

By: Senator(s) Michel

To: Insurance

SENATE BILL NO. 2703

1 AN ACT TO ENSURE ACCESS TO EYE CARE SERVICES AND MATERIALS
 2 FOR PATIENTS THROUGH TRANSPARENT AND FAIR BUSINESS PRACTICES; TO
 3 PROVIDE DEFINITIONS; TO PROVIDE TRANSPARENCY AND DISCLOSURE
 4 REQUIREMENTS FOR INSURERS AND VISION BENEFIT MANAGERS; TO PROVIDE
 5 FOR COVERED AND NONCOVERED SERVICES AND MATERIAL IN INSURANCE
 6 POLICIES; TO PROHIBIT CERTAIN COERCIVE TACTICS BY INSURERS AND
 7 VISION BENEFIT MANAGERS; TO PROVIDE FOR CREDENTIALING AND
 8 CONTRACTING REQUIREMENTS FOR INSURERS OR VISION BENEFIT MANAGERS;
 9 TO PROHIBIT CHANGING THE TERMS OF PROVIDER AGREEMENTS; TO
 10 AUTHORIZE EYE CARE PROVIDERS TO USE ANY LAB OR SUPPLIER; TO
 11 PROHIBIT EXTRAPOLATION; TO PROVIDE A PRIVATE RIGHT OF ACTION FOR
 12 EYE CARE PROVIDERS; TO PROVIDE FOR ENFORCEMENT OF THIS ACT BY THE
 13 MISSISSIPPI COMMISSIONER OF INSURANCE AND THE ATTORNEY GENERAL;
 14 AND FOR RELATED PURPOSES.

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

16 **SECTION 1. Definitions.** For purposes of this section:

17 (a) "Contractual discount" means a percentage reduction
 18 from a provider's usual and customary rate for covered services
 19 and covered materials required under a participating provider
 20 agreement.

21 (b) "Materials" means ophthalmic devices, including,
 22 but not limited to, lenses, devices containing lenses, artificial
 23 intraocular lenses, ophthalmic frames and other lens mounting
 24 apparatus, prisms, lens treatments and coatings, contact lenses,



25 low-vision devices, vision therapy devices, and prosthetic devices
26 to correct, relieve, or treat defects or abnormal conditions of
27 the human eye or its adnexa, or any material allowed to be
28 utilized by the Mississippi State Board of Optometry and Practice
29 Act.

30 (c) "Covered services" means the professional work
31 performed by an eye care provider for which reimbursement from an
32 insurer, vision benefit manager, or subcontractor is provided to
33 an eye care provider by an enrollee's plan contract, or for which
34 a reimbursement would be available but for the application of the
35 enrollee's contractual plan limitations of deductibles,
36 copayments, or coinsurance, regardless of how the services are
37 listed or described in an enrollee's benefit plan's definition of
38 benefits.

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

47 (e) "Eye care provider" means a licensed doctor of
48 optometry practicing under the authority of Section 73-19-19,
49 Mississippi Code of 1972, or a licensed medical or osteopathic



50 doctor practicing under the authority of Sections 73-19-25 and
51 73-19-43, Mississippi Code of 1972.

52 (f) "Participating eye care provider" means an eye care
53 provider that has entered into a contractual agreement or other
54 business relationship with an insurer, vision benefit manager,
55 third-party administrator, or subcontractor to provide covered
56 services or covered materials.

57 (g) "Health benefit plan" means a policy, contract, or
58 agreement offered by an insurer, third-party administrator, or
59 subcontractor to an enrollee to pay for, reimburse, discount, or
60 offset health care costs.

61 (h) "Vision benefit plan" means a policy, contract, or
62 agreement offered by an insurer or vision benefit manager to an
63 enrollee to pay for, reimburse, or offset health and vision care
64 costs.

65 (i) "Vision benefit discount plan" means a policy,
66 contract, or agreement offered by an insurer or vision benefit
67 manager to an enrollee that solely provides for a discount for
68 vision care services or materials.

69 (j) "Vision benefit manager" means an individual,
70 company, organization, group, or other entity, including, but not
71 limited to, insurers, third-party administrators, and
72 subcontractors, that creates, promotes, sells, provides,
73 advertises or administers, an integrated or stand-alone vision
74 benefit plan, vision benefit discount plan, or other insurance



75 policy or contract which provides vision benefits or discounts to
76 an enrollee pertaining to the provision of covered services or
77 covered materials.

78 (k) "Insurer" means, for the purposes of this act, an
79 individual, corporation, partnership, company, organization,
80 group, HMO, captive, risk-retention group, self-insurance group,
81 optometric service and indemnity corporation or other entity,
82 whether organized for profit or not-for-profit, whether foreign or
83 domestic, that conducts business in this state and that offers a
84 vision benefit plan or provides coverage for vision-related
85 services or vision-related materials to enrollees. For avoidance
86 of doubt, an entity is considered an insurer for purposes of this
87 act irrespective of: (i) its corporate form or category of
88 licensure, if applicable, including whether it is otherwise
89 subject to insurance regulations or any other regulations; (ii)
90 whether it, either directly or indirectly reimburses, indemnifies,
91 pays, or discounts the costs of vision services or vision
92 materials; or (iii) whether it delegates, assigns, or contracts
93 performance of any function regulated by this act to an affiliate,
94 subsidiary, contractor, intermediary, or network leasing entity.

95 (l) "Third-party administrator" means an individual,
96 company, organization, group, or other entity that provides
97 services, including, but not limited to, administrative,
98 operational, regulatory, human resource, compliance, and claim
99 adjudication services for an insurer, vision benefit manager,



100 individual, company, organization, group, or other entity under a
101 contract or agreement.

