

2026 Regular Session

SENATE BILL NO. 404

BY SENATORS MCMATH, ABRAHAM, BARROW, BASS, BOUDREAUX, EDMONDS, HODGES, JACKSON-ANDREWS, JENKINS, KLEINPETER, MIZELL, MYERS, OWEN, PRICE, SELDERS, STINE AND WHEAT AND REPRESENTATIVES BAGLEY, BERAULT, CARPENTER, CARVER, DICKERSON, EDMONSTON, EGAN, FISHER, GALLE, JACKSON, MIKE JOHNSON, MCMAHEN, MENA, MILLER, WILDER AND ZERINGUE

HEALTH CARE. Provides relative to eye care providers. (gov sig)

AN ACT

To amend and reenact R.S. 22:997 and to enact Part XIII of Chapter 5 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1809 through 1809.15, relative to eye care providers; to provide for coverage of visual services; to provide for vision benefit managers and vision benefit plans; to provide for legislative findings; to provide for definitions; to provide for covered and noncovered services and materials; to provide for credentialing and contracting requirements; to provide for unfair trade practices; to provide for enforcement; to provide for applicability; to provide for an effective date; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:997 is hereby amended and reenacted and Part XIII of Chapter 5 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1809 through 1809.15, is hereby enacted to read as follows:

§997. Visual services, choice of practitioners

A. Whenever any medical eye care or vision care benefits are provided by or available through a **health benefit plan**, health maintenance organization, preferred

1 provider organization, managed care organization, accountable care organization,
2 **vision benefit plan, vision benefit discount plan, or other** plan or contract of
3 insurance or any medical hospital service contract that are within the lawful scope
4 of practice of a duly licensed optometrist as defined in R.S. 37:1041(C), there shall
5 be no discrimination in the amount of either:

6 (1) Medical eye care or vision care benefits available to an insured,
7 participant, **enrollee**, or other person entitled to such benefits, whether provided by
8 an optometrist or physician, in instances where the services performed are within the
9 lawful scope of practice of both professions.

10 (2) Reimbursements or payments **for covered services or covered materials**
11 to the provider of such medical eye care or vision care services, whether performed
12 by an optometrist or physician, in instances where the services performed are within
13 the lawful scope of practice of both professions.

14 B. A duly licensed optometrist shall be entitled to participate in contracts or
15 plans providing for medical eye care or vision care services as a healthcare provider
16 or otherwise, to the same extent as a duly licensed physician, and there shall be no
17 discrimination against any provider, whether an optometrist or physician, who is
18 located within the geographic area of the **health benefit plan**, health maintenance
19 organization, preferred provider organization, managed care organization,
20 accountable care organization, **vision benefit plan, vision benefit discount plan,**
21 or **other** plan, **agreement**, or contract of insurance. A health maintenance
22 organization, preferred provider organization, managed care organization,
23 accountable care organization, **vision benefit plan, vision benefit discount plan,**
24 **or other** plan or contract of insurance, or any medical or hospital service contract
25 shall not impose a co-payment, co-insurance amount, or any other fee on a covered
26 participant or insured that is greater than the amount charged for the same service
27 when provided by an allopathic physician or an osteopathic physician.

28 C. It shall be unlawful for a **health benefit plan**, health maintenance
29 organization, preferred provider organization, managed care organization,

1 accountable care organization, vision benefit plan, vision benefit discount plan,
2 or other plan, agreement, or contract of insurance to require a duly licensed
3 optometrist to participate as a provider in another medical, ~~or~~ vision care plan, vision
4 benefit plan, or other plan, agreement, or contract as a condition of or requirement
5 for participation by such duly licensed optometrist as a provider in any medical or
6 vision care plan or contract.

7 D. The provisions, requirements, and prohibitions of this Section shall
8 apply equally to any agent acting on behalf of a health maintenance
9 organization, preferred provider organization, managed care organization,
10 accountable care organization, vision benefit plan, vision benefit discount plan,
11 or other plan or entity that offers an agreement or contract of insurance that
12 provides medical eye care or vision care benefits.

13 E. As used in this Section, the definitions provided for in R.S. 22:1809.3
14 shall apply.

15 * * *

16 PART XIII. VISION BENEFIT INSURANCE AND VISION DISCOUNT PLANS

17 §1809. Short Title

18 This Part shall be cited as the "Louisiana Vision Plan Transparency and
19 Fair Practice Act".

20 §1809.1. Purpose

21 The purpose of this Part is to ensure patient access to eye care services
22 and materials through transparent and fair business practices by vision benefit
23 managers.

24 §1809.2. Legislative findings; access to eye care services

25 A. The legislature finds and declares that access to timely, affordable,
26 and appropriate eye care services is a matter of public health and patient safety
27 within the state of Louisiana.

28 B. The legislature further finds that:

29 (1) Vision benefit managers and vision benefit plans increasingly

1 influence where patients may obtain eye care services and materials, which
2 providers may participate in care delivery, and which treatments or materials
3 may be practically available to patients.

4 (2) Business practices that steer patients to affiliated providers, restrict
5 provider participation, limit access to independent laboratories or suppliers, or
6 interfere with clinical judgment may reduce access to care, particularly in rural
7 and underserved areas of this state.

8 (3) Independent eye care providers are essential to maintaining access
9 to vision and medical eye care services for Louisiana residents, including in
10 communities where alternative providers are limited or unavailable.

11 C. It is therefore the intent of the legislature that this Part be construed
12 and applied primarily to:

13 (1) Protect patient access to eye care services and materials.

14 (2) Preserve the integrity of the doctor-patient relationship.

15 (3) Ensure that clinical and prescriptive decisions remain under the
16 control of licensed healthcare professionals.

17 (4) Prevent practices that impair access to care through coercion,
18 steering, or anti-competitive conduct.

19 (5) Support a competitive healthcare environment that serves the health
20 needs of Louisiana residents.

21 D. The provisions of this Part are enacted pursuant to the state's
22 authority to regulate the professional delivery of health care services and to
23 protect public health, safety, and welfare.

24 §1809.3. Definitions

25 As used in this Part, the following definitions shall apply:

26 (1) "Chargeback" means a dollar amount, fee, surcharge, rebate, or item
27 of value that reduces, modifies, or offsets all or part of the patient responsibility,
28 provider reimbursement, allowed amount, or fee schedule for a covered service
29 or covered material.

