Myth: Stand-alone vision plans are not allowed to sell their products through the exchanges.

Fact: All vision plan companies have the ability to participate in the exchanges if they choose to do so. While it is true that the Affordable Care Act (ACA) does not allow them to sell their products directly in the exchanges, the truth is that ALL stand-alone vision plans are free to contract with qualified health plans (QHPs) to administer the QHP’s vision benefits. There are no legal or business prohibitions keeping vision plans from collaborating with qualified health plans. In fact, independent companies such as VSP have contracts with many health plans across the country today. Thus they are well-positioned and capable of health plan contracting within the new state-based insurance exchanges.

Myth: Stand-alone vision plans will be locked out of providing care to patients who purchase insurance coverage through the exchanges.

Fact: It is true that if a stand-alone vision plan chooses not to participate in the exchange marketplace, you may see a reduction in new patients purchasing these benefits. However, regardless of the delivery model and the particulars of contractual arrangements, patients will still need eye care services and those services will, by necessity, still be delivered by optometrists. QHPs must offer a pediatric vision benefit as one of the Essential Health Benefits mandated by the ACA. In addition, QHPs competing in the exchanges are likely to offer enhanced benefit packages to attract new members. Vision benefits have proven to be a popular, relatively inexpensive add-on benefit for employers and employees. Also, if a QHP is required by law to offer a children’s vision benefit, what motive would they have not to also offer vision benefits for adults? Those same QHPs will also be required to meet provider access adequacy standards to ensure there are enough eye care professionals readily available to provide the necessary care demanded by children and their family members after the implementation of health care reform. The expected patient demand for primary eye care and vision services covered by QHPs in the exchanges cannot be met without a sufficient supply of participating optometrists.

Myth: The Harkin Amendment may not help optometrists because it does not guarantee the ability to become participating providers on health plan provider panels.

Fact: The Harkin Amendment is a law that states health plans shall not discriminate in participation or coverage against optometrists acting within their scope of practice. Ophthalmologists will most certainly be allowed to participate as providers on health plan provider panels. Optometrists who provide many of the same professional medical eye care services as ophthalmologists should therefore be allowed to participate as providers (as a class) on the same health plan provider panels and provide the services they are licensed to provide in accordance with the specific scope of practice laws of each state.
**Myth:** Stand-alone vision plans, if allowed a new loophole to sell their products independently in the exchanges, will ensure optometrists the ability to participate as medical providers on QHP provider panels and will steer patients covered by QHPs to optometrists’ offices for medical eye care.

**Fact:** Stand-alone vision plans have demonstrated limited success in adding optometrists to health plan provider panels as providers of medical eye care services. Where that has been accomplished, optometrists have frequently been paid less than ophthalmologists for providing the same care. If QHPs contract with stand-alone vision plans for a carved-out pediatric vision benefit, satisfying the requirement that a QHP offer a pediatric vision benefit as one of the Essential Health Benefits, the QHPs would have no incentive to include optometrists as providers of medical eye care. Optometrists are trained and licensed to provide medical eye care services and should be included as participating providers on QHP provider panels for providing these services. Patients should not be required to seek care from different providers for vision and medical care simply because of contractual arrangements between QHPs and stand-alone vision plans.

**Myth:** Stand-alone vision plans must be allowed to sell their products directly to participants in the health insurance exchanges (the uninsured, small-employer groups and individuals) to assure that optometrists receive equal pay to ophthalmologists for the same professional services.

**Fact:** When SAPs have contracted for medical services, they have historically reimbursed optometrists at heavily discounted rates that are oftentimes less than reimbursement rates paid to ophthalmologists. Therefore, if stand-alone vision plans are allowed to sell their products in the health insurance exchanges apart from QHPs, this trend is expected to continue and optometrists will continue to be reimbursed less for medical eye care compared to ophthalmologists’ reimbursement for providing the same services.

**Myth:** In 2014, when the exchanges become operational, I will lose all my patients who now come from stand-alone vision plans.

**Fact:** Not true at all. The exchanges will provide coverage for those currently uninsured as well as individuals and the small employer insurance markets. In fact, much of the new business in the exchanges will come from those patients who currently have no health or vision coverage at all. This will increase, NOT decrease, the demand for optometry care.
Myth: In 2014, when the exchanges become operational, if stand-alone vision plans can’t sell apart from QHPs, companies such as VSP will simply fade away and my patient volume from stand-alone vision plans will dry up.

Fact: Stand-alone vision plans have the ability and every right to adapt their business model to accommodate the changes being demanded of them and all other insurers operating after health care reform is implemented. However, if in the long run vision plans choose not to contract with health plans, refuse to keep pace with changes in health care integration, and fail to advocate for ODs’ full integration into medical eye care, then the role of stand-alone vision plans in your practice may in fact decline over time. The choice lies with the vision plan companies. They can modernize their business model and join the new world of integrated health insurance or they can live in the past of 1960s segregated, limited-scope optometry. The marketplace, not the AOA, is demanding a more integrated model for health care delivery. We at AOA hope stand-alone vision plans will embrace the future and embrace the demands of the marketplace.

Myth: If vision plans work with qualified health plans under the terms of the ACA, optometrists’ optical dispensaries will be negatively impacted.

Fact: Optometrists’ optical dispensaries are impacted more negatively by stand-alone vision plans than anything. When optometrists enter into contractual agreements to provide services via stand-alone vision plans, the terms almost always include discounted arrangements for professional services and materials. Additionally, stand-alone vision plans that sell eyewear, including prescription eyeglasses, directly to patients via wholly or partially owned optical dispensaries or online retail Web sites undermine the financial stability of many optometric practices. If the stand-alone vision plans require or strongly incentivize their members to buy eyewear exclusively from them or their companies, they will drive ODs out of a line of business that has served ODs well over the years and that many rely on today for a large part of their financial success.