

By: Representative Zuber

To: Insurance

HOUSE BILL NO. 1328

1 AN ACT ESTABLISHING REQUIREMENTS RELATING TO CONTRACTS AND
2 AGREEMENTS BETWEEN INSURERS AND VISION BENEFIT PROVIDERS AND EYE
3 CARE PROVIDERS; TO DEFINE CERTAIN TERMS; TO REQUIRE CERTAIN PUBLIC
4 DISCLOSURES BY INSURERS AND VISION BENEFIT MANAGERS; TO REQUIRE
5 NOTICE TO BE PROVIDED TO PARTICIPATING EYE CARE PROVIDERS OF
6 AMENDMENTS TO AGREEMENTS AND OTHER DOCUMENTS; TO PRESCRIBE CERTAIN
7 REQUIREMENTS FOR CONTRACTS BETWEEN EYE CARE PROVIDERS AND INSURERS
8 AND VISION BENEFIT MANAGERS; TO PROHIBIT CERTAIN COERCIVE TACTICS
9 BY INSURERS AND VISION BENEFIT MANAGERS IN CONTRACTS WITH EYE CARE
10 PROVIDERS; TO PROHIBIT DIFFERENTIAL TREATMENT BY INSURERS AND
11 VISION BENEFIT MANAGERS TOWARD OPTOMETRISTS AND OPHTHALMOLOGISTS;
12 TO PROHIBIT INSURERS AND VISION BENEFIT MANAGERS FROM REQUIRING
13 PROVIDERS TO PARTICIPATE IN CERTAIN HEALTHCARE NETWORKS; TO
14 ESTABLISH CERTAIN REQUIREMENTS THAT MUST BE INCLUDED IN THE
15 PROCESS OF CREDENTIALING AND CONTRACTING WITH EYE CARE PROVIDERS;
16 TO PROHIBIT INSURERS AND VISION BENEFIT MANAGERS FROM CHANGING THE
17 TERMS OF AN AGREEMENT WITH A PARTICIPATING EYE CARE PROVIDER
18 WITHOUT CLEAR WRITTEN COMMUNICATION TO, AND ACCEPTANCE OF THE
19 CHANGES BY, THE PROVIDER; TO PROHIBIT INSURERS AND VISION BENEFIT
20 MANAGERS FROM RESTRICTING PARTICIPATING PROVIDERS FROM USING
21 CERTAIN SOURCES AND SUPPLIERS; TO PROHIBIT THE USE OF
22 EXTRAPOLATION IN AUDITING PARTICIPATING EYE CARE PROVIDERS; TO
23 AUTHORIZE AN AGGRIEVED PARTICIPATING PROVIDER TO INSTITUTE AN
24 ACTION AGAINST AN INSURER OR VISION BENEFIT PROVIDER; TO REQUIRE
25 THE INSURANCE COMMISSIONER AND DEPARTMENT OF INSURANCE, ALONG WITH
26 THE ATTORNEY GENERAL, TO ENFORCE THE PROVISIONS OF THIS ACT; TO
27 PROVIDE THAT THIS ACT APPLIES TO AN ENROLLEE'S CURRENT BENEFIT
28 PLAN UPON RENEWAL THE INITIATION OF NEW PROVIDER AGREEMENTS OR
29 AMENDMENTS TO EXISTING AGREEMENTS AFTER THE EFFECTIVE DATE OF THIS
30 ACT; AND FOR RELATED PURPOSES.

31 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:



32 **SECTION 1.** For purposes of this act, the following words and
33 phrases have the meanings provided in this section unless the
34 context clearly requires otherwise:

35 (a) "Chargeback" means a dollar amount, fee, surcharge,
36 rebate or item of value that reduces, modifies or offsets all or
37 part of the patient responsibility, provider reimbursement,
38 allowed amount, or fee schedule for a covered service or covered
39 material.

40 (b) "Contractual discount" means a percentage reduction
41 from a provider's usual and customary rate for covered services
42 and covered materials required under a participating provider
43 agreement.

44 (c) "Covered materials" means materials for which
45 reimbursement from an insurer, vision benefit manager, or
46 subcontractor is provided to an eye care provider by an enrollee's
47 plan contract, or for which a reimbursement would be available but
48 for the application of the enrollee's contractual limitations of
49 deductibles, copayments or coinsurance, regardless of how the
50 materials are listed or described in an enrollee's benefit plan's
51 definition of benefits.

52 (d) "Covered services" means the professional work
53 performed by an eye care provider for which reimbursement from an
54 insurer, vision benefit manager, or subcontractor is provided to
55 an eye care provider by an enrollee's plan contract, or for which
56 a reimbursement would be available but for the application of the



57 enrollee's contractual plan limitations of deductibles, copayments
58 or coinsurance, regardless of how the services are listed or
59 described in an enrollee's benefit plan's definition of benefits.

60 (e) "De minimis" means equal to zero or an otherwise
61 negligible amount.

62 (f) "Extrapolation" means a mathematical formula,
63 process or technique used by a vision benefit manager, or the
64 vision benefit manager's agent, in the audit of an optometrist to
65 estimate audit results or findings for a larger batch or group of
66 claims not reviewed by the vision benefit manager.

67 (g) "Eye care provider" means a licensed doctor of
68 optometry practicing under the authority of Chapter 18, Title 73,
69 Mississippi Code of 1972, or a licensed medical or osteopathic
70 doctor practicing under the authority of Chapters 25 and 43, Title
71 73, Mississippi Code of 1972.

72 (h) "Fee Schedule" means the document or system that
73 lists the predetermined payment rates or allowed amounts for
74 covered services or covered materials, or both, and determines how
75 much eye care providers are reimbursed by the insurer or vision
76 benefit manager and how much patients are charged by the insurer,
77 vision benefit manager or eye care provider.

78 (i) "Health benefit plan" means a policy, contract or
79 agreement offered by an insurer, third party administrator, or
80 subcontractor to an enrollee to pay for, reimburse, discount or
81 offset health care costs.



