SLS 26RS-490 **ENGROSSED**

2026 Regular Session

SENATE BILL NO. 404

BY SENATORS MCMATH, ABRAHAM, BARROW, BASS, BOUDREAUX, EDMONDS, FESI, HENSGENS, HODGES, JACKSON-ANDREWS, JENKINS, KLEINPETER, MIGUEZ, MIZELL, MYERS, OWEN, PRICE, SELDERS, STINE AND WHEAT AND REPRESENTATIVES ADAMS, BAGLEY, BERAULT, BILLINGS, BOYER, CARPENTER, CARVER, CREWS, DICKERSON, EDMONSTON, EGAN, FARNUM, FISHER, GALLE, JACKSON, MIKE JOHNSON, TRAVIS JOHNSON, TERRY LANDRY, MACK, MCMAHEN, MENA, MILLER, MOORE, NEWELL, PHELPS, STAGNI, VILLIO, WALTERS, WILDER, WILEY AND ZERINGUE

HEALTH CARE. Provides relative to eye care providers. (gov sig)

AN ACT

To amend and reenact R.S. 22:997 and to enact Part XIII of Chapter 5 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1809 through 1809.15, relative to eye care providers; to provide for coverage of visual services; to provide for vision benefit managers and vision benefit plans; to provide for legislative findings; to provide for definitions; to provide for covered and noncovered services and materials; to provide for credentialing and contracting requirements; to provide for unfair trade practices; to provide for enforcement; to provide for applicability; to provide for an effective date; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:997 is hereby amended and reenacted and Part XIII of Chapter 5 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1809 through 1809.15, is hereby enacted to read as follows:

§997. Visual services, choice of practitioners

A. Whenever any medical eye care or vision care benefits are provided by or available through a **health benefit plan,** health maintenance organization, preferred

provider organization, managed care organization, accountable care organization, **vision benefit plan, vision benefit discount plan, or other** plan or contract of insurance or any medical hospital service contract that are within the lawful scope of practice of a duly licensed optometrist as defined in R.S. 37:1041(C), there shall be no discrimination in the amount of either:

(1) Medical eye care or vision care benefits available to an insured, participant, **enrollee,** or other person entitled to such benefits, whether provided by an optometrist or physician, in instances where the services performed are within the lawful scope of practice of both professions.

(2) Reimbursements or payments **for covered services or covered materials** to the provider of such medical eye care or vision care services, whether performed by an optometrist or physician, in instances where the services performed are within the lawful scope of practice of both professions.

B. A duly licensed optometrist shall be entitled to participate in contracts or plans providing for medical eye care or vision care services as a healthcare provider or otherwise, to the same extent as a duly licensed physician, and there shall be no discrimination against any provider, whether an optometrist or physician, who is located within the geographic area of the **health benefit plan,** health maintenance organization, preferred provider organization, managed care organization, accountable care organization, **vision benefit plan, vision benefit discount plan,** or **other** plan**, agreement,** or contract of insurance. A health maintenance organization, preferred provider organization, managed care organization, accountable care organization, **vision benefit plan, vision benefit discount plan, or other** plan or contract of insurance, or any medical or hospital service contract shall not impose a co-payment, co-insurance amount, or any other fee on a covered participant or insured that is greater than the amount charged for the same service when provided by an allopathic physician or an osteopathic physician.

C. It shall be unlawful for a **health benefit plan,** health maintenance organization, preferred provider organization, managed care organization,

accountable care organization, **vision benefit plan, vision benefit discount plan,** or **other** plan**, agreement,** or contract of insurance to require a duly licensed optometrist to participate as a provider in another medical**,** ~~or~~ vision care plan**, vision benefit plan,** or **other plan, agreement, or** contract as a condition of or requirement for participation by such duly licensed optometrist as a provider in any medical or vision care plan or contract.

D. The provisions, requirements, and prohibitions of this Section shall apply equally to any agent acting on behalf of a health maintenance organization, preferred provider organization, managed care organization, accountable care organization, vision benefit plan, vision benefit discount plan, or other plan or entity that offers an agreement or contract of insurance that provides medical eye care or vision care benefits.

E. As used in this Section, the definitions provided for in R.S. 22:1809.3 shall apply.

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PART XIII. VISION BENEFIT INSURANCE AND VISION DISCOUNT PLANS

§1809. Short Title

This Part shall be cited as the "Louisiana Vision Plan Transparency and Fair Practice Act".

§1809.1. Purpose

The purpose of this Part is to ensure patient access to eye care services and materials through transparent and fair business practices by vision benefit managers. Nothing in this Part shall be construed to expand or limit the scope of practice of any licensed healthcare professional.

§1809.2. Legislative findings; access to eye care services

A. The legislature finds and declares that access to timely, affordable, and appropriate eye care services is a matter of public health and patient safety within the state of Louisiana.

B. The legislature further finds that:

(1) Vision benefit managers and vision benefit plans increasingly influence where patients may obtain eye care services and materials, which providers may participate in care delivery, and which treatments or materials may be practically available to patients.

(2) Business practices that steer patients to affiliated providers, restrict provider participation, limit access to independent laboratories or suppliers, or interfere with clinical judgment may reduce access to care, particularly in rural and underserved areas of this state.

(3) Independent eye care providers are essential to maintaining access to vision and medical eye care services for Louisiana residents, including in communities where alternative providers are limited or unavailable.

C. It is therefore the intent of the legislature that this Part be construed and applied primarily to:

(1) Protect patient access to eye care services and materials.

(2) Preserve the integrity of the doctor-patient relationship.

(3) Ensure that clinical and prescriptive decisions remain under the control of licensed healthcare professionals.

(4) Prevent practices that impair access to care through coercion, steering, or anti-competitive conduct.

(5) Support a competitive healthcare environment that serves the health needs of Louisiana residents.

D. The provisions of this Part are enacted pursuant to the state's authority to regulate the professional delivery of healthcare services and to protect public health, safety, and welfare.

§1809.3. Definitions

As used in this Part, the following definitions shall apply:

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

or covered material.

(2) "Contractual discount" means a percentage reduction from a provider's usual and customary rate for covered services and covered materials required under a participating provider agreement.