1 **(2) "Contractual discount" means a percentage reduction from a**
2 **provider's usual and customary rate for covered services and covered materials**
3 **required under a participating provider agreement.**

4 **(3) "Covered service" means the professional work performed by an eye**
5 **care provider for which reimbursement from an insurer, vision benefit**
6 **manager, or subcontractor is provided to an eye care provider by an enrollee's**
7 **plan contract, or for which a reimbursement would be available but for the**
8 **application of the enrollee's contractual plan limitations of deductibles,**
9 **copayments, or coinsurance, regardless of how the services are listed or**
10 **described in an enrollee's benefit plan's definition of benefits.**

11 **(4) "Covered material" means a material for which reimbursement from**
12 **an insurer, vision benefit manager, or subcontractor is provided to an eye care**
13 **provider by an enrollee's plan contract, or for which a reimbursement would**
14 **be available but for the application of the enrollee's contractual limitations of**
15 **deductibles, copayments, or coinsurance, regardless of how the materials are**
16 **listed or described in an enrollee's benefit plan's definition of benefits.**

17 **(5) "De minimis" means equal to zero or an otherwise negligible amount.**

18 **(6) "Enrollee" means any individual participating in a health benefit**
19 **plan, vision benefit plan, or vision benefit discount plan that is purchased by an**
20 **individual or provided to an individual by an insurer, company, organization,**
21 **group, employer, government assistance program, or any other entity that**
22 **purchases or supplies coverage for a health benefit plan, vision care benefit**
23 **plan, or vision benefit discount plan.**

24 **(7) "Eye care provider" means a licensed doctor of optometry practicing**
25 **under the authority of R.S. 37:1041 or a licensed medical or osteopathic doctor**
26 **as defined in R.S. 37:1262.**

27 **(8) "Fee schedule" means the document or system that lists the**
28 **predetermined payment rates or allowed amounts for covered services or**
29 **covered materials and determines how much eye care providers are reimbursed**

1 by the insurer or vision benefit manager and how much patients are charged by
2 the insurer, vision benefit manager, or eye care provider.

3 (9) "Health benefit plan" means a policy, contract, or agreement offered
4 by an insurer, third party administrator, or subcontractor to an enrollee to pay
5 for, reimburse, discount, or offset healthcare costs.

6 (10) "Insurer" means an individual, corporation, partnership, company,
7 organization, group, health maintenance organization, captive, risk-retention
8 group, self-insurance group, optometric service and indemnity corporation, or
9 other entity, whether organized for profit or not-for-profit, whether foreign or
10 domestic, that conducts business in this state and that offers a vision benefit
11 plan or provides coverage for vision-related services or vision-related materials
12 to enrollees. An entity is considered an insurer for purposes of this Part
13 irrespective of:

14 (a) Its corporate form or category of licensure, if applicable, including
15 whether it is otherwise subject to insurance regulations or any other
16 regulations.

17 (b) Whether it, either directly or indirectly reimburses, indemnifies,
18 pays, or discounts the costs of vision services or vision materials.

19 (c) Whether it delegates, assigns, or contracts performance of any
20 function regulated by this Part to an affiliate, subsidiary, contractor,
21 intermediary, or network leasing entity.

22 (11) "Material" means an ophthalmic device including but not limited
23 to lenses, devices containing lenses, artificial intraocular lenses, ophthalmic
24 frames, and other lens mounting apparatus, prisms, lens treatments, and
25 coatings, contact lenses, low vision devices, vision therapy devices, and
26 prosthetic devices to correct, relieve, or treat defects or abnormal conditions of
27 the human eye or its adnexa, or any material allowed to be utilized by the
28 Louisiana State Board of Optometry Examiners and the Louisiana Optometry
29 Practice Act.

1 (12) "Nominal" means, when there is no corresponding reimbursement
2 in the current year's published Physician Fee Schedule released annually by the
3 Centers for Medicare and Medicaid Services or in the current year's published
4 state Medicaid fee schedule, an amount less than the reasonable compensation
5 to the vision care provider rendering the covered service or covered materials,
6 taking into account the provider's direct and indirect costs, including the actual
7 acquisition costs and actual pro rata overhead costs, and reasonable profit.

8 (13) "Optometrist" means a licensed doctor of optometry practicing
9 under the authority of R.S. 37:1041.

10 (14) "Participating eye care provider" means an eye care provider that
11 has entered into a contractual agreement or other business relationship with an
12 insurer, vision benefit manager, third party administrator, or subcontractor to
13 provide covered services or covered materials.

14 (15) "Subcontractor" means an individual, company, organization,
15 group, or other entity, including but not limited to an agent, servant, broker,
16 wholesaler, distributor, partially-owned or wholly-owned subsidiary, or
17 controlled organization that is contracted by the vision benefit manager to
18 supply services or materials to another vision benefit manager, eye care
19 provider, or enrollee to execute or fulfill the health benefit plan, vision benefit
20 plan, or vision benefit discount plan of a vision benefit manager.

21 (16) "Third party administrator" means an individual, company,
22 organization, group, or other entity that provides services, including but not
23 limited to administrative, operational, regulatory, human resource, compliance,
24 and claim adjudication services for an insurer, vision benefit manager,
25 individual, company, organization, group, or other entity under a contract or
26 agreement.

27 (17) "Vision benefit plan" means a policy, contract, or agreement offered
28 by an insurer or vision benefit manager to an enrollee to pay for, reimburse, or
29 offset health and vision care costs.

1 **(18) "Vision benefit discount plan" means a policy, contract, or**
2 **agreement offered by an insurer or vision benefit manager to an enrollee that**
3 **solely provides for a discount for vision care services or materials.**

4 **(19) "Vision benefit manager" means an individual, company,**
5 **organization, group, or other entity, including but not limited to insurers, third**
6 **party administrators, and subcontractors, that creates, promotes, sells,**
7 **provides, advertises, or administers an integrated or stand-alone vision benefit**
8 **plan, vision benefit discount plan, or other insurance policy or contract which**
9 **provides vision benefits or discounts to an enrollee pertaining to the provision**
10 **of covered services or covered materials.**

11 **§1809.4. Covered and noncovered services and materials**

12 **A. No contract or agreement between an insurer or vision benefit**
13 **manager and an eye care provider may seek to or require that an eye care**
14 **provider provide services or materials at a fee limited or set by the insurer or**
15 **vision benefit manager unless the services or materials are defined and**
16 **reimbursed as covered services or covered materials under the contract or**
17 **agreement.**

18 **B. An insurer or vision benefit manager shall only use standardized**
19 **codes, names, descriptions, and definitions published in the Healthcare**
20 **Common Procedure Coding System, including Current Procedural**
21 **Terminology codes published by the American Medical Association and Level**
22 **II codes published by the Centers for Medicare and Medicaid Services, to**
23 **identify and describe all covered services and covered materials of the vision**
24 **benefit plan to purchasers and enrollees of the vision benefit plan.**

25 **C. An insurer or vision benefit manager shall only use standardized**
26 **codes, names, descriptions, and definitions published in the Healthcare**
27 **Common Procedure Coding System, including all Current Procedural**
28 **Terminology codes published by the American Medical Association and all**
29 **Level II codes published by the Centers for Medicare and Medicaid Services,**

1 to create and offer a fee schedule of allowed amounts for covered services and
2 covered materials in a contract or agreement between the insurer or vision
3 benefit manager and an eye care provider.

