AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," providing for quality eye care for insured Pennsylvanians.

Section 1. The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 2701. Short title of article.

This article shall be known and may be cited as the Quality Eye Care for Insured Pennsylvanians Act.
Section 2702. Definitions.

The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Covered vision services." Vision services AND MATERIALS for which reimbursement is available under an insured's A HEALTH INSURANCE policy, regardless of whether the reimbursement is contractually limited by a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation or alternative benefit payment.

"Enrollee." A subscriber afforded coverage for services, materials or both under an insurance policy, a vision care plan or a government program.

"Eye care provider." A licensed doctor of optometry practicing under the authority of the act of June 6, 1980 (P.L.197, No.57), known as the Optometric Practice and Licensure Act, or a licensed physician who has also completed a residency in ophthalmology.

"Government program." A program that issues coverage for materials or services pursuant to this act and is governed by or subject to any of the following:

(1) The medical assistance program established under the act of June 13, 1967 (P.L.31, No.21), known as the Human Services Code.

(2) A program administered by a Medicaid managed care organization as defined in section 1903(m)(1)(A) of the Social Security Act (42 U.S.C. § 1396b(m)(1)(A)) that is a party to a Medicaid managed care contract with the Department of Human Services.

(3) The Medicare program established under the Social
Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.).

(4) The Medicare Advantage program established under the Social Security Act.

"DEPARTMENT." THE INSURANCE DEPARTMENT OF THE COMMONWEALTH.

"Insurance "HEALTH INSURANCE policy." An individual or group health insurance policy, SUBSCRIBER contract, CERTIFICATE or plan issued by or through an insurer, a vision care plan or a government program that provides coverage for materials, services or both provided by an eye care provider, THAT PROVIDES COVERED VISION CARE. FOR PURPOSES OF THIS ARTICLE, THE TERM INCLUDES VISION ONLY INSURANCE COVERAGE. The term does not include accident only, fixed indemnity, limited benefit, credit, dental, specified disease, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, long-term care or disability income, workers' compensation or automobile medical payment insurance.

"Insurer." An entity or affiliate entity that issues an insurance policy pursuant to this act and is subject to any one of the following:

"HEALTH INSURER." AN ENTITY LICENSED BY THE DEPARTMENT WITH AN ACCIDENT AND HEALTH AUTHORITY TO ISSUE A POLICY, SUBSCRIBER CONTRACT, CERTIFICATE OR PLAN THAT PROVIDES MEDICAL OR HEALTH CARE COVERAGE, INCLUDING VISION COVERAGE, AND IS OFFERED OR GOVERNED UNDER ANY OF THE FOLLOWING:

(1) This act SECTION 630, ARTICLE XXIV OR OTHER PROVISION OF THIS ACT.


(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).
(4) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

(5) A preferred provider organization. "Licensure board." Any or all of the following, depending on the licensure of the affected individual:

(1) The State Board of Medicine.

(2) The State Board of Osteopathic Medicine.

(3) The State Board of Optometry.

"INSURED." AN INDIVIDUAL ON WHOSE BEHALF A HEALTH INSURER IS OBLIGATED TO PAY FOR VISION CARE UNDER A HEALTH INSURANCE POLICY.

"Materials." Ophthalmic devices, including, but not limited to, lenses, devices containing lenses, artificial intraocular lenses, ophthalmic frames and other lens mounting apparatus, prisms, lens treatments and coating, contact lenses and prosthetic devices to correct, relieve or treat defects or abnormal conditions of the human eye or its adnexa associated with the delivery of services, materials or both by an eye care provider. VISION CARE.

"NONCOVERED SERVICES." VISION CARE THAT IS NOT COVERED BUT FOR WHICH A DISCOUNT MAY BE PROVIDED UNDER THE TERMS OF A HEALTH INSURANCE POLICY.

"Physician." An individual licensed under the laws of this Commonwealth to engage in the practice of:


(2) Osteopathic medicine and surgery within the scope of the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act.
"Services." The delivery of eye care services, materials or both by an eye care provider.