(3) "Covered service" means the professional work performed by an eye care provider for which reimbursement from an insurer, vision benefit manager, or subcontractor is provided to an eye care provider by an enrollee's plan contract, or for which a reimbursement would be available but for the application of the enrollee's contractual plan limitations of deductibles, copayments, or coinsurance, regardless of how the services are listed or described in an enrollee's benefit plan's definition of benefits.

(4) "Covered material" means a material for which reimbursement from an insurer, vision benefit manager, or subcontractor is provided to an eye care provider by an enrollee's plan contract, or for which a reimbursement would be available but for the application of the enrollee's contractual limitations of deductibles, copayments, or coinsurance, regardless of how the materials are listed or described in an enrollee's benefit plan's definition of benefits.

(5) "De minimis" means equal to zero or an otherwise negligible amount.

(6) "Enrollee" means any individual participating in a health benefit plan, vision benefit plan, or vision benefit discount plan that is purchased by an individual or provided to an individual by an insurer, company, organization, group, employer, government assistance program, or any other entity that purchases or supplies coverage for a health benefit plan, vision care benefit plan, or vision benefit discount plan.

(7) "Eye care provider" means a licensed doctor of optometry practicing under the authority of R.S. 37:1041 or a licensed medical or osteopathic doctor as defined in R.S. 37:1262.

(8) "Fee schedule" means the document or system that lists the predetermined payment rates or allowed amounts for covered services or

covered materials and determines how much eye care providers are reimbursed by the insurer or vision benefit manager and how much patients are charged by the insurer, vision benefit manager, or eye care provider.

(9) "Health benefit plan" means a policy, contract, or agreement offered by an insurer, third party administrator, or subcontractor to an enrollee to pay for, reimburse, discount, or offset healthcare costs.

(10) "Insurer" means an individual, corporation, partnership, company, organization, group, health maintenance organization, captive, risk-retention group, self-insurance group, optometric service and indemnity corporation, or other entity, whether organized for profit or not-for-profit, whether foreign or domestic, that conducts business in this state and that offers a vision benefit plan or provides coverage for vision-related services or vision-related materials to enrollees. An entity is considered an insurer for purposes of this Part irrespective of:

(a) Its corporate form or category of licensure, if applicable, including whether it is otherwise subject to insurance regulations or any other regulations.

(b) Whether it, either directly or indirectly reimburses, indemnifies, pays, or discounts the costs of vision services or vision materials.

(c) Whether it delegates, assigns, or contracts performance of any function regulated by this Part to an affiliate, subsidiary, contractor, intermediary, or network leasing entity.

(11) "Material" means an ophthalmic device including but not limited to lenses, devices containing lenses, artificial intraocular lenses, ophthalmic frames, and other lens mounting apparatus, prisms, lens treatments, and coatings, contact lenses, low vision devices, vision therapy devices, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa, or any material allowed to be utilized by the Louisiana State Board of Optometry Examiners and the Louisiana Optometry

Practice Act.

(12) "Nominal" means, when there is no corresponding reimbursement in the current year's published Physician Fee Schedule released annually by the Centers for Medicare and Medicaid Services or in the current year's published state Medicaid fee schedule, an amount less than the reasonable compensation to the vision care provider rendering the covered service or covered materials, taking into account the provider's direct and indirect costs, including the actual acquisition costs and actual pro rata overhead costs, and reasonable profit.

(13) "Optometrist" means a licensed doctor of optometry practicing under the authority of R.S. 37:1041.

(14) "Participating eye care provider" means an eye care provider that has entered into a contractual agreement or other business relationship with an insurer, vision benefit manager, third party administrator, or subcontractor to provide covered services or covered materials.

(15) "Subcontractor" means an individual, company, organization, group, or other entity, including but not limited to an agent, servant, broker, wholesaler, distributor, partially-owned or wholly-owned subsidiary, or controlled organization that is contracted by the vision benefit manager to supply services or materials to another vision benefit manager, eye care provider, or enrollee to execute or fulfill the health benefit plan, vision benefit plan, or vision benefit discount plan of a vision benefit manager.

(16) "Third party administrator" means an individual, company, organization, group, or other entity that provides services, including but not limited to administrative, operational, regulatory, human resource, compliance, and claim adjudication services for an insurer, vision benefit manager, individual, company, organization, group, or other entity under a contract or agreement.

(17) "Vision benefit plan" means a policy, contract, or agreement offered by an insurer or vision benefit manager to an enrollee to pay for, reimburse, or

offset health and vision care costs.

(18) "Vision benefit discount plan" means a policy, contract, or agreement offered by an insurer or vision benefit manager to an enrollee that solely provides for a discount for vision care services or materials.

(19) "Vision benefit manager" means an individual, company, organization, group, or other entity, including but not limited to insurers, third party administrators, and subcontractors, that creates, promotes, sells, provides, advertises, or administers an integrated or stand-alone vision benefit plan, vision benefit discount plan, or other insurance policy or contract which provides vision benefits or discounts to an enrollee pertaining to the provision of covered services or covered materials.

§1809.4. Covered and noncovered services and materials

A. No contract or agreement between an insurer or vision benefit manager and an eye care provider may seek to or require that an eye care provider provide services or materials at a fee limited or set by the insurer or vision benefit manager unless the services or materials are defined and reimbursed as covered services or covered materials under the contract or agreement.

B. An insurer or vision benefit manager shall only use standardized codes, names, descriptions, and definitions published in the Healthcare Common Procedure Coding System, including Current Procedural Terminology codes published by the American Medical Association and Level II codes published by the Centers for Medicare and Medicaid Services, to identify and describe all covered services and covered materials of the vision benefit plan to purchasers and enrollees of the vision benefit plan.

C. An insurer or vision benefit manager shall only use standardized codes, names, descriptions, and definitions published in the Healthcare Common Procedure Coding System, including all Current Procedural Terminology codes published by the American Medical Association and all

Level II codes published by the Centers for Medicare and Medicaid Services, to create and offer a fee schedule of allowed amounts for covered services and covered materials in a contract or agreement between the insurer or vision benefit manager and an eye care provider.

D. An insurer or vision benefit manager shall not misuse, misrepresent, or change the meaning of any of the standardized codes, names, descriptions, and definitions published in the Healthcare Common Procedure Coding System, including all Current Procedural Terminology codes published by the American Medical Association and all Level II codes published by the Centers for Medicare and Medicaid Services. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of the foregoing shall be void and unenforceable.