4 D. An insurer or vision benefit manager shall not misuse, misrepresent,
5 or change the meaning of any of the standardized codes, names, descriptions,
6 and definitions published in the Healthcare Common Procedure Coding System,
7 including all Current Procedural Terminology codes published by the American
8 Medical Association and all Level II codes published by the Centers for
9 Medicare and Medicaid Services. Any such contractual language, policies, or
10 procedures set by the insurer or vision benefit manager in violation of the
11 foregoing shall be void and unenforceable.

12 E. All fee schedules in an agreement between an insurer or vision benefit
13 manager and an eye care provider and all reimbursements paid by an insurer
14 or vision benefit manager to an eye care provider for all covered services and
15 covered materials shall not be nominal or de minimis. There shall be no
16 limitation on the ability of an individual eye care provider or a group of eye
17 care providers who practice under a single Employer Identification Number or
18 Tax Identification Number to engage in direct negotiations with the insurer or
19 vision benefit manager regarding reimbursement fee schedules, and agreeing
20 to a different fee schedule than the fee schedule provided by the insurer or
21 vision benefit manager to other participating providers or groups.

22 F. All fee schedule allowed amounts and all reimbursements paid by an
23 insurer or vision benefit manager for each covered service and covered material
24 shall be clearly and individually listed on a fee schedule made available to the
25 eye care provider:

26 (1) At the time a contract or agreement is offered to the eye care
27 provider by an insurer or vision benefit manager.

28 (2) Within ten business days from the date an application is made to
29 become a participating eye care provider with the insurer or vision benefit

1 manager by the eye care provider.

2 (3) At all times via electronic means to the participating eye care
3 provider.

4 G. A contract or agreement between an insurer or vision benefit
5 manager and an eye care provider shall include a fee schedule that includes and
6 individually identifies each covered service and covered material and its
7 corresponding allowed amount, reimbursement amount paid to the eye care
8 provider, and any form of a cost-sharing amount paid by the enrollee to the eye
9 care provider.

10 H. Insurers or vision benefit managers shall not advertise, claim, or
11 represent to purchasers or enrollees that services and materials provided by a
12 participating eye care provider are covered or included, or covered or included
13 with an additional deductible, copay, or coinsurance, if the insurer or vision
14 benefit manager does not remit an actual payment to the participating eye care
15 provider as full or partial reimbursement for the service or material.

16 I. A service or material provided by a participating eye care provider
17 shall not be designated as a covered service or covered material by the insurer
18 or vision benefit manager in the design of a health benefit plan or vision benefit
19 plan if the reimbursement amount to the participating eye care provider is only
20 comprised of an enrollee's payment to the participating eye care provider.

21 J. Insurers or vision benefit managers shall not condition application to
22 a network or participation in a health benefit plan, vision benefit plan, or vision
23 benefit discount plan by an eye care provider based on the eye care provider's
24 usual and customary pricing or discounts on usual and customary pricing for
25 services or materials that are not covered services or not covered materials. Any
26 such contractual language, policies, or procedures set by the insurer or vision
27 benefit manager in violation of the foregoing shall be void and unenforceable.

28 K. An insurer or vision benefit manager shall not make conditional a fee
29 schedule proposed or made to an eye care provider of a health benefit plan,

1 vision benefit plan, or vision benefit discount plan for covered services or
2 covered materials based on the eye care provider's usual and customary pricing
3 or discounts on usual and customary pricing for services or materials that are
4 not covered services or not covered materials. Any such contractual language,
5 policies, or procedures set by the insurer or vision benefit manager in violation
6 of the foregoing shall be void and unenforceable.

7 L. A contract or agreement between an insurer or vision benefit manager
8 and an eye care provider shall not contain a provision, fee schedule, or
9 reimbursement amount requiring the eye care provider, taking into account any
10 applicable deductibles, copays, coinsurances, discounts, rebates, or chargebacks,
11 to provide covered services or covered materials to an enrollee at a financial
12 loss. Any such contractual language, policies, or procedures set by the insurer
13 or vision benefit manager in violation of the foregoing shall be void and
14 unenforceable.

15 M. All fee schedule-allowed amounts in a provider agreement between
16 an insurer or vision benefit manager and an eye care provider for all covered
17 services and covered materials shall not be less than the current year's
18 published Physician Fee Schedule released annually by the Centers for
19 Medicare and Medicaid Services, unless:

20 (1) In the event that a covered service or covered material does not have
21 an allowed amount listed or if the allowed amount is listed at zero in the current
22 year's published Physician Fee Schedule released annually by the Centers for
23 Medicare & Medicaid Services, the allowed amount for the covered service or
24 covered material shall not be less than the current year's published state
25 Medicaid fee schedule rate.

26 (2) In the event that a covered service or covered material does not have
27 an allowed amount listed or if the allowed amount is listed at zero in the current
28 year's published Physician Fee Schedule released annually by the Centers for
29 Medicare & Medicaid Services or in the current year's published state Medicaid

1 fee schedule rate, the allowed amount for the covered service or covered
2 material shall be reasonable, and not nominal or de minimis.

3 N. The period of time prescribed by a contract or agreement between an
4 insurer or vision benefit manager and an eye care provider for the insurer or
5 vision benefit manager to recover any reimbursement amount from an eye care
6 provider shall be the same period of time allowed or required for any insurer
7 or vision benefit manager to remit the applicable reimbursement following an
8 eye care provider's submission of a clean claim for services rendered or
9 materials furnished. The foregoing shall not limit an insurer or vision benefit
10 manager's ability to conduct an audit of claims, in accordance with the insurer
11 or vision benefit plan manager's written policies and applicable law, in the event
12 that the insurer or vision benefit manager has a reasonable belief that the eye
13 care provider has engaged in fraud, waste, or abuse.

14 O. An insurer or vision benefit manager shall not falsely represent the
15 number of participating providers in a region nor the benefits that comprise a
16 health benefit plan, vision benefit plan, or vision benefit discount plan to clients,
17 groups, employers, purchasers, companies, enrollees, or prospective enrollees.
18 Such acts are considered deceptive trade practices and subject to penalty under
19 R.S. 22:1964.

20 P. An insurer or vision benefit manager shall not promote or use in any
21 marketing or advertising that a covered service or covered material is "free",
22 "no charge", or "complimentary" or any materially similar language to a
23 client, group, employer, purchaser, company, enrollee, or prospective enrollee
24 to purchase services, materials, supplies, or plans from the insurer, vision
25 benefit manager, or affiliate of the insurer or vision benefit manager.

