A bill

TO AMEND THE SOUTH CAROLINA CODE OF LAWS BY AMENDING SECTION 38‑71‑440, RELATING TO HMOS AND HEALTH BENEFIT PLANS OFFERING MEDICAL EYE CARE OR VISION CARE BENEFITS AND PROHIBITED ACTIONS, SO AS TO DEFINE TERMS AND OUTLINE ADDITIONAL PROHIBITED ACTIONS AND ALLOWABLE ACTIONS; BY ADDING SECTIONS 38‑71‑441 AND 38‑71‑442 BOTH SO AS TO PROHIBIT CERTAIN ACTIONS BETWEEN A HEALTH BENEFIT PLAN AND AN OPTOMETRIST OR THERAPEUTIC OPTOMETRIST; AND BY ADDING SECTION 38‑71‑443 SO AS TO PROHIBIT A VISION CARE PLAN FROM USING EXTRAPOLATION TO COMPLETE AN AUDIT.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Section 38‑71‑440 of the S.C. Code is amended to read:

 Section 38‑71‑440. (A) As used in this section:

 (1) “Health benefit plan” means any public or private health plan implemented in this State that provides medical eye care or vision care benefits, or both, to covered persons including payments and reimbursements.

 (2) “Ophthalmologist” means a physician licensed pursuant to Title 40, Chapter 47 who practices in South Carolina and who specializes in the medical and surgical care of the eye and visual system and routine vision care.

 (3) “Optometrist” means a doctor of optometry licensed pursuant to Title 40, Chapter 37 who is engaged in the practice of optometry in South Carolina.

 (4) “Therapeutic‑certified optometrist” means a doctor of optometry as defined in Section 40‑37‑20.

 (5) “Vision panel” means the optometrists and therapeutic optometrists who are listed as participating providers for routine eye examinations under a health benefit plan or who a patient seeking a routine eye examination is encouraged or required to use under a health benefit plan.

 (B) No health maintenance organization or health benefit plan which maintains or contracts with a network of ophthalmologists or optometrists, or both, to provide medical eye care or vision care benefits, or both, shall prohibit a participating optometrist from performing medical services within that optometrist's scope of practice set forth in Title 40, Chapter 37, in accordance with the terms of the health maintenance organization or health benefit plan and in accordance with subsections (C) and (I).

 (C) No health maintenance organization or health benefit plan which maintains or contracts with a network of ophthalmologists or optometrists, or both, to provide medical eye care or vision care benefits, or both, excepting all self‑funded health benefit plans as defined under the Federal Employee Retirement Income Security Act (ERISA) of 1974, shall discriminate against optometry, as a class, or ophthalmology, as a class, with respect to the terms, conditions, privileges, and opportunity of participation or compensation for the same eye care services provided in this section.

 (D) No health benefit plan or health maintenance organization shall impose on optometry, as a class, any condition or restriction which is not necessary for the delivery of services or materials, or both, in accordance with and subject to Chapter 37, Title 40.

 (E) A health benefit plan or health maintenance organization may not:

 (1) discriminate against a health care practitioner because the practitioner is an optometrist or a therapeutic optometrist;

 (2) restrict or discourage a plan participant from obtaining covered vision or medical eye care services or procedures from a participating optometrist or therapeutic optometrist solely because the practitioner is an optometrist or therapeutic optometrist;

 (3) exclude an optometrist or a therapeutic optometrist as a participating practitioner in the plan because the optometrist or therapeutic optometrist does not have medical staff privileges at a hospital or at a particular hospital;

 (4) identify a participating optometrist or therapeutic optometrist differently from another optometrist or therapeutic optometrist based on:

 (a) a discount or incentive offered on a medical or vision care product or service that is not a covered product or service by the optometrist or therapeutic optometrist;

 (b) the dollar amount, volume amount, or percent usage of any product or good purchased by the optometrist or therapeutic optometrist; or

 (c) the brand, source, manufacturer, or supplier of a medical or vision care product or service utilized by the optometrist or therapeutic optometrist to practice optometry;

 (5) incentivize, recommend, encourage, persuade, or attempt to persuade an enrollee to obtain covered or uncovered products or services:

 (a) at any particular participating optometrist or therapeutic optometrist instead of another participating optometrist or therapeutic optometrist;

 (b) at a retail establishment owned by, partially owned by, contracted with, or otherwise affiliated with the managed care plan instead of a different participating optometrist or therapeutic optometrist; or

 (c) at any Internet or virtual provider or retailer owned by, partially owned by, contracted with, or otherwise affiliated with the managed care plan instead of a different participating optometrist or therapeutic optometrist;

 (6) exclude an optometrist or therapeutic optometrist as a participating practitioner in the plan because the services or procedures provided by the optometrist or therapeutic optometrist may be provided by another type of health care practitioner; or

 (7) as a condition for a therapeutic optometrist to be included in one or more of the plan’s medical panels, require the therapeutic optometrist to be included in, or to accept the terms of payment under or for, a particular vision panel in which the therapeutic optometrist does not otherwise wish to be included.