E. All fee schedules in an agreement between an insurer or vision benefit manager and an eye care provider and all reimbursements paid by an insurer or vision benefit manager to an eye care provider for all covered services and covered materials shall not be nominal or de minimis. There shall be no limitation on the ability of an individual eye care provider or a group of eye care providers who practice under a single Employer Identification Number or Tax Identification Number to engage in direct negotiations with the insurer or vision benefit manager regarding reimbursement fee schedules, and agreeing to a different fee schedule than the fee schedule provided by the insurer or vision benefit manager to other participating providers or groups.

F. All fee schedule allowed amounts and all reimbursements paid by an insurer or vision benefit manager for each covered service and covered material shall be clearly and individually listed on a fee schedule made available to the eye care provider:

(1) At the time a contract or agreement is offered to the eye care provider by an insurer or vision benefit manager.

(2) Within ten business days from the date an application is made to

become a participating eye care provider with the insurer or vision benefit manager by the eye care provider.

(3) At all times via electronic means to the participating eye care provider.

G. A contract or agreement between an insurer or vision benefit manager and an eye care provider shall include a fee schedule that includes and individually identifies each covered service and covered material and its corresponding allowed amount, reimbursement amount paid to the eye care provider, and any form of a cost-sharing amount paid by the enrollee to the eye care provider.

H. Insurers or vision benefit managers shall not advertise, claim, or represent to purchasers or enrollees that services and materials provided by a participating eye care provider are covered or included, or covered or included with an additional deductible, copay, or coinsurance, if the insurer or vision benefit manager does not remit an actual payment to the participating eye care provider as full or partial reimbursement for the service or material.

I. A service or material provided by a participating eye care provider shall not be designated as a covered service or covered material by the insurer or vision benefit manager in the design of a health benefit plan or vision benefit plan if the reimbursement amount to the participating eye care provider is only comprised of an enrollee's payment to the participating eye care provider.

J. Insurers or vision benefit managers shall not condition application to a network or participation in a health benefit plan, vision benefit plan, or vision benefit discount plan by an eye care provider based on the eye care provider's usual and customary pricing or discounts on usual and customary pricing for services or materials that are not covered services or not covered materials. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of the foregoing shall be void and unenforceable.

K. An insurer or vision benefit manager shall not make conditional a fee

schedule proposed or made to an eye care provider of a health benefit plan, vision benefit plan, or vision benefit discount plan for covered services or covered materials based on the eye care provider's usual and customary pricing or discounts on usual and customary pricing for services or materials that are not covered services or not covered materials. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of the foregoing shall be void and unenforceable.

L. A contract or agreement between an insurer or vision benefit manager and an eye care provider shall not contain a provision, fee schedule, or reimbursement amount requiring the eye care provider, taking into account any applicable deductibles, copays, coinsurances, discounts, rebates, or chargebacks, to provide covered services or covered materials to an enrollee at a financial loss. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of the foregoing shall be void and unenforceable.

M. All fee schedule-allowed amounts in a provider agreement between an insurer or vision benefit manager and an eye care provider for all covered services and covered materials shall not be less than the current year's published Physician Fee Schedule released annually by the Centers for Medicare and Medicaid Services, unless:

(1) In the event that a covered service or covered material does not have an allowed amount listed or if the allowed amount is listed at zero in the current year's published Physician Fee Schedule released annually by the Centers for Medicare & Medicaid Services, the allowed amount for the covered service or covered material shall not be less than the current year's published state Medicaid fee schedule rate.

(2) In the event that a covered service or covered material does not have an allowed amount listed or if the allowed amount is listed at zero in the current year's published Physician Fee Schedule released annually by the Centers for

Medicare & Medicaid Services or in the current year's published state Medicaid fee schedule rate, the allowed amount for the covered service or covered material shall be reasonable, and not nominal or de minimis.

N. The period of time prescribed by a contract or agreement between an insurer or vision benefit manager and an eye care provider for the insurer or vision benefit manager to recover any reimbursement amount from an eye care provider shall be the same period of time allowed or required for any insurer or vision benefit manager to remit the applicable reimbursement following an eye care provider's submission of a clean claim for services rendered or materials furnished. The foregoing shall not limit an insurer or vision benefit manager's ability to conduct an audit of claims, in accordance with the insurer or vision benefit plan manager's written policies and applicable law, in the event that the insurer or vision benefit manager has a reasonable belief that the eye care provider has engaged in fraud, waste, or abuse.

O. An insurer or vision benefit manager shall not falsely represent the number of participating providers in a region nor the benefits that comprise a health benefit plan, vision benefit plan, or vision benefit discount plan to clients, groups, employers, purchasers, companies, enrollees, or prospective enrollees. Such acts are considered deceptive trade practices and subject to penalty under R.S. 22:1964.

P. An insurer or vision benefit manager shall not promote or use in any marketing or advertising that a covered service or covered material is "free", "no charge", or "complimentary" or any materially similar language to a client, group, employer, purchaser, company, enrollee, or prospective enrollee to purchase services, materials, supplies, or plans from the insurer, vision benefit manager, or affiliate of the insurer or vision benefit manager.

Q. An insurer or vision benefit manager shall not offer enrollees varying deductibles, copays, coinsurances, coverage amounts, rebates, gift cards, or other monetary or nonmonetary incentives to obtain covered services, covered

materials, noncovered services, or noncovered materials:

(1) At any particular participating eye care provider.

(2) At a retail establishment owned by, partially owned by, contracted with, or otherwise affiliated with the insurer or vision benefit manager.

(3) At any internet or virtual provider or retailer owned by, partially owned by, contracted with, or otherwise affiliated with the insurer or vision benefit manager.

R. An insurer or vision benefit manager shall not engage in marketing or advertising activities that may be misleading or deceptive to the public. Upon request by a jurisdictional enforcement agency, insurers and vision benefit managers shall submit all information regarding alleged savings and discounts offered by affiliates of the insurer or vision benefit manager.

S. An insurer or vision benefit manager shall remit to the participating eye care provider the contracted reimbursement amount for a covered service or covered material provided to an enrollee if the enrollee is verified to be eligible by the participating eye care provider through customary verification methods of the insurer or vision benefit manager to receive the covered service or covered material on the date of service.