26 Q. An insurer or vision benefit manager shall not offer enrollees varying
27 deductibles, copays, coinsurances, coverage amounts, rebates, gift cards, or
28 other monetary or nonmonetary incentives to obtain covered services, covered
29 materials, noncovered services, or noncovered materials:

1 **(1) At any particular participating eye care provider.**

2 **(2) At a retail establishment owned by, partially owned by, contracted**
3 **with, or otherwise affiliated with the insurer or vision benefit manager.**

4 **(3) At any internet or virtual provider or retailer owned by, partially**
5 **owned by, contracted with, or otherwise affiliated with the insurer or vision**
6 **benefit manager.**

7 **R. An insurer or vision benefit manager shall not engage in marketing**
8 **or advertising activities that may be misleading or deceptive to the public. Upon**
9 **request by a jurisdictional enforcement agency, insurers and vision benefit**
10 **managers shall submit all information regarding alleged savings and discounts**
11 **offered by affiliates of the insurer or vision benefit manager.**

12 **S. An insurer or vision benefit manager shall remit to the participating**
13 **eye care provider the contracted reimbursement amount for a covered service**
14 **or covered material provided to an enrollee if the enrollee is verified to be**
15 **eligible by the participating eye care provider through customary verification**
16 **methods of the insurer or vision benefit manager to receive the covered service**
17 **or covered material on the date of service.**

18 **T. A participating eye care provider is allowed, but not required, to offer**
19 **an enrollee the opportunity to pay the participating eye care provider directly**
20 **for covered services and covered materials if such direct payment would be less**
21 **costly to the enrollee than the total out-of-pocket cost required under the terms**
22 **of a health benefit plan or vision benefit plan. An eye care provider may not be**
23 **subject to an audit, removed from participation in the network, or otherwise**
24 **penalized or discriminated against in any manner for offering an enrollee the**
25 **opportunity to pay the participating provider directly under the conditions of**
26 **this Subsection.**

27 **U. An insurer or vision benefit manager shall not retroactively reverse**
28 **a reimbursement or withhold a future reimbursement to an eye care provider**
29 **who relied in good faith on an individual's presented coverage credentials and**

1 the customary verification methods of the insurer or vision benefits manager,
2 if the insurer or vision benefit manager later determines that the enrollee was
3 ineligible to receive covered services or covered materials on the date of service.

4 V. An insurer or vision benefit manager shall not require a participating
5 eye care provider, purchaser, or enrollee of a health benefit plan, vision benefit
6 plan, or vision benefit discount plan to obtain prior authorization,
7 preauthorization, precertification, or any similar mechanism that restricts the
8 enrollee from receiving a covered service or covered material recommended by
9 the eye care provider and requested by the enrollee.

10 W.(1) An insurer or vision benefit manager shall not, in the course of
11 adjudicating a claim for reimbursement by a participating eye care provider for
12 a covered service or covered material, alter, delete, substitute, or otherwise
13 change any code or modifier submitted by the eye care provider, including
14 downcoding, bundling, or reassigning to a different code, if such change would
15 reduce payment or otherwise adversely affect the provider or enrollee.

16 (2) For purposes of this Subsection, the following definitions apply:

17 (a) "Downcoding" means to alter, delete, substitute, or assign a code that
18 results in a lower level of service, a lower-valued code, or a reduced
19 reimbursement amount relative to the code submitted by the eye care provider.

20 (b) "Bundling" means to combine, substitute, or treat two or more
21 distinct services, supplies, or materials reported on the same claim, date, or
22 service as included within a single code, package, or global service, and denying,
23 reducing, or disallowing separate reimbursement for one or more of the codes.

24 X. The provisions of this Section shall apply to any affiliate or
25 subcontractor that is used by an insurer or vision benefit manager to supply
26 covered services or covered materials to an eye care provider or enrollee and
27 be subject to all applicable penalties as provided for in this Part.

28 Y. An insurer or vision benefit manager shall not require nor request an
29 eye care provider to opt-in or opt-out of the provisions set forth in this Section.

1 or vision benefit discount plan where the subcontracted provider seeks
2 reimbursement from the plan, or enrollee for the subcontracted services, the
3 subcontract agreement must meet all requirements of this Section.

4 F. The provisions of this Section shall apply to any contract or agreement
5 an insurer or vision benefit manager enters into with another entity to provide
6 an enrollee with covered services or covered materials.

7 §1809.6. Unfair trade practices

8 A. It is prohibited for an insurer or vision benefit manager that offers
9 multiple health benefit plans, vision benefit plans, or vision benefit discount
10 plans to require an eye care provider, as a condition of participation in the
11 network for a health benefit plan, vision benefit plan, or vision benefit discount
12 plan, to participate in the network of any of the insurer's or vision benefit
13 manager's other health benefit plans, vision benefit plans, or vision benefit
14 discount plans. A contract provision or agreement violating this Subsection
15 shall be void. The penalties and remedies provided for violation of provisions
16 of this Part shall not waive, limit, or otherwise affect the applicability of
17 Louisiana's Unfair Trade Practices and Consumer Protection Law, R.S. 51:1401
18 et seq., or any other law providing for civil or criminal penalties or remedies for
19 unfair, deceptive, or unlawful business practices.

20 B. It is prohibited for an insurer or vision benefit manager that offers
21 multiple health benefit plans, vision benefit plans, or vision benefit discount
22 plans to withhold participation in the network of one or more of the insurer's
23 or vision benefit manager's other health benefit plans, vision benefit plans, or
24 vision benefit discount plans if the eye care provider is already participating in
25 the network of one or more of the insurer's or vision benefit manager's health
26 benefit plans, vision benefit plans, or vision benefit discount plans and seeks to
27 participate in the network of the insurer's or vision benefit manager's other
28 health benefit plans, vision benefit plans, or vision benefit discount plans.

29 C. This Section applies to all plan types that a health benefit plan, vision

1 benefit plan, or vision benefit discount plan sells, administers, or offers,
2 including but not limited to individually purchased plans and
3 employer-sponsored plans.

4 §1809.7. Credentialing and contracting requirements; acceptance as
5 participating eye care provider

6 A. An insurer or vision benefit manager must include on their website:

7 (1) A method for an eye care provider to submit an application for
8 inclusion and credentialing as a participating provider in the health benefit
9 plan, vision benefit plan, or vision benefit discount plan.

10 (2) A description of the credentialing requirements, which shall be
11 reasonable, related to the delivery of covered eye care services, and applied in
12 an objective, uniform, and nondiscriminatory manner.

13 B. An insurer's or vision benefit manager's application for inclusion and
14 credentialing as a participating eye care provider in the health benefit plan,
15 vision benefit plan, or vision benefit discount plan shall only require
16 standardized information specified in the current version of the Louisiana
17 Standardized Credentialing Application Form or the current format used by
18 the Council for Affordable Quality Healthcare credentialing application.

19 C. An insurer's or vision benefit manager's application for inclusion and
20 credentialing as a participating eye care provider in the health insurance benefit
21 plan, vision benefit plan, or vision benefit discount plan must impose the same
22 application requirements on each eye care provider.

23 D. Not later than the thirtieth business day after the date the insurer or
24 vision benefit manager receives an application from an eye care provider for
25 inclusion as a participating provider in the health benefit plan, vision benefit
26 plan, or vision benefit discount plan, the insurer or vision benefit manager shall
27 inform the applicant of all defects and reasons known at the time by the insurer
28 or vision benefit manager in the event that the application is deemed to be not
29 correctly completed.

