BILL ANALYSIS

C.S.H.B. 3211
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The American Optometric Association reports that many vision benefit managers have restricted or closed provider panels, preventing unaffiliated optometrists or practices from participating in vision plans as in-network providers. The bill author has informed the committee that this type of restriction or exclusion creates an anti-competitive environment that could reduce the availability of eye care providers within certain communities, thereby limiting patients' ability to choose their preferred optometrist and potentially forcing patients to travel further for care. C.S.H.B. 3211 seeks to protect patients' access to optometrists and therapeutic optometrists by prohibiting certain managed care plans providing for vision or eye care benefits from excluding optometrists or therapeutic optometrists who satisfy the plan's credentialing requirements as participating providers in the plan.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 3211 amends the Insurance Code, with respect to a managed care plan that provides or arranges for benefits for vision or medical eye care services or procedures that are within the scope of an optometrist's or therapeutic optometrist's license, to prohibit a managed care plan from excluding an optometrist or a therapeutic optometrist as a participating practitioner in the plan if the optometrist or therapeutic optometrist satisfies the plan's credentialing requirements and agrees to the plan's contractual terms. The bill requires such a managed care plan to describe all reimbursable medical or vision care products or services covered under the plan using the standardized codes, names, and definitions published in the Healthcare Common Procedure Coding System, including the following:

- Level I codes published by the American Medical Association; and
- Level II codes published by the Centers for Medicare and Medicaid Services.

C.S.H.B. 3211 requires a vision care plan issuer to include on the issuer's website a method for a licensed optometrist or therapeutic optometrist to submit an application for inclusion as a participating provider in the vision care plan. The application must impose the same application requirements on each optometrist and therapeutic optometrist and may only require an applicant to provide the following:

- standardized information prescribed by rules adopted under statutory provisions regarding the standardized form for the verification of physician and other provider credentials that is applicable to an optometrist or therapeutic optometrist; or
- information specified on the Council for Affordable Quality Healthcare credentialing application.

C.S.H.B. 3211 requires a vision care plan issuer to do the following:

- not later than the 10th business day after the date the issuer receives the application described by the bill that meets the plan's application requirements, electronically deliver to the applicant a participating provider contract, including applicable reimbursement fee schedules, provider handbooks, and provider manuals;
- not later than the 30th business day after the date the issuer receives the application, complete the credentialing determination and take either of the following actions:
    - approve the application and deliver to the applicant a participating provider contract for acceptance and signature by the approved applicant; or
    - deny the application and, not later than the 10th business day after the date of the denial, deliver to the applicant a written explanation of the issuer's decision; and
- not later than the 20th business day after the date an approved applicant accepts the delivered contract, include the credentialed and approved applicant as a participating provider in the plan.

The bill limits the information a vision care plan issuer may consider in making a credentialing determination of an optometrist or therapeutic optometrist to the information included in the individual's credentialing application and requires the issuer to impose the same credentialing requirements on each applicant optometrist or therapeutic optometrist.

C.S.H.B. 3211 requires a vision care plan issuer to allow an optometrist or therapeutic optometrist to be a participating provider to the full extent of the optometrist's or therapeutic optometrist's license on all of the issuer's vision care plans and other managed care plans with vision benefits that have enrollees located in Texas and on all of the issuer's vision panels, defined by reference to statutory provisions regarding the participation of a therapeutic optometrist under a managed care plan. The bill prohibits this requirement from being construed to require a vision plan issuer to contract with an optometrist or a therapeutic optometrist for a particular covered product or service as defined by reference to statutory provisions regarding contracts with optometrists or therapeutic optometrists. The bill further prohibits a vision care plan issuer from excluding an optometrist or a therapeutic optometrist as a participating provider in the plan because of either of the following:

- the aggregate number of optometrists or therapeutic optometrists on a vision panel, including the aggregate number of optometrists or therapeutic optometrists on a vision panel in a geographic service area; or
- the time, distance, and appointment availability for a patient to access a participating practitioner.

C.S.H.B. 3211 requires a contract between an applicable managed care plan and an optometrist or therapeutic optometrist to do the following:

- include a fee schedule that includes and individually identifies each medical or vision care product or service covered under the plan; and
- use the standardized codes, names, and definitions as provided by the bill to describe all reimbursable medical or vision care products or services covered under the plan.

C.S.H.B. 3211, in revising the definition of "vision care plan" for the bill's purposes and for purposes of the prohibition under current law against the use of extrapolation by a vision care plan to complete an applicable audit of a participating optometrist or therapeutic optometrist, clarifies that such a plan is a managed care plan that is offered in the form of a limited-scope policy, agreement, contract, or evidence of coverage and that provides coverage for eye care expenses but does not provide comprehensive medical coverage.

C.S.H.B. 3211 applies only to a contract between a vision care plan issuer and an optometrist or therapeutic optometrist entered into or renewed on or after the bill's effective date.

EFFECTIVE DATE

On passage, or, if the bill does not receive the necessary vote, September 1, 2025.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 3211 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute includes provisions absent from the introduced that do the following:

- prohibits a managed care plan from excluding an optometrist or a therapeutic optometrist as a participating practitioner in the plan under certain conditions; and
- requires a managed care plan to describe all reimbursable medical or vision care products or services covered under the plan in a manner specified by the bill.

Both the introduced and the substitute set out provisions relating to the inclusion of a licensed optometrist or therapeutic optometrist as a participating provider in a vision care plan but differ in the following ways:

- whereas the introduced required an application for such inclusion to impose the same requirements on each optometrist and therapeutic optometrist, the substitute clarifies that the same requirements that must be imposed on each such applicant are application requirements;
- the substitute replaces a provision of the introduced specifying that the information an optometrist or therapeutic optometrist applicant may be required to provide to a vision care plan issuer is information available from the Council for Affordable Quality Healthcare with a provision specifying that the information such an applicant may be required to provide to the plan issuer is information specified on that council's credentialing application;
- the substitute changes the deadline for a vision care plan issuer to electronically deliver to an applicant a participating provider contract from not later than the 5th day after the date the issuer receives an application that meets the plan's credentialing requirements, as in the introduced, to not later than the 10th business day after the date the issuer receives an application that meets the plan's application requirements; and
- the substitute includes provisions absent from the introduced providing for the following:
    - requirements for a vision care plan issuer to either approve or deny an application not later than the 30th business day after the date the issuer receives the application and, as applicable, either deliver to the applicant a participating provider contract for acceptance and signature or deliver to the applicant a written explanation of the issuer's decision;
    - limits on the information a vision care plan issuer may consider in making a credentialing determination;
    - a requirement that a vision care plan issuer impose the same credentialing requirements on each applicable applicant;
    - a prohibition against certain of the bill's provisions being construed to require a vision plan issuer to contract with an optometrist or a therapeutic optometrist for a particular covered product or service; and
    - a prohibition against a vision care plan issuer excluding an optometrist or a therapeutic optometrist as a participating provider in the plan because of the aggregate number of optometrists or therapeutic optometrists on a vision panel or the time, distance, and appointment availability for a patient to access a participating practitioner.

The substitute includes a requirement absent from the introduced for a contract between a managed care plan and an optometrist or therapeutic optometrist to include a fee schedule that includes and identifies certain information and to use the standardized codes, names, and definitions specified by the bill for all reimbursable medical or vision care products or services covered under the plan.