"Vision care plan." An entity that creates, promotes, sells, provides, advertises or administers an integrated or stand-alone vision benefit plan, or a vision care insurance policy or contract that provides coverage for materials, services or both to an enrollee pursuant to an insurance policy, vision care plan or government program.

Section 2702. Restrictions on participating provider agreements.

A participating provider agreement between an eye care provider and an insurer, vision care plan or government program shall comply with all of the following:

1. The eye care provider may not be required to provide services to the insurer's insureds at a fee set by the insurer unless those services are covered vision services.

2. Reimbursements paid by an insurer, vision care plan or government program for covered services and covered materials under the participating provider agreement shall be reasonable and shall not provide nominal reimbursement in order to claim that services and materials are included in covered vision services under the insurance policy, vision care plan or government program.

3. An eye care provider may not charge more for services and materials that are noncovered services or noncovered materials to an enrollee of an insurer, vision care plan or government program than the usual and customary rate for those services and materials.

4. The participating provider agreement may not restrict or limit, either directly or indirectly, the eye
care provider's choice of sources and suppliers of services or materials or the use of optical laboratories provided by the eye care provider to an enrollee.

(5) The terms or reimbursement rates contained in the participating provider agreement may not be changed without a signed acknowledgment of written consent and agreement from the eye care provider.

Section 2704. Prohibition on contracting.

No insurance policy, vision care plan or government program may impose a condition or restriction on an eye care provider that is not necessary for the delivery of services or materials or that has the effect of excluding the eye care provider from participation in the insurance policy, vision care plan, government program or any of the participating provider panels for those entities.

Section 2705. Penalties.

A violation of the provisions of this article by an insurer or a vision care plan with frequency sufficient to constitute a general business practice shall be considered a violation of the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act, and is deemed an unfair method of competition and an unfair deceptive act or practice pursuant to that act.

Section 2706. Applicability.

The requirements of this article shall apply to an insurer, insurance policy, a vision care plan or a government program and any contracts, addendums and certificates executed, delivered, issued for delivery, continued or renewed in this Commonwealth.

"VISION CARE SUPPLIER." A PERSON OR ENTITY, OTHER THAN A VISION CARE PROVIDER, THAT CREATES, PROMOTES, SELLS, PROVIDES,
ADVERTISES OR ADMINISTERS VISION CARE, INCLUDING AN OPTICAL
LABORATORY. THE TERM INCLUDES PERSONS OR ENTITIES AFFILIATED
WITH A HEALTH INSURER.

SECTION 2703. VISION CARE PROVIDER AND VISION CARE SUPPLIER.
A HEALTH INSURANCE POLICY SHALL ALLOW AN INSURED WHO RECEIVES
VISION CARE FROM AN IN-NETWORK VISION CARE PROVIDER TO SELECT AN
OUT-OF-NETWORK VISION CARE SUPPLIER FOR RELATED VISION CARE ON
THE RECOMMENDATION OR REFERRAL OF THE IN-NETWORK VISION CARE
PROVIDER, PROVIDED THAT THE IN-NETWORK VISION CARE PROVIDER
GIVES TO THE INSURED, PRIOR TO RECOMMENDING, REFERRING,
PREScribing OR ORDERING ANY VISION CARE FROM THE OUT-OF-NETWORK
VISION CARE SUPPLIER, WRITTEN NOTICE THAT:

(1) THE OUT-OF-NETWORK VISION CARE SUPPLIER IS NOT AN
IN-NETWORK VISION CARE SUPPLIER.

(2) THE INSURED HAS THE OPTION OF SELECTING AN IN-
NETWORK VISION CARE SUPPLIER.

(3) THE INSURED MAY HAVE DIFFERENT FINANCIAL OBLIGATIONS
DEPENDING ON WHETHER THE VISION CARE SUPPLIER IS IN-NETWORK
OR OUT-OF-NETWORK.