102 (m) "Subcontractor" means an individual, company,
103 organization, group or other entity, including, but not limited
104 to, agents, servants, brokers, wholesalers, distributors,
105 partially or wholly owned subsidiaries, and controlled
106 organizations that is contracted by the vision benefit manager to
107 supply services or materials to another vision benefit manager,
108 eye care provider, or enrollee to execute or fulfill the health
109 benefit plan, vision benefit plan, or vision benefit discount plan
110 of a vision benefit manager.

111 (n) "Enrollee" means any individual participating in a
112 health benefit plan, vision benefit plan or vision benefit
113 discount plan that is purchased by an individual or provided to an
114 individual by an insurer, company, organization, group, employer,
115 government assistance program, or any other entity that purchases
116 or supplies coverage for a health benefit plan, vision care
117 benefit plan or vision benefit discount plan.

118 (o) "Chargeback" means a dollar amount, fee, surcharge,
119 rebate, or item of value that reduces, modifies, or offsets all or
120 part of the patient responsibility, provider reimbursement,
121 allowed amount, or fee schedule for a covered service or covered
122 material.

123 (p) "Fee Schedule" means the document or system that
124 lists the predetermined payment rates or allowed amounts for



125 covered services and/or covered materials and determines how much
126 eye care providers are reimbursed by the insurer or vision benefit
127 manager and how much patients are charged by the insurer, vision
128 benefit manager, or eye care provider.

129 (q) "Extrapolation" means a mathematical formula,
130 process, or technique used by a vision benefit manager, or the
131 vision benefit manager's agent, in the audit of an optometrist to
132 estimate audit results or findings for a larger batch or group of
133 claims not reviewed by the vision benefit manager.

134 (r) "Nominal" means, when there is no corresponding
135 reimbursement in the current year's published Physician Fee
136 Schedule (PFS) released annually by the Centers for Medicare &
137 Medicaid Services (CMS) or in the current year's published state
138 Medicaid fee schedule, an amount less than the reasonable
139 compensation to the vision care provider rendering the covered
140 service or covered materials, taking into account the provider's
141 direct and indirect costs, i.e., the actual acquisition costs and
142 actual pro rata overhead costs, and reasonable profit.

143 (s) "De minimis" means equal to zero or an otherwise
144 negligible amount.

145 **SECTION 2. Transparency and disclosure requirements for**
146 **insurers and vision benefit managers.** (1) An insurer or vision
147 benefit manager shall disclose the following information publicly
148 on its internet website and with all documents and document
149 packages, including, but not limited to, proposals, responses to



150 requests for proposals, sales documents, enrollment documents,
151 benefit plan documents, purchaser contracts, enrollee contracts,
152 and provider agreements that are presented to purchasers,
153 potential purchasers, enrollees, potential enrollees,
154 participating eye care providers, potential participating
155 providers, and state agencies with jurisdictional, regulatory, or
156 enforcement authority over its business:

157 (a) Its legal name and entity type;

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

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

162 (d) The agencies, departments, committees, commissions,
163 and other bodies that have jurisdictional, regulatory, or
164 enforcement authority over the business;

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

167 (f) The names, physical addresses, mailing addresses,
168 electronic mail addresses, and phone numbers of all parent
169 companies, related holding companies, wholly owned subsidiary
170 companies, and partially owned subsidiary companies;

171 (g) All federal and state litigation in which the
172 company is, or has been, a party to in the current year and during
173 the preceding five (5) years.



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

177 (2) All information required to be disclosed by an insurer
178 or vision benefit manager in subsection (1) of this section shall
179 be conveyed in plain language and typed with a minimum of ten (10)
180 point font size and prominently displayed:

181 (a) On the insurer's or vision benefit manager's
182 website in a publicly accessible section titled "Required
183 Transparency Information for Patients, Doctors, and Purchasers";
184 and

185 (b) In a separately created document titled "Required
186 Transparency Information for Patients, Doctors, and Purchasers"
187 that shall be included with all documents and document packages,
188 including, but not limited to, proposals, responses to requests
189 for proposals, benefit plan documents, sales documents, enrollment
190 documents, purchaser contracts, enrollee contracts, and provider
191 agreements.

192 (3) An insurer or vision benefit manager shall provide
193 notice to each participating eye care provider of any proposed
194 amendments to existing provider agreements, fee schedules,
195 provider handbooks, provider manuals, or related policy documents
196 via electronic mail.

197 (4) A participating eye care provider shall be provided with
198 a minimum of ninety (90) calendar days from the time of



199 distribution to review changes and respond, if necessary, to any
200 proposed amendments from an insurer or vision benefit manager to
201 existing provider agreements, fee schedules, provider handbooks,
202 provider manuals, or related policy documents. Any such proposed
203 amendments proffered by the insurer or vision benefit manager in
204 violation of the foregoing shall be void and unenforceable as a
205 matter of law.

206 (5) Any proposed amendments to existing provider agreements,
207 fee schedules, provider handbooks, provider manuals, or related
208 policy documents by an insurer or vision benefit manager delivered
209 to a participating eye care provider shall be:

210 (a) Enumerated in a cover letter;

211 (b) Marked with highlights or in tracked changes within
212 the applicable agreements and/or documents to clearly display all
213 changes over the previous version(s);

214 (c) Structured to include implications of agreeance or
215 nonagreeance by the participating eye care provider.

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

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

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

222 (c) The ability for an eye care provider to have a live
223 phone discussion with a company representative within twenty-four



224 (24) hours of an initial phone call or a voice message left with
225 the insurer or vision benefit manager.

