

NV AB448: Higher Cost Vision Care for Nevadans

Vision Care Plans are:

- Valued by employers, with 82% of employers offering the plans to their employees, a 310% increase over 2006 (when only 20% of employers offered it)
- Valued by employees, with 94% of enrollees in a recent survey stating that vision plans provide “valuable” services, with 60% calling vision benefits “very valuable”
- Making vision care services more affordable by mitigating out-of-pocket costs for consumers
- Providing a critical healthcare role: vision coverage is an independent predictor of vision health and vision exams provide early diagnosis of many underlying health conditions
- Maintaining steady premiums and benefit levels over a 10-year time horizon, despite significant premium increases and benefit decreases in general health insurance overall

AB 448 undermines the effectiveness and affordability of providing healthcare by:

INCREASING CONSUMER COSTS BY 30% AND ERASING SAVINGS OF NEARLY \$300 ON AVERAGE

- Requires reimbursement that is “substantially similar to rates...under Medicare” (even though routine vision care is not covered by Medicare Parts A & B), overriding previously contracted and negotiated rates [Section 37(2)(a-b)]
- Prevents plans from recouping overpayments, even if an enrollee is found to be ineligible [Section 23(2)]
- Prevents plans from negotiating and passing on important savings to consumers for materials and supplies [Section 18(1)]
- Requires plans to bear the cost of arbitration with non-compliant providers [Section 19(3)]
- Prohibits a vision care plan from offering differing reimbursement rates to providers based on an extensive and substantive criteria list [Section 28(4)]
- Prevents plans from differentiating among providers based on educational achievements, forcing overly high reimbursement rates to lesser qualified providers [Section 25(3)(a)]
- Raises the cost of insurance by creating a new litigation path for alleged “violations” [Section 37(2)(a-b)]

WEAKENING CONSUMER PROTECTIONS

- Prohibits vision care plans from both:
 - (1) Informing consumers which providers offer the ability to maximize their plan benefits [Section 25(3)(b)(1-3)] and
 - (2) Offering additional financial incentives for use of preferred providers [Section 22(2)(a-c)]
- Prohibits vision care plans from conveying information about available out-of-pocket discounts, removing the ability for consumers to “shop” for the best prices [Section 25(3)(b)]
- Interferes with plans’ efforts to fully qualify providers and conduct due diligence regarding provider eligibility [Section 28(3)]
- Violates free speech and deprives consumers of access to helpful, truthful information about access to care and lower cost options to obtain it [Section 25(3)(b)]

INCREASING ADMINISTRATIVE BURDEN

- Invents a new definition of “vision benefit manager” designed to create an artificial correlation with “pharmacy benefit managers”, despite the lack of parity between the two business models [Section 13]
- Requires vision care plans to allow providers to “exhaust all opportunities for appeals” prior to receiving appropriate recoupment funds [Section 29(3)(a-b)]
- Prohibits plans from effectively managing their networks by preventing the removal of non-compliant providers from the plans’ networks [Section 27(3) and Section 27(5)(a)]
- Unduly restricts a vision care plan’s ability to properly credential providers [Section 25(1)]
- Forces plans to recontract every two years [Section 31(1)]