 (F) A health benefit plan or health maintenance organization must:

 (1) include optometrist and therapeutic optometrists as participating health care practitioners in the plan;

 (2) include the name of a participating optometrist or therapeutic optometrist in any list of participating health care practitioners and give equal prominence to each name;

 (3) provide directly to an optometrist, therapeutic optometrist, or plan enrollee immediate access by electronic means to an enrollee’s complete plan coverage information, including in‑network and out‑of‑network coverage details;

 (4) publish complete plan information, including in‑network and out‑of‑network coverage details, with any marketing materials that describe the plan benefits, including any summary plan description;

 (5) allow an optometrist or a therapeutic optometrist to utilize any third‑party claim‑filing service, billing service, or electronic data interchange clearinghouse company that uses the standardized claim submission protocol of the National Uniform Claim Committee and that allows the optometrist or therapeutic optometrist to submit details for both services and vision care products to facilitate the authorization, submission, and reimbursement of claims; and

 (6) allow an optometrist or a therapeutic optometrist to receive reimbursement through an electronic funds transfer.

 (E)(G) Any health maintenance organization or health benefit plan may contract for vision care benefits or medical eye care benefits, or both. A health maintenance organization or health benefit plan may contract for surgery only services with ophthalmologists. A health maintenance organization or health benefit plan must be authorized to contract with optometrists and ophthalmologists as either individual panelists or network panelists.

 (F)(H) Nothing in this section may be construed to limit, expand, or otherwise affect the scope of practice of optometrists and therapeutically certified optometrists as provided for in Chapter 37, Title 40.

 (G)(I) Nothing in this section may be construed to preclude a covered person from receiving emergency medical eye care or to preclude a primary care physician from providing treatment for covered services in accordance with the terms of a health maintenance organization or health benefit plan.

 (H)(J) Nothing in this section may be construed to mandate coverage of any service.

 (I)(K) Nothing in this plan may be construed to prohibit a health maintenance organization or health benefit plan from professionally credentialing and evaluating all individual optometrists or ophthalmologists within a network or plan in a nondiscriminatory manner. Nothing in this section may be construed to prohibit any health maintenance organization or health benefit plan from limiting the number of optometrists or ophthalmologists in a nondiscriminatory manner or to prohibit a health maintenance organization or health benefit plan from negotiating individually with optometrists or ophthalmologists for individual rates and eye care services in a nondiscriminatory manner.

 (J)(L) Any person aggrieved by a violation of this section may file a complaint with the Department of Insurance. After notice to the health maintenance organization or health benefit plan and an opportunity for it to submit a written response to the complaint, the director of the department may make a written determination regarding the complaint. Any party aggrieved by the director's determination is entitled to administrative and judicial review pursuant to Article 3, Chapter 23, Title 1. The director or the administrative law judge, if a hearing before the Administrative Law Court is requested, may impose sanctions that are authorized under current insurance laws if a violation of this section is found to have occurred.

SECTION 2. SubArticle 1, Article 3, Chapter 71, Title 38 of the S.C. Code is amended by adding:

 Section 38‑71‑441. (A) For purposes of this section:

 (1) “Chargeback” means a dollar amount, fee, surcharge, or item of value that reduces, modifies, or offsets all or part of the patient responsibility, provider reimbursement, or fee schedule for a covered product or service.

 (2) “Covered product or service” means a medical or vision care product or service for which reimbursement is available under an enrollee’s managed care plan contract or for which reimbursement is available subject to a contractual limitation, including:

 (a) deductible;

 (b) copayment;

 (c) coinsurance;

 (d) a waiting period;

 (e) an annual or lifetime maximum limit;

 (f) frequency limitation; or

 (g) an alternative benefit payment.

 (3) “Medical or vision care product or service” means a product or service provided within the scope of the practice of optometry or therapeutic optometry under Title 40, Chapter 37. It does not include a product or service reimbursed to an optometrist or therapeutic optometrist at a nominal or de minimus rate or reimbursed solely by the enrollee.

 (B) A contract between a health benefit plan and an optometrist or therapeutic optometrist may not:

 (1) limit the fee the optometrist or therapeutic optometrist may charge for a product or service that is not a covered product or service;

 (2) require a discount on a product or service that is not a covered product or service;

 (3) contain a provision authorizing a chargeback to the patient, optometrist, or therapeutic optometrist if the chargeback is for a covered product or service that the managed care plan does not incur the cost to produce, deliver, or provide to the patient, optometrist, or therapeutic optometrist;

 (4) contain a provision authorizing a reimbursement fee schedule for a covered product or service that is different from the fee schedule applicable to another optometrist or therapeutic optometrist because of the optometrist’s or therapeutic optometrist’s choice of:

 (a) optical laboratory;

 (b) source of supplier of contact lenses, ophthalmic lenses, ophthalmic glasses or frames, or covered or uncovered products or services;

 (c) equipment used for patient care;

 (d) retail optical affiliation;

 (e) vision support organization;

 (f) group purchasing organization;

 (g) doctor alliance;

 (h) professional trade association membership;

 (i) electronic health record software, electronic medical record software, or practice management software; or

 (j) third‑party claim‑filing service, billing service, or electronic data interchange clearinghouse company;

 (5) change a contract between a managed care plan and an optometrist or therapeutic optometrist, including terms, reimbursements, or fee schedules, unless the health benefit plan provides written notice of the change to the optometrist or therapeutic optometrist at least ninety days before the date the proposed change takes effect; or

 (6) contain a provision requiring the optometrist or therapeutic optometrist to accept a reimbursement for payment in the form of a virtual credit card or any other payment method where a processing fee, administrative fee, percentage amount, or dollar amount is assessed to receive the reimbursement payment, except in the case of a nominal fee assessed by the optometrist’s or therapeutic optometrist’s bank to receive an electronic funds transfer.

