Lower Health Care Costs, Boost Choices and Grow Access By Ending Abusive VBM Practices
Co-sponsor H.R. 1385/S. 1424, the Dental and Optometric Care (DOC) Access Act

Reps. Buddy Carter, R-Ga., and Yvette Clarke, D-N.Y., and Sens. Joe Manchin, D-W. Va., and Kevin Cramer, R-N.D., have introduced the Dental and Optometric Care (DOC) Access Act (H.R. 1385/S. 1424), which aims to combat costly and controlling practices of federally regulated vision and dental benefit managers.

The two most dominant VBMs administer vision benefits for roughly 2/3 of Americans with vision benefits.

Unfortunately for patients and their doctors, VBMs enjoy special legal treatment (not regulated like health plans), there is little or no competition in the market, and VBMs essentially force patients and doctors to buy and use the goods and services their vertically integrated company makes and owns.

Summary

Each year, tens of millions of Americans rely on local doctors of optometry for their comprehensive vision and eye health care needs. Many patients are covered for this essential care through a combination of health plan and vision benefit plan.

Special legal treatment for and a lack of competition among vision benefit managers has led to costly, choice-limiting mandates being forced on patients and their doctors—leading to higher prices and less access to care for patients while doctors face the tough choice of providing needed care to neighbors or keeping their practices viable.

So far, 45 states have enacted laws similar to the DOC Access Act; however, a federal effort is now needed as roughly one-third to one-half of patients in any given state now have a vision and/or dental plan that is federally regulated and not complying with these state laws.

The AOA, the American Dental Association and a growing number of patient, consumer and community advocacy groups support the bipartisan Dental and Optometric Care Access Act (H.R. 1385/S. 1424) to help put patients and their doctors back in control of important health care decisions. U.S. House members and senators are asked to co-sponsor the DOC Access Act (H.R. 1385/S. 1424).
While 45 states have so far enacted legislation addressing these and other plan abuses—some states having both a dental and vision law, some with only a dental law and some with only a vision law—roughly one-third to one-half of plans operating in any given state are able to sidestep those state-level laws because they are instead federally regulated. That is why a federal effort is now needed. The DOC Access Act will not mandate increased coverage or benefits or raise coverage costs for patients because this effort would not require vision or dental plans to add any additional services. The DOC Access Act does not supersede state law.

Reports produced in 2016 and expanded in 2021 by a group of independent health economists (Avalon Health Economics) found that the kind of monopsony behavior exhibited by VBMs “is not the kind that’s good for consumers—it’s the kind designed to transfer operating margins from providers to plans without benefiting consumers.” Further, Avalon says that “such mandates have another effect—they lead to higher overall costs for these consumers and, especially, for consumers without vision plans as doctors are forced to compensate for the transfer of operating margins from doctors to the plans.”

Lower health care costs, boost choices, and grow access by ending abusive VBM practices. U.S. House members and senators are urged to co-sponsor the DOC Access Act (H.R. 1385/S. 1424).


Putting a stop to VBM abuses is supported by: Patients Rising, National Consumers League, Americans for Limited Government, Southern Christian Leadership Conference, Hispanic Leadership Fund, Health Equity Collaborative, American Innovation and Opportunity Fund, Patients Rising Now, Hispanic Institute, People Over Profits, Faith Works, Black Women’s Health Imperative, MANA (a national Latina organization), and more.

For more information please contact AOA Washington office staffers: Matt Willette | mwillette@aoa.org | 703.837.1001 or Ruth Hazdovac | rhazdovac@aoa.org | 703.837.1011
## DOC Access Act (H.R. 1385/S.1424) Co-sponsors*

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* As of 4/10/24
January 30, 2024

The Honorable Gene Dodaro
Comptroller General of the United States
Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Comptroller General Dodaro,

We write to request a Government Accountability Office (GAO) study that details the state of consolidation and vertical integration in the vision and dental benefits industries. Further, we ask that such study evaluate the impacts of such consolidation and vertical integration on consumers and independent health care practices.

According to recent reporting, there are over 45 million Americans enrolled in fully-insured vision plans, with the largest insurer controlling over 70 percent of the market share.¹ The two largest vision plans in the U.S. reportedly cover more than two-thirds of those with vision care coverage and are vertically integrated with manufacturers of eyeglass frames and lenses. Additionally, they own and operate laboratories that produce finished prescription eyewear and retail locations that employ eye doctors. Similar consolidation and vertical integration concerns exist in the dental benefits market.

