



Stagnation in Vision Plan Fee Schedules

Note: The American Optometric Association (AOA) does not discuss prices charged by doctors of optometry with its member doctors or other competitors, and does not make recommendations about whether or not doctors should accept contracts with purchasers of services (health and vision plans). Doctors must make individual business decisions about the prices they charge and the contracts they accept. The AOA also reminds doctors not to discuss their prices with their peers and competitors, nor to take collective action against a purchaser.

The old adage “you get what you pay for” hasn’t exactly been true lately in vision care. Americans get much *more* clinical value than their vision plans pay for when it comes to an eye examination. Vision plan fee schedules have been stagnant over decades, according to new research by the AOA Health Policy Institute (HPI).

The AOA Health Policy Institute (HPI) surveyed more than 800 doctors in June 2020 about historical increases in vision plan fee schedules. The HPI learned that 70% of doctors reported not receiving an increase in the fee schedule for their largest vision plan in at least five years, and, thinking back to that last increase, 69% of doctors reported that it had been at least six years or more since the previous increase. In other words, most doctors of optometry have had no increase or just one increase in payment from their largest vision plan in the last decade even as the economy flourished and the cost of providing high quality eye health and vision care steadily rose (as evidenced by a 40% increase in the Medicare Economic Index since 2000, as explained below). Furthermore, 38% of doctors reported *never* receiving a rate increase from their largest vision plan.

A regular eye exam is a high clinical value service that patients youngⁱ and oldⁱⁱ should receive. Both the Centers for Disease Control and Prevention (CDC)ⁱⁱⁱ and the National Eye Institute (NEI)^{iv} have explained that the only way for people to know whether their eyes (or their children’s eyes) are healthy is to have a comprehensive eye exam by a doctor of optometry or an ophthalmologist. According to the Centers for Medicare & Medicaid Services (CMS), the largest payer for health care in the US, eye exams are “relatively low-cost interventions and early detection of conditions that can be identified through an eye exam may reduce more costly treatment later.”^v

Doctors of optometry, the primary eye care provider, are widely available in the US^{vi} and furnish the bulk of eye health and vision care services needed by Americans. In a dilated eye examination, the foundational service of primary eye care, a doctor of optometry can assess eye health and vision as well as overall health. For example, a doctor of optometry can identify more than 270 systemic diseases,^{vii} including diabetes, hypertension, and cancers, often before the patient is aware or has been diagnosed.

Many Americans have vision plans or vision benefits that cover an annual eye exam at a discount. Health plans cover medical and surgical eye care while vision plans usually cover annual eye exams, glasses, and contact lenses. Some vision plans administer additional medical and surgical benefits for health plans.

Americans purchase health plans to insure against the risk of health care costs, and purchase vision plans to presumably reduce costs for annual eye examinations, eyeglasses, and contact lenses. Most Americans obtain subsidized group health plans through work, while many vision plans are available but unsubsidized through employers.

Doctors typically sign contracts with health plans and vision plans to be in the plan's network of doctors. In exchange, health plans and vision plans steer their customers to in-network doctors. While doctors determine their prices independently, the contracts with health and vision plans typically establish a reimbursement amount (known as the fee schedule) that the doctor will be paid for the covered services provided to patients.

Renowned health care economist Uwe Reinhardt frequently lamented the role of prices in the high cost of care in the United States,^{viii} but thought paying doctors less was a "poor strategy" that would demoralize the medical profession who should instead be incentivized to help reduce unwarranted health spending elsewhere.^{ix}

Many health policy experts have called for doctors and hospitals to be paid more according to the clinical value of the care they provide to patients rather than based on the amounts they negotiate with insurance companies. "Value" is a buzzword in health care policy. For example, from July 2015 until June 2020, CMS mentioned "value" in more than 300 press releases and fact sheets (more than once per week).^x On June 22, 2020, CMS called for "a renewed national commitment to value-based care."^{xi}

The American Medical Association (AMA) described value-based care: "The National Academy of Medicine has developed a widely accepted approach that describes high-value health care as: safe, timely, effective, efficient, equitable and patient-centered—STEEEP for short. The Institute for Healthcare Improvement later translated this into a framework for action, the Triple Aim, which is made up of better patient outcomes, improved patient satisfaction and lower costs. The Triple Aim has since been expanded to the Quadruple Aim, which includes physician and health care professional well-being."^{xii}