 Section 38‑71‑442. A health benefit plan, as defined in Section 38‑71‑440(A), may not directly or indirectly:

 (A) control or attempt to control the professional judgment, manner of practice, or practice of an optometrist or therapeutic optometrist;

 (B) employ an optometrist or therapeutic optometrist to provide a vision care product or service as defined in Section 38‑71‑441(A);

 (C) pay an optometrist or therapeutic optometrist for a service not provided;

 (D) reimburse an optometrist or therapeutic optometrist a different amount for a covered product or service as defined by Section 38‑71‑441(A) because of the optometrist’s or therapeutic optometrist’s choice of:

 (1) optical laboratory;

 (2) source of supplier of contact lenses, ophthalmic lenses, ophthalmic glasses or frames, or covered or uncovered products or services;

 (3) equipment used for patient care;

 (4) retail optical affiliation;

 (5) vision support organization;

 (6) group purchasing organization;

 (7) doctor alliance;

 (8) professional trade association membership;

 (9) electronic health record software, electronic medical record software, or practice management software; or

 (10) third‑party claim‑filing service, billing service, or electronic data interchange clearinghouse company;

 (E) restrict, limit, or influence an optometrist’s or therapeutic optometrist’s choice of sources or suppliers of services or materials, including optical laboratories used by the optometrist or therapeutic optometrist to provide services or materials to a patient;

 (F) restrict, limit, or influence an optometrist’s or therapeutic optometrist’s choice of electronic health record software, electronic medical record software, or practice management software;

 (G) restrict, limit, or influence an optometrist’s or therapeutic optometrist’s choice of third‑party claim‑filing service, billing service, or electronic data interchange clearinghouse company;

 (H) restrict or limit an optometrist’s or therapeutic optometrist’s access to a patient’s complete plan coverage information, including in‑network and out‑of‑network coverage details;

 (I) apply a chargeback, as defined by Section 38‑71‑441(A), to a patient, optometrist, or therapeutic optometrist if the chargeback is for a covered product or service that the managed care plan does not incur the cost to produce, deliver, or provide to the patient, optometrist, or therapeutic optometrist;

 (J) require an optometrist or therapeutic optometrist to provide a covered product at a loss;

 (K) require an optometrist or therapeutic optometrist to disclose a patient’s confidential or protected health information unless the disclosure is authorized by the patient or permitted without authorization under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d, et seq.);

 (L) require an optometrist or therapeutic optometrist to disclose or report a medical history or diagnosis as a condition to file a claim, adjudicate a claim, or receive reimbursement for a routine or wellness vision eye exam;

 (M) require an optometrist or therapeutic optometrist to disclose or report a patient’s glasses prescription, contact lens prescription, ophthalmic device measurements, facial photograph, or unique anatomical measurements as a condition to file a claim, adjudicate a claim, or receive reimbursement for a claim unless the information is needed for the managed care plan to manufacture or cause to be manufactured a covered product that is submitted on the claim;

 (N) require an optometrist or therapeutic optometrist to disclose any patient information, other than information identified on the version of the Health Insurance Claim Form approved by the National Uniform Claim Committee as of March 1, 2023, as a condition to file a claim, adjudicate a claim, or receive reimbursement for a claim unless the information is needed for the managed care plan to manufacture or cause to be manufactured a covered product that is submitted on the claim; or

 (O) require an optometrist or therapeutic optometrist to accept a reimbursement payment in the form of a virtual credit card or any other payment method where a processing fee, administrative fee, percentage amount, or dollar amount is assessed to receive the reimbursement payment, except in the case of a nominal fee assessed by the optometrist’s or therapeutic optometrist’s bank to receive an electronic funds transfer.

 Section 38‑71‑443. (A) For purposes of this section:

 (1) “Extrapolation” means a mathematical process or technique used by a vision care plan in the audit of an optometrist or therapeutic optometrist to estimate audit results or findings for a larger batch or group of claims not reviewed by the plan.

 (2) “Vision care plan” means a limited‑scope policy, agreement, contract, or evidence of coverage that provides coverage for eye care expenses but does not provide comprehensive medical coverage.

 (B) A vision care plan may not use extrapolation to complete an audit of a participating optometrist or therapeutic optometrist. Any additional payment due to a participating optometrist or therapeutic optometrist or any refund due to the vision care plan must be based on the actual overpayment or underpayment and may not be based on an extrapolation.

SECTION 3. This act takes effect upon approval by the Governor.

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