§4314. Access to eye care providers

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Eye care provider" means a participating provider who is an optometrist licensed to practice optometry pursuant to Title 32, chapter 34-A, or an ophthalmologist licensed to practice medicine pursuant to Title 32, chapter 48. [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

B. "Eye care services" means those urgent health care services related to the examination, diagnosis, treatment and management of conditions, illnesses and diseases of the eye and related structures that are provided to treat conditions, illnesses or diseases of the eye that if not treated within 24 hours present a serious risk of harm. [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

C. "Contractual discount" means a percentage or other reduction from a provider's usual and customary rate for a covered service or covered material required under a participating provider agreement. [PL 2015, c. 171, §1 (NEW); PL 2015, c. 171, §4 (AFF).]

D. "Covered material" means a material for which benefits are provided under a health plan that provides coverage for vision care or eye care services or a limited benefit vision insurance plan. [PL 2015, c. 171, §1 (NEW); PL 2015, c. 171, §4 (AFF).]

E. "Covered service" means a service for which benefits are provided under a health plan that provides coverage for vision care or eye care services or a limited benefit vision insurance plan. [PL 2015, c. 171, §1 (NEW); PL 2015, c. 171, §4 (AFF).]

F. "Limited benefit vision insurance plan" means a plan offered or administered by a carrier that covers only vision care or any other plan offered or administered by a carrier that includes vision care benefits and is not a health plan. [PL 2015, c. 171, §1 (NEW); PL 2015, c. 171, §4 (AFF).]

G. "Materials" means ophthalmic devices, including, but not limited to, lenses, devices containing lenses, artificial intraocular lenses, ophthalmic frames and other lens mounting apparatuses, 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. [PL 2015, c. 171, §1 (NEW); PL 2015, c. 171, §4 (AFF).]

H. "Services" means the professional work performed by an eye care provider. [PL 2015, c. 171, §1 (NEW); PL 2015, c. 171, §4 (AFF).]

I. "Vision insurance" means a health plan that provides coverage for vision care or eye care services or a limited benefit vision insurance plan. [PL 2015, c. 171, §1 (NEW); PL 2015, c. 171, §4 (AFF).]

[PL 2015, c. 171, §1 (AMD); PL 2015, c. 171, §4 (AFF).]

2. Coverage of eye care services. A carrier that provides coverage for eye care services as part of a health plan shall provide coverage for eye care services in accordance with the following.

A. An enrollee may receive eye care services from an eye care provider participating in the enrollee's health plan without the prior approval or authorization of the enrollee's primary care provider for a maximum of 2 visits, one initial visit and one follow-up visit, for each occurrence requiring urgent care as described in subsection 1, paragraph B. A carrier may not retrospectively deny coverage under this section on the basis that the eye care services received by the enrollee did not meet the requirements of subsection 1, paragraph B. In order to receive continuing benefits for treatment related to the initial visit, an enrollee must receive the approval of the enrollee's primary care provider for any visit after the 2nd visit. Within 3 working days of the initial visit, the eye care provider shall send to the enrollee's primary care provider a report containing the enrollee's complaint, related history, examination results, initial diagnosis and recommendations for

treatment. If the eye care provider does not send a report to the primary care provider within 3 working days, the carrier is not obligated to provide benefits for the self-referred visits under this paragraph and the enrollee is not liable to the eye care provider for any unpaid fees. [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

B. A carrier shall ensure that all eye care providers participating in the carrier's health plans are included on any publicly accessible list of participating providers for the carrier. [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

C. A carrier shall allow each eye care provider participating in the carrier's health plans to furnish covered eye care services to enrollees without discrimination between classes of eye care providers and to provide the eye care services permitted by the eye care provider's license. [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

[PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

3. Prohibitions. A carrier or a subsidiary or subcontractor of a carrier may not:

A. Impose a deductible or coinsurance for eye care services that is greater than the deductible or coinsurance imposed for other health care services under a health plan; [PL 2015, c. 171, §2 (AMD); PL 2015, c. 171, §4 (AFF).]

B. Require an eye care provider to hold hospital privileges as a condition of participation as a provider under a health plan; [PL 2015, c. 171, §2 (AMD); PL 2015, c. 171, §4 (AFF).]

C. Require in an agreement with an eye care provider that the eye care provider provide services or materials to an enrollee in a health plan that provides coverage for vision care or eye care services or a limited benefit vision insurance plan at a specified or limited fee unless the services or materials are a covered service or a covered material under the health plan or limited benefit vision insurance plan; [PL 2015, c. 171, §2 (NEW); PL 2015, c. 171, §4 (AFF).]

D. Restrict or limit, directly or indirectly, in an agreement with an eye care provider, the eye care provider's choice of sources and suppliers of services or materials provided by the eye care provider to an enrollee or the optical laboratories used by the eye care provider; [PL 2015, c. 171, §2 (NEW); PL 2015, c. 171, §4 (AFF).]

E. Change any term, contractual discount or reimbursement rate contained in an agreement with an eye care provider without notice to the eye care provider at least 60 days before the change is implemented; [PL 2015, c. 171, §2 (NEW); PL 2015, c. 171, §4 (AFF).]

F. Require in an agreement with an eye care provider that the eye care provider participate in other vision insurance as a condition of joining an insurer's provider network for a health plan that provides coverage for vision care or eye care services or a limited benefit vision insurance plan; or [PL 2015, c. 171, §2 (NEW); PL 2015, c. 171, §4 (AFF).]

G. Enter into an agreement with an eye care provider that is longer than 2 years from the date the agreement is first signed. [PL 2015, c. 171, §2 (NEW); PL 2015, c. 171, §4 (AFF).]

[PL 2015, c. 171, §2 (AMD); PL 2015, c. 171, §4 (AFF).]

4. Construction. This section may not be construed as:

A. Requiring coverage for routine eye examinations; [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

B. Creating coverage for any health care service that is not otherwise covered under the terms of a health plan; [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

C. Requiring a carrier to include as a participating provider every willing provider or health care professional who meets the terms and conditions of a health plan; [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

D. Preventing an enrollee from seeking eye care services from the enrollee's primary care provider in accordance with the terms of the enrollee's health plan; [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

E. Increasing or decreasing the scope of practice of optometry or ophthalmology as defined in Title 32; [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

F. Requiring eye care services to be provided in a hospital or similar health care facility; or [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

G. Notwithstanding the definition of eye care services in subsection 1, paragraph B, prohibiting a carrier from requiring an enrollee to receive prior approval or authorization from a primary care provider for any subsequent surgical procedures. [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

[PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

5. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[PL 2003, c. 517, Pt. B, §33 (NEW).]

6. Enforcement. A violation of this section by a carrier or a subsidiary or subcontractor of a carrier is enforced by the superintendent under the authority granted by section 12-A.

[PL 2015, c. 171, §3 (NEW); PL 2015, c. 171, §4 (AFF).]

SECTION HISTORY

PL 2001, c. 408, §1 (NEW). PL 2001, c. 408, §2 (AFF). PL 2003, c. 517, §B33 (AMD). PL 2015, c. 171, §§1-3 (AMD). PL 2015, c. 171, §4 (AFF).