We are interested in understanding the effects of consolidation and vertical integration in health care and how incentives change when the entity responsible for paying for care financially aligns itself with the entity responsible for providing such care. As such, we request that GAO please examine the following topics in its report:

- An analysis of the concentration of local, regional, state, and national markets for limited scope vision and dental benefits and of how vision and dental benefit manager consolidation, market concentration, and acquisitions of small and other independent health care practices may impact consumers – including through the prices paid by consumers, and health care providers;

¹ https://www.markfarrah.com/mfa-briefs/highly-concentrated-vision-insurance-market-increasing/
• An analysis of vertical integration among vision benefit and dental benefit managers and whether limited scope vision and dental benefit plans encourage enrolled individuals to purchase materials and utilize services that are wholly or partially-owned by a vision or dental benefit manager or its parent entity, and the impact this practice may have on consumers, including through the prices paid by consumers, and small and other independent health care providers; and

• An analysis of the extent to which providers of vision and dental benefits are vertically integrated with payers, whether these arrangements create an opportunity to evade existing laws and regulations, and whether there is sufficient enforcement authority and capacity to address concerns.

We appreciate your attention to this important issue and look forward to working together to understand the state of the vision and dental benefit market better. As a result, we will be able to help ensure that patients face lower prices, more choice, and increased access to care.

If you have any questions, please contact the Majority Energy and Commerce Committee staff at (202) 225-3641.

Sincerely,

Cathy McMorris Rodgers
Chair
Committee on Energy and Commerce

Brett Guthrie
Chair
Subcommittee on Health
March 19, 2024

The Honorable Hakeem Jeffries  
Democratic Leader  
U.S. House of Representatives  
H-222, The Capitol  
Washington, D.C. 20515

Re: Efforts to Address Harmful Health Care Middlemen Must Include Vision Benefit Managers

Dear Leader Jeffries,

As Congress works to confront the harmful methods and practices of health care middlemen, we ask for your support in advancing policies to address the negative impacts of consolidation and vertical integration in the vision insurance industry, which continue to harm American families, particularly those within traditionally underserved communities. The rise in inequities across America – notably in health spaces – is well documented. And the key drivers of that growing imbalance, especially for those with modest incomes, the elderly, and communities of color, remain spiraling costs, a lack of benefit transparency, and dwindling control over important health care decisions.

Through Executive Order 14036, President Biden has identified excessive concentration and market power abuses by insurers as significant sources of these issues and has committed to addressing them. Reports consistently show that the vision insurance market is highly concentrated, with the top vision insurer controlling more than 70 percent of the market. While vision insurance is typically offered for a low premium, once consumers utilize that benefit, they’re faced with a system rigged by their vision benefit manager to limit choice, control behavior, and maximize profit at every step of the process.

Furthermore, insurers are able to exert control over the market though the mandated contracts eye doctors are compelled to sign as a condition of being an in-network provider. Even with goods and services not covered by a plan, these contracts often play a role in setting prices. Consumers are steered towards eyeglass frames and lenses the insurer manufactures and sells, and patients and doctors are forced to rely on the laboratories the insurers own and operate. These policies and other abuses contribute to ever higher prices, a loss of control over important health care choices, and growing disruption to the doctor-patient relationship.

Now is the time to ensure the voices of marginalized and underserved individuals and communities are included in the conversation on solutions to address important issues of health care access and affordability.
care costs, choice, and benefit transparency. We look forward to working alongside you in this critical endeavor.

Sincerely,

Yvette D. Clarke
Member of Congress

Terri A. Sewell
Member of Congress

Julia Brownley
Member of Congress

Jonathan L. Jackson
Member of Congress

Bennie G. Thompson
Member of Congress

Sheila Cherfilus-McCormick
Member of Congress

Lloyd Doggett
Member of Congress
Donald G. Davis
Member of Congress

Katie Porter
Member of Congress

Sylvia R. Garcia
Member of Congress

Troy A. Carter, Sr.
Member of Congress

Mark Pocan
Member of Congress

Gabe Amo
Member of Congress

Lisa Blunt Rochester
Member of Congress

Raja Krishnamoorthi
Member of Congress

Sanford D. Bishop, Jr.
Member of Congress

Eric Swalwell
Member of Congress
Patients Rising Now, a national nonprofit organization advocacy group that advocates for the rights of patients, released a helpful explainer video detailing how vertical integration in the vision insurance market results in higher costs and fewer options for patients and threatens independent providers. This video explains how insurers exert maximum influence over every step of the patient encounter, highlighting the need for the DOC Access Act to protect both patients and providers, stop price fixing, and create a level playing field with major insurers.

What’s better for patients? More choices or fewer? Higher costs or lower? Making decisions with their doctor or getting the insurance company involved?

200 million Americans have supplemental preventive eye exam and materials (glasses/contacts) benefits through a vision plan.

When patients see an optometrist for a comprehensive exam, they might not know they’re facing fewer choices and higher costs that drive up profits for their insurer.

Patients with these insurance plans can choose their independent doctor, but not much else, thanks to a gap in federal law.

Big insurers control almost every part of eye care – they own the vision benefit manager, the frame and lens manufacturers, and the labs that finish eyeglasses. They set the prices, too – even on items their plans don’t cover.

These insurers rig the system to force doctors and patients into using the products and services that the insurers own. That raises prices for everyone, whether they have insurance or not. And it forces doctors to decide whether to shut their doors or get bought out by big conglomerates.

Congress can fix the rigged system, stop vision benefit manager abuses, and put patients and doctors back in control.