82 (j) "Insurer" means an individual, corporation,
83 partnership, company, organization, group, HMO, captive,
84 risk-retention group, self-insurance group, optometric service and
85 indemnity corporation or other entity, whether organized for
86 profit or not-for-profit, whether foreign or domestic, which
87 conducts business in this state and offers a vision benefit plan
88 or provides coverage for vision-related services or vision-related
89 materials to enrollees. An entity is considered an insurer
90 irrespective of:

91 (i) Its corporate form or category of licensure,
92 if applicable, including whether it is otherwise subject to
93 insurance regulations or other regulations;

94 (ii) Whether it, either directly or indirectly
95 reimburses, indemnifies, pays or discounts the costs of vision
96 services or vision materials; or

97 (iii) Whether it delegates, assigns or contracts
98 performance of any function regulated by this act to an affiliate,
99 subsidiary, contractor, intermediary or network leasing entity.

100 (k) "Materials" means ophthalmic devices, including,
101 but not limited to, lenses, devices containing lenses, artificial
102 intraocular lenses, ophthalmic frames and other lens mounting
103 apparatus, prisms, lens treatments and coatings, contact lenses,
104 low vision devices, vision therapy devices, and prosthetic devices
105 to correct, relieve or treat defects or abnormal conditions of the



106 human eye or its adnexa, or any material allowed to be utilized by
107 the State Board of Optometry.

108 (l) "Nominal" means, when there is no corresponding
109 reimbursement in the current year's published Physician Fee
110 Schedule (PFS) released annually by the Centers for Medicare &
111 Medicaid Services (CMS) or in the current year's published state
112 Medicaid fee schedule, an amount less than the reasonable
113 compensation to the vision care provider rendering the covered
114 service or covered materials, taking into account the provider's
115 direct and indirect costs, such as the actual acquisition costs
116 and actual pro rata overhead costs, and reasonable profit.

117 (m) "Participating eye care provider" means an eye care
118 provider that has entered into a contractual agreement or other
119 business relationship with an insurer, vision benefit manager,
120 third party administrator, or subcontractor to provide covered
121 services or covered materials.

122 (n) "Subcontractor" means an individual, company,
123 organization, group or other entity, including, but not limited
124 to, agents, servants, brokers, wholesalers, distributors,
125 partially or wholly-owned subsidiaries, and controlled
126 organizations, which are contracted by the vision benefit manager
127 to supply services or materials to another vision benefit manager,
128 eye care provider or enrollee to execute or fulfill the health
129 benefit plan, vision benefit plan or vision benefit discount plan
130 of a vision benefit manager.



131 (o) "Third party administrator" means an individual,
132 company, organization, group or other entity that provides
133 services, including, but not limited to, administrative,
134 operational, regulatory, human resource, compliance and claim
135 adjudication services for an insurer, vision benefit manager,
136 individual, company, organization, group or other entity under a
137 contract or agreement.

138 (p) "Vision benefit discount plan" means a policy,
139 contract or agreement offered by an insurer or vision benefit
140 manager to an enrollee which solely provides for a discount for
141 vision care services or materials.

142 (q) "Vision benefit manager" means an individual,
143 company, organization, group or other entity, including, but not
144 limited to insurers, third party administrators, and
145 subcontractors, which creates, promotes, sells, provides,
146 advertises or administers an integrated or stand-alone vision
147 benefit plan, vision benefit discount plan, or other insurance
148 policy or contract which provides vision benefits or discounts to
149 an enrollee pertaining to the provision of covered services or
150 covered materials.

151 (r) "Vision benefit plan" means a policy, contract or
152 agreement offered by an insurer or vision benefit manager to an
153 enrollee to pay for, reimburse or offset health and vision care
154 costs.



155 SECTION 2. (1) An insurer or vision benefit manager shall
156 disclose the following information publicly on its internet
157 website and with all documents and document packages, including,
158 but not limited to, proposals, responses to requests for
159 proposals, sales documents, enrollment documents, benefit plan
160 documents, purchaser contracts, enrollee contracts, and provider
161 agreements, which are presented to purchasers, potential
162 purchasers, enrollees, potential enrollees, participating eye care
163 providers, potential participating providers, and state agencies
164 with jurisdictional, regulatory or enforcement authority over its
165 business:

166 (a) Its legal name and entity type;

167 (b) Its legal address and state in which the legal
168 entity is formed or organized;

169 (c) The physical address, mailing address, electronic
170 mail address and phone number of its operational headquarters;

171 (d) The agencies, departments, committees, commissions
172 and other bodies that have jurisdictional, regulatory or
173 enforcement authority over the business;

174 (e) A statement that no jurisdictional, regulatory or
175 enforcement authority exists over its business, if none exists;

176 (f) The names, physical addresses, mailing addresses,
177 email addresses and phone numbers of all parent companies, related
178 holding companies, wholly-owned subsidiary companies, and
179 partially-owned subsidiary companies;



180 (g) All federal and state litigation in which the
181 company is or has been a party to in the current year and during
182 the preceding five (5) years.

183 (h) All Department of Insurance formal complaints
184 against the company in the current year and during the preceding
185 five (5) years by purchasers, enrollees or eye care providers.

186 (2) All information required to be disclosed by an insurer
187 or vision benefit manager in subsection (1) must be conveyed in
188 plain language and typed with a minimum of ten (10) point font
189 size and prominently displayed as follows:

190 (a) On the insurer's or vision benefit manager's
191 website in a publicly accessible section entitled "Required
192 Transparency Information for Patients, Doctors and Purchasers";
193 and

194 (b) In a separately created document entitled "Required
195 Transparency Information for Patients, Doctors and Purchasers"
196 which must be included with all documents and document packages,
197 including, but not limited to, proposals, responses to requests
198 for proposals, benefit plan documents, sales documents, enrollment
199 documents, purchaser contracts, enrollee contracts, and provider
200 agreements.

201 (3) An insurer or vision benefit manager shall provide
202 notice to each participating eye care provider of any proposed
203 amendments to existing provider agreements, fee schedules,



204 provider handbooks, provider manuals, or related policy documents
205 via email.

206 (4) A participating eye care provider must be provided with
207 a minimum of ninety (90) calendar days from the time of
208 distribution to review changes and respond, if necessary, to any
209 proposed amendments from an insurer or vision benefit manager to
210 existing provider agreements, fee schedules, provider handbooks,
211 provider manuals, or related policy documents. A proposed
212 amendment proffered by the insurer or vision benefit manager in
213 violation of this subsection is void and unenforceable as a matter
214 of law.