SECTION 2704. DISCOUNT ACCESS.
A HEALTH INSURANCE POLICY PROVIDING DISCOUNTS FOR NONCOVERED
SERVICES PROVIDED BY A VISION CARE PROVIDER SHALL ALLOW THE
VISION CARE PROVIDER TO OPT OUT OF THE CONTRACTUAL OBLIGATION TO
PROVIDE SUCH DISCOUNTS, PROVIDED THAT THE VISION CARE PROVIDER
PROVIDES WRITTEN DISCLOSURE TO THE INSURED THAT THE VISION CARE
PROVIDER DOES NOT PARTICIPATE IN THE INSURED'S DISCOUNT PROGRAM.

SECTION 2705. ENFORCEMENT.
(A) SCOPE.--THE DEPARTMENT MAY INVESTIGATE AND ENFORCE THE
PROVISIONS OF THIS ARTICLE ONLY INsofar AS THE ACTIONS OR
INACtIONS BEING INVESTIGATED RELATE TO COVERAGE UNDER A HEALTH
INSURANCE POLICY.


(C) REMEDIES CUMULATIVE.--THE ENFORCEMENT REMEDIES IMPOSED UNDER THIS SECTION ARE IN ADDITION TO ANY OTHER REMEDIES OR PENALTIES THAT MAY BE IMPOSED UNDER ANY OTHER APPLICABLE LAW OF THIS COMMONWEALTH, INCLUDING THE ACT OF JULY 22, 1974 (P.L.589, NO.205), KNOWN AS THE UNFAIR INSURANCE PRACTICES ACT. A VIOLATION OF THIS ARTICLE SHALL BE DEEMED TO BE AN UNFAIR METHOD OF COMPETITION AND AN UNFAIR OR DECEPTIVE ACT OR PRACTICE UNDER THE UNFAIR INSURANCE PRACTICES ACT.

(D) ADMINISTRATIVE PROCEDURE.--THE ADMINISTRATIVE PROVISIONS OF THIS SECTION SHALL BE SUBJECT TO 2 PA.C.S. CH. 5 SUBCH. A (RELATING TO PRACTICE AND PROCEDURE OF COMMONWEALTH AGENCIES). A PARTY AGAINST WHOM PENALTIES ARE ASSESSED IN AN ADMINISTRATIVE ACTION MAY APPEAL TO COMMONWEALTH COURT AS PROVIDED IN 2 PA.C.S. CH. 7 SUBCH. A (RELATING TO JUDICIAL REVIEW OF COMMONWEALTH AGENCY ACTION).

(E) ENFORCEMENT REMEDIES.--THE ENFORCEMENT REMEDIES IMPOSED UNDER THIS SECTION SHALL BE IN ADDITION TO ANY OTHER REMEDIES OR PENALTIES THAT MAY BE IMPOSED UNDER THE LAWS OF THIS COMMONWEALTH.

SECTION 2706. REGULATIONS.

THE DEPARTMENT MAY PROMULGATE REGULATIONS AS MAY BE NECESSARY OR APPROPRIATE TO IMPLEMENT THIS ARTICLE.
SECTION 2707. APPLICABILITY.

THIS ACT SHALL APPLY AS FOLLOWS:

(1) FOR HEALTH INSURANCE POLICIES FOR WHICH EITHER RATES
OR FORMS ARE REQUIRED TO BE FILED WITH FEDERAL GOVERNMENT OR
THE INSURANCE DEPARTMENT, THIS ACT SHALL APPLY TO ANY POLICY
FOR WHICH A FORM OR RATE IS FIRST FILED ON OR AFTER THE
EFFECTIVE DATE OF THIS SECTION.

(2) FOR HEALTH INSURANCE POLICIES FOR WHICH NEITHER
RATES NOR FORMS ARE REQUIRED TO BE FILED WITH THE FEDERAL
GOVERNMENT OR THE INSURANCE DEPARTMENT, THIS ACT SHALL APPLY
TO ANY POLICY ISSUED OR RENEWED ON OR AFTER 180 DAYS AFTER
THE EFFECTIVE DATE OF THIS SECTION.

Section 2. This act shall take effect in 60 days.