Since eye exams are such a high value service, patients should not have high costs or cost sharing for them. Many health plans have no-cost or low-cost benefits for patients, so that patients have fewer barriers to care.^{xiii} The ACA mandated four categories of preventive services^{xiv} be covered by health insurers and group health plans with no patient cost-sharing. However, that does not mean that the clinician providing the service need not be paid. For example, a recommended colonoscopy may be free for an at-risk patient, but the doctor providing the service is still paid the regular rate for a colonoscopy by the patient's health insurance.

Rather than pay for value, vision plans typically pay doctors of optometry minimum amounts for high value care, and have kept fee schedules flat for years even while medical inflation increases the cost for doctors providing care. Some vision plans sell several products to employers, at different price points, and pay doctors lower amounts for patients covered by the less expensive plans. The doctor's duty of care remains the same, but when the vision plan moves a large employer to a cheaper plan, suddenly the doctor receives lower payments for the same patients. While this might appear to keep costs low for consumers, assuming those savings are passed along, the stagnant low fee schedules have several undesirable consequences that are bad for patients and the health care system.

According to the Ontario Association of Optometrists, chronic underfunding for eye care over the last 30 years has caused optometrists there “to subsidize more than half of the province’s eye care system, at a cost of \$173 million a year.”^{xv} This situation may lead to a shortage of eye care, exacerbated by the COVID-19 pandemic.

The federal government is the dominant rate-setter in U.S. health care. Medicare pays 600,000 physicians, including doctors of optometry, based on the Medicare physician fee schedule.^{xvi} Many health insurance companies base their own fee schedules as a multiple of the Medicare amount.^{xvii} CMS itself makes minor adjustments to the payment amount based primarily on the location of the doctor (areas with higher overhead costs get reimbursed at slightly higher rates).^{xviii} In Medicare, doctors of optometry and ophthalmologists are paid the same amount for the same service, known as equal pay for equal work.^{xix}

Policymakers looking at ways to expand health coverage in the U.S., increase transparency and reduce spending have looked at Medicare rates as a baseline. Commercial health plans typically pay higher than Medicare rates. A recent review of the literature (eight studies) found that private health insurance, on average, pays 143% of Medicare rates for physician services, including eye exams.^{xx} The private insurance payments are increasing at a faster rate than Medicare (from 118% of Medicare in 2010 in one study to 179% in a 2019 study).^{xxi}

Medicare does not negotiate the rates. Instead, since 1992, CMS has established prices for more than 7,000 services based on a resource-based, relative value scale.^{xxii} In this system, “value” is the cost of providing the care. The AMA Relative Value Scale Update Committee (RUC) recommends amounts to CMS, and the Medicare agency makes a final decision. The AOA participates in the RUC valuation process. CMS revises the rates and updates overall payment amounts each year, as required by law.

The relative value scale is determined by evaluating the resources required to deliver the service. In other words, while some health policy experts believe Medicare should make payments based more on the value of the outcome of the care, the current methodology for establishing rates is based on the cost to doctors to deliver the service. The relative value of each service depends primarily on practice expenses (overhead) and physician work (a measurement that loosely correlates with the time needed to provide the care).^{xxiii} Professional liability insurance costs are also evaluated. Medicare has been increasingly using alternative payment models, but these other approaches often rely on the fee schedule rates as a baseline.

The AMA and CMS pay strict attention to the relative resources needed for each service. Many services may be studied and revalued in a given year. Furthermore, the federal government resists a steady increase in code values by applying a budget neutrality adjustment. When the value of a code increases, the relative value of all other codes decreases.

In Medicare, the four most common ophthalmic eye examination codes^{xxiv} have increased on average more than 27% since 2005. The last time CMS directly revalued the eye codes was in 2007. The 10 most common evaluation and management (E&M) codes^{xxv} for physician office visits have increased on average more than 21% since 2005. These increased valuations over time reflect an intentional effort by policy makers and CMS to pay more for primary care services at the expense of more costly surgical services.