215 (5) A proposed amendment to existing provider agreements,
216 fee schedules, provider handbooks, provider manuals, or related
217 policy documents by an insurer or vision benefit manager delivered
218 to a participating eye care provider must be:

219 (a) Enumerated in a cover letter;

220 (b) Marked with highlights or in tracked changes within
221 the applicable agreements or documents, or both, to clearly
222 display all changes over the previous version(s); and

223 (c) Structured to include implications of agreement or
224 non-agreement by the participating eye care provider.

225 (6) An insurer or vision benefit manager shall maintain:

226 (a) A phone number to company representatives to
227 receive questions and communications from participating eye care
228 providers at all times during standard business hours;



229 (b) The ability for an eye care provider to leave voice
230 messages at all times; and

231 (c) The ability for an eye care provider to have a live
232 phone discussion with a company representative within twenty-four
233 (24) hours of an initial phone call or a voice message left with
234 the insurer or vision benefit manager.

235 (7) An insurer or vision benefit manager shall maintain a
236 physical mailing address and an email address to company
237 representatives to receive questions, disputes and communications
238 from participating eye care providers about all matters, at all
239 times, including, but not limited to, proposed amendments to
240 existing provider agreements, fee schedules, provider handbooks,
241 provider manuals, and related policy documents. The insurer or
242 vision benefit manager will publish instructions for mail
243 submission and email submission of questions, disputes and
244 communications in a place visible to participating eye care
245 providers, including on its website and in any provider
246 agreements, provider handbooks, provider manuals, or related
247 policy documents.

248 (8) An insurer or vision benefit manager shall acknowledge
249 receipt of an email message within one (1) hour by use of a return
250 email message with a communication tracking number and shall
251 respond to the substantive questions or communications of the
252 email message within seventy-two (72) hours in writing by use of a
253 return email message.



254 (9) An insurer or vision benefit manager, at all times,
255 shall make available to the eye care provider the most up-to-date
256 provider agreements, fee schedules, provider handbooks, provider
257 manuals, and related policy documents via website access.

258 (10) Insurers or vision benefit managers may not engage in
259 marketing or advertising activities that are misleading or
260 deceptive to the public. Such acts are considered deceptive trade
261 practices and subject to penalty under Section 75-24-5.

262 (11) Upon request by a state agency with jurisdictional,
263 regulatory or enforcement authority over its business, insurers
264 and vision benefit managers shall submit all information related
265 to a health benefit plan, vision benefit plan, or vision benefit
266 discount plan, including, but not limited to, proposals, responses
267 to requests for proposals, benefit plan documents, sales
268 documents, enrollment documents, purchaser contracts, enrollee
269 contracts, provider agreements, and marketing and advertising
270 activities for review.

271 **SECTION 3.** (1) An agreement or contract between an insurer
272 or vision benefit manager and an eye care provider may not seek to
273 or require that an eye care provider provide services or materials
274 at a fee limited or set by the insurer or vision benefit manager
275 unless the services or materials are defined and reimbursed as
276 covered services or covered materials under the agreement or
277 contract.



278 (2) An insurer or vision benefit manager may use only
279 standardized codes, names, descriptions and definitions published
280 in the Healthcare Common Procedure Coding System (HCPCS),
281 including Current Procedural Terminology codes published by the
282 American Medical Association and Level II codes published by the
283 Centers for Medicare and Medicaid Services, to identify and
284 describe the covered services and covered materials of the vision
285 benefit plan to purchasers, enrollees and eye care providers of
286 the vision benefit plan.

287 (3) An insurer or vision benefit manager shall adhere to the
288 standardized codes, names, descriptions and definitions published
289 in the Healthcare Common Procedure Coding System (HCPCS),
290 including Current Procedural Terminology codes published by the
291 American Medical Association and Level II codes published by the
292 Centers for Medicare and Medicaid Services, to create and offer a
293 fee schedule for covered services and covered materials in an
294 agreement between the insurer or vision benefit manager and an eye
295 care provider.

296 (4) An insurer or vision benefit manager may not attempt to
297 alter the meaning of any of the standardized codes, names,
298 descriptions or definitions published in the Healthcare Common
299 Procedure Coding System (HCPCS), including Current Procedural
300 Terminology codes published by the American Medical Association
301 and Level II codes published by the Centers for Medicare and
302 Medicaid Services. Contractual language, policies or procedures



303 set by the insurer or vision benefit manager in violation of the
304 this subsection are void and unenforceable.

305 (5) Fee schedules in an agreement between an Insurer or
306 vision benefit manager and an eye care provider and reimbursements
307 paid by an insurer or vision benefit manager to an eye care
308 provider for covered services and covered materials may not be
309 nominal or de minimis. There is no limitation on the ability of
310 an individual eye care provider or a group of eye care providers
311 who practice under a single Employer Identification Number (EIN)
312 or Tax Identification Number (TIN) to engage in direct
313 negotiations with the insurer or vision benefit manager regarding
314 reimbursement fee schedules and ultimately agreeing to a different
315 fee schedule than the fee schedule provided by the insurer or
316 vision benefit manager to other participating providers or groups.

317 (6) Fee schedule allowed amounts and reimbursements paid by
318 an insurer or vision benefit manager for each covered service and
319 covered material must be listed clearly and individually on a fee
320 schedule made available to the eye care provider:

321 (a) At the time an agreement is offered to the eye care
322 provider by an insurer or vision benefit manager;

323 (b) Within ten (10) business days from the date an
324 application is made to become a participating eye care provider
325 with the insurer or vision benefit manager by the eye care
326 provider; and



327 (c) At all times via electronic means to the
328 participating eye care provider.

329 (7) A contract between an insurer or vision benefit manager
330 and an eye care provider must include a fee schedule that includes
331 and individually identifies each covered service and covered
332 material and its corresponding allowed amount, reimbursement
333 amount paid to the eye care provider, and any form of a
334 cost-sharing amount paid by the enrollee to the eye care provider.

335 (8) Insurers or vision benefit managers may not advertise,
336 claim or represent to purchasers or enrollees that services and
337 materials provided by a participating eye care provider are
338 covered, included or covered with an additional deductible, copay
339 or coinsurance if the insurer or vision benefit manager does not
340 remit an actual payment to the participating eye care provider as
341 full or partial reimbursement for the service or material.