1 E. Not later than the fortieth business day after the date the insurer or
2 vision benefit manager receives an application from an eye care provider for
3 inclusion as a participating provider in the health benefit plan, vision benefit,
4 or vision benefit discount planning, the insurer or vision benefit manager shall
5 make available electronically to the eye care provider the proposed
6 participating provider contract, including applicable fee schedules, provider
7 handbooks, and provider manuals.

8 F. Not later than the ninetieth business day after the date the insurer or
9 vision benefit manager receives an application from an eye care provider for
10 inclusion as a participating provider in the health benefit plan, vision benefit
11 plan, or vision benefit discount plan, the insurer or vision benefit manager shall
12 complete the credentialing determination of the eye care provider, approve or
13 disapprove the application of the eye care provider, and deliver electronically
14 a proposed participating provider contract as provided for in this Section for
15 acceptance and signature to the approved eye care provider.

16 G. If the application for inclusion and credentialing as a participating
17 provider is denied by the insurer or vision benefit manager, the insurer or
18 vision benefit manager shall deliver to the applicant a detailed explanation for
19 the denial, both electronically and in writing via certified mail.

20 H. If the application for inclusion and credentialing as a participating
21 provider is denied by the insurer or vision benefit manager, the eye care
22 provider must be allowed a reasonable period of time in which to appeal the
23 decision to the insurer or vision benefit manager and provide in the appeal
24 evidence that supports the reconsideration of the denied application. The
25 insurer or vision benefit managers shall consider, and render a decision on the
26 eye care provider's appeal submission within thirty days of the date of receipt
27 of the submission by the insurer or vision benefit manager.

28 I. If the appeal to the application denial for inclusion and credentialing
29 as a participating provider is denied by the insurer or vision benefit manager,

1 the insurer or vision benefit manager shall deliver to the applicant a detailed
2 explanation for the denial of the appeal, both electronically and in writing via
3 certified mail.

4 J. If the appeal to the application denial for inclusion and credentialing
5 as a participating provider is denied by the insurer or vision benefit manager,
6 the applicant may appeal the decision to the commissioner and seek a ruling
7 that allows the eye care provider to become a participating provider in the
8 health benefit plan, vision benefit plan, or vision benefit discount plan.

9 K. An insurer or vision benefit manager, concurrent with the electronic
10 delivery of the proposed participating provider contract to the approved eye
11 care provider, must provide the name, email address, and phone number of the
12 representative of the insurer or vision benefit manager to allow the approved
13 eye care provider the opportunity to:

14 (1) Contact the representative before signing the contract or agreement.

15 (2) Discuss the proposed contract with the representative before signing
16 the contract or agreement.

17 (3) Electronically send the representative modifications to the proposed
18 contract or agreement before signing the contract.

19 L. In the event that the approved eye care provider sends the
20 representative of the insurer or vision benefit manager modifications to the
21 proposed participating provider contract, the insurer or vision benefit manager
22 must respond to the submission of the approved eye care provider within five
23 business days. Each subsequent response made by the insurer, vision benefit
24 manager, or approved eye care provider to the other party shall be responded
25 to within five business days by the receiving party.

26 M. Once the insurer or vision benefit manager has approved and
27 delivered electronically a proposed participating provider contract, the
28 approved eye care provider has a total allotted time frame of ninety business
29 days to reach agreement with the insurer or vision benefit manager and sign a

1 participating provider contract or agreement. If the parties fail to reach an
2 agreement and no participating provider contract is signed by the approved eye
3 care provider within the allotted time frame, the insurer or vision benefit
4 manager may retract the participating provider's contract or agreement.

5 N. Not later than the twentieth business day after the date the approved
6 eye care provider signs a participating provider contract, the insurer or vision
7 benefit manager shall include the credentialed and approved eye care provider
8 as a participating provider in the health benefit plan, vision benefit plan, or
9 vision benefit discount plan, and list the eye care provider without limitation in
10 all of the plan directories that are available to enrollees and the public.

11 O. The earliest that an eye care provider may submit another application
12 to an insurer or vision benefit manager, after a previous approval and
13 subsequent unsuccessful attempt to sign a participating provider contract, is
14 one hundred eighty calendar days from the date of the previous application.

15 P. The earliest that an eye care provider may submit another application
16 to an insurer or vision benefit manager after a previous disapproval of an
17 application is one hundred eighty calendar days from the date of the previous
18 application.

19 Q. An insurer or vision benefit manager shall allow an eye care provider
20 to become a participating provider in the network of a health benefit plan,
21 vision benefit plan, or vision benefit discount plan if the eye care provider:

22 (1) Meets the credentialing requirements of the insurer or vision benefit
23 manager.

24 (2) Agrees in writing to the applicable provider agreement.

25 R. An insurer or vision benefit manager shall allow all eye care providers
26 who practice under a single Employer Identification Number or Tax
27 Identification Number to become participating providers in the network of a
28 health benefit plan, vision benefit plan, or vision benefit discount plan if one eye
29 care provider practicing in that practice:

1 (1) Meets the credentialing requirements of the insurer or vision benefit
2 manager.

3 (2) Agrees in writing to the applicable provider agreement.

4 S. An insurer or vision benefit manager shall not exclude an eye care
5 provider from applying to or becoming a participating provider in the network
6 of a health benefit plan, vision benefit plan, or vision benefit discount plan
7 because of:

8 (1) The aggregate number of eye care providers in a state, county, city,
9 zip code, or other geographically defined service area.

10 (2) The time, distance, or appointment availability for an enrollee to
11 access a participating eye care provider.

12 (3) The eye care provider's professional designation, independent
13 practice affiliation, or participation status in other health benefit plans, vision
14 benefit plans, or vision benefit discount plans.

15 §1809.8. Transparency and disclosure requirements for insurers and vision
16 benefit managers

17 A. An insurer or vision benefit manager shall disclose the following
18 information publicly on its internet website and with all documents and
19 document packages, including but not limited to proposals, responses to
20 requests for proposals, sales documents, enrollment documents, benefit plan
21 documents, purchaser contracts, enrollee contracts, and provider agreements
22 that are presented to purchasers, potential purchasers, enrollees, potential
23 enrollees, participating eye care providers, potential participating providers,
24 and state agencies with jurisdictional, regulatory, or enforcement authority over
25 its business:

26 (1) Its legal name and entity type.

27 (2) Its legal address and state in which the legal entity is formed or
28 organized.

29 (3) The physical address, mailing address, electronic mail address, and

1 phone number of its operational headquarters.

2 (4) The agencies, departments, committees, commissions, and other
3 bodies that have jurisdictional, regulatory, or enforcement authority over the
4 business.

5 (5) A statement that no jurisdictional, regulatory, or enforcement
6 authority exists over its business, if none exists.