In the past, annual increases in the Medicare fee schedule also considered inflation in medical overhead as measured by the Medicare Economic Index (MEI), an index that CMS has calculated since 1975.^{xxvi} In

the last two decades, the MEI, which also adjusts for national economic productivity, has increased up to 3% a year, and this adds up over time: 40% since 2000.

The Medicare Payment Advisory Commission (MedPAC) annually studies whether the Medicare payments are adequate, and equates “value” with access and efficiency. According to MedPAC, “The goal of Medicare payment policy should be to obtain good value for the program’s expenditures, which means maintaining beneficiaries’ access to high-quality services while encouraging efficient use of resources.”^{xxvii} MedPAC reported in March 2020 that Medicare beneficiaries’ access to care is comparable to privately insured individuals.^{xxviii}

The average Medicare fee schedule payment for the eye examination codes (92xxx series) was \$90 in 2005 and is \$114 in 2020. Rates paid by health plans are typically higher and have grown faster. Meanwhile, the average Medicaid payment across all states for those four codes is \$70. At the beginning of 2020, vision plans typically paid \$35-90 for these services, lower than Medicare’s rates 15 years ago, sometimes lower than Medicaid rates, and about the same as 25 years ago, when vision plan fee schedules paid \$30-55 for eye exams.^{xxix}

Medicaid rates are established differently than Medicare. Each state sets its own fee schedule for services. Generally, state legislatures approve the rates, based on state policy and budget considerations rather than updated by formula annually as Medicare does.

Medicaid is usually the lowest payer in health care. For many doctors and hospitals, the Medicaid payment rates are accepted as something akin to donating services for the greater good, without full compensation.^{xxx} Health care providers accept lower Medicaid rates as one way the providers contribute to the safety net for society’s disadvantaged populations. By statute, Medicaid reimbursement is supposed to be good enough that doctors and hospitals participate in large enough numbers that Medicaid recipients have comparable access to care that patients have in the commercial market.^{xxxi} However, this is a fine line that has been subject to frequent litigation—even a Supreme Court ruling^{xxxii}—in the last decade. Recently, the COVID-19 pandemic has inflamed longstanding issues for businesses that deliver care to the Medicaid population.^{xxxiii}

Yet, vision plan fee schedules are comparable with Medicaid. This does not reflect any public policy to subsidize the large vision plan corporations. Doctors may be expected to contribute to the public good by seeing Medicaid patients at reduced rates, but no such good will should be required to subsidize billion-dollar vision plans.

As far back as the 1990s, vision plans presented contracts “that contain no reimbursement details.”^{xxxiv} According to one expert^{xxxv} more than 20 years ago, vision plans decline to reveal fee schedules while utilizing the doctors’ “good will and...reputation, which have taken years to form in the community in order to sell their contract” with employers. According to one guide to managed vision care benefits, low fees can lead to low quality, by reducing the amount of time the doctor can spend with patients.^{xxxvi}

Vision plan rates might also prevent doctors of optometry from competing on a level playing field with other health care professionals, which could begin to threaten access to quality of eye care for Americans. This advantages ophthalmologists, who tend to be subspecialist eye surgeons. Ophthalmologists receive more income per patient than doctors of optometry, even when they are paid the same rates, because ophthalmologists are more likely to provide more expensive treatments, and the difference is exacerbated

when doctors of optometry are paid less by a vision plan than ophthalmologists and doctors of optometry are paid by health plans. Ophthalmologists report much higher average personal income than doctors of optometry. While doctors of optometry and ophthalmologists pour money back into their practices to improve the quality of care, higher-paid ophthalmologists might have additional resources to market their practices, to the detriment of competing doctors of optometry who provide many of the same services.