226 (7) An insurer or vision benefit manager shall maintain a
227 physical mailing address and an electronic mail address to company
228 representatives to receive questions, disputes, and communications
229 from participating eye care providers about all matters, at all
230 times, including, but not limited to, proposed amendments to
231 existing provider agreements, fee schedules, provider handbooks,
232 provider manuals, and related policy documents, and will publish
233 instructions for mail submission and electronic mail submission of
234 questions, disputes, and communications in a place visible to
235 participating eye care providers including on its website and in
236 any provider agreements, provider handbooks, provider manuals, or
237 related policy documents.

238 (8) An insurer or vision benefit manager shall acknowledge
239 receipt of an electronic mail message within one (1) hour by use
240 of a return electronic mail message with a communication tracking
241 number, and shall respond to the substantive questions or
242 communications of the electronic mail message within seventy-two
243 (72) hours in writing by use of a return electronic mail message.

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



248 (10) Insurers or vision benefit managers shall not engage in
249 marketing or advertising activities that are misleading or
250 deceptive to the public. Such acts are considered deceptive trade
251 practices and subject to penalty under the Unfair Trade Practices
252 Act, Section 83-9-209, Mississippi Code of 1972.

253 (11) Upon request by a state agency with jurisdictional,
254 regulatory, or enforcement authority over its business, insurers
255 and vision benefit managers shall submit all information related
256 to a health benefit plan, vision benefit plan, or vision benefit
257 discount plan, including, but not limited to, proposals, responses
258 to requests for proposals, benefit plan documents, sales
259 documents, enrollment documents, purchaser contracts, enrollee
260 contracts, provider agreements, and marketing and advertising
261 activities for review.

262 **SECTION 3. Covered and noncovered services and materials**

263 **provisions.** (1) No agreement or contract between an insurer or
264 vision benefit manager and an eye care provider may seek to or
265 require that an eye care provider provide services or materials at
266 a fee limited or set by the insurer or vision benefit manager
267 unless the services or materials are defined and reimbursed as
268 covered services or covered materials under the agreement or
269 contract.

270 (2) An insurer or vision benefit manager shall only use
271 standardized codes, names, descriptions, and definitions published
272 in the Healthcare Common Procedure Coding System ("HCPCS"),



273 including Current Procedural Terminology codes published by the
274 American Medical Association and Level II codes published by the
275 Centers for Medicare and Medicaid Services, to identify and
276 describe such covered services and covered materials of the vision
277 benefit plan to purchasers, enrollees, and eye care providers of
278 the vision benefit plan.

279 (3) An insurer or vision benefit manager shall adhere to the
280 standardized codes, names, descriptions, and definitions published
281 in the Healthcare Common Procedure Coding System ("HCPCS"),
282 including all Current Procedural Terminology codes published by
283 the American Medical Association and all Level II codes published
284 by the Centers for Medicare and Medicaid Services, to create and
285 offer a fee schedule for covered services and covered materials in
286 an agreement between the insurer or vision benefit manager and an
287 eye care provider.

288 (4) An insurer or vision benefit manager shall not attempt
289 to alter the meaning of any of the standardized codes, names,
290 descriptions, or definitions published in the Healthcare Common
291 Procedure Coding System ("HCPCS"), including all Current
292 Procedural Terminology codes published by the American Medical
293 Association and all Level II codes published by the Centers for
294 Medicare and Medicaid Services. Any such contractual language,
295 policies or procedures set by the insurer or vision benefit
296 manager in violation of the foregoing shall be void and
297 unenforceable as a matter of law.



298 (5) All fee schedules in an agreement between an insurer or
299 vision benefit manager and an eye care provider and all
300 reimbursements paid by an insurer or vision benefit manager to an
301 eye care provider for all covered services and covered materials
302 shall not be nominal or de minimis. There shall be no limitation
303 on the ability of an individual eye care provider or a group of
304 eye care providers who practice under a single Employer
305 Identification Number (EIN) or Tax Identification Number (TIN) to
306 engage in direct negotiations with the insurer or vision benefit
307 manager regarding reimbursement fee schedules, and ultimately
308 agreeing to a different fee schedule than the fee schedule
309 provided by the insurer or vision benefit manager to other
310 participating providers or groups.

311 (6) All fee schedule allowed amounts and all reimbursements
312 paid by an insurer or vision benefit manager for each covered
313 service and covered material shall be clearly and individually
314 listed on a fee schedule made available to the eye care provider:

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

317 (b) Within ten (10) business days from the date an
318 application is made to become a participating eye care provider
319 with the insurer or vision benefit manager by the eye care
320 provider; and

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



323 (7) A contract between an insurer or vision benefit manager
324 and an eye care provider shall include a fee schedule that
325 includes and individually identifies each covered service and
326 covered material and its corresponding allowed amount,
327 reimbursement amount paid to the eye care provider, and any form
328 of a cost-sharing amount paid by the enrollee to the eye care
329 provider.

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

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

345 (10) Insurers or vision benefit managers shall not condition
346 application to or network participation in a health benefit plan,
347 vision benefit plan, or vision benefit discount plan by an eye



348 care provider based on the eye care provider's usual and customary
349 pricing or discounts on usual and customary pricing for services
350 or materials that are not covered services or not covered
351 materials. Any such contractual language, policies, or procedures
352 set by the insurer or vision benefit manager in violation of the
353 foregoing shall be void and unenforceable as a matter of law.

354 (11) Insurers or vision benefit managers shall not make
355 conditional a fee schedule proposed or made to an eye care
356 provider of a health benefit plan, vision benefit plan, or vision
357 benefit discount plan for covered services or covered materials
358 based on the eye care provider's usual and customary pricing or
359 discounts on usual and customary pricing for services or materials
360 that are not covered services or not covered materials. Any such
361 contractual language, policies, or procedures set by the insurer
362 or vision benefit manager in violation of the foregoing shall be
363 void and unenforceable as a matter of law.