7 (6) The names, physical addresses, mailing addresses, electronic mail
8 addresses, and phone numbers of all parent companies, related holding
9 companies, wholly-owned subsidiary companies, and partially-owned subsidiary
10 companies.

11 (7) All federal and state litigation in which the company is, or has been,
12 a party to in the current year and during the preceding five years.

13 (8) All Department of Insurance formal complaints against the company
14 in the current year and during the preceding five years by purchasers, enrollees,
15 or eye care providers.

16 B. All information required to be disclosed by an insurer or vision
17 benefit manager in Subsection A of this Section shall be conveyed in plain
18 language and typed with a minimum of ten point font size and prominently
19 displayed:

20 (1) On the insurer's or vision benefit manager's website in a publicly
21 accessible section titled "Required Transparency Information for Patients,
22 Doctors, and Purchasers".

23 (2) In a separately created document titled "Required Transparency
24 Information for Patients, Doctors, and Purchasers" that shall be included with
25 all documents and document packages, including but not limited to proposals,
26 responses to requests for proposals, benefit plan documents, sales documents,
27 enrollment documents, purchaser contracts, enrollee contracts, and provider
28 agreements.

29 C. An insurer or vision benefit manager shall provide notice to each

1 participating eye care provider of any proposed amendments to existing
2 provider agreements, fee schedules, provider handbooks, provider manuals, or
3 related policy documents via electronic mail.

4 D. A participating eye care provider shall be provided with a minimum
5 of ninety calendar days from the time of distribution to review changes and
6 respond, if necessary, to any proposed amendments from an insurer or vision
7 benefit manager to existing provider agreements, fee schedules, provider
8 handbooks, provider manuals, or related policy documents. Any such proposed
9 amendments proffered by the insurer or vision benefit manager in violation of
10 the foregoing shall be void and unenforceable.

11 E. Any proposed amendments to existing provider agreements, fee
12 schedules, provider handbooks, provider manuals, or related policy documents
13 by an insurer or vision benefit manager delivered to a participating eye care
14 provider shall be:

15 (1) Enumerated in a cover letter.

16 (2) Marked with highlights or as tracked changes within the applicable
17 agreements or documents, to clearly display all changes over any of the previous
18 version.

19 (3) Structured to include implications of agreeance or nonagreeance by
20 the participating eye care provider.

21 F. An insurer or vision benefit manager shall maintain:

22 (1) A phone number for company representatives to receive questions
23 and communications from participating eye care providers at all times during
24 standard business hours.

25 (2) The ability for an eye care provider to leave voice messages at all
26 times.

27 (3) The ability for an eye care provider to have a live phone discussion
28 with a company representative within twenty-four hours of an initial phone call
29 or a voice message left with the insurer or vision benefit manager.

1 G. An insurer or vision benefit manager shall maintain a physical
2 mailing address and an electronic mail address to company representatives to
3 receive questions, disputes, and communications from participating eye care
4 providers about all matters, at all times, including but not limited to proposed
5 amendments to existing provider agreements, fee schedules, provider
6 handbooks, provider manuals, and related policy documents, and will publish
7 instructions for mail submission and electronic mail submission of questions,
8 disputes, and communications in a place visible to participating eye care
9 providers including on its website and in any provider agreements, provider
10 handbooks, provider manuals, or related policy documents.

11 H. An insurer or vision benefit manager shall acknowledge receipt of an
12 electronic mail message within one hour by use of a return electronic mail
13 message with a communication tracking number and shall respond to the
14 substantive questions or communications of the electronic mail message within
15 seventy-two hours in writing by use of a return electronic mail message.

16 I. An insurer or vision benefit manager shall, at all times, make available
17 to the eye care provider the most up-to-date provider agreements, fee schedules,
18 provider handbooks, provider manuals, and related policy documents via
19 website access.

20 J. Insurers or vision benefit managers shall not engage in marketing or
21 advertising activities that are misleading or deceptive to the public. Such acts
22 are considered an unfair practice or act in accordance with the Unfair Trade
23 Practices and Consumer Protection Law, R.S. 51:1401 et seq.

24 K. Upon request by a state agency with jurisdictional, regulatory, or
25 enforcement authority over its business, insurers and vision benefit managers
26 shall submit all information related to a health benefit plan, vision benefit plan,
27 or vision benefit discount plan, including but not limited to proposals, responses
28 to requests for proposals, benefit plan documents, sales documents, enrollment
29 documents, purchaser contracts, enrollee contracts, provider agreements, and

1 marketing and advertising activities for review.

2 §1809.9. Amending agreements; contracts; payment methods; security
3 interests; arbitration expenses

4 A. An insurer or vision benefit manager shall not change or alter a
5 contract or agreement, including terms, reimbursements, or fee schedules,
6 entered into with a participating eye care provider unless the insurer or vision
7 benefit manager complies with the following requirements at least ninety days
8 before the date of the proposed change would take effect:

9 (1) A certified letter, or an electronic communication requiring an
10 electronic signature proving receipt, detailing proposed changes is required to
11 be sent to the eye care provider.

12 (2) A face-to-face or virtual meeting is required to discuss proposed
13 changes if requested by the eye care provider.

14 (3) The eye care provider shall either agree or not agree in writing to
15 proposed changes. If the changes in the contract or agreement are not agreed
16 to by the eye care provider then the current agreement shall continue and the
17 insurer or vision benefit manager may not remove the eye care provider from
18 a network panel or plan for not accepting the proposed changes to a contract
19 or agreement.

20 (4) A new agreement is required to be established and agreed upon after
21 three or more material changes are made to an existing agreement between an
22 eye care provider and an insurer or vision benefit manager.

23 (5) Any proposed amendment to an existing contract or agreement shall
24 be presented to the participating eye care provider in a manner conducive to the
25 provider's review. Proposed changes will be enumerated in a cover letter and
26 clearly marked as tracked changes within the body of the applicable contract
27 or agreement.

28 B. A contract or agreement between an insurer or vision benefit manager
29 and an eye care provider shall not contain any provision requiring an

1 optometrist to accept a reimbursement payment in the form of a virtual credit
2 card or any other payment method wherein a processing fee, administrative fee,
3 percentage amount, or dollar amount is assessed for the provider to receive the
4 reimbursement payment.

5 C. Termination of any contract or agreement shall be permissible only
6 in the event of a material breach, wherein the eye care provider fails to remedy
7 the alleged breach to the reasonable satisfaction of the insurer or vision benefit
8 manager within thirty days of receipt of written notice specifying the alleged
9 breach.

10 D. It shall be prohibited for an insurer or vision benefit manager to
11 require an eye care provider to establish a security interest in all or part of their
12 property and assets, including assets pertaining to their practice, in a sum
13 equivalent to the funds owed to the insurer or vision benefit manager at
14 termination. Any such contractual language, policies, or procedures set by the
15 insurer or vision benefit manager in violation of the foregoing shall be void and
16 unenforceable.