342 (9) A service or material provided by a participating eye
343 care provider may not be designated as a covered service or
344 covered material by the insurer or vision benefit manager in the
345 design of a health benefit plan, vision benefit plan, or vision
346 benefit discount plan if the reimbursement amount to the
347 participating eye care provider is comprised only of an enrollee's
348 payment to the participating eye care provider.

349 (10) Insurers or vision benefit managers may not condition
350 application to or network participation in a health benefit plan,
351 vision benefit plan, or vision benefit discount plan by an eye



352 care provider based on the eye care provider's usual and customary
353 pricing or discounts on usual and customary pricing for services
354 or materials that are not covered services or not covered
355 materials. Contractual language, policies or procedures set by
356 the insurer or vision Benefit manager in violation of this
357 subsection are void and unenforceable.

358 (11) Insurers or vision benefit managers may not make
359 conditional a fee schedule proposed or made to an eye care
360 provider of a health benefit plan, vision benefit plan, or vision
361 benefit discount plan for covered services or covered materials
362 based on the eye care provider's usual and customary pricing or
363 discounts on usual and customary pricing for services or materials
364 that are not covered services or not covered materials.
365 Contractual language, policies or procedures set by the insurer or
366 vision benefit manager in violation of this subsection are void
367 and unenforceable.

368 (12) A contract between an insurer or vision benefit manager
369 and an eye care provider may not contain a provision, fee schedule
370 or reimbursement amount in which the eye care provider, with
371 consideration of any applicable deductibles, copays, coinsurances,
372 discounts, rebates or chargebacks, agrees to provide covered
373 services or covered materials to an enrollee at a financial loss.
374 Contractual language, policies or procedures set by the insurer or
375 vision benefit manager in violation of this subsection are void
376 and unenforceable.



377 (13) The period of time prescribed by a contract between an
378 insurer or vision benefit manager and an eye care provider for the
379 insurer or vision benefit manager to recover a reimbursement
380 amount from an eye care provider must be the same period of time
381 allowed or required for an insurer or vision benefit manager to
382 remit the applicable reimbursement following an eye care
383 provider's submission of a clean claim for services rendered or
384 materials furnished, or both. This subsection does not limit an
385 insurer or vision benefit manager's ability to conduct an audit of
386 claims, in accordance with the insurer or vision benefit manager's
387 written policies and applicable law, if the insurer or vision
388 benefit manager has a reasonable belief that the eye care provider
389 has engaged in fraud, waste or abuse.

390 (14) Insurers or vision benefit managers may not represent
391 falsely the number of participating providers in a region nor the
392 benefits that comprise a health benefit plan, vision benefit plan,
393 or vision benefit discount plan to clients, groups, employers,
394 purchasers, companies, enrollees or prospective enrollees. These
395 acts are considered deceptive trade practices and subject to
396 penalty under Section 75-24-5.

397 (15) An insurer or vision benefit manager may not promote or
398 use in marketing or advertising for a health benefit plan, vision
399 benefit plan, or vision benefit discount plan that a covered
400 service or covered material is "free," "no charge,"
401 "complimentary" or any materially similar language to induce a



402 client, group, employer, purchaser, company, enrollee or
403 prospective enrollee to purchase services, materials, supplies or
404 plans from the insurer, vision benefit manager or affiliate of the
405 insurer or vision benefit manager.

406 (16) Insurers or vision benefit managers may not offer
407 enrollees of a health benefit plan, vision benefit plan, or vision
408 benefit discount plan varying deductibles, copays, coinsurances,
409 coverage amounts, rebates, gift cards or other monetary or
410 non-monetary incentives to obtain covered services, covered
411 materials, noncovered services, or noncovered materials:

412 (a) At a particular participating eye care provider;

413 (b) At a retail establishment owned by, partially owned
414 by, contracted with, or otherwise affiliated with the insurer or
415 vision benefit manager; or

416 (c) At an Internet or virtual provider or retailer
417 owned by, partially owned by, contracted with, or otherwise
418 affiliated with the insurer or vision benefit manager.

419 (17) Insurers or vision benefit managers shall remit to the
420 participating eye care provider the contracted reimbursement
421 amount from the fee schedule for a covered service or covered
422 material provided to an enrollee if the enrollee is verified to be
423 eligible by the participating eye care provider through customary
424 verification methods of the insurer or vision benefit manager to
425 receive the covered service or covered material on the date of
426 service.



427 (18) Insurers or vision benefit managers may not reverse a
428 reimbursement retroactively or withhold a future reimbursement to
429 a participating eye care provider who relied in good faith on an
430 individual's presented coverage credentials and the customary
431 verification methods of the insurer or vision benefit manager if
432 the vision benefit manager later determines that the enrollee was
433 ineligible to receive covered services or covered materials on the
434 date of service.

435 (19) Insurers or vision benefit managers may not require a
436 participating eye care provider, purchaser or enrollee of a health
437 benefit plan, vision benefit plan, or vision benefit discount plan
438 to obtain prior authorization, preauthorization, precertification
439 or any similar mechanism that restricts the enrollee from
440 receiving a covered service or covered material recommended by the
441 eye care provider and requested by the enrollee.

442 (20) Participating eye care providers may offer an enrollee
443 the opportunity to pay the participating eye care provider
444 directly for covered services and covered materials if the direct
445 payment would be less costly to the enrollee than the total
446 out-of-pocket cost required under the terms of a health benefit
447 plan or vision benefit plan. A provider may not be subject to an
448 audit, removed from participation in the network, or otherwise
449 penalized or discriminated against for offering an enrollee the
450 opportunity to pay the participating provider directly under the
451 conditions of this subsection.



452 (21) Insurers or vision benefit managers may not, in the
453 course of adjudicating a claim for reimbursement by a
454 participating eye care provider for a covered service or covered
455 material, alter, delete, substitute or otherwise change a code or
456 modifier submitted by the eye care provider, including by
457 downcoding, bundling or reassigning to a different code, if the
458 change would reduce payment or otherwise adversely affect the
459 provider or enrollee, or both. For purposes of this act,
460 "downcoding" means to alter, delete, substitute or assign a code
461 that results in a lower level of service, a lower-valued code, or
462 a reduced reimbursement amount relative of the codes submitted by
463 the eye care provider; "bundling" means to combine, substitute or
464 treat two (2) or more distinct services, supplies or materials
465 reported on the same claim or date or service as included within a
466 single code, package or global service, and denying, reducing or
467 disallowing separate reimbursement for one or more of these codes.

