VSP
Vision care for life

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President & CEO

The Honorable Kathleen Sebelius
Secretary
United States Department of Health and Human Services
Hubert H.HumphreyBuilding
200 Independence Avenue, S.W.
Washington, DC20201

October 31, 2011

Submitted electronically via www regulations.gov

RE: RIN 0938-AQ67: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans

Dear Secretary Sebelius,

Vision Service Plan ("VSP") appreciates the opportunity to provide comments on the proposed regulations relating to Affordable Insurance Exchanges ("Exchanges") established under the Affordable Care Act (ACA).[1] VSP's comments focus on including stand-alone vision plans in Exchanges in order to meet the pediatric vision care component of the essential health benefits package ("EHBP").

VSP is the nation's largest provider of eye care coverage with more than 55 years of experience in the eye care field. VSP provides vision benefits on a not-for-profit basis through a national network of independent private-practice eye doctors. VSP, the largest insurer by membership in the country, currently covers 56 million individuals, or one in every six Americans, and it provides eye health benefits for more than 39,800 employer clients. While VSP is known for covering 56% of Fortune 500 corporations, 87% of VSP clients are employers that have less than 5,000 employees and 56% of VSP clients have less than 50 employees. VSP clients include federal, state, and local government employers, as well as private employers.

SUMMARY

Today, over 90% of Americans with vision coverage have comprehensive coverage, including an exam and eye glasses or contact lenses, provided through a stand-alone vision plan. Preserving the ability of Americans to obtain vision services through stand-alone vision plans by allowing such plans to be offered in Exchanges in order to provide required pediatric vision benefits is essential for the following reasons:

- Providing continuity of coverage as Exchanges become effective and reducing consumer confusion. Over 90% of Americans with vision coverage today currently receive their comprehensive eye coverage through a stand-alone vision plan. Thus, maintaining stand-alone coverage as an option is likely to provide the smoothest transition to Exchanges and avoid confusion as Americans transition to receiving coverage through Exchanges.

[1] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866 (July 15, 2011) (the "Proposed Regulations").

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- Avoiding market segmentation and gaps in coverage. The vision coverage market today is based on family coverage. Failure to allow stand-alone vision coverage in Exchanges is likely to bifurcate vision coverage between adults and children, resulting in market disruption and possible loss of coverage and the reduction of coverage choices.

- Fostering wellness and the early detection of chronic diseases. Independent research has shown that individuals with stand-alone vision coverage are far more likely to obtain regular comprehensive eye exams, not only leading to better vision health but early detection of chronic diseases such as diabetes and hypertension.

- Satisfying the statutory requirements for the essential health benefits package (EHBP). ACA grants the Secretary authority to determine the details of the EHBP, with the proviso that it is to be consistent with the "typical" employer plan. Stand-alone vision coverage is not only typical, but the predominant method of providing vision care in the employer context. Thus, the statutory provisions relating to the EHBP support allowing required pediatric vision benefits to be provided through stand-alone coverage.

The Affordable Care Act expressly grants the Secretary authority to develop standards for the certification of plans as qualified health plans (QHPs) and also includes an express, broad grant of authority to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs, and other components of title I of the Affordable Care Act.

VSP requests that the Secretary exercise the authority granted under ACA to provide that an Exchange allow limited scope stand-alone vision plans to be offered in the Exchange, in the same manner provided for stand-alone dental benefits. Thus, an Exchange would be required to allow stand-alone vision benefits to be offered in an Exchange if the vision plan furnishes at least the required pediatric vision benefit and the stand-alone vision plan complies with the provisions in the Internal Revenue Code and the Public Health Service Act relating to stand-alone vision plans.[2] Another health plan offered in the Exchange would not fail to be treated as a QHP solely because the plan does not offer coverage of otherwise required pediatric vision benefits. As under the Proposed Regulations as applied to dental plans, an Exchange could allow a vision plan to be offered as a separate plan, or in conjunction with a QHP As under the Proposed Regulations, a stand-alone vision plan offered in an Exchange would be subject to Exchange fees and could be required to certain consumer protection standards.

Stand-alone vision plans should also be permitted to satisfy the EHBP with respect to plans offered outside Exchanges. VSP understands that regulations regarding plans outside the Exchange will be issued at a future date. Thus, this comment letter focuses on rules to be applied within Exchanges. Detailed discussion of these issues follows.

DISCUSSION

[2] These provisions are contained in Code §9832(c)(2)(A) and PHS Act §2791(c)(2)(A), the same sections that describe stand-alone dental plans.