T. A participating eye care provider is allowed, but not required, to offer an enrollee the opportunity to pay the participating eye care provider directly for covered services and covered materials if such direct payment would be less costly to the enrollee than the total out-of-pocket cost required under the terms of a health benefit plan or vision benefit plan. An eye care provider may not be subject to an audit, removed from participation in the network, or otherwise penalized or discriminated against in any manner for offering an enrollee the opportunity to pay the participating provider directly under the conditions of this Subsection.

U. An insurer or vision benefit manager shall not retroactively reverse a reimbursement or withhold a future reimbursement to an eye care provider

who relied in good faith on an individual's presented coverage credentials and the customary verification methods of the insurer or vision benefits manager, if the insurer or vision benefit manager later determines that the enrollee was ineligible to receive covered services or covered materials on the date of service.

V. An insurer or vision benefit manager shall not require a participating eye care provider, purchaser, or enrollee of a health benefit plan, vision benefit plan, or vision benefit discount plan to obtain prior authorization, preauthorization, precertification, or any similar mechanism that restricts the enrollee from receiving a covered service or covered material recommended by the eye care provider and requested by the enrollee.

W.(1) An insurer or vision benefit manager shall not, in the course of adjudicating a claim for reimbursement by a participating eye care provider for a covered service or covered material, alter, delete, substitute, or otherwise change any code or modifier submitted by the eye care provider, including downcoding, bundling, or reassigning to a different code, if such change would reduce payment or otherwise adversely affect the provider or enrollee.

(2) For purposes of this Subsection, the following definitions apply:

(a) "Downcoding" means to alter, delete, substitute, or assign a code that results in a lower level of service, a lower-valued code, or a reduced reimbursement amount relative to the code submitted by the eye care provider.

(b) "Bundling" means to combine, substitute, or treat two or more distinct services, supplies, or materials reported on the same claim, date, or service as included within a single code, package, or global service, and denying, reducing, or disallowing separate reimbursement for one or more of the codes.

X. The provisions of this Section shall apply to any affiliate or subcontractor that is used by an insurer or vision benefit manager to supply covered services or covered materials to an eye care provider or enrollee and be subject to all applicable penalties as provided for in this Part.

Y. An insurer or vision benefit manager shall not require nor request an

eye care provider to opt-in or opt-out of the provisions set forth in this Section.

§1809.5. Credentialing; forced participation in panel prohibition; payment parity

A. No contract or agreement between an insurer or vision benefit manager and an eye care provider shall require an eye care provider to participate with, be credentialed by, or enter into a contract or agreement with any specific vision benefit plan or vision benefit discount plan as a condition for participation in the health benefit plan provider network of the insurer or vision benefit manager to provide covered services to the enrollees of the health benefit plan.

B. Any insurer or vision benefit manager issuing or renewing a health benefit plan, vision benefit plan, or vision benefit discount plan, which provides benefits for covered services or covered materials rendered by a medical doctor or an osteopathic doctor that is within the scope of practice of an optometrist, shall provide no less than the same reimbursement for covered services or covered materials to optometrists as allowed for those covered services or covered materials rendered by medical doctors or osteopathic doctors.

C. An insurer or vision benefit manager shall apply the same terms and conditions of participation for all eye care providers irrespective of their educational credentials, subject to the permitted scope of practice for the licensee under applicable state law.

D. An insurer or vision benefit manager shall not require an eye care provider to possess, offer, or sell materials or covered materials in their office as a condition of participation in the provider network of health benefit plan, vision benefit plan, or vision benefit discount plan. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of the foregoing shall be void and unenforceable.

E. If an eye care provider enters into any subcontract agreement with another provider to provide licensed healthcare services to an enrollee or a

covered dependent of an enrollee of a health benefit plan, vision benefit plan, or vision benefit discount plan where the subcontracted provider seeks reimbursement from the plan, or enrollee for the subcontracted services, the subcontract agreement must meet all requirements of this Section.

F. The provisions of this Section shall apply to any contract or agreement an insurer or vision benefit manager enters into with another entity to provide an enrollee with covered services or covered materials.

§1809.6. Unfair trade practices

A. It is prohibited for an insurer or vision benefit manager that offers multiple health benefit plans, vision benefit plans, or vision benefit discount plans to require an eye care provider, as a condition of participation in the network for a health benefit plan, vision benefit plan, or vision benefit discount plan, to participate in the network of any of the insurer's or vision benefit manager's other health benefit plans, vision benefit plans, or vision benefit discount plans. A contract provision or agreement violating this Subsection shall be void. The penalties and remedies provided for violation of provisions of this Part shall not waive, limit, or otherwise affect the applicability of Louisiana's Unfair Trade Practices and Consumer Protection Law, R.S. 51:1401 et seq., or any other law providing for civil or criminal penalties or remedies for unfair, deceptive, or unlawful business practices.

B. It is prohibited for an insurer or vision benefit manager that offers multiple health benefit plans, vision benefit plans, or vision benefit discount plans to withhold participation in the network of one or more of the insurer's or vision benefit manager's other health benefit plans, vision benefit plans, or vision benefit discount plans if the eye care provider is already participating in the network of one or more of the insurer's or vision benefit manager's health benefit plans, vision benefit plans, or vision benefit discount plans and seeks to participate in the network of the insurer's or vision benefit manager's other health benefit plans, vision benefit plans, or vision benefit discount plans.

C. This Section applies to all plan types that a health benefit plan, vision benefit plan, or vision benefit discount plan sells, administers, or offers, including but not limited to individually purchased plans and employer-sponsored plans.

§1809.7. Credentialing and contracting requirements; acceptance as participating eye care provider

A. An insurer or vision benefit manager must include on their website:

(1) A method for an eye care provider to submit an application for inclusion and credentialing as a participating provider in the health benefit plan, vision benefit plan, or vision benefit discount plan.

(2) A description of the credentialing requirements, which shall be reasonable, related to the delivery of covered eye care services, and applied in an objective, uniform, and nondiscriminatory manner.