468 (22) The provisions of this act, including applicable
469 penalties, apply to all affiliates, parent companies, third party
470 administrators, and subcontractors that are used by an insurer or
471 vision benefit manager to supply covered services or covered
472 materials to an eye care provider or enrollee.

473 (23) An insurer or vision benefit manager may not require or
474 request an eye care provider to opt-in or opt-out of the
475 provisions set forth in this act.



476 **SECTION 4.** (1) An agreement between an insurer or vision
477 benefit manager and an eye care provider may not require that an
478 eye care provider participate with, be credentialed by, or enter
479 into an agreement with a specific vision benefit plan or vision
480 benefit discount plan as a condition for participation in the
481 health benefit plan provider network of the insurer or vision
482 benefit manager to provide covered services or covered materials
483 to the enrollees of the health benefit plan.

484 (2) An agreement between an insurer or vision benefit
485 manager and an eye care provider may not require that an eye care
486 provider participate with, be credentialed by, or enter into an
487 agreement with a specific health benefit plan as a condition for
488 participation in the vision benefit plan or vision benefit
489 discount plan provider network of the insurer or vision benefit
490 manager to provide covered services or covered materials to the
491 enrollees of the vision benefit plan or vision benefit discount
492 plan.

493 (3) An insurer or vision benefit manager issuing or renewing
494 a health benefit plan, vision benefit plan or vision benefit
495 discount plan that provides benefits for covered services or
496 covered materials rendered by a physician or osteopath duly
497 licensed under Chapters 25 and 43, Title 73, Mississippi Code of
498 1972, which are within the scope of practice of an optometrist
499 duly licensed under Chapter 18, Title 73, Mississippi Code of
500 1972, shall provide the same reimbursement for covered services or



501 covered materials to optometrists as allowed for those covered
502 services or covered materials rendered by physicians or
503 osteopaths.

504 (4) An insurer or vision benefit manager shall apply the
505 same terms and conditions of participation for all eye care
506 providers, irrespective of their educational credentials, such as
507 medical doctor, osteopathic doctor or optometrist, subject to the
508 permitted scope of practice for the licensee under applicable
509 state law.

510 (5) An insurer or vision benefit manager may not require an
511 eye care provider to possess, offer, procure or sell materials or
512 covered materials in their office as a condition of participation
513 in the provider network or health benefit plan, vision benefit
514 plan, or vision benefit discount plan. Contractual language,
515 policies or procedures set by the insurer or vision benefit
516 manager in violation of this subsection is void and unenforceable.

517 (6) If an eye care provider enters into a subcontract
518 agreement with another provider to provide his or her licensed
519 health care services to an enrollee or a covered dependent of an
520 enrollee of a health benefit plan, vision benefit plan, or vision
521 benefit discount plan where the subcontracted provider will seek
522 reimbursement from the plan or enrollee for the subcontracted
523 services, the subcontract agreement must meet all requirements of
524 this act.



525 (7) This subsection also applies to an agreement an insurer
526 or vision benefit manager enters into with another entity to
527 provide an enrollee with covered services or covered materials.

528 **SECTION 5.** (1) An insurer or vision benefit manager that
529 offers multiple health benefit plans, vision benefit plans, or
530 vision benefit discount plans may not require an eye care
531 provider, as a condition of participation in the network for a
532 health benefit plan, vision benefit plan or vision benefit
533 discount plan, to participate in the network of any of the
534 insurer's or vision benefit manager's other health benefit plans,
535 vision benefit plans or vision benefit discount plans. A contract
536 provision violating this subsection is void. The penalties and
537 remedies provided in this chapter for a violation of this
538 subsection do not waive, limit or otherwise affect the
539 applicability of Section 75-24-5, or any other law providing for
540 civil or criminal penalties or remedies for unfair, deceptive or
541 unlawful business practices.

542 (2) An insurer or vision benefit manager that offers
543 multiple health benefit plans, vision benefit plans, or vision
544 benefit discount plans may not withhold participation in the
545 network of one or more of the insurer's or vision benefit
546 manager's other health benefit plans, vision benefit plans, or
547 vision benefit discount plans if the eye care provider, having
548 completed the credentialing requirements of the insurer or vision
549 benefit manager for participation, already is participating in the



550 network of one or more of the insurer's or vision benefit
551 manager's health benefit plans, vision benefit plans, or vision
552 benefit discount plans and seeks to participate in the network of
553 the insurer's or vision benefit manager's other health benefit
554 plans, vision benefit plans, or vision benefit discount plans.

555 (3) This section applies to all plan types that a health
556 benefit plan, vision benefit plan, or vision benefit discount plan
557 sells, administers or offers, including, but not limited to,
558 individually purchased plans, employer-sponsored plans, and
559 government-sponsored plans such as Medicare, Medicaid and Tricare.

560 **SECTION 6.** (1) An insurer or vision benefit manager must
561 include on their Internet website: (i) a method for an eye care
562 provider to submit an application for inclusion and credentialing
563 as a participating provider in the health benefit plan, vision
564 benefit plan, or vision benefit discount plan; and (ii) a
565 description of the credentialing requirements, which must be
566 reasonable, related to the delivery of covered eye care services,
567 and applied in an objective, uniform and nondiscriminatory manner.

568 (2) An insurer's or vision benefit manager's application for
569 inclusion and credentialing as a participating eye care provider
570 in the health benefit plan, vision benefit plan, or vision benefit
571 discount plan may require only standardized information prescribed
572 by the Commissioner of Insurance or information specified on the
573 Council for Affordable Quality Healthcare credentialing
574 application.



575 (3) An insurer's or vision benefit manager's application for
576 inclusion and credentialing as a participating eye care provider
577 in the health benefit plan, vision benefit plan, or vision benefit
578 discount plan must impose the same application and credentialing
579 requirements on each eye care provider.

580 (4) No later than the ten (10) business days after the date
581 the insurer or vision benefit manager receives an application from
582 an eye care provider for inclusion and credentialing as a
583 participating provider in the health benefit plan, vision benefit
584 plan, or vision benefit discount plan, the insurer or vision
585 benefit manager shall make available electronically to the eye
586 care provider a proposed participating provider agreement,
587 including applicable fee schedules, provider handbooks, and
588 provider manuals.