364 (12) A contract between an insurer or vision benefit manager
365 and an eye care provider shall not contain a provision, fee
366 schedule, or reimbursement amount in which the eye care provider,
367 with consideration of any applicable deductibles, copays,
368 coinsurances, discounts, rebates, or chargebacks, to provide
369 covered services or covered materials to an enrollee at a
370 financial loss. Any such contractual language, policies or
371 procedures set by the insurer or vision benefit manager in



372 violation of the foregoing shall be void and unenforceable as a
373 matter of law.

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

387 (14) Insurers or vision benefit managers shall not falsely
388 represent the number of participating providers in a region nor
389 the benefits that comprise a health benefit plan, vision benefit
390 plan, or vision benefit discount plan to clients, groups,
391 employers, purchasers, companies, enrollees, or prospective
392 enrollees. Such acts are considered deceptive trade practices and
393 subject to penalty under the Unfair Trade Practices Act, Section
394 83-9-209, Mississippi Code of 1972.

395 (15) An insurer or vision benefit manager shall not promote
396 or use in any marketing or advertising for a health benefit plan,



397 vision benefit plan, or vision benefit discount plan that a
398 covered service or covered material is "free" or "no charge" or
399 "complimentary" or any materially similar language to induce a
400 client, group, employer, purchaser, company, enrollee or
401 prospective enrollee to purchase services, materials, supplies, or
402 plans from the insurer, vision benefit manager, or affiliate of
403 the insurer or vision benefit manager.

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

410 (a) At any particular participating eye care provider;

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

414 (c) At any internet or virtual provider or retailer
415 owned by, partially owned by, contracted with, or otherwise
416 affiliated with the insurer or vision benefit manager.

417 (17) Insurers or vision benefit managers shall remit to the
418 participating eye care provider the contracted reimbursement
419 amount from the fee schedule for a covered service or covered
420 material provided to an enrollee if the enrollee is verified to be
421 eligible by the participating eye care provider through customary



422 verification methods of the insurer or vision benefit manager to
423 receive the covered service or covered material on the date of
424 service.

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

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

441 (20) Participating eye care providers are allowed, but not
442 required, to offer an enrollee the opportunity to pay the
443 participating eye care provider directly for covered services and
444 covered materials if such direct payment would be less costly to
445 the enrollee than the total out-of-pocket cost required under the
446 terms of a health benefit plan or vision benefit plan. A provider



447 may not be subject to an audit, removed from participation in the
448 network, or otherwise penalized or discriminated against in any
449 manner for offering an enrollee the opportunity to pay the
450 participating provider directly under the conditions of this
451 provision.

452 (21) Insurers or vision benefit managers shall 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 any code
456 or modifier submitted by the eye care provider, including by
457 downcoding, bundling or reassigning to a different code, if such
458 change would reduce payment or otherwise adversely affect the
459 provider and/or enrollee. For purposes of this section, "down
460 coding" means to alter, delete, substitute or assign a code that
461 results in a lower level of service, a lower-valued code, or a
462 reduced reimbursement amount relative of the code(s) submitted by
463 the eye care provider; and "bundling" means to combine,
464 substitute, or treat two (2) or more distinct services, supplied,
465 or materials reported on the same claim or date or service as
466 included within a single code, package, or global service, and
467 denying, reducing, or disallowing separate reimbursement for one
468 or more of these codes.

469 (22) All provisions in this chapter shall apply to all
470 affiliates, parent companies, third party administrators, and
471 subcontractors that are used by an insurer or vision benefit



472 manager to supply covered services or covered materials to an eye
473 care provider or enrollee and be subject to all applicable
474 penalties as referenced in this chapter.

475 (23) An insurer or vision benefit manager shall not require
476 nor request an eye care provider to opt-in or opt-out of the
477 provisions set forth in this act.

478 **SECTION 4. Prohibiting coercive tactics by insurers and**
479 **vision benefit managers; providing reimbursement parity for**

480 **Optometrists and Ophthalmologists; requiring affiliates to comply**

481 **with statute.** (1) No agreement between an insurer or vision
482 benefit manager and an eye care provider shall require that an eye
483 care provider must participate with, be credentialed by, or enter
484 into an agreement with any specific vision benefit plan or vision
485 benefit discount plan as a condition for participation in the
486 health benefit plan provider network of the insurer or vision
487 benefit manager to provide covered services or covered materials
488 to the enrollees of the health benefit plan.

489 (2) No agreement between an insurer or vision benefit
490 manager and an eye care provider shall require that an eye care
491 provider must participate with, be credentialed by, or enter into
492 an agreement with any specific health benefit plan as a condition
493 for participation in the vision benefit plan or vision benefit
494 discount plan provider network of the insurer or vision benefit
495 manager to provide covered services or covered materials to the



496 enrollees of the vision benefit plan or vision benefit discount
497 plan.

498 (3) Any insurer or vision benefit manager issuing or
499 renewing a health benefit plan, vision benefit plan or vision
500 benefit discount plan which provides benefits for covered services
501 or covered materials rendered by a physician or osteopath duly
502 licensed under Section 73-25-1 et seq. that are within the scope
503 of practice of an optometrist duly licensed under the provisions
504 of Section 73-19-1 et seq. shall provide the same reimbursement
505 for covered services or covered materials to optometrists as
506 allowed for those covered services or covered materials rendered
507 by physicians or osteopaths.

508 (4) An insurer or vision benefit manager shall apply the
509 same terms and conditions of participation for all eye care
510 providers, irrespective of their educational credentials, i.e.,
511 MD, DO, OD, subject to the permitted scope of practice for the
512 licensee under applicable state law.

