometry or medicine, formal reprimand, monetary penalties, or other corrective action.[14]

General Assembly's intent and findings

The bill states that its provisions seek to prevent health insuring corporations, vision insurers, vision benefit plans, and other contracting entities from establishing fee limitations on vision care services and materials that are not covered vision services for enrollees under an insurance plan.

Furthermore, strategies by these entities to adopt or impose a deductible, copayment, coinsurance, or any other requirement for vision care services or materials as a method to avoid the impact of the bill is contrary to the spirit and intent of the General Assembly.

Finally, the bill states that the provisions concerning the declaration by vision care providers on whether to accept as payment an amount set by the contracting entity noncovered services and the publication of this declaration to enrollees should treat providers equally regardless of the declaration made and should be communicated in such a manner as not to imply that the provider is favored or disfavored based on the declaration.[15]

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[12] R.C. 3963.09, not in the bill.

[13] R.C. 3901.21(BB).

[14] R.C. 4725.19 and 4731.22.

[15] Section 3 of the bill.

HISTORY

ACTION	DATE
Introduced	03-23-17
Reported, H. Insurance	04-12-18
Passed House (92-2)	06-27-18
Reported, S. Insurance and Financial Institutions	----

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