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House Bill 156
Proponent Testimony of Keith Kerns
Executive Director, Ohio Optometric Association
September 13, 2017

Chairman Brinkman and members of the Ohio House Insurance Committee, my name is Keith Kerns and I serve as the Executive Director of the Ohio Optometric Association. The Ohio Optometric Association represents approximately 70% of the practicing doctors of optometry in Ohio. Thank you for the opportunity to testify in support of House Bill 156.

HB 156 is important legislation that will address aggressive tactics within vision insurance that are splintering the doctor-patient relationship, hindering patients' choice in health care and harming small business vision care providers. The bill contains several simple reforms aimed at providing patients more transparency and choice in the vision care marketplace.

First, the legislation will ensure that optometrists and patients will be able to utilize the vision material suppliers of their choice when purchasing eyewear and other products. Recent insurance practices are directing many of these purchases towards designated suppliers which sometimes provide substandard quality products and delays in delivery. Even more troubling is that sometimes these purchases are steered toward suppliers in which the insurer has an ownership interest. These practices remove important health care decisions from the hands of patients and their doctors which can jeopardize quality care. HB 156 also adds an additional safeguard ensuring transparency for patients when purchasing vision materials. The bill requires both insurers and doctors to disclose any business interest they have in a supplier of vision materials to a patient prior to purchase.

Secondly, the bill will prohibit the placement of fee limitations on vision services and vision materials that are not covered under an enrollee's benefit plan. This practice is commonly referred to as "non-covered services" provisions. The House and this committee dealt with a similar issue within dentistry in recent years. Non-covered service provisions are particularly onerous on providers who operate an optical dispensary. The most common vision service that is not covered under an enrollee's benefit plan is the purchase of a second pair of prescriptive eye glasses. Placing an artificial price limitation on this product can have the effect of removing the optometrist from the marketplace for the sale of the eyewear because oftentimes the optometrist is required to provide the product at a rate lower than the cost of obtaining the product initially. Patients may then be forced to leave the provider they trust and seek vision materials from another retailer who may not have the same limitations placed on it by an insurer. This other retailer could be down the street in the form of a major retailer or an online supplier located out-of-state.

Finally, the bill will preserve a vision care provider's ability to contract with insurance plans that coincide with the provider's business model and practice philosophy. This prevents insurers

from requiring that a vision care provider participate with a secondary discount plan as a precondition of joining an insurer's provider panel.

Nineteen other states, including Texas, New York, Florida, Kentucky, North Carolina and Virginia have passed similar legislation to House Bill 156 with no known negative implications to patients, the vision insurance marketplace or the cost of care. The OOA does not undertake legislative initiatives lightly. However, in this instance, the tactics being implemented in the vision insurance marketplace are significant and legislative action is the profession's only option for relief. Antitrust restrictions eliminate vision care providers' means to bargain or negotiate with insurers resulting in "take it or leave it" standardized contracts containing unfair provisions such as those addressed in this bill.

The subject matter of HB 156 is not new. Last session a similar bill was pending before the General Assembly. Over the course of that session, the bill's sponsor, Rep. Kirk Schuring convened multiple interested party meetings to discuss concerns which resulted in over a dozen significant changes reflected in the bill before the committee today.

These significant changes include:

- Removes all language restricting a plan's ability to establish networks.
- Clarifies that nothing in the bill shall limit a plan's ability to set coverage amounts and reimbursement levels for in-network and out-of-network suppliers.
- Requires providers to notify patients, in writing, when a supplier of vision materials is out-of-network and inform patients of the costs associated with those materials.
- Requires providers to notify patients, in writing, of any business interest the provider has in a recommended out-of-network supplier of materials.
- Requires plans to disclose to patients any business interest the plan has in a supplier of materials.
- Removes a provision that required plans to inform patients that the plan utilizes a proprietary or exclusive network of suppliers of materials.
- Clarifies that plans may not "directly" limit a provider's choice in sources or suppliers of materials. Previous language had prohibited both "direct" and "indirect" limitations.
- Removes language prohibiting plans from establishing fee limitations for services and materials that are not-covered under a plan.
- Outlines that providers are not required to accept fee limitations for services and materials that are not covered as long as certain criteria are met, including:
    - 1) That the provider post, in a conspicuous place, a notice stating that the provider does not accept the fee schedule for non-covered services and materials and that the provider instead charges his or her normal fee for those non-covered services and materials, and
    - 2) That the provider gives the patient an estimated cost for those non-covered services and materials.

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- Clarifies that the bill only prohibits a plan from requiring, as a condition of contracting, that a provider enter into a contract with a separate plan.
- Specifically states that the bill does not restrict or limit a plan's ability to enter into an agreement with another plan.
- Removes all language related to Discount Medical Cards.
- Clarifies the definition of vision service provider.
- Removes language related to the usual and customary rates of providers.
- Clarifies that only a pattern of continuous behavior would be considered an unfair practice in the business of insurance.

As you can see, HB 156 places several new requirements on doctors, many of which do not exist in similar legislation passed by other states. However, we believe these changes, in addition to helping address many of the concerns raised by interested parties, are patient-centered and stress the importance of transparency, disclosure and choice in health care.

For these reasons, I again urge your support for House Bill 156. Thank you for your consideration and I would be happy to answer any questions.

P.O. Box 6036 • Worthington OH 43085 • 614-781-0708 • 800-874-9111(in Ohio) • Fax 614-781-6521
www.ooa.org • info@ooa.org