513 (5) An insurer or vision benefit manager shall not require
514 an eye care provider to possess, offer, procure, or sell materials
515 or covered materials in their office as a condition of
516 participation in the provider network of health benefit plan,
517 vision benefit plan, or vision benefit discount plan. Any such
518 contractual language, policies or procedures set by the insurer or
519 vision benefit manager in violation of the foregoing shall be void
520 and unenforceable as a matter of law.



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

529 (7) The provisions of this subsection shall also apply to
530 any agreements an insurer or vision benefit manager enters into
531 with another entity to provide an enrollee with covered services
532 or covered materials.

533 **SECTION 5. Relating to conditional or coercive participation**
534 **of eye care providers in vision benefit manager networks.** (1) It
535 is prohibited for an insurer or vision benefit manager that offers
536 multiple health benefit plans, vision benefit plans, or vision
537 benefit discount plans to require an eye care provider, as a
538 condition of participation in the network for a health benefit
539 plan, vision benefit plan or vision benefit discount plan, to
540 participate in the network of any of the insurer's or vision
541 benefit manager's other health benefit plans, vision benefit plans
542 or vision benefit discount plans. A contract provision violating
543 this subsection is void as a matter of law. The penalties and
544 remedies provided in this chapter for violation of this provision
545 shall not waive, limit, or otherwise affect the applicability of



546 Mississippi's Unfair Trade Practices Act, or any other law
547 providing for civil or criminal penalties or remedies for unfair,
548 deceptive, or unlawful business practices.

549 (2) It is prohibited for an insurer or vision benefit
550 manager that offers multiple health benefit plans, vision benefit
551 plans, or vision benefit discount plans to withhold participation
552 in the network of one or more of the insurer's or vision benefit
553 manager's other health benefit plans, vision benefit plans, or
554 vision benefit discount plans if the eye care provider, having
555 completed the credentialing requirements of the insurer or vision
556 benefit manager for participation, is already participating in the
557 network of one or more of the insurer's or vision benefit
558 manager's health benefit plans, vision benefit plans, or vision
559 benefit discount plans and seeks to participate in the network of
560 the insurer's or vision benefit manager's other health benefit
561 plans, vision benefit plans, or vision benefit discount plans.

562 (3) Subsections (1) and (2) of this section apply to all
563 plan types that a health benefit plan, vision benefit plan, or
564 vision benefit discount plan sells, administers, or offers,
565 including, but not limited to, individually purchased plans,
566 employer-sponsored plans, and government-sponsored plans, e.g.,
567 Medicare, Medicaid, and Tricare, etc.

568 **SECTION 6. Credentialing and contracting requirements;**
569 **acceptance as participating eye care provider.** (1) An insurer or
570 vision benefit manager must include on their internet website:



571 (a) a method for an eye care provider to submit an application for
572 inclusion and credentialing as a participating provider in the
573 health benefit plan, vision benefit plan, or vision benefit
574 discount plan; and (b) a description of the credentialing
575 requirements, which must be reasonable, related to the delivery of
576 covered eye care services, and applied in an objective, uniform,
577 and nondiscriminatory manner.

578 (2) An insurer's or vision benefit manager's application for
579 inclusion and credentialing as a participating eye care provider
580 in the health benefit plan, vision benefit plan, or vision benefit
581 discount plan shall only require standardized information
582 prescribed by law or regulation or information specified on the
583 Council for Affordable Quality Healthcare credentialing
584 application.

585 (3) An insurer's or vision benefit manager's application for
586 inclusion and credentialing as a participating eye care provider
587 in the health benefit plan, vision benefit plan, or vision benefit
588 discount plan must impose the same application and credentialing
589 requirements on each eye care provider.

590 (4) No later than the 10th business day after the date the
591 insurer or vision benefit manager receives an application from an
592 eye care provider for inclusion and credentialing as a
593 participating provider in the health benefit plan, vision benefit
594 plan, or vision benefit discount plan, the insurer or vision
595 benefit manager shall make available electronically to the eye



596 care provider a proposed participating provider agreement,
597 including applicable fee schedules, provider handbooks, and
598 provider manuals.

599 (5) No later than the 30th business day after the date the
600 insurer or vision benefit manager receives an application from an
601 eye care provider for inclusion and credentialing as a
602 participating provider in the health benefit plan, vision benefit
603 plan, or vision benefit discount plan, the insurer or vision
604 benefit manager shall complete the credentialing determination of
605 the eye care provider, approve or disapprove the application of
606 the eye care provider, and deliver electronically a proposed
607 participating provider agreement described by subsection (4) of
608 this section for acceptance and signature of the approved eye care
609 provider.

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

615 (7) If the application for inclusion and credentialing as a
616 participating provider is denied by the insurer or vision benefit
617 manager, the eye care provider must be allowed a reasonable period
618 of time in which to appeal the decision to the insurer or vision
619 benefit manager and provide in the appeal evidence that supports
620 the reconsideration of the denied application. The insurer or



621 vision benefit manager shall consider, and render a decision on,
622 the eye care provider's appeal submission within thirty (30) days
623 of the date of receipt of the submission by the insurer or vision
624 benefit manager.

625 (8) If the appeal to the application denial for inclusion
626 and credentialing as a participating provider is denied by the
627 insurer or vision benefit manager, the insurer or vision benefit
628 manager shall deliver to the applicant eye care provider a
629 detailed explanation for the denial of the appeal both
630 electronically and in writing via certified mail.

631 (9) If the appeal to the application denial for inclusion
632 and credentialing as a participating provider is denied by the
633 insurer or vision benefit manager, the applicant eye care provider
634 may appeal the decision to the Mississippi Commissioner of
635 Insurance and seek a ruling that allows the eye care provider to
636 become a participating provider in the health benefit plan, vision
637 benefit plan, or vision benefit discount plan.