B. An insurer's or vision benefit manager's application for inclusion and credentialing as a participating eye care provider in the health benefit plan, vision benefit plan, or vision benefit discount plan shall only require standardized information specified in the current version of the Louisiana Standardized Credentialing Application Form or the current format used by the Council for Affordable Quality Healthcare credentialing application.

C. An insurer's or vision benefit manager's application for inclusion and credentialing as a participating eye care provider in the health insurance benefit plan, vision benefit plan, or vision benefit discount plan must impose the same application requirements on each eye care provider.

D. Not later than the thirtieth business day after the date the insurer or vision benefit manager receives an application from an eye care provider for inclusion as a participating provider in the health benefit plan, vision benefit plan, or vision benefit discount plan, the insurer or vision benefit manager shall inform the applicant of all defects and reasons known at the time by the insurer or vision benefit manager in the event that the application is deemed to be not

correctly completed.

E. Not later than the fortieth business day after the date the insurer or vision benefit manager receives an application from an eye care provider for inclusion as a participating provider in the health benefit plan, vision benefit, or vision benefit discount planning, the insurer or vision benefit manager shall make available electronically to the eye care provider the proposed participating provider contract, including applicable fee schedules, provider handbooks, and provider manuals.

F. Not later than the ninetieth business day after the date the insurer or vision benefit manager receives an application from an eye care provider for inclusion as a participating provider in the health benefit plan, vision benefit plan, or vision benefit discount plan, the insurer or vision benefit manager shall complete the credentialing determination of the eye care provider, approve or disapprove the application of the eye care provider, and deliver electronically a proposed participating provider contract as provided for in this Section for acceptance and signature to the approved eye care provider.

G. If the application for inclusion and credentialing as a participating provider is denied by the insurer or vision benefit manager, the insurer or vision benefit manager shall deliver to the applicant a detailed explanation for the denial, both electronically and in writing via certified mail.

H. If the application for inclusion and credentialing as a participating provider is denied by the insurer or vision benefit manager, the eye care provider must be allowed a reasonable period of time in which to appeal the decision to the insurer or vision benefit manager and provide in the appeal evidence that supports the reconsideration of the denied application. The insurer or vision benefit managers shall consider, and render a decision on the eye care provider's appeal submission within thirty days of the date of receipt of the submission by the insurer or vision benefit manager.

I. If the appeal to the application denial for inclusion and credentialing

as a participating provider is denied by the insurer or vision benefit manager, the insurer or vision benefit manager shall deliver to the applicant a detailed explanation for the denial of the appeal, both electronically and in writing via certified mail.

J. If the appeal to the application denial for inclusion and credentialing as a participating provider is denied by the insurer or vision benefit manager, the applicant may appeal the decision to the commissioner and seek a ruling that allows the eye care provider to become a participating provider in the health benefit plan, vision benefit plan, or vision benefit discount plan.

K. An insurer or vision benefit manager, concurrent with the electronic delivery of the proposed participating provider contract to the approved eye care provider, must provide the name, email address, and phone number of the representative of the insurer or vision benefit manager to allow the approved eye care provider the opportunity to:

(1) Contact the representative before signing the contract or agreement.

(2) Discuss the proposed contract with the representative before signing the contract or agreement.

(3) Electronically send the representative modifications to the proposed contract or agreement before signing the contract.

L. In the event that the approved eye care provider sends the representative of the insurer or vision benefit manager modifications to the proposed participating provider contract, the insurer or vision benefit manager must respond to the submission of the approved eye care provider within five business days. Each subsequent response made by the insurer, vision benefit manager, or approved eye care provider to the other party shall be responded to within five business days by the receiving party.

M. Once the insurer or vision benefit manager has approved and delivered electronically a proposed participating provider contract, the approved eye care provider has a total allotted time frame of ninety business

days to reach agreement with the insurer or vision benefit manager and sign a participating provider contract or agreement. If the parties fail to reach an agreement and no participating provider contract is signed by the approved eye care provider within the allotted time frame, the insurer or vision benefit manager may retract the participating provider's contract or agreement.

N. Not later than the twentieth business day after the date the approved eye care provider signs a participating provider contract, the insurer or vision benefit manager shall include the credentialed and approved eye care provider as a participating provider in the health benefit plan, vision benefit plan, or vision benefit discount plan, and list the eye care provider without limitation in all of the plan directories that are available to enrollees and the public.

O. The earliest that an eye care provider may submit another application to an insurer or vision benefit manager, after a previous approval and subsequent unsuccessful attempt to sign a participating provider contract, is one hundred eighty calendar days from the date of the previous application.

P. The earliest that an eye care provider may submit another application to an insurer or vision benefit manager after a previous disapproval of an application is one hundred eighty calendar days from the date of the previous application.

Q. An insurer or vision benefit manager shall allow an eye care provider to become a participating provider in the network of a health benefit plan, vision benefit plan, or vision benefit discount plan if the eye care provider:

(1) Meets the credentialing requirements of the insurer or vision benefit manager.

(2) Agrees in writing to the applicable provider agreement.

R. An insurer or vision benefit manager shall allow all eye care providers who practice under a single Employer Identification Number or Tax Identification Number to become participating providers in the network of a health benefit plan, vision benefit plan, or vision benefit discount plan if one eye

care provider practicing in that practice:

(1) Meets the credentialing requirements of the insurer or vision benefit manager.

(2) Agrees in writing to the applicable provider agreement.

S. An insurer or vision benefit manager shall not exclude an eye care provider from applying to or becoming a participating provider in the network of a health benefit plan, vision benefit plan, or vision benefit discount plan because of:

(1) The aggregate number of eye care providers in a state, county, city, zip code, or other geographically defined service area.

(2) The time, distance, or appointment availability for an enrollee to access a participating eye care provider.

(3) The eye care provider's professional designation, independent practice affiliation, or participation status in other health benefit plans, vision benefit plans, or vision benefit discount plans.

§1809.8. Transparency and disclosure requirements for insurers and vision benefit managers

A. An insurer or vision benefit manager shall disclose the following information publicly on its internet website and with all documents and document packages, including but not limited to proposals, responses to requests for proposals, sales documents, enrollment documents, benefit plan documents, purchaser contracts, enrollee contracts, and provider agreements that are presented to purchasers, potential purchasers, enrollees, potential enrollees, participating eye care providers, potential participating providers, and state agencies with jurisdictional, regulatory, or enforcement authority over its business:

(1) Its legal name and entity type.