Doctors of optometry remain more accessible than ophthalmologists,^{xxxvii} and continue to provide most of the eye health and vision care that most people need a majority of the time. Nevertheless, vision plan fee schedules may begin to have a negative impact on the ability of optometrists to compete in the market, which could then threaten access to eye health and vision care. Independent doctors of optometry, much like primary care doctors,^{xxxviii} are indispensable access points and offer personalized service that is responsive to individual patient and community needs.^{xxxix}

Under the Affordable Care Act (ACA), health insurance plans are required to report their medical loss ratios (MLRs) and issue refunds on premiums collected if the MLR (the ratio of the amount paid in claims to the amount collected in premiums) is less than 80-85%. MLR identifies the ratio of premiums collected that go to patient care, or to administrative overhead and profits.^{xl} This year, those rebates are expected to go to eight million individuals and total \$2.7 billion.^{xli} Over nine years, these health plan rebates have totaled \$8 billion, yet insurers have been highly profitable.^{xlii}

Vision plans are exempt from the ACA requirement to report and refund excess premiums collected. As a result, vision plans may spend a higher percentage of premium income on expenses such as executive salaries, and promoting their products that are not directly related to patient care. As health plans maintain MLRs over 80-85% (and issue \$8 billion in consumer rebates when they don't) while remaining highly profitable, vision plans should be able to pay more in claims, increase their MLRs and remain competitive.

The biggest vision plans are part of large, vertically integrated corporations that dominate the market in lenses and frames.^{xliii} These companies make lenses, frames and related supplies and materials, own retail chain stores where they sell their products, and use their vision plans to steer patients to corporate locations or doctors where their products will be available to patients.^{xliv} The biggest vision plans "are focused on driving efficiencies in their delivery systems and are locked in a price and service battle...these giants view their sole responsibility is to sell more frames, more lenses, more contact lenses."^{xlv}

The largest vision plans typically require doctors to have an optical store and sell the frames and lenses made by the vision plans. According to a former industry executive, "plans often shortchange optometrists in reimbursing for eye exams, with payments as low as \$50. This keeps optometrists focused on sales of high-priced frames and lenses to cover overhead and meet expenses."^{xlvi}

The savings from stagnant vision plan fee schedules might not be passed on to consumers, but instead support the dominant market power of these large vertically integrated corporations. This might also affect payment amounts set by competing vision plans that do not have profits from other stages in the supply chain made possible by vertical integration.

Pharmacists have raised similar concerns in the pharmaceutical industry because three vertically integrated companies (CVS/Aetna, Express Scripts/Cigna, and OptumRx/UnitedHealth) process the majority of prescription drug claims and force community pharmacists "to provide services at

unsustainable rates, often at a financial loss,” according to comments submitted to the FTC by the American Pharmacists Association.^{xlvii} Pharmacy benefit managers (PBMs) have been criticized as “middlemen” whose integration in large vertically integrated companies allows these “mega firms” to use market power “to drive down reimbursement rates to uncompetitive levels.”^{xlviii}

Stagnant fee schedules that do not reflect the clinical value of service, are not based on the cost of furnishing a service, and that don’t contribute to a public policy objective might historically undervalue primary eye care. These artificially low payments over time might have undesirable effects on the overall cost, quality and efficiency of eye health and vision care in the United States.

ⁱ <https://www.aoa.org/optometrists/tools-and-resources/evidence-based-optometry/evidence-based-clinical-practice-guidelines/evidence-based-clinical-practice-guideline-comprehensive-pediatric-eye-and-vision-examination>

ⁱⁱ <https://www.aoa.org/optometrists/tools-and-resources/evidence-based-optometry/evidence-based-clinical-practice-guidelines/evidence-based-clinical-practice-guideline-adult-eye-and-vision-examination->

ⁱⁱⁱ <https://www.cdc.gov/visionhealth/risk/tips.htm>

^{iv} <https://www.nei.nih.gov/learn-about-eye-health/healthy-vision/keep-your-eyes-healthy>

^v <https://www.aoa.org/news/practice-management/medicare-2019-pfs>

^{vi}

<https://www.aoa.org/documents/HPI/HPI%20Uniform%20Edit%20Format%20ACCESS%20TO%20EYE%20CARE.pdf>

^{vii} <https://www.aoa.org/documents/2020/AOA-Start-With Eye Toolkit.pdf>

^{viii} <https://www.healthaffairs.org/doi/10.1377/hlthaff.22.3.89>

^{ix} <https://www.nytimes.com/2007/08/05/opinion/l05doctors.html>

^x <https://www.cms.gov/newsroom>

^{xi} <https://www.cms.gov/newsroom/press-releases/trump-administration-issues-call-action-based-new-data-detailing-covid-19-impacts-medicare>