638 (10) An insurer or vision benefit manager, concurrent with
639 the electronic delivery of the proposed participating provider
640 agreement to the approved eye care provider described by
641 subsection (5) of this section, must provide the name, email
642 address, and phone number of a representative of the insurer or
643 vision benefit manager to allow the approved eye care provider the
644 opportunity to:



645 (a) Contact the representative before signing the
646 agreement;

647 (b) Discuss the proposed agreement with the
648 representative before signing the agreement; and

649 (c) Electronically send the representative
650 modifications to the proposed agreement before signing the
651 agreement.

652 (11) In the event that the approved eye care provider sends
653 the representative of the insurer or vision benefit manager
654 modifications to the proposed participating provider agreement
655 described by subsection (10)(c) of this section, the insurer or
656 vision benefit manager must respond to the submission of the
657 approved eye care provider within five (5) business days. Each
658 subsequent response made by the insurer, vision benefit manager,
659 or approved eye care provider to the other party must be responded
660 to within five (5) business days by the receiving party.

661 (12) Once the insurer or vision benefit manager has approved
662 and delivered electronically a proposed participating provider
663 agreement described by subsection (5) of this section, the
664 approved eye care provider has a total allotted timeframe of
665 ninety (90) business days to reach agreement with the insurer or
666 vision benefit manager and sign a participating provider
667 agreement. If the parties fail to reach agreement and no
668 participating provider agreement is signed by the approved eye



669 care provider within the allotted timeframe, the insurer or vision
670 benefit manager may retract the participating provider agreement.

671 (13) No later than the 20th business day after the date the
672 approved eye care provider signs a participating provider
673 agreement, the insurer or vision benefit manager shall include the
674 credentialed and approved eye care provider as a participating
675 provider in the health benefit plan, vision benefit plan, or
676 vision benefit discount plan, and list the eye care provider in
677 all of the plan's directories that are available to enrollees and
678 the public.

679 (14) The earliest that an eye care provider may submit
680 another application to an insurer or vision benefit manager after
681 a previous approval and subsequent unsuccessful attempt to
682 negotiate a mutually acceptable participating provider agreement
683 is one hundred eighty (180) calendar days from the date of
684 submission of the previous application.

685 (15) The earliest that an eye care provider may submit
686 another application to an insurer or vision benefit manager after
687 a previous disapproval of application is one hundred eighty (180)
688 calendar days from the date of submission of the previous
689 application.

690 (16) An insurer or vision benefit manager shall allow an eye
691 care provider to become a participating provider in the network of
692 a health benefit plan, vision benefit plan, or vision benefit
693 discount plan if the eye care provider: (a) meets the



694 credentialing requirements of the insurer or vision benefit
695 manager; and (b) agrees in writing to the applicable provider
696 agreement.

697 (17) An insurer or vision benefit manager shall not exclude
698 an eye care provider from applying to, or becoming a participating
699 provider in, the network of a health benefit plan, vision benefit
700 plan, or vision benefit discount plan because of:

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

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

706 (c) The provider's professional designation,
707 independent practice affiliation, or participation status in other
708 health benefit plans, vision benefit plans, or vision benefit
709 discount plans.

710 **SECTION 7. Prohibits insurer, vision benefit manager from**
711 **changing the terms of a provider agreement with a participating**
712 **eye care provider without clear written communication to, and**
713 **affirmative acceptance by, the eye care provider.** (1) An insurer
714 or vision benefit manager shall not change or alter a provider
715 agreement, including terms, reimbursements, fee schedules,
716 policies, procedures, or provider manuals incorporated by
717 reference into the provider agreement, entered into with a
718 participating eye care provider unless the insurer or vision



719 benefit manager performs the following steps at least ninety (90)
720 days before the date of the proposed change would take effect:

721 (a) A certified letter, or an electronic communication
722 requiring an electronic signature proving receipt, clearly
723 detailing proposed changes is required to be sent to the eye care
724 provider;

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

727 (c) The eye care provider must either agree or protest
728 in writing to the proposed changes. If the changes are not agreed
729 to by the eye care provider, then the current agreement shall
730 continue and the insurer or vision benefit manager may not remove
731 the eye care provider from participation with a health benefit
732 plan, vision benefit plan, or vision benefit discount plan for not
733 accepting the proposed changes;

734 (d) Any proposed amendment to an existing provider
735 agreement shall be presented to the participating eye care
736 provider in a manner conducive to the eye care provider's review.
737 Proposed changes will be: (i) enumerated in a cover letter; and
738 (ii) clearly marked in tracked changes within the body of the
739 applicable agreement;

740 (e) An agreement between an insurer or vision benefit
741 manager and an eye care provider shall not contain a provision
742 requiring the optometrist to accept a reimbursement payment in the
743 form of a virtual credit card or any other payment method wherein



744 a processing fee, administrative fee, percentage amount, or dollar
745 amount is assessed for the provider to receive the reimbursement
746 payment.

747 (2) Termination of any provider agreement shall be
748 permissible only in the event of a material breach, wherein the
749 eye care provider fails to remedy the alleged breach to the
750 reasonable satisfaction of the insurer or vision benefit manager
751 within thirty (30) days of receipt of written notice specifying
752 the alleged breach.

753 (3) It shall be prohibited for an insurer or vision benefit
754 manager to require an eye care provider to establish a security
755 interest in all or part of their property and assets, including
756 assets pertaining to their practice, in a sum equivalent to the
757 funds owed to the insurer or vision benefit manager at
758 termination. Any such contractual language, policies or
759 procedures set by the insurer or vision benefit manager in
760 violation of the foregoing shall be void and unenforceable as a
761 matter of law.