17 E. A contract or agreement between an insurer or vision benefit manager
18 and an eye care provider shall not contain a provision obligating the eye care
19 provider to equally share the expenses of arbitration. Each party shall bear
20 their own arbitration costs, contingent upon a fee-shifting provision that grants
21 prevailing party status.

22 F. An insurer or vision benefit manager shall not retaliate in any manner
23 against an eye care provider for discussing, or attempting in good faith to
24 negotiate, the terms and provisions of a provider agreement with the insurer or
25 vision benefit manager.

26 G. An insurer or vision benefit manager shall not retaliate in any manner
27 against an eye care provider for filing a complaint against the insurer or vision
28 benefit manager with any state agency with jurisdictional, regulatory, or
29 enforcement authority over the business of the insurer or vision benefit

1 manager.

2 H. Should retaliation by an insurer or vision benefit manager occur
3 against an eye care provider in violation of Subsections F or G of this Section,
4 the commissioner may sanction the insurer or vision benefit manager, including
5 fines and other remedies deemed appropriate, and provide an appropriate
6 remedy for the aggrieved eye care provider.

7 §1809.10. Optical labs and suppliers

8 A. No contract or agreement between an insurer or vision benefit
9 manager and an eye care provider shall restrict or limit, either directly or
10 indirectly, the eye care provider's choice or use of sources and suppliers of
11 covered or uncovered services or materials, including the choice or use of
12 optical laboratories, provided by the eye care provider to an enrollee. Any such
13 contractual language, policies, or procedures set by the insurer or vision benefit
14 manager in violation of the foregoing shall be void and unenforceable.

15 B. An insurer or vision benefit manager shall not directly or indirectly:

16 (1) Control or attempt to control the professional judgment, manner of
17 practice, or practice of an eye care provider.

18 (2) Employ an eye care provider to provide a covered service or covered
19 material.

20 (3) Withhold or recoup payment to an eye care provider for covered
21 services or covered materials provided for an enrollee if the enrollee was shown
22 to be eligible on the date that the covered services or covered materials were
23 provided.

24 (4) Reimburse an eye care provider a different amount for covered
25 services or covered materials because of the eye care provider's choice of:

26 (a) Optical laboratory.

27 (b) Source of supplier of:

28 (i) Contact lenses.

29 (ii) Ophthalmic lenses.

- 1 **(iii) Ophthalmic glasses frames.**
- 2 **(iv) Covered or non-covered services or materials.**
- 3 **(c) Equipment used for patient care.**
- 4 **(d) Retail optical affiliation.**
- 5 **(e) Vision support organization.**
- 6 **(f) Group purchasing organization.**
- 7 **(g) Doctor alliance or group.**
- 8 **(h) Professional trade association membership.**
- 9 **(i) Electronic health record software, electronic medical record software,**
10 **or practice management software.**
- 11 **(j) Third-party claim filing service, billing service, or electronic data**
12 **interchange clearinghouse company.**
- 13 **(5) Restrict, limit, or influence an eye care provider's choice of sources**
14 **or suppliers of services or materials, including optical laboratories used by the**
15 **eye care provider to provide services or materials to the enrollee.**
- 16 **(6) Restrict, limit, or influence an eye care provider's choice of electronic**
17 **health record software, electronic medical record software, or practice**
18 **management software.**
- 19 **(7) Restrict, limit, or influence an eye care provider's choice of**
20 **third-party claim filing service, billing service, or electronic data interchange**
21 **clearinghouse company.**
- 22 **(8) Restrict or limit an eye care provider's access to an enrollee's**
23 **complete plan coverage information, including in-network and out-of-network**
24 **coverage details.**
- 25 **(9) Apply a chargeback to an enrollee or eye care provider if the**
26 **chargeback is for a covered product or service for which the insurer or vision**
27 **benefit manager does not incur the cost to produce, deliver, or provide to the**
28 **enrollee or eye care provider.**
- 29 **(10) Require an eye care provider to disclose an enrollee's confidential**

1 or protected health information unless the disclosure is expressly authorized by
2 the enrollee, or permitted without authorization under the Health Insurance
3 Portability and Accountability Act of 1996.

4 (11) Require an eye care provider to disclose or report a medical history
5 or diagnosis as a condition to file a claim, adjudicate a claim, or receive
6 reimbursement for a routine or wellness eye exam.

7 (12) Require an eye care provider to disclose or report an enrollee's
8 glasses prescription, contact lens prescription, ophthalmic device
9 measurements, facial photograph, or unique anatomical measurements as
10 condition to file a claim, adjudicate a claim, or receive reimbursement for a
11 claim, unless the information in needed for the vision benefit manager to
12 manufacture, or cause to be manufactured, a covered product that is submitted
13 on the applicable claim.

14 (13) Require an eye care provider to disclose any enrollee information,
15 other than information identified on the version of the Health Insurance Claim
16 Form approved by the National Uniform Claim Committee as of March 1, 2023,
17 or its approved successor, as a condition to file a claim, adjudicate a claim, or
18 receive reimbursement for a claim unless the information is needed for the
19 vision benefit manager to manufacture, or cause to be manufactured, a covered
20 product that is submitted on the applicable claim.

21 C. An insurer or vision benefit manager shall not solicit patients or
22 referrals for supplies on behalf of itself or its affiliates by identifying
23 participating eye care providers in an inaccurate or otherwise misleading
24 manner, in any list of participating providers, or in any communications to
25 purchasers or enrollees. All communications which distinguish between
26 participating eye care providers, or which otherwise claim professional
27 superiority or the performance of a professional service in a superior manner,
28 based on the following characteristics, shall be readily subject to verification by
29 the Department of Insurance:

1 (1) A discount or incentive offered by the participating eye care provider
2 on services and materials that are not covered by the insurer or vision benefit
3 manager.

4 (2) The dollar amount, volume amount, or percent usage amount of any
5 material, product, or good purchased by the participating eye care provider.

6 (3) The brand, source, manufacturer, or supplier of a covered service or
7 covered material utilized by the participating eye care provider.

8 D. This Section shall not prohibit advertising, provided that such
9 advertising is not false, misleading, or deceptive and is readily subject to
10 verification.

11 §1809.11. Extrapolation prohibited

12 A. An insurer or vision benefit manager shall not use extrapolation to
13 complete an audit of a participating eye care provider. Any additional payment
14 due to a participating eye care provider or any refund due to the insurer or
15 vision benefit manager shall not be based on an extrapolation, but shall be
16 based on the actual overpayment or underpayment, as determined after an
17 investigation by the insurer or vision benefit manager, and participating eye
18 care provider has been afforded, and has exhausted, all opportunities to appeal
19 the insurer or vision benefit manager's findings, as set forth in the provider
20 manual, policy document, or applicable law.

21 B. For purposes of this Section, "extrapolation" means a mathematical
22 formula, process, or technique used by a vision benefit manager, or the vision
23 benefit manager's agent, in the audit of an optometrist to estimate audit results
24 or findings for a larger batch or group of claims not reviewed by the vision
25 benefit manager.

