SENATE
STATE OF MINNESOTA
NINETIETH SESSION

S.F. No. 1609

(SENATE AUTHORS: UTKE and Koran)

DATE	D-PG	OFFICIAL STATUS
03/01/2017	922	Introduction and first reading Referred to Health and Human Services Finance and Policy

A bill for an act

relating to health; specifying optometrist services payment and certain contract requirements; proposing coding for new law in Minnesota Statutes, chapter 62Q.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[62Q.741] OPTOMETRIST SERVICES.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision have the meanings given them.

(b) "Materials" means durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), 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.

(c) "Services" means the health care professional procedures and work performed by an optometrist as defined in this section, not including the sale of materials.

(d) "Vision care plan" means an entity that creates, promotes, sells, provides, advertises, or administers an integrated or stand-alone vision benefits plan, or a vision care insurance policy or contract that provides vision benefits to an enrollee through services or materials.

Subd. 2. **Noncovered vision care services contract prohibitions.** (a) No vision care plan shall require in any contract with an optometrist that is entered into or amended on or after January 1, 2018, any provision that:

(1) requires the optometrist to accept as payment an amount set by a vision care plan for a service provided to an insured individual or enrollee that is not a covered service under the insured individual's or enrollee's plan; and

(2) precludes an optometrist from discussing treatment options with a patient.

(b) No optometrist shall charge more for services that are not covered services than the optometrist's usual and customary rate for the services.

(c) Each evidence of coverage or provider locator for an individual or a group vision care plan shall include:

(1) the following statement:

"IMPORTANT: If a covered member elects to receive vision care services that are not covered services under this plan, a participating provider may charge the member the provider's usual and customary rate for the services. Before providing a member with vision care services that are not covered services, the provider shall provide the member with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each service or procedure. To fully understand the coverage, a member may wish to review the member's complete evidence of coverage document"; and

(2) if applicable, a statement that the plan uses a proprietary or exclusive network of laboratories and suppliers.

(d) Each optometrist shall notify patients that services that are not covered services under an insurance policy or plan might not be offered at a discounted rate by:

(1) posting a notice in a conspicuous place;

(2) providing the patient with a treatment plan that includes each anticipated service to be provided and the estimated cost of each service, before providing the patient with services that are not covered services; and

(3) obtaining a written confirmation of understanding from the patient.

(e) Optometrists recommending out-of-network suppliers or laboratories must notify the patient that those suppliers or laboratories are out of network and must further notify the patient of any ownership or other financial interest or incentive that the optometrist may have in the use of the out-of-network supplier or laboratory.