Put patients and doctors back in control of important health care decisions. U.S. House and Senate members are urged to co-sponsor the **DOC Access Act**
November 15, 2023

The Honorable Bernie Sanders
Chairman
Committee on Health, Education Labor, and Pensions
428 Senate Dirksen Office Building
Washington, D.C. 20510

Re: Efforts to Address Harmful Health Care Middlemen Must Include Vision Benefit Managers

Dear Chairman Sanders,

The National Consumers League (NCL), America’s pioneering consumer advocacy organization, appreciates your long track record of continued advocacy on behalf of our nation’s consumers and workers. As Congress looks to address the harmful practices of health care middlemen – like pharmacy benefit managers, we ask you to help us advance policies aimed at addressing the negative impacts of consolidation and vertical integration in the vision insurance industry, which are now hurting consumers and workers, especially those in traditionally underserved communities.

As the data well documents, inequity - including health inequity - is soaring across America. And the key drivers of that growing imbalance, especially for those with modest incomes, the elderly, and communities of color, are spiraling costs, a lack of benefit transparency, and dwindling control over important health care decisions. Thankfully, President Biden has identified (EO 14036) the main culprit behind many of these problems – excessive concentration and market power abuses by insurers – and has committed to addressing them. Reports consistently show that the vision insurance market is highly concentrated, with the top vision insurer controlling more than 70 percent of the market.

Vision insurance is typically offered for a low premium. However, once consumers utilize that benefit, they’re often faced with a system rigged by their vision benefit manager to limit choice, control behavior, and maximize profit at each step of the process. The insurers exert control over the market though the contracts they force doctors to sign as a condition of being an in-network provider. These contracts often set prices, even on goods and services the plan does not cover, they steer consumers toward the eyeglass frames and lenses the
insurer manufactures and sells, and they force patients and doctors to use the laboratories the insurers own and operate. These policies and other abuses contribute to ever higher prices, a loss of control over important health care choices, and growing disruption to the doctor-patient relationship.

As Congress looks to address the harmful practices of health care middlemen, we ask you to help us advance policies aimed at addressing the negative impacts of consolidation and vertical integration in the vision insurance industry. Now is the time to ensure the voices of underserved individuals, communities, and organizations are part of the conversation on solutions to address important issues of health care costs, choice, and benefit transparency.

Sincerely,

Sally Greenberg
Chief Executive Officer
National Consumers League
Analysis of Dental and Vision Plan Non-Covered Services and Materials Mandates: An Update

**Background.** In the last decade, most states have enacted limitations on dental and vision plans' ability to set fees on non-covered services and require materials to be provided by specific laboratories or manufacturers. However, federally regulated plans take the position that they are exempt from these state laws, despite the enactment of many state-level prohibitions. As a solution, the DOC Access Act would align federally regulated plan law with existing state non-covered services laws to provide greater consistency.

**Economics.** The practice of plans setting prices on non-covered services is an example of monopsony, which is an economic term for the demand-side version of a monopoly: a single or concentrated buyer. In the case of non-covered services, the plans are essentially using their market power to dictate pricing structures on items and services for which they bear no financial responsibility. This practice is mostly inconsequential from a consumer perspective, but only if there are no negative externalities. If practices are not overcharging patients and are faced with providing discounts for non-covered services from patients with certain insurance plans, they may need to increase charges for these or other services to make up for the losses. This results in cost-shifting to enrollees of other insurance plans or to those who are uninsured and may even lead to overall higher expenses for the enrollees of the plan receiving the discount.

**Past Research.** In 2016, we conducted a survey-based study of optometry and dentistry in North Carolina and Texas to determine the impact on fees charged in states with laws prohibiting insurers from setting fees for non-covered services. The study found that allowing insurers to set the fees doctors can charge for non-covered services led to higher costs for dental and vision patients in the U.S.

**Current Research.** In this study, we update the 2016 study relying on the same survey design to maintain comparability. We also expand the number of targeted states to 10. The survey questions aimed to assess how dental and optometry providers changed their behavior based on state-level non-covered services laws. There were 496 responses to the dental survey and 102 responses to the optometry survey that were included in the analysis.

**Results.** Consistent with the 2016 research, our findings clearly suggest that dentists and doctors of optometry are not charging unreasonable prices for non-covered services after state-level laws passed prohibiting insurers from setting fees on non-covered services. In fact, many dentists and doctors of optometry reported having increased their prices in response to plan-required discounts when regulations preventing this practice were not in place.

**Conclusions.** Allowing federally regulated dental and vision plans to set fees for non-covered services and require materials to be provided by specific laboratories results in cost-shifting and worse outcomes for patients. The DOC Access Act would end these practices that are harming patients and allow dentists and doctors of optometry more freedom to make the best decisions for their patients.

The full report is available for viewing and download on the [Avalon Health Economics website](#). —John E. Schneider, PhD, Kenna D. Garrison, MA, Cara M. Scheibling, MBA, Karen Beltran