26 §1809.12. Private right of action; eye care providers

27 Any eye care provider adversely affected by a violation of this Part may
28 bring an action in a court of competent jurisdiction for injunctive relief against
29 the insurer or vision benefit manager and, upon prevailing, in addition to such

1 injunctive relief, shall recover monetary damages, including but not limited to
2 direct, indirect, special, and punitive damages and penalties, of no more than
3 ten thousand dollars for each violation, plus attorney fees and costs.

4 §1809.13. Relationship to other laws

5 The requirements of this Part are in addition to, and do not limit, any
6 other requirement applicable to an insurer under state law. In the event of a
7 conflict between this Part and another provision of law applicable to insurers,
8 the provision that affords greater protection to eye care providers or plan
9 enrollees shall control. Notwithstanding any other provision of law, including
10 any law that purports to be the sole body of law governing the insurer, an
11 insurer shall comply with this Part, to the extent not preempted by federal law.

12 §1809.14. Authorization for enforcement

13 A. The Department of Insurance has jurisdiction to administer and
14 enforce this Part with respect to any insurer or vision benefit manager. The
15 department may:

16 (1) Bring an action, issue orders, and impose remedies authorized by this
17 Part against any insurer or vision benefit manager.

18 (2) Adopt rules to identify activities that constitute the administration,
19 management, or control of vision benefits or materials.

20 (3) Coordinate enforcement with other state agencies that regulate
21 insurers under other applicable law. The attorney general shall have concurrent
22 enforcement authority for violations constituting unfair or deceptive acts or
23 practices.

24 B. The Department of Insurance shall:

25 (1) Provide a mechanism for aggrieved individuals, whether actively or
26 formerly enrolled with a particular vision care plan, to submit complaints to the
27 department for review, investigation, and as appropriate, discipline under
28 applicable law.

29 (2) Enforce the state's insurance laws and the provisions of this Part

1 using powers granted to the commissioner in this Title.

2 (3) Ensure that insurers and vision benefit managers comply with the
3 requirements of this Part.

4 (4) Be entitled to seek an injunction against an insurer or vision benefit
5 manager in a court of competent jurisdiction if the insurer or vision benefit
6 manager:

7 (a) Issues a coverage policy that does not comply with the requirements
8 of this Part, uses fraudulent, coercive, or dishonest practices, or demonstrates
9 incompetence, untrustworthiness, or financial irresponsibility in the conduct of
10 business.

11 (b) Fails to deal equitably with any eye care provider or other persons
12 or facilities which offer services or materials covered within an agreement or
13 contractor policy issued pursuant to this Part.

14 (c) Fails to substantially comply with the insurance laws of this state or
15 violates any regulation, rule, subpoena. or order of the commissioner.

16 C. The attorney general shall:

17 (1) Enforce the provisions of this Part concerning discount card plans,
18 using powers granted to the attorney general pursuant to this Title and the
19 Unfair Trade Practices and Consumer Protection Law, R.S. 51:1401, et seq.

20 (2) Be entitled to seek an injunction against an insurer or vision benefit
21 manager in a court of competent jurisdiction.

22 §1809.15. Enactment provisions

23 A. The requirements of this Part shall apply to insurer or vision benefit
24 manager policies, agreements, contracts, addenda, and certificates executed,
25 delivered, issued for delivery, continued, or renewed in the state of Louisiana.

26 B. No insurer or vision benefit manager agreement may be longer than
27 two years from the date that it was signed by both parties.

28 C. No insurer or vision benefit manager shall construe re-credentialing
29 as re-contracting with a participating eye care provider. A provider contract or

1 agreement shall be a distinctly separate document from any credentialing
 2 materials and shall be signed by the eye care provider and the insurer or vision
 3 benefit manager.

4 D. An insurer or vision benefit manager shall include a copy of the
 5 current plan provider manual referred to in a provider contract or agreement
 6 at the time a contract or agreement is sent to any provider and prospective
 7 provider, as well as any policies referenced in the contract or agreement.

8 Section 2. The provisions of this Act shall apply to all insurers and vision benefit
 9 managers upon the earlier of:

10 (A) The renewal of enrollee's current benefit plan or upon issue of a new benefit plan
 11 to any enrollee.

12 (B) The initiation of a new contract or agreement with an eye care provider or upon
 13 any modification of an existing contract or agreement with an eye care provider.

14 (C) January 1, 2027.

15 Section 3. If any provision or item of this Act, or the application thereof, is held
 16 invalid, such invalidity shall not affect other provisions, items, or applications of the Act
 17 which can be given effect without the invalid provision, item, or application and to this end
 18 the provisions of this Act are hereby declared severable.

19 Section 4. This Act shall become effective upon signature by the governor or, if not
 20 signed by the governor, upon expiration of the time for bills to become law without signature
 21 by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If
 22 vetoed by the governor and subsequently approved by the legislature, this Act shall become
 23 effective on the day following such approval.

The original instrument and the following digest, which constitutes no part
 of the legislative instrument, were prepared by Senate Legislative Services.
 The keyword, summary, and digest do not constitute part of the law or proof
 or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

SB Original DIGEST 2026 Regular Session McMath

Present law provides for requirements and prohibitions for medical eye care or vision care
 benefits provided by or available through a health benefit plan, health maintenance
 organization, preferred provider organization, managed care organization, accountable care

organization, or contract of insurance or any medical hospital service contract that are within the lawful scope of practice of a duly licensed optometrist.

Proposed law expands the applicability of present law to vision benefit plans, vision benefit discount plans, and any agent acting on behalf of any plan or entity that offers an agreement or contract of insurance that provides medical eye care or vision care benefits.

Proposed law provides that proposed law shall be cited as the "Louisiana Vision Plan Transparency and Fair Practice Act".

Proposed law provides for legislative findings and definitions relative to eye care providers and services, vision benefit managers, and vision benefit plans.

Proposed law provides for requirements and prohibitions relative to covered and noncovered services and fee schedules in contracts or agreements between insurers or vision benefit managers and eye care providers.

Proposed law provides for requirements and prohibitions for eye care provider participation and credentialing by an insurer or vision benefit manager.

Proposed law provides for transparency and disclosure requirements for insurers and vision benefit managers.

Proposed law establishes requirements for amending contracts and agreements between eye care providers and insurers or vision benefit managers.

Proposed law prohibits an insurer or vision benefit manager from using extrapolation to complete an audit of a participating eye care provider.

Proposed law establishes a private right of action for any eye care provider adversely affected by a violation of proposed law, including injunctive relief and monetary damages of up to \$10,000 for each violation, plus attorney fees and costs.

Proposed law provides for the authority of the Dept. of Insurance and the attorney general to enforce the provisions of proposed law.

Proposed law provides for the applicability, severability, and effectiveness of proposed law.

Effective upon signature of the governor or lapse of time for gubernatorial action.

(Amend R.S. 22:997; adds R.S. 22:1809-1809.15)