A. The Benefits of Stand-Alone Vision Coverage Currently Received by Millions of Americans Should Be Preserved by Providing that Stand-Alone Vision Coverage Offered in Exchanges Will Qualify as Meeting the Pediatric Vision Component of The Essential Health Benefits Package

Allowing stand-alone vision coverage to be offered in the Exchanges will provide continuity of coverage as the Exchanges become effective and reduce consumer confusion.

ACA seeks to enhance continuity of care through the establishment of the Exchanges. The Proposed Regulations reflect efforts to ensure that the transition to Exchanges is smooth and, in particular, include rules to "reduce potential consumer confusion, while maintaining plan offerings and rating structures that are similar to those that are currently available in the health insurance market."[3] With respect to vision coverage, this goal is best met by preserving stand-alone vision benefits as a coverage option within the Exchanges. As indicated above, vision coverage today is overwhelmingly provided through stand-alone plans. An independent study (the "NAVCP Study")[4] found that stand-alone vision plans deliver 84% of all vision care benefits in the United States, and 87% of comprehensive vision coverage (i.e., coverage that includes materials, such as eye glasses or contact lenses, as well as eye exams). This is consistent with VSP's own experience, which indicates that approximately 90% of vision coverage is provided on a stand-alone basis. These numbers alone lead to the result that "maintaining plan offerings and rating structures that are similar to those that are currently available in the health insurance market" with respect to vision care means preserving stand-alone vision coverage.

Further, because stand-alone coverage is predominant today, consumers are very familiar with selecting vision coverage on a stand-alone basis along with major medical coverage. Over time, systems have developed that simplify enrollee choices with respect to vision coverage provided separately from a major medical plan. VSP has worked with many employers and insurers over time to make choices simple. For example, in a typical employer context where enrollment is accomplished on-line, the employee will be presented with a screen shot that lists all coverage options by type, e.g., major medical, vision, dental, and the employee premiums based on the type of coverage (including whether self-only or family), and allows the employee to select coverage. The program will automatically adjust to reflect options selected, so that the consumer easily knows how different choices may affect premiums. These systems have also produced detailed pricing programs so that, for example, if an employer varies the employee premium based on the number of individuals covered by a plan, the pricing for each additional person is known. A good example of how this works in a large exchange-type marketplace is the Federal Employees Dental and Vision Insurance Plan (FEDVIP) within the Federal Employee Health Benefits Plan (FEHBP). Since 2006, federal employees have been able to select a vision and/or dental plan from multiple providers, and apart from the provider of their major medical plan. VSP has been the one stand-alone option available to participants, along with two major medical-based vision care plans. The BENEFEDS™ website that is used to

[3] 76 Fed Reg at 41901

[4] The study was conducted for the National Association of Vision Care Plans (NAVCP). Information regarding the study (the "NAVCP Study") may be found on their website at http://navcp.org/documents/NAVCP_PressRelease_FINAL.pdf

enroll participants is a simple, straightforward process that allows participants to compare options based on price, benefit level, and coverage type. In the private employer marketplace, systems are widely available that enable employers to simplify even more complex contribution and tax treatment arrangements.

These systems will translate easily to the Exchanges, producing a simpler, more familiar election process for consumers and a seamless administrative process for Exchanges and federal agencies, as well.

Allowing stand-alone vision coverage to be offered in Exchanges will avoid market segmentation and gaps in coverage.

Just as health care needs vary, vision coverage needs vary as well. Allowing stand-alone vision plans to satisfy the EHBP within Exchanges will help prevent gaps in coverage with respect to vision care and tend to increase coverage, by providing individuals with a broader range of choices with respect to their vision coverage. For example, as a not-for-profit stand-alone plan, VSP, covering 56 million lives, has been able to develop the industry's broadest provider network, which expands access and choices for patients, and to develop other innovations, such as a nation-wide health information technology platform that improves efficiency and provides important clinical data for chronic disease management and prevention. Again, these innovations are a result of being a stand-alone vision plan and the unique expertise that is developed through a sole commitment to eye care.