^{xii} <https://www.ama-assn.org/practice-management/payment-delivery-models/what-value-based-care-these-are-key-elements>

^{xiii} <https://nam.edu/wp-content/uploads/2016/09/Benefit-Design-to-Promote-Effective-Efficient-and-Affordable-Care.pdf>

^{xiv} <https://www.healthcare.gov/coverage/preventive-care-benefits/>

^{xv} <https://www.newswire.ca/news-releases/ontario-faces-crisis-as-millions-of-eye-exams-in-jeopardy-896299807.html>

^{xvi} http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_physician_final_sec.pdf?sfvrsn=0

^{xvii} <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/>

^{xviii} http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_physician_final_sec.pdf?sfvrsn=0

^{xix} Section 1861(r) of the Social Security Act.

^{xx} <https://www.kff.org/report-section/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature-issue-brief/>

^{xxi} <https://www.kff.org/report-section/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature-issue-brief/>

^{xxii} http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_physician_final_sec.pdf?sfvrsn=0

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- xxiii http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_physician_final_sec.pdf?sfvrsn=0
- xxiv Current Procedural Terminology codes 92002, 92004, 92012, 92014 collectively were billed more than 20 million times by doctors of optometry and ophthalmologists to Medicare in 2018.
- xxv CPT codes 99201-05 and 99210-99215.
- xxvi <https://www.cms.gov/newsroom/fact-sheets/effect-medicare-economic-index-mei-physician-update>
- xxvii http://medpac.gov/docs/default-source/reports/mar20_entirereport_sec.pdf
- xxviii http://medpac.gov/docs/default-source/reports/mar20_entirereport_sec.pdf
- xxix “Managed Vision Benefits,” 2nd edition, by Jesse Rosenthal, OD, MPH, and Mort Soroka, PhD, 1998.
- xxx <https://www.forbes.com/sites/peterubel/2013/11/07/why-many-physicians-are-reluctant-to-see-medicaid-patients/#42f6205a1045>
- xxxi https://www.supremecourt.gov/opinions/14pdf/14-15_d1oe.pdf
- xxxii https://www.supremecourt.gov/opinions/14pdf/14-15_d1oe.pdf
- xxxiii <https://jamanetwork.com/journals/jama/fullarticle/2766599>
- xxxiv “Reimbursement & Managed Care,” 2nd edition, by Mark Wright, OD, 1998
- xxxv “Reimbursement & Managed Care,” 2nd edition, by Mark Wright, OD, 1998.
- xxxvi “Managed Vision Benefits,” 2nd edition, by Jesse Rosenthal, OD, MPH, and Mort Soroka, PhD, 1998.
- xxxvii <https://www.aoa.org/documents/HPI/HPI%20Uniform%20Edit%20Format%20ACCESS%20TO%20EYE%20CARE.pdf>
- xxxviii <https://www.healthaffairs.org/doi/10.1377/hblog20200721.6981/full/>
- xxxix <https://www.aoa.org/news/advocacy/doctors-of-optometry-step-up-as-pandemic-sets-in>
- xl <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio>
- xli <https://www.kff.org/private-insurance/issue-brief/data-note-2020-medical-loss-ratio-rebates/>
- xlii <https://www.fiercehealthcare.com/payer/big-name-payers-earned-35-7-billion-2019-here-s-one-common-thread-their-reports>
- xliii <https://www.latimes.com/business/lazarus/la-fi-lazarus-eyewear-vision-plans-20190319-story.html>
- xliv <https://www.latimes.com/business/lazarus/la-fi-lazarus-glasses-lenscrafters-luxottica-monopoly-20190305-story.html>
- xlv “Exiting Vision Plans Profitably” 2nd edition, by Alan Cleinman, 2019.
- xlvi <https://www.latimes.com/business/lazarus/la-fi-lazarus-eyewear-vision-plans-20190319-story.html>
- xlvii https://www.ftc.gov/system/files/attachments/798-draft-vertical-merger-guidelines/apha_comments_-_ftc.pdf
- xlviii https://www.ftc.gov/system/files/attachments/798-draft-vertical-merger-guidelines/ftc_doj_vertical_merger_guidelines_comments_ahf_2-26-20.pdf