589 (5) No later than the thirty (30) business days after the
590 date the insurer or vision benefit manager receives an application
591 from an eye care provider for inclusion and credentialing as a
592 participating provider in the health benefit plan, vision benefit
593 plan, or vision benefit discount plan, the insurer or vision
594 benefit manager shall complete the credentialing determination of
595 the eye care provider, approve or disapprove the application of
596 the eye care provider, and deliver electronically a proposed
597 participating provider agreement described under subsection (4)
598 for acceptance and signature of the approved eye care provider.



599 (6) If the application for inclusion and credentialing as a
600 participating provider is denied by the insurer or vision benefit
601 manager, the insurer or vision benefit manager shall deliver to
602 the applicant eye care provider a detailed explanation for the
603 denial both electronically and in writing via certified mail.

604 (7) If the application for inclusion and credentialing as a
605 participating provider is denied by the insurer or vision benefit
606 manager, the eye care provider must be allowed a reasonable period
607 of time in which to appeal the decision to the insurer or vision
608 benefit manager and provide in the appeal evidence that supports
609 the reconsideration of the denied application. The insurer or
610 vision benefit manager shall consider, and render a decision on,
611 the eye care provider's appeal submission within thirty (30) days
612 of the date of receipt of the submission by the insurer or vision
613 benefit manager.

614 (8) If the appeal to the application denial for inclusion
615 and credentialing as a participating provider is denied by the
616 insurer or vision benefit manager, the insurer or vision benefit
617 manager shall deliver to the applicant eye care provider a
618 detailed explanation for the denial of the appeal both
619 electronically and in writing via certified mail.

620 (9) If the appeal to the application denial for inclusion
621 and credentialing as a participating provider is denied by the
622 insurer or vision benefit manager, the applicant eye care provider
623 may appeal the decision to the Commissioner of Insurance and seek



624 a ruling that allows the eye care provider to become a
625 participating provider in the health benefit plan, vision benefit
626 plan, or vision benefit discount plan.

627 (10) An insurer or vision benefit manager, concurrent with
628 the electronic delivery of the proposed participating provider
629 agreement to the approved eye care provider described under
630 subsection (5), must provide the name, email address and phone
631 number of a representative of the insurer or vision benefit
632 manager to allow the approved eye care provider the opportunity
633 to:

634 (a) Contact the representative before signing the
635 agreement;

636 (b) Discuss the proposed agreement with the
637 representative before signing the agreement; and

638 (c) Electronically send the representative
639 modifications to the proposed agreement before signing the
640 agreement.

641 (11) If the approved eye care provider sends the
642 representative of the insurer or vision benefit manager
643 modifications to the proposed participating provider agreement
644 described under paragraph (c) of subsection (10), the insurer or
645 vision benefit manager must respond to the submission of the
646 approved eye care provider within five (5) business days. Each
647 subsequent response made by the insurer, vision benefit manager,



648 or approved eye care provider to the other party must be responded
649 to within five (5) business days by the receiving party.

650 (12) Once the insurer or vision benefit manager has approved
651 and delivered electronically a proposed participating provider
652 agreement described under subsection (5), the approved eye care
653 provider has a total allotted timeframe of ninety (90) business
654 days to reach agreement with the insurer or vision benefit manager
655 and sign a participating provider agreement. If the parties fail
656 to reach agreement and no participating provider agreement is
657 signed by the approved eye care provider within the allotted
658 timeframe, the insurer or vision benefit manager may retract the
659 participating provider agreement.

660 (13) No later than twenty (20) business days after the date
661 the approved eye care provider signs a participating provider
662 agreement, the insurer or vision benefit manager shall include the
663 credentialed and approved eye care provider as a participating
664 provider in the health benefit plan, vision benefit plan, or
665 vision benefit discount plan and list the eye care provider in all
666 of the plan's directories that are available to enrollees and the
667 public.

668 (14) The earliest that an eye care provider may submit
669 another application to an insurer or vision benefit manager after
670 a previous approval and subsequent unsuccessful attempt to
671 negotiate a mutually acceptable participating provider agreement



672 is one hundred eighty (180) calendar days from the date of
673 submission of the previous application.

674 (15) The earliest that an eye care provider may submit
675 another application to an insurer or vision benefit manager after
676 a previous disapproval of application is one hundred eighty (180)
677 calendar days from the date of submission of the previous
678 application.

679 (16) An insurer or vision benefit manager shall allow an eye
680 care provider to become a participating provider in the network of
681 a health benefit plan, vision benefit plan, or vision benefit
682 discount plan if the eye care provider: (i) meets the
683 credentialing requirements of the insurer or vision benefit
684 manager; and (ii) agrees in writing to the applicable provider
685 agreement.

686 (17) An insurer or vision benefit manager may not exclude an
687 eye care provider from applying to, or becoming a participating
688 provider in, the network of a health benefit plan, vision benefit
689 plan, or vision benefit discount plan because of:

690 (a) The aggregate number of eye care providers in a
691 state, county, city, zip code or other geographically defined
692 service area;

693 (b) The time, distance or appointment availability for
694 an enrollee to access a participating eye care provider; or

695 (c) The provider's professional designation,
696 independent practice affiliation, or participation status in other



697 health benefit plans, vision benefit plans, or vision benefit
698 discount plans.

699 **SECTION 7.** (1) An insurer or vision benefit manager may not
700 change or alter a provider agreement, including terms,
701 reimbursements, fee schedules, policies, procedures or provider
702 manuals incorporated by reference into the provider agreement,
703 entered into with a participating eye care provider unless the
704 insurer or vision benefit manager performs the following steps at
705 least ninety (90) days before the date of the proposed change
706 would take effect:

707 (a) A certified letter, or an electronic communication
708 requiring an electronic signature proving receipt, clearly
709 detailing proposed changes is required to be sent to the eye care
710 provider;

711 (b) A face-to-face or virtual meeting is required to
712 discuss proposed changes if requested by the eye care provider;

713 (c) The eye care provider must either agree or protest
714 in writing to the proposed changes. If the changes are not agreed
715 to by the eye care provider, then the current agreement must
716 continue and the insurer or vision benefit manager may not remove
717 the eye care provider from participation with a health benefit
718 plan, vision benefit plan, or vision benefit discount plan for
719 not;

720 (d) Accepting the proposed changes;



721 (e) A proposed amendment to an existing provider
722 agreement must be presented to the participating eye care provider
723 in a manner conducive to the eye care provider's review. Proposed
724 changes must be: (i) enumerated in a cover letter; and (ii)
725 clearly marked in tracked changes within the body of the
726 applicable agreement; and

727 (f) An agreement between an insurer or vision benefit
728 manager and an eye care provider may not contain a provision
729 requiring the optometrist to accept a reimbursement payment in the
730 form of a virtual credit card or any other payment method where a
731 processing fee, administrative fee, percentage amount, or dollar
732 amount is assessed for the provider to receive the reimbursement
733 payment.