(2) Its legal address and state in which the legal entity is formed or organized.

(3) The physical address, mailing address, electronic mail address, and phone number of its operational headquarters.

(4) The agencies, departments, committees, commissions, and other bodies that have jurisdictional, regulatory, or enforcement authority over the business.

(5) A statement that no jurisdictional, regulatory, or enforcement authority exists over its business, if none exists.

(6) The names, physical addresses, mailing addresses, electronic mail addresses, and phone numbers of all parent companies, related holding companies, wholly-owned subsidiary companies, and partially-owned subsidiary companies.

(7) All federal and state litigation in which the company is, or has been, a party to in the current year and during the preceding five years.

(8) All Department of Insurance formal complaints against the company in the current year and during the preceding five years by purchasers, enrollees, or eye care providers.

B. All information required to be disclosed by an insurer or vision benefit manager in Subsection A of this Section shall be conveyed in plain language and typed with a minimum of ten point font size and prominently displayed:

(1) On the insurer's or vision benefit manager's website in a publicly accessible section titled "Required Transparency Information for Patients, Doctors, and Purchasers".

(2) In a separately created document titled "Required Transparency Information for Patients, Doctors, and Purchasers" that shall be included with all documents and document packages, including but not limited to proposals, responses to requests for proposals, benefit plan documents, sales documents, enrollment documents, purchaser contracts, enrollee contracts, and provider agreements.

C. An insurer or vision benefit manager shall provide notice to each participating eye care provider of any proposed amendments to existing provider agreements, fee schedules, provider handbooks, provider manuals, or related policy documents via electronic mail.

D. A participating eye care provider shall be provided with a minimum of ninety calendar days from the time of distribution to review changes and respond, if necessary, to any proposed amendments from an insurer or vision benefit manager to existing provider agreements, fee schedules, provider handbooks, provider manuals, or related policy documents. Any such proposed amendments proffered by the insurer or vision benefit manager in violation of the foregoing shall be void and unenforceable.

E. Any proposed amendments to existing provider agreements, fee schedules, provider handbooks, provider manuals, or related policy documents by an insurer or vision benefit manager delivered to a participating eye care provider shall be:

(1) Enumerated in a cover letter.

(2) Marked with highlights or as tracked changes within the applicable agreements or documents, to clearly display all changes over any of the previous version.

(3) Structured to include implications of agreeance or nonagreeance by the participating eye care provider.

F. An insurer or vision benefit manager shall maintain:

(1) A phone number for company representatives to receive questions and communications from participating eye care providers at all times during standard business hours.

(2) The ability for an eye care provider to leave voice messages at all times.

(3) The ability for an eye care provider to have a live phone discussion with a company representative within twenty-four hours of an initial phone call

or a voice message left with the insurer or vision benefit manager.

G. An insurer or vision benefit manager shall maintain a physical mailing address and an electronic mail address to company representatives to receive questions, disputes, and communications from participating eye care providers about all matters, at all times, including but not limited to proposed amendments to existing provider agreements, fee schedules, provider handbooks, provider manuals, and related policy documents, and will publish instructions for mail submission and electronic mail submission of questions, disputes, and communications in a place visible to participating eye care providers including on its website and in any provider agreements, provider handbooks, provider manuals, or related policy documents.

H. An insurer or vision benefit manager shall acknowledge receipt of an electronic mail message within one hour by use of a return electronic mail message with a communication tracking number and shall respond to the substantive questions or communications of the electronic mail message within seventy-two hours in writing by use of a return electronic mail message.

I. An insurer or vision benefit manager shall, at all times, make available to the eye care provider the most up-to-date provider agreements, fee schedules, provider handbooks, provider manuals, and related policy documents via website access.

J. Insurers or vision benefit managers shall not engage in marketing or advertising activities that are misleading or deceptive to the public. Such acts are considered an unfair practice or act in accordance with the Unfair Trade Practices and Consumer Protection Law, R.S. 51:1401 et seq.

K. Upon request by a state agency with jurisdictional, regulatory, or enforcement authority over its business, insurers and vision benefit managers shall submit all information related to a health benefit plan, vision benefit plan, or vision benefit discount plan, including but not limited to proposals, responses to requests for proposals, benefit plan documents, sales documents, enrollment

documents, purchaser contracts, enrollee contracts, provider agreements, and marketing and advertising activities for review.

§1809.9. Amending agreements; contracts; payment methods; security interests; arbitration expenses

A. An insurer or vision benefit manager shall not change or alter a contract or agreement, including terms, reimbursements, or fee schedules, entered into with a participating eye care provider unless the insurer or vision benefit manager complies with the following requirements at least ninety days before the date of the proposed change would take effect:

(1) A certified letter, or an electronic communication requiring an electronic signature proving receipt, detailing proposed changes is required to be sent to the eye care provider.

(2) A face-to-face or virtual meeting is required to discuss proposed changes if requested by the eye care provider.

(3) The eye care provider shall either agree or not agree in writing to proposed changes. If the changes in the contract or agreement are not agreed to by the eye care provider then the current agreement shall continue and the insurer or vision benefit manager may not remove the eye care provider from a network panel or plan for not accepting the proposed changes to a contract or agreement.

(4) A new agreement is required to be established and agreed upon after three or more material changes are made to an existing agreement between an eye care provider and an insurer or vision benefit manager.

(5) Any proposed amendment to an existing contract or agreement shall be presented to the participating eye care provider in a manner conducive to the provider's review. Proposed changes will be enumerated in a cover letter and clearly marked as tracked changes within the body of the applicable contract or agreement.

B. A contract or agreement between an insurer or vision benefit manager

and an eye care provider shall not contain any provision requiring an optometrist to accept a reimbursement payment in the form of a virtual credit card or any other payment method wherein a processing fee, administrative fee, percentage amount, or dollar amount is assessed for the provider to receive the reimbursement payment.

C. Termination of any contract or agreement shall be permissible only in the event of a material breach, wherein the eye care provider fails to remedy the alleged breach to the reasonable satisfaction of the insurer or vision benefit manager within thirty days of receipt of written notice specifying the alleged breach.