762 (4) A provider agreement between an insurer or vision
763 benefit manager and an eye care provider shall not contain a
764 provision obligating the eye care provider to share equally the
765 expenses of arbitration. Any such contractual language, policies
766 or procedures set by the insurer or vision benefit manager in
767 violation of the foregoing shall be void and unenforceable as a
768 matter of law. Each party shall bear their own arbitration costs,



769 contingent upon a fee-shifting provision that grants prevailing
770 party status.

771 (5) An insurer or vision benefit manager shall not retaliate
772 in any manner against an eye care provider for discussing, or
773 attempting in good faith to negotiate, the terms and provision of
774 a provider agreement with the insurer or vision benefit manager.

775 (6) An insurer or vision benefit manager shall not retaliate
776 in any manner against an eye care provider for filing a complaint
777 against the insurer or vision benefit manager with any state
778 agency with jurisdictional, regulatory, or enforcement authority
779 over the business of the insurer or vision benefit manager.

780 (7) Should retaliation by an insurer or vision benefit
781 manager occur against an eye care provider in violation of
782 subsections (5) and (6) of this section, a state agency that has
783 jurisdictional, regulatory, or enforcement authority over the
784 business of the insurer or vision benefit manager may sanction the
785 insurer or vision benefit manager, including fines and other
786 remedies deemed appropriate, and provide an appropriate remedy for
787 the aggrieved eye care provider.

788 **SECTION 8. Permitting eye care providers to use any lab or**

789 **supplier.** (1) No agreement between an insurer or vision benefit
790 manager and an eye care provider shall restrict or limit, either
791 directly or indirectly, the eye care provider's choice or use of
792 sources and suppliers of covered or uncovered services or
793 materials, including the choice or use of optical laboratories,



794 provided by the eye care provider to an enrollee. Any such
795 contractual language, policies or procedures set by the insurer or
796 vision benefit manager in violation of the foregoing shall be void
797 and unenforceable as a matter of law.

798 (2) An insurer or vision benefit manager shall not directly
799 or indirectly:

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

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

804 (c) Reimburse an eye care provider a different amount
805 for covered services or covered materials because of the eye care
806 provider's choice of:

807 (i) Optical laboratory;

808 (ii) Source of supplier of:

809 1. Contact lenses;

810 2. Ophthalmic lenses;

811 3. Ophthalmic glasses frames; or

812 4. Covered or noncovered services or

813 materials;

814 (iii) Equipment used for patient care;

815 (iv) Retail optical affiliation;

816 (v) Vision support organization;

817 (vi) Group purchasing organization;

818 (vii) Doctor alliance;



819 (viii) Professional trade association membership;
820 (ix) Electronic health record software, electronic
821 medical record software, or practice management software; or
822 (x) Third-party claim filing service, billing
823 service, or electronic data interchange clearinghouse company;
824 (d) Restrict, limit or influence an eye care provider's
825 choice of sources or suppliers of services or materials, including
826 optical laboratories used by the eye care provider to provide
827 services or materials to the enrollee;
828 (e) Restrict, limit, or influence an eye care
829 provider's choice of electronic health record software, electronic
830 medical record software, or practice management software;
831 (f) Restrict, limit, or influence an eye care
832 provider's choice of third-party claim filing service, billing
833 service, or electronic data interchange clearinghouse company;
834 (g) Restrict or limit an eye care provider's access to
835 an enrollee's complete plan coverage information, including
836 in-network and out-of-network coverage details;
837 (h) Apply a chargeback to an enrollee or eye care
838 provider if the chargeback is for a covered product or service for
839 which the insurer or vision benefit manager does not incur the
840 cost to produce, deliver, or provide to the enrollee or eye care
841 provider;
842 (i) Require an eye care provider to disclose an
843 enrollee's confidential or protected health information unless the



844 disclosure is expressly authorized by the enrollee, or permitted
845 without authorization under the Health Insurance Portability and
846 Accountability Act of 1996;

847 (j) Require an eye care provider to disclose or report
848 a medical history or diagnosis as a condition to file a claim,
849 adjudicate a claim, or receive reimbursement for a routine or
850 wellness eye exam;

851 (k) Require an eye care provider to disclose or report
852 an enrollee's glasses prescription, contact lens prescription,
853 ophthalmic device measurements, facial photograph, or unique
854 anatomical measurements as condition to file a claim, adjudicate a
855 claim, or receive reimbursement for a claim, unless the
856 information is needed for the vision benefit manager to
857 manufacture, or cause to be manufactured, a covered product that
858 is submitted on the applicable claim; or

859 (l) Require an eye care provider to disclose any
860 enrollee information, other than information identified on the
861 version of the Health Insurance Claim Form approved by the
862 National Uniform Claim Committee as of March 1, 2023, (or its
863 approved successor), as a condition to file a claim, adjudicate a
864 claim, or receive reimbursement for a claim unless the information
865 is needed for the vision benefit manager to manufacture, or cause
866 to be manufactured, a covered product that is submitted on the
867 applicable claim.



868 (3) An insurer or vision benefit manager shall not solicit
869 patients or referrals for supplies on behalf of themselves and/or
870 their affiliates by identifying participating eye care providers
871 in an inaccurate or otherwise misleading manner in any list of
872 participating providers or in any communications to purchasers or
873 enrollees. All communications which distinguish between
874 participating eye care providers, or which otherwise claim
875 professional superiority or the performance of a professional
876 service in a superior manner, based on the following
877 characteristics, shall be readily subject to verification by the
878 Department of Insurance:

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

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

885 (c) The brand, source, manufacturer, or supplier of a
886 covered service or covered material utilized by the participating
887 eye care provider.

888 (4) For the avoidance of doubt, this section does not
889 prohibit advertising, provided that such advertising is: (a) not
890 false, misleading, or deceptive; or (b) readily subject to
891 verification.