734 (2) Termination of a provider agreement is permissible only
735 in the event of a material breach where the eye care provider
736 fails to remedy the alleged breach to the reasonable satisfaction
737 of the insurer or vision benefit manager within thirty (30) days
738 of receipt of written notice specifying the alleged breach.

739 (3) An insurer or vision benefit manager may not require an
740 eye care provider to establish a security interest in all or part
741 of their property and assets, including assets pertaining to their
742 practice, in a sum equivalent to the funds owed to the insurer or
743 vision benefit manager at termination. Contractual language,
744 policies or procedures set by the insurer or vision benefit



745 manager in violation of this subsection are void and
746 unenforceable.

747 (4) A provider agreement between an insurer or vision
748 benefit manager and an eye care provider may not contain a
749 provision obligating the eye care provider to share equally the
750 expenses of arbitration. Contractual language, policies or
751 procedures set by the insurer or vision benefit manager in
752 violation of this subsection are void and unenforceable. Each
753 party shall bear their own arbitration costs, contingent upon a
754 fee-shifting provision that grants prevailing party status.

755 (5) An insurer or vision benefit manager may not retaliate
756 against an eye care provider for discussing, or attempting in good
757 faith to negotiate, the terms and provisions of a provider
758 agreement with the insurer or vision benefit manager.

759 (6) An insurer or vision benefit manager may not retaliate
760 against an eye care provider for filing a complaint against the
761 insurer or vision benefit manager with a state agency with
762 jurisdictional, regulatory or enforcement authority over the
763 business of the insurer or vision benefit manager.

764 (7) If retaliation by an insurer or vision benefit manager
765 occurs against an eye care provider in violation of subsection (5)
766 or (6) of this section, a state agency that has jurisdictional,
767 regulatory or enforcement authority over the business of the
768 insurer or vision benefit manager may sanction the insurer or
769 vision benefit manager, including imposition of fines and other



770 remedies deemed appropriate, and provide an appropriate remedy for
771 the aggrieved eye care provider.

772 **SECTION 8.** (1) An agreement between an insurer or vision
773 benefit manager and an eye care provider may not restrict or
774 limit, either directly or indirectly, the eye care provider's
775 choice or use of sources and suppliers of covered or uncovered
776 services or materials, including the choice or use of optical
777 laboratories, provided by the eye care provider to an enrollee.
778 Contractual language, policies or procedures set by the insurer or
779 vision benefit manager in violation of this subsection are void
780 and unenforceable.

781 (2) An insurer or vision benefit manager may not, directly
782 or indirectly:

783 (a) Control or attempt to control the professional
784 judgment, manner of practice, or practice of an eye care provider;

785 (b) Employ an eye care provider to provide a covered
786 service or covered material;

787 (c) Reimburse an eye care provider a different amount
788 for covered services or covered materials because of the eye care
789 provider's choice of:

790 (i) Optical laboratory;

791 (ii) Source of supplier of:

792 1. Contact lenses;

793 2. Ophthalmic lenses;

794 3. Ophthalmic glasses frames; or



795 4. Covered or noncovered services or
796 materials;

797 (iii) Equipment used for patient care;
798 (iv) Retail optical affiliation;
799 (v) Vision support organization;
800 (vi) Group purchasing organization;
801 (vii) Doctor alliance;
802 (viii) Professional trade association membership;
803 (viii) Electronic health record software,
804 electronic medical record software, or practice management
805 software; or

806 (ix) Third-party claim filing service, billing
807 service, or electronic data interchange clearinghouse company;

808 (d) Restrict, limit or influence an eye care provider's
809 choice of sources or suppliers of services or materials, including
810 optical laboratories used by the eye care provider to provide
811 services or materials to the enrollee;

812 (e) Restrict, limit or influence an eye care provider's
813 choice of electronic health record software, electronic medical
814 record software, or practice management software;

815 (f) Restrict, limit or influence an eye care provider's
816 choice of third-party claim filing service, billing service, or
817 electronic data interchange clearinghouse company;



818 (g) Restrict or limit an eye care provider's access to
819 an enrollee's complete plan coverage information, including
820 in-network and out-of-network coverage details;

821 (h) Apply a chargeback to an enrollee or eye care
822 provider if the chargeback is for a covered product or service for
823 which the insurer or vision benefit manager does not incur the
824 cost to produce, deliver or provide to the enrollee or eye care
825 provider;

826 (i) Require an eye care provider to disclose an
827 enrollee's confidential or protected health information unless the
828 disclosure is authorized expressly by the enrollee or permitted
829 without authorization under the Health Insurance Portability and
830 Accountability Act of 1996;

831 (j) Require an eye care provider to disclose or report
832 a medical history or diagnosis as a condition to file a claim,
833 adjudicate a claim, or receive reimbursement for a routine or
834 wellness eye exam;

835 (k) Require an eye care provider to disclose or report
836 an enrollee's glasses prescription, contact lens prescription,
837 ophthalmic device measurements, facial photograph, or unique
838 anatomical measurements as a condition to file a claim, adjudicate
839 a claim, or receive reimbursement for a claim, unless the
840 information is needed for the vision benefit manager to
841 manufacture, or cause to be manufactured, a covered product that
842 is submitted on the applicable claim; or



843 (1) Require an eye care provider to disclose enrollee
844 information, other than information identified on the version of
845 the Health Insurance Claim Form approved by the National Uniform
846 Claim Committee as of March 1, 2023, or its approved successor, as
847 a condition to file a claim, adjudicate a claim, or receive
848 reimbursement for a claim unless the information is needed for the
849 vision benefit manager to manufacture, or cause to be
850 manufactured, a covered product that is submitted on the
851 applicable claim.

