

Statement of the Pennsylvania Optometric Association on SB 204
Presented to the Senate Banking and Insurance Committee
March 24, 2010

Chairman White, Chairman Stack, and members of the Banking and Insurance Committee, I am pleased and honored to present this testimony on behalf of the Pennsylvania Optometric Association. I am Dr. Carl Urbanski, a practicing optometrist in Kingston. I am a past president of the Pennsylvania Optometric Association and a past president of the Northeastern Pennsylvania Optometric Society. I am currently a member of the Pennsylvania Optometric Association's Legislative Affairs Committee and served as chairman for the past five years. Accompanying me today is POA's lobbyist, Ted Mowatt.

The Pennsylvania Optometric Association represents approximately 1,500 optometrists practicing in nearly every county in the Commonwealth. Optometrists serve as the "family eye doctor" for the vast majority of Pennsylvania citizens. Optometrists are the entry point for most patients seeking vision and eye health services. We provide primary eye care and work in cooperation with our physician colleagues when our patients require specialty eye care services. Optometrists, like many other health care providers, are often at the mercy of large insurers and, increasingly, vertically-integrated health care companies. The reality of the health care marketplace is that patients with insurance benefits tend to follow the rules established by their health plan. Patients will seek out providers based on their health plan and will often limit their care to what their plan covers. Providers may seem to have the choice not to participate in plans, but the economic reality of the market often dictates otherwise for the survival of a practice. In the eye care field, policies of certain vision benefit plans have a negative impact on the quality, access and continuity of eye care available to the residents of the Commonwealth of Pennsylvania. This legislation seeks only to level the playing field somewhat for all providers, and make participation in these plans reasonable and sustainable.

The following points with regard to vision benefit plans are of most concern to optometry and our patients:

- **Some vision benefit plans create different levels of provider participation within the same specialty. These varied policies create disparity that is not transparent to the patient.**
- **Some vision plans also have a policy of not subscribing to uniform standards among providers.**
- **Some vision plans have an "all products" requirement.**
- **Some vision plans require that ophthalmic materials be purchased from the plan owned suppliers.**
- **Some vision plans sell benefits and also operate vision care and retail locations within the same market.**

Please allow me to briefly expand on these key issues.

Some plans require independent eye care providers to use the vision benefit plan's wholly-owned, for-profit laboratories and products. However, within the same employer benefit contract, some commercial optical providers, large provider groups or plan-owned locations are permitted to use their own laboratories and their own products. The result is that patients who choose their family eye doctor who is on panel and met all the requirements of being credentialed may be limited in their choice of product and timeliness of service. Even if the family eye doctor's office has the ability to provide better quality products or offer same-day service, they are unable to do so under some contracts since they are required to use the vision benefit plan's laboratory, unlike the corporate-affiliated or large group providers. This disparity can significantly delay processing time of the patient's eyewear. On many occasions the plan-owned laboratory produces an inferior or incorrect product. This forces the doctor-provider to correct these deficiencies prior dispensing the final product. Our personal return rate for laboratory mistakes or defects for the plan that dominates the northeastern Pennsylvania market is roughly 30%. This is 10-15 times higher than the rate of return with our local Wilkes-Barre labs or other quality labs we utilize. If the accuracy of the lab where you had your blood work done was 70%, would you consider that quality health care? Would you, perhaps, like to have options other than the lab **owned** by the health care plan?

Some vision benefit plans enter into contracts with select providers and pay higher levels of reimbursement to those providers for the same services and products. This is done to secure panels of doctors in certain areas, but this disparity among doctors who are held to the same credentialing requirements and levels of service is an unfair business practice. If all of you on this committee are elected to the same job as a senator and take the same oath to serve the citizens of Pennsylvania, but some of your colleagues are given two votes not one, would you consider this fair to you or your constituents? In our case, all providers that agree to provide the same level of care should be reimbursed equally.

Eye care is one of the unique situations where a patient may have a vision benefit plan that covers some services related to vision and glasses and a health care plan that covers eye health care. This mixing of benefits is often confusing for patients. Some vision benefit plans are owned by both non-profit and for-profit insurance companies. These same companies may make the eye care provider participate in the for-profit vision benefit plan as a requirement for participation in a health insurance plan. For patients to have access to their benefit coverage while continuing to see their optometrist or ophthalmologist for treatment of an eye infection or glaucoma, the doctor must agree to participate in the company's vision plan, regardless of requirements, reimbursement or quality of product. This unfair business practice has the potential to significantly disrupt continuity of care. Some vision benefit plans may also require eye care providers to accept all contracts for both commercial and government benefit plans, which may have greatly varied rules of participation. This creates an all or none situation.

With the regional dominance of certain plans and current lack of significant competition within the health care market in Pennsylvania, there exists a monopolistic-like system that has limited incentive to control costs and results in higher premium costs to the employer and other plan sponsors. This same monopolistic-like system creates no choice for providers on whether to participate with a plan. If 50 to 70 percent of patients in a geographic area are covered by one health plan and their wholly-owned vision plan, providers, employers and patients are left to deal with the consequences. **We believe restoring competition into the payer equation, and with regard to vision care allowing the providers to choose an ophthalmic lab based on quality of product and service at the most appropriate cost for the patient's needs, would lower the premiums to the employer/sponsors and improve quality for Pennsylvanians.** The interests

of Pennsylvania optometrists and the POA are to promote fair competition in the marketplace, giving patients choice of providers and products on a level playing field, which eventually would lead to lower costs to Pennsylvania employers and patients. The current system seems to promote providing profits for large vertically-integrated health insurance companies with little concern for quality or choice.

Another key issue is that plans operate their own vision care and retail offices in the same market where they sell benefits and reimburse providers. With one hand, a plan controls prices providers can charge, has access to the providers' patient base and dictates what products patients may purchase and how quickly they can be supplied; and with the other hand, the plan competes for those same patients in its vision care and retail offices. If, for example, a plan-owned retail establishment can offer one-hour or one-day service but requires an independent provider across the street to utilize the plan-owned laboratory that may take ten to fourteen days to fabricate the eyewear, how is that not anticompetitive? This is yet another example of the competitive disparity wielded by these vision benefit plans.

My personal experience may illustrate our dilemma. I have been practicing in northeastern Pennsylvania for seventeen years. I joined my father's optometry practice in Kingston, which was started in 1958. The practice was built on our reputation for thorough quality eye care. The practice and patient loyalty was not built upon, "Do you take my plan?" Yet, our practice, like many others, has no voice or leverage against such dominant plans. When we spend more of our day correcting laboratory errors, lenses reversed left and right, delays in processing up to more than a month instead of less than a week, and glasses returned in someone else's frame or with incorrect powers, less time is left to care for the patient. In a normal competitive business, we could choose to utilize them or not based on normal business principles. But competition does not exist here. So instead of asking the patient to lose their entire benefit, we are forced into a position of using a second-rate lab, which ultimately reflects poorly on our first-rate practice and service. Statistics and surveys from plans may show patients are pleased in the end, but that is because independent providers are fixing all the errors and making the appropriate corrections before products reach the patient. Perhaps a better survey would ask, "In a free market environment, would you utilize the product and lab services offered by the plan?"

My experience is not unique or new. In fact, in 2006, POA passed a resolution asking that action be taken to address this state-wide concern. That resolution is attached. The time to correct these unfair practices is now and SB 204 is the vehicle to address these issues.

Thank you for your attention and consideration.