892 **SECTION 9. Extrapolation prohibited.** An insurer or vision
893 benefit manager shall not use extrapolation to complete an audit
894 of a participating eye care provider. Any additional payment due
895 to a participating eye care provider or any refund due to the
896 insurer or vision benefit manager shall not be based on an
897 extrapolation, but shall be based on the actual overpayment or
898 underpayment, as determined after an investigation by the insurer
899 or vision benefit manager, and participating eye care provider has
900 been afforded, and has exhausted, all opportunities to appeal the
901 insurer or vision benefit manager's findings, as set forth in the
902 provider manual or policy document, and/or applicable law.

903 **SECTION 10. A private right of action for eye care**
904 **providers.** Any eye care provider adversely affected by a
905 violation of this act may bring an action in a court of competent
906 jurisdiction for injunctive relief against the insurer or vision
907 benefit manager and, upon prevailing, in addition to such
908 injunctive relief, shall recover monetary damages, including, but
909 not limited to, direct, indirect, special and punitive damages,
910 and penalties, of no more than Ten Thousand Dollars (\$10,000.00)
911 for each violation, plus attorney's fees and costs.

912 **SECTION 11. Relationship to other laws.** The requirements of
913 this act are in addition to, and do not limit, any other
914 requirement applicable to an insurer under state law. In the
915 event of a conflict between this act and another provision of
916 state law applicable to insurers, the provision that affords



917 greater protection to eye care providers or plan enrollees shall
918 control. Notwithstanding any other provision of state law,
919 including any law that purports to be the sole body of law
920 governing the insurer, an insurer shall comply with this act, to
921 the extent not preempted by federal law.

922 **SECTION 12. Enforcement.** (1) The Mississippi Insurance
923 Commissioner, Mississippi Insurance Department, has jurisdiction
924 to administer and enforce this act with respect to any insurer, as
925 such term is defined herein. The Mississippi Insurance
926 Commissioner, Mississippi Insurance Department, may: (a) bring an
927 action, issue orders, and impose remedies authorized by this act
928 against any Insurer; (b) adopt rules to identify activities that
929 constitute the administration, management, or control of vision
930 benefits or materials; and (c) coordinate enforcement with other
931 State agencies that regulate insurers under other applicable law.
932 The Attorney General has concurrent enforcement authority for
933 violations constituting unfair or deceptive acts or practices.

934 (2) The Insurance Commissioner shall:

935 (a) Provide a mechanism for aggrieved individuals,
936 whether actively or formerly enrolled with a particular vision
937 care plan, to submit complaints to the Insurance Commissioner for
938 review, investigation, and as appropriate, discipline under
939 applicable law.



940 (b) Enforce the state's insurance laws and this
941 provision using powers granted to the commissioner in the
942 Mississippi Insurance Code, Title 83;

943 (c) Ensure that insurers and vision benefit managers
944 comply with the requirements of this act; and

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

948 (i) Issues a coverage policy that does not comply
949 with the requirement of this act, uses fraudulent, coercive or
950 dishonest practices, or demonstrates incompetence,
951 untrustworthiness, or financial irresponsibility in the conduct of
952 business;

953 (ii) Fails to deal equitably with any eye care
954 providers or other persons or facilities which offer services or
955 materials covered within a contract or policy issued pursuant to
956 this act; or

957 (iii) Fails to substantially comply with the
958 insurance laws of this state or violates any regulation, rule,
959 subpoena or order of the Mississippi Insurance Commissioner,
960 Mississippi Insurance Department.

961 (3) The Attorney General shall:

962 (a) Enforce the state's laws and this act's provisions,
963 using powers granted to the Attorney General in the Mississippi



964 Insurance Code Title 83 and/or the state's consumer protection
965 statutes; and

966 (b) Be entitled to seek an injunction against an
967 insurer or vision benefit manager in a court of competent
968 jurisdiction.

969 (4) The penalties and remedies provided in this chapter for
970 violation of this provision: (a) are cumulative, and in addition
971 to any other penalties and remedies available under state law; and
972 (b) shall not waive, limit, or otherwise affect the applicability
973 of Mississippi's Consumer Protection Act, Title 75, Chapter 24, or
974 any other law providing for civil or criminal penalties or
975 remedies for unfair, deceptive, or unlawful business practices.

976 **SECTION 13. Severability clause.** If any provision of this
977 act or the application thereof to any person or circumstance is
978 held invalid, the remainder of the chapter and the application of
979 such provision to other persons or circumstances shall not be
980 affected thereby.

981 **SECTION 14. Enactment provisions.** (1) The requirements of
982 this section apply to insurer or vision benefit manager policies,
983 contracts, addenda and certificates executed, delivered, issued
984 for delivery, continued or renewed in Mississippi.

985 (a) No insurer or vision benefit manager shall construe
986 re-credentialing as re-contracting with a participating eye care
987 provider. A provider agreement must be a distinctly separate



988 document from any credentialing materials and must be signed by
989 the eye care provider and the insurer or vision benefit manager.

990 (b) An insurer or vision benefit manager must include a
991 copy of the current plan provider manual referred to in a provider
992 agreement at the time an agreement is sent to any provider and
993 prospective provider, as well as any policies referenced in the
994 provider agreement, e.g. dispute resolution policies.

995 (2) This law shall go into effect immediately upon passage
996 and shall apply to all insurers and vision benefit managers upon
997 the earlier of:

998 (a) The renewal of enrollee's current benefit plan or
999 upon issue of a new benefit plan to any enrollee;

1000 (b) The initiation of a new provider agreement with an
1001 eye care provider or upon any amendment of an existing provider
1002 agreement with an eye care provider; or

1003 (c) July 1, 2026.

1004 **SECTION 15.** This act shall take effect and be in force from
1005 and after its passage.