852 (3) An insurer or vision benefit manager may not solicit
853 patients or referrals for supplies on behalf of themselves or
854 their affiliates, or both, by identifying participating eye care
855 providers in an inaccurate or otherwise misleading manner in a
856 list of participating providers or in communications to purchasers
857 or enrollees. Communications that distinguish between
858 participating eye care providers, or which otherwise claim
859 professional superiority or the performance of a professional
860 service in a superior manner, based on the following
861 characteristics, are readily subject to verification by the
862 Department of Insurance:

863 (a) A discount or incentive offered by the
864 participating eye care provider on services and materials that are
865 not covered by the insurer or vision benefit manager;



866 (b) The dollar amount, volume amount or percent usage
867 amount of any material, product or good purchased by the
868 participating eye care provider; or

869 (c) The brand, source, manufacturer or supplier of a
870 covered service or covered material utilized by the participating
871 eye care provider.

872 (4) This section does not prohibit advertising if the
873 advertising is: (a) not false, misleading or deceptive; or (b)
874 readily subject to verification.

875 **SECTION 9.** An insurer or vision benefit manager may not use
876 extrapolation to complete an audit of a participating eye care
877 provider. An additional payment due to a participating eye care
878 provider or a refund due to the insurer or vision benefit manager
879 may not be based on an extrapolation but must be based on the
880 actual overpayment or underpayment, as determined after an
881 investigation by the insurer or vision benefit manager, and the
882 participating eye care provider has been afforded, and has
883 exhausted, all opportunities to appeal the insurer or vision
884 benefit manager's findings, as set forth in the provider manual or
885 policy document or applicable law, or both.

886 **SECTION 10.** An eye care provider adversely affected by a
887 violation of this act may bring an action in a court of competent
888 jurisdiction for injunctive relief against the insurer or vision
889 benefit manager and, upon prevailing, in addition to the
890 injunctive relief, may recover monetary damages, including, but



891 not limited to direct, indirect, special and punitive damages, and
892 penalties of no more than Ten Thousand Dollars (\$10,000.00) for
893 each violation, plus attorney's fees and costs.

894 **SECTION 11.** The requirements of this act are in addition to,
895 and do not limit, any other requirement applicable to an insurer
896 under state law. If there is a conflict between this act and
897 another provision of state law applicable to insurers, the
898 provision that affords greater protection to eye care providers or
899 plan enrollees are controlling. Notwithstanding any other
900 provision of law, including any law that purports to be the sole
901 body of law governing the insurer, an insurer shall comply with
902 this act to the extent not preempted by federal law.

903 **SECTION 12.** (1) The Commissioner of Insurance and the
904 Department of Insurance has jurisdiction to administer and enforce
905 this act with respect to any insurer and may:

906 (a) Bring an action, issue orders, and impose remedies
907 authorized by this act against any insurer;

908 (b) Adopt rules to identify activities that constitute
909 the administration, management or control of vision benefits or
910 materials; and

911 (c) Coordinate enforcement with other state agencies
912 that regulate insurers under other applicable law. The Attorney
913 General has concurrent enforcement authority for violations
914 constituting unfair or deceptive acts or practices.

915 (2) The Commissioner of Insurance shall:



916 (a) Provide a mechanism for aggrieved individuals,
917 whether actively or formerly enrolled with a particular vision
918 care plan, to submit complaints to the commissioner for review,
919 investigation, and as appropriate, discipline under applicable
920 law.

921 (b) Enforce the state's insurance laws and this act
922 using powers granted to the commissioner under Title 83,
923 Mississippi Code of 1972;

924 (c) Ensure that insurers and vision benefit managers
925 comply with the requirement of this act; and

926 (d) Be entitled to seek an injunction against an
927 insurer or vision benefit manager in a court of competent
928 jurisdiction if the insurer or vision benefit manager:

929 (i) Issues a coverage policy that does not comply
930 with the requirements of this act, uses fraudulent, coercive or
931 dishonest practices, or demonstrates incompetence,
932 untrustworthiness or financial irresponsibility in the conduct of
933 business;

934 (ii) Fails to deal equitably with eye care
935 providers or other persons at facilities that offer services or
936 materials covered within a contract or policy issued pursuant to
937 this act; or

938 (iii) Fails to substantially comply with the
939 insurance laws of this state or violates any regulation, rule,
940 subpoena or order of the commissioner.



941 (3) The Attorney General shall:

942 (a) Enforce the state's laws and this act's provisions,
943 using powers granted to the Attorney General under Title 83,
944 Mississippi Code of 1972, or the state's consumer protection
945 statutes; and

946 (b) Be entitled to seek an injunction against an
947 insurer or vision benefit manager in a court of competent
948 jurisdiction.

949 (4) The penalties and remedies provided in this act for
950 violation of this act:

951 (a) Are cumulative and in addition to other penalties
952 and remedies available under state law; and

953 (b) Do not waive, limit or otherwise affect the
954 applicability of the state's consumer protection laws or any other
955 law providing for civil or criminal penalties or remedies for
956 unfair, deceptive or unlawful business practices.

957 **SECTION 13.** If any provision of this act or the application
958 of a provision to any person or circumstance is held invalid, the
959 remainder of the act and the application of that provision to
960 other persons or circumstances are not affected.

961 **SECTION 14.** (1) (a) The requirements of this section apply
962 to insurer or vision benefit manager policies, contracts, addenda
963 and certificates executed, delivered, issued for delivery,
964 continued or renewed in Mississippi.



965 (b) An insurer or vision benefit manager may not
966 construe re-credentialing as re-contracting with a participating
967 eye care provider. A provider agreement must be a distinctly
968 separate document from credentialing materials and must be signed
969 by the eye care provider and the insurer or vision benefit
970 manager.

971 (c) An insurer or vision benefit manager must include a
972 copy of the current plan provider manual referred to in a provider
973 agreement when an agreement is sent to a provider or prospective
974 provider, as well as those policies referenced in the provider
975 agreement, such as dispute resolution policies.

976 (2) This act applies to all insurers and vision benefit
977 managers upon the earlier of:

978 (a) The renewal of an enrollee's current benefit plan
979 or upon issuance of a new benefit plan to an enrollee; or

980 (b) The initiation of a new provider agreement with an
981 eye care provider or upon an amendment of an existing provider
982 agreement with an eye care provider.

983 **SECTION 15.** This act shall take effect and be in force from
984 and after its passage.

