STATE OF OKLAHOMA

2nd Session of the 60th Legislature (2026)

POLICY COMMITTEE
RECOMMENDATION
FOR
HOUSE BILL NO. 3928 By: Worthen

POLICY COMMITTEE RECOMMENDATION

An Act relating to vision insurance; amending Section 2, Chapter 360, O.S.L. 2024 (36 O.S. Supp. 2025, Section 6973), which relates to reimbursements, charges, and pricing related to vision insurance; modifying citation; requiring reimbursement of services provided which are payable by Medicare or Medicaid to be paid according to Medicare and Medicaid reimbursement rates; requiring non-Medicare reimbursements to be not less than sixtieth percentile of usual charge for same services; prohibiting increases in reimbursement being offset by decrease for ophthalmic materials; providing exception for uniform application of changes; prohibiting reduction in reimbursements to providers for using nonaffiliated labs or frame vendors if credentialing standards are met; requiring disclosure of certain reimbursements; providing for codification; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY Section 2, Chapter 360, O.S.L. 2024 (36 O.S. Supp. 2025, Section 6973), is amended to read as follows:

Section 6973. A. No agreement between an insurer or prepaid vision plan and a vision care provider may require that a provider

provide services or materials at a fee limited or set by the insurer or prepaid vision plan, unless the services or materials are reimbursed as covered services or covered materials under the contract.

B. A provider shall not charge more for services and materials that are not covered services or materials to an enrollee of a prepaid vision plan or insurer than his or her usual and customary rate for those services and materials.

C. Reimbursements paid by an insurer or prepaid vision plan for covered services and covered materials, regardless of the supplier or optical lab used to obtain materials, shall be at the usual, customary, and reasonable rate and made available to the vision care provider prior to the provider accepting a contract from the insurer or prepaid vision plan. An insurer or prepaid vision plan shall not provide nominal reimbursement or advertise services and materials to be covered with additional copay or coinsurance in order to claim that services and materials are covered services and materials if the health benefit plan or prepaid vision plan does not reimburse for the services or materials.

D. Prepaid vision plans shall not in any manner impact the pricing of noncovered services or materials.

E. Prepaid vision plans shall provide standard reimbursements for all lenses with the same design, quality, and composition. The period of time prescribed by a contract between any prepaid vision

plan and a provider for the plan to recover any reimbursement amount from a provider shall be the same period of time allowed or required for any provider to recover any reimbursement amount from a prepaid vision plan.

F. A prepaid vision plan shall not use extrapolation to complete an audit of a vision care provider. Any additional payment due to a provider or any refund to a prepaid vision plan shall be based on actual overpayment or underpayment and shall not be based on extrapolation.

G. A prepaid vision plan shall not incentivize patients to receive vision care services at an entity owned wholly or in part by the plan or subsidiaries of the plan. Any entity providing vision care services shall provide notice to patients that an entity is owned wholly or in part by the plan or subsidiaries of the plan.

H. No person or entity shall sell, solicit, or negotiate any prepaid vision plan to an enrollee in this state without an approved certificate of authority under Section ~~7 of this act~~ 6978 of this title.

I. A vision benefit plan or an insurer/insurance company, health maintenance organization (HMO), vision benefit managers, or nonprofit optometric service and indemnity corporation and any affiliate, subsidiary, agent, contractor, subcontractor, or other designee acting on behalf of, at the direction of, or under

common control with any of the foregoing, shall reimburse licensed optometric physicians for any and all services provided by an optometrist which are payable by Medicare or Medicaid and shall be reimbursed according to said Medicare and Medicaid reimbursement rates depending upon the coverage held by the subscriber.

J. Any increase in reimbursement for covered services shall not be offset by a decrease in reimbursement for ophthalmic materials (including frames, lenses, and contacts), unless such changes apply uniformly to all providers, including those owned or employed by the vision benefit plan and including those practicing in a clinic owned by the vision benefit plan, or the provider is employed by a company which has any ownership by the plan.

K. A vision benefit plan or an insurer/insurance company, health maintenance organization (HMO), vision benefit managers, or nonprofit optometric service and indemnity corporation and any affiliate, subsidiary, agent, contractor, subcontractor, or other designee acting on behalf of, at the direction of, or under common control with any of the foregoing shall not reduce reimbursements to providers for using nonaffiliated labs or frame vendors if they meet credentialing standards.

L. A vision benefit plan or an insurer/insurance company, health maintenance organization (HMO), vision benefit managers, or nonprofit optometric service and indemnity corporation and any affiliate, subsidiary, agent, contractor, subcontractor, or other

designee acting on behalf of, at the direction of, or under common control with any of the foregoing shall be required to disclose average reimbursements to affiliated and independent providers for both services and materials.

SECTION 2. This act shall become effective November 1, 2026.

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