In contrast, failure to recognize the importance of stand-alone vision plans is likely to be disruptive to the market and reduce competition. If only bundled eye coverage is permitted to satisfy the EHBP, then QHPs may choose to offer required pediatric vision coverage only In that case, adult coverage might not be available in the Exchanges, causing some adults who currently have stand-alone vision coverage to drop vision coverage entirely In addition, those adults who do not have vision coverage currently may be even less likely to choose to obtain vision coverage if they must do so separately from their children. That is, some adults will not seek vision coverage outside of an Exchange, because that would require additional effort to enroll. Another possible result is that adults will seek coverage outside of the Exchanges (while their children are covered under an Exchange plan), resulting in the bifurcation and segmentation of a market which has traditionally been based on family coverage. Either or both of these could result if only bundled eye coverage is permitted to satisfy the EHBP, and either or both will have the effect of disrupting what today is an innovative and expanding market, including the reduction of available plans and options, negative price impacts, and reductions in network and provider availability, and innovation.[5]

[5] Further complications will ensue if similar requirements do not apply both inside and outside Exchanges. ACA contemplates continued employer coverage and the ability to obtain coverage both inside and outside Exchanges. It is likely that individuals will move in and out of Exchange-based coverage from time to time, such as if the individual changes jobs, leaves or re-enters the work force, or moves geographically Such moves necessitate parallels between coverage inside and outside the Exchanges in order to provide options to individuals as well as consistent pricing structures. In order to provide a smooth transition from the current health care system to that contemplated by heath care reform, as well as to provide for a long-term sustainable health care system, the continued role of stand-alone vision coverage should be preserved as an option both inside and outside Exchanges.

Stand-alone vision coverage leads not only to better vision health but also to early detection of chronic diseases compared to vision coverage that is bundled as part of a major medical plan.

The NAVCP Study, referenced earlier, indicates that the benefits of stand-alone vision care include wellness benefits and the early recognition of chronic diseases. The study found that persons with stand-alone vision coverage (as compared to coverage bundled in a major medical plan) were twice as likely to obtain regular eye health examinations and preventive services, allowing for early diagnosis and prevention of eye conditions, as well as chronic conditions such as type 2 diabetes and hypertension.[6]This is in large part because the stand-alone vision coverage is focused on a particular benefit. Stand-alone plans are thus naturally encouraged to focus on providing and demonstrating value for the beneficiary and differentiating themselves from their vision plan peers. Further, the study found that children whose parents have stand-alone vision coverage are more than twice as likely to receive eye care, compared to children with parents in bundled plans.

Early diagnosis of such chronic diseases benefit the individual, but also the health care system as a whole. These benefits may be reduced if only embedded coverage is permitted. The National Association of School Nurses has recognized the importance of stand-alone vision plans in promoting primary eye care for children to aid in early learning. Meanwhile, VSP's own data has demonstrated to its network of providers and to its clients how important the company's efforts have been to require providers to check for early signs of certain chronic diseases, such as diabetic retinopathy, an early indicator of pre-diabetes and diabetes. This can be detected via a dilated retinal exam, a test that provides a unique, non-invasive view of a patient's vascular health via retinal capillaries. An eye doctor can detect diabetic retinopathy up to seven years prior to the onset of external symptoms of diabetes. Thus, it is important that adults continue to have easy access to eye care coverage. Precluding stand-alone vision plans in the Exchange will be counterproductive, because the resulting bifurcation or other market and coverage disruptions will reduce the likelihood that adults will obtain comprehensive eye coverage.

The most logical reading of the statutory requirements relating to the EHBP supports allowing stand-alone vision to be offered in Exchanges.

ACA expressly grants broad authority to the Secretary to define the EHBP – Section 1302(b)(1) states that "the Secretary shall define the essential health benefits...". The statute includes certain elements that the Secretary is to consider when defining the EHBP, including that the scope of the EHBP is to be equal in scope to the benefits provided under a "typical" employer plan[7] and that, subject to the preceding limitation, the EHBP is to include at least 10 general categories and the items and services included in those categories, including pediatric vision services.[8]

To inform the Secretary as to the scope of benefits under the typical employer plan, ACA directs the Secretary of Labor to conduct a survey of employer plans. In response, the Department of Labor made available information based on the on-going work of the Bureau of

[6] See footnote 4
[7] ACA §1302(b)(2)(A).
[8] ACA §1302(b)(1).

Labor statistics.[9] While this information is helpful in many cases, it does not contain detail regarding vision coverage, and whether it is typically provided in employer plans on a bundled or stand-alone basis.