D. It shall be prohibited for an insurer or vision benefit manager to require an eye care provider to establish a security interest in all or part of their property and assets, including assets pertaining to their practice, in a sum equivalent to the funds owed to the insurer or vision benefit manager at termination. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of the foregoing shall be void and unenforceable.

E. A contract or agreement between an insurer or vision benefit manager and an eye care provider shall not contain a provision obligating the eye care provider to equally share the expenses of arbitration. Each party shall bear their own arbitration costs, contingent upon a fee-shifting provision that grants prevailing party status.

F. An insurer or vision benefit manager shall not retaliate in any manner against an eye care provider for discussing, or attempting in good faith to negotiate, the terms and provisions of a provider agreement with the insurer or vision benefit manager.

G. An insurer or vision benefit manager shall not retaliate in any manner against an eye care provider for filing a complaint against the insurer or vision benefit manager with any state agency with jurisdictional, regulatory, or

enforcement authority over the business of the insurer or vision benefit manager.

H. Should retaliation by an insurer or vision benefit manager occur against an eye care provider in violation of Subsections F or G of this Section, the commissioner may sanction the insurer or vision benefit manager, including fines and other remedies deemed appropriate, and provide an appropriate remedy for the aggrieved eye care provider.

§1809.10. Optical labs and suppliers

A. No contract or agreement between an insurer or vision benefit manager and an eye care provider shall restrict or limit, either directly or indirectly, the eye care provider's choice or use of sources and suppliers of covered or uncovered services or materials, including the choice or use of optical laboratories, provided by the eye care provider to an enrollee. Any such contractual language, policies, or procedures set by the insurer or vision benefit manager in violation of the foregoing shall be void and unenforceable.

B. An insurer or vision benefit manager shall not directly or indirectly:

(1) Control or attempt to control the professional judgment, manner of practice, or practice of an eye care provider.

(2) Employ an eye care provider to provide a covered service or covered material.

(3) Withhold or recoup payment to an eye care provider for covered services or covered materials provided for an enrollee if the enrollee was shown to be eligible on the date that the covered services or covered materials were provided.

(4) Reimburse an eye care provider a different amount for covered services or covered materials because of the eye care provider's choice of:

(a) Optical laboratory.

(b) Source of supplier of:

(i) Contact lenses.

(ii) Ophthalmic lenses.

(iii) Ophthalmic glasses frames.

(iv) Covered or non-covered services or materials.

(c) Equipment used for patient care.

(d) Retail optical affiliation.

(e) Vision support organization.

(f) Group purchasing organization.

(g) Doctor alliance or group.

(h) Professional trade association membership.

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

(j) Third-party claim filing service, billing service, or electronic data interchange clearinghouse company.

(5) Restrict, limit, or influence an eye care provider's choice of sources or suppliers of services or materials, including optical laboratories used by the eye care provider to provide services or materials to the enrollee.

(6) Restrict, limit, or influence an eye care provider's choice of electronic health record software, electronic medical record software, or practice management software.

(7) Restrict, limit, or influence an eye care provider's choice of third-party claim filing service, billing service, or electronic data interchange clearinghouse company.

(8) Restrict or limit an eye care provider's access to an enrollee's complete plan coverage information, including in-network and out-of-network coverage details.

(9) Apply a chargeback to an enrollee or eye care provider if the chargeback is for a covered product or service for which the insurer or vision benefit manager does not incur the cost to produce, deliver, or provide to the enrollee or eye care provider.

(10) Require an eye care provider to disclose an enrollee's confidential or protected health information unless the disclosure is expressly authorized by the enrollee, or permitted without authorization under the Health Insurance Portability and Accountability Act of 1996.

(11) Require an eye care provider 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 eye exam.

(12) Require an eye care provider to disclose or report an enrollee's glasses prescription, contact lens prescription, ophthalmic device measurements, facial photograph, or unique anatomical measurements as condition to file a claim, adjudicate a claim, or receive reimbursement for a claim, unless the information in needed for the vision benefit manager to manufacture, or cause to be manufactured, a covered product that is submitted on the applicable claim.

(13) Require an eye care provider to disclose any enrollee 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, or its approved successor, as a condition to file a claim, adjudicate a claim, or receive reimbursement for a claim unless the information is needed for the vision benefit manager to manufacture, or cause to be manufactured, a covered product that is submitted on the applicable claim.

C. An insurer or vision benefit manager shall not solicit patients or referrals for supplies on behalf of itself or its affiliates by identifying participating eye care providers in an inaccurate or otherwise misleading manner, in any list of participating providers, or in any communications to purchasers or enrollees. All communications which distinguish between participating eye care providers, or which otherwise claim professional superiority or the performance of a professional service in a superior manner, based on the following characteristics, shall be readily subject to verification by

the Department of Insurance:

(1) A discount or incentive offered by the participating eye care provider on services and materials that are not covered by the insurer or vision benefit manager.

(2) The dollar amount, volume amount, or percent usage amount of any material, product, or good purchased by the participating eye care provider.

(3) The brand, source, manufacturer, or supplier of a covered service or covered material utilized by the participating eye care provider.

D. This Section shall not prohibit advertising, provided that such advertising is not false, misleading, or deceptive and is readily subject to verification.

§1809.11. Extrapolation prohibited

A. An insurer or vision benefit manager shall not use extrapolation to complete an audit of a participating eye care provider. Any additional payment due to a participating eye care provider or any refund due to the insurer or vision benefit manager shall not be based on an extrapolation, but shall be based on the actual overpayment or underpayment, as determined after an investigation by the insurer or vision benefit manager, and participating eye care provider has been afforded, and has exhausted, all opportunities to appeal the insurer or vision benefit manager's findings, as set forth in the provider manual, policy document, or applicable law.

B. For purposes of this Section, "extrapolation" means a mathematical formula, process, or technique used by a vision benefit manager, or the vision benefit manager's agent, in the audit of an optometrist to estimate audit results or findings for a larger batch or group of claims not reviewed by the vision benefit manager.

§1809.12. Private right of action; eye care providers

Any eye care provider adversely affected by a violation of this Part may bring an action in a court of competent jurisdiction for injunctive relief against

the insurer or vision benefit manager and, upon prevailing, in addition to such injunctive relief, shall recover monetary damages, including but not limited to direct, indirect, special, and punitive damages and penalties, of no more than ten thousand dollars for each violation, plus attorney fees and costs.

§1809.13. Relationship to other laws

The requirements of this Part are in addition to, and do not limit, any other requirement applicable to an insurer under state law. In the event of a conflict between this Part and another provision of law applicable to insurers, the provision that affords greater protection to eye care providers or plan enrollees shall control. Notwithstanding any other provision of law, including any law that purports to be the sole body of law governing the insurer, an insurer shall comply with this Part, to the extent not preempted by federal law.

§1809.14. Authorization for enforcement

A. The Department of Insurance has jurisdiction to administer and enforce this Part with respect to any insurer or vision benefit manager. The department may:

(1) Bring an action, issue orders, and impose remedies authorized by this Part against any insurer or vision benefit manager.

(2) Adopt rules to identify activities that constitute the administration, management, or control of vision benefits or materials.

(3) Coordinate enforcement with other state agencies that regulate insurers under other applicable law. The attorney general shall have concurrent enforcement authority for violations constituting unfair or deceptive acts or practices.

B. The Department of Insurance shall:

(1) Provide a mechanism for aggrieved individuals, whether actively or formerly enrolled with a particular vision care plan, to submit complaints to the department for review, investigation, and as appropriate, discipline under applicable law.

(2) Enforce the state's insurance laws and the provisions of this Part using powers granted to the commissioner in this Title.

(3) Ensure that insurers and vision benefit managers comply with the requirements of this Part.

(4) Be entitled to seek an injunction against an insurer or vision benefit manager in a court of competent jurisdiction if the insurer or vision benefit manager:

(a) Issues a coverage policy that does not comply with the requirements of this Part, uses fraudulent, coercive, or dishonest practices, or demonstrates incompetence, untrustworthiness, or financial irresponsibility in the conduct of business.

(b) Fails to deal equitably with any eye care provider or other persons or facilities which offer services or materials covered within an agreement or contractor policy issued pursuant to this Part.

(c) Fails to substantially comply with the insurance laws of this state or violates any regulation, rule, subpoena, or order of the commissioner.

C. The attorney general shall:

(1) Enforce the provisions of this Part concerning discount card plans, using powers granted to the attorney general pursuant to this Title and the Unfair Trade Practices and Consumer Protection Law, R.S. 51:1401, et seq.

(2) Be entitled to seek an injunction against an insurer or vision benefit manager in a court of competent jurisdiction.

§1809.15. Enactment provisions

A. The requirements of this Part shall apply to insurer or vision benefit manager policies, agreements, contracts, addenda, and certificates executed, delivered, issued for delivery, continued, or renewed in the state of Louisiana.

B. No insurer or vision benefit manager agreement may be longer than two years from the date that it was signed by both parties.

C. No insurer or vision benefit manager shall construe re-credentialing

as re-contracting with a participating eye care provider. A provider contract or agreement shall be a distinctly separate document from any credentialing materials and shall be signed by the eye care provider and the insurer or vision benefit manager.

D. An insurer or vision benefit manager shall include a copy of the current plan provider manual referred to in a provider contract or agreement at the time a contract or agreement is sent to any provider and prospective provider, as well as any policies referenced in the contract or agreement.

Section 2. The provisions of this Act shall apply to all insurers and vision benefit managers upon the earlier of:

(A) The renewal of enrollee's current benefit plan or upon issue of a new benefit plan to any enrollee.

(B) The initiation of a new contract or agreement with an eye care provider or upon any modification of an existing contract or agreement with an eye care provider.

(C) January 1, 2027.

Section 3. If any provision or item of this Act, or the application thereof, is held invalid, such invalidity shall not affect other provisions, items, or applications of the Act which can be given effect without the invalid provision, item, or application and to this end the provisions of this Act are hereby declared severable.

Section 4. This Act shall become effective upon signature by the governor or, if not signed by the governor, upon expiration of the time for bills to become law without signature by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If vetoed by the governor and subsequently approved by the legislature, this Act shall become effective on the day following such approval.

The original instrument and the following digest, which constitutes no part of the legislative instrument, were prepared by Senate Legislative Services. The keyword, summary, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

DIGEST

SB 404 Engrossed 2026 Regular Session McMath

Present law provides for requirements and prohibitions for medical eye care or vision care

benefits provided by or available through a health benefit plan, health maintenance organization, preferred provider organization, managed care organization, accountable care organization, or contract of insurance or any medical hospital service contract that are within the lawful scope of practice of a duly licensed optometrist.

Proposed law expands the applicability of present law to vision benefit plans, vision benefit discount plans, and any agent acting on behalf of any plan or entity that offers an agreement or contract of insurance that provides medical eye care or vision care benefits.

Proposed law provides that proposed law shall be cited as the "Louisiana Vision Plan Transparency and Fair Practice Act".

Proposed law provides that proposed law shall not be construed to expand or limit the scope of practice of any healthcare provider.

Proposed law provides for legislative findings and definitions relative to eye care providers and services, vision benefit managers, and vision benefit plans.

Proposed law provides for requirements and prohibitions relative to covered and noncovered services and fee schedules in contracts or agreements between insurers or vision benefit managers and eye care providers.

Proposed law provides for requirements and prohibitions for eye care provider participation and credentialing by an insurer or vision benefit manager.

Proposed law provides for transparency and disclosure requirements for insurers and vision benefit managers.

Proposed law establishes requirements for amending contracts and agreements between eye care providers and insurers or vision benefit managers.

Proposed law prohibits an insurer or vision benefit manager from using extrapolation to complete an audit of a participating eye care provider.

Proposed law establishes a private right of action for any eye care provider adversely affected by a violation of proposed law, including injunctive relief and monetary damages of up to $10,000 for each violation, plus attorney fees and costs.

Proposed law provides for the authority of the Dept. of Insurance and the attorney general to enforce the provisions of proposed law.

Proposed law provides for the applicability, severability, and effectiveness of proposed law.

Effective upon signature of the governor or lapse of time for gubernatorial action.

(Amend R.S. 22:997; adds R.S. 22:1809-1809.15)

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Health and Welfare to the original bill

1. Adds provision that proposed law does not change the scope of practice of any healthcare provider.