As mentioned, above, the NAVCP Study does contain this type of information and demonstrates that stand-alone vision coverage is not merely "typical," but by far the favored means by which vision coverage is offered in the employer market today We also note that the Institute of Medicine (IOM) recently released its report on criteria to be used in determining the essential health benefits package. The IOM report focuses on the typical employer plan in the small employer group market. Like others, VSP is in the process of fully reviewing the IOM report. We note, however, that the IOM report indicates that both dental and vision pediatric benefits, when offered under a small employer plan, are typically offered as separate policy riders, rather than imbedded in the major medical plan.[10] Requiring QHPs to cover pediatric vision services as part of a "major medical" plan would not reflect the "typical employer plan," as called for by the statute. In fact, stand-alone vision plans initially developed from an absence of or deficiencies in major medical coverage for primary vision services. As a result, stand-alone plans, led by VSP, have developed robust provider networks, care integration, chronic disease screening and diagnosis, and vision health awareness.

B. The Statute Gives The Secretary The Authority To Require That Stand-Alone Vision Benefits Be Allowed To Be Offered In Exchanges

A number of statutory provisions in ACA support the ability of the Secretary to adopt implementing regulations that allow stand-alone vision benefits to be offered in Exchanges in order to satisfy the pediatric vision requirement, including the following:

- Section 1301(a) of ACA defines a QHP and requires, among other things, that a QHP have in effect a certification that the plan meets the requirements described in Section 1311(c). Section 1311(c)(1), in turn, provides that the Secretary shall "establish criteria for the certification of health plans as qualified health plans" Further, section 1311(e) requires that a State may certify a plan as qualified on an Exchange only if the plan meets the requirements for certification promulgated by the Secretary Section 1311(k) provides that an Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under title I of ACA, which include the provisions relating to Exchanges. These provisions support the ability of the Secretary to require that States certify stand-alone vision plans that contain the essential pediatric vision benefits as able to be offered on the Exchanges and to provide that a health plan shall not fail to be certified as a QHP merely because pediatric vision benefits are provided through a stand-alone plan.

- Section 1321(a) of ACA gives the Secretary broad authority to issue regulations setting standards for meeting the requirements of title I of ACA, with respect to the

[9] ACA, § 1302(b)(2). The Department of Labor's survey, which draws from its existing data, may be found here: http://www.bls.gov/ncs/ebs/smb_health.htm.

[10] See, for example, page 5-3 of the IOM report ("Essential Health Benefits – Balancing Coverage and Cost"), prepublication copy, which is available at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx

establishment and operation of Exchanges, the offering of QHPs, and "such other requirements as the Secretary determines appropriate" This Section expressly grants authority that would permit the Secretary to provide that stand-alone vision benefits may be offered through Exchanges.

- Section 1301(a) requires that a QHP contain the EHBP described in Section 1302(a). Section 1302(a) provides that the Secretary is to determine the EHBP, subject to the proviso in Section 1302(b)(2) that the scope of the EHBP is to be equal to the scope of benefits provided under a typical employer plan. As discussed above, in the typical employer plan, vision benefits are provided on a stand-alone basis.

- Section 1551 of ACA provides that, unless specifically provided for otherwise, the definitions of Section 2791 of the Public Health Service Act shall apply for purposes of title I of ACA. Since HIPAA, Section 2791(c)(2)(A) has contained requirements relating to stand alone vision plans. Thus, there is a clear definition of stand-alone vision plans that may be used under ACA for purposes of the Exchange rules.[11]

CONCLUSION

The Affordable Care Act expressly grants the Secretary authority with respect to various aspects of the Exchanges and QHPs, including developing standards for the certification of plans as qualified health plans (QHPs) and a broad grant of authority to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs, and other components of title I of the Affordable Care Act.

VSP requests that the Secretary exercise the authority granted under ACA to provide that an Exchange would be required to allow stand-alone vision benefits to be offered in an Exchange if the vision plan furnishes at least the required pediatric vision benefit under rules similar to those that apply to stand-alone dental plans under the Proposed Regulations

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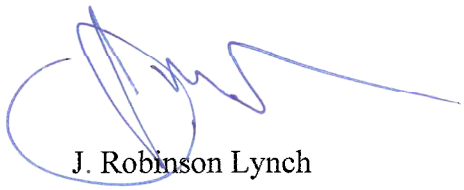
[11]In addition to the authority cited in the text, CA's statutory provisions reflect a number of different goals which would be served by allowing stand-alone vision benefits to be offered in Exchanges, including expanding coverage, avoiding gaps in coverage, providing affordable health care choices for Americans, fostering insurance competition, preserving the employer-based market, and reducing health care costs while providing additional coverage options through exchanges. See, for example, subparagraph (G) of ACA Section 1302(b)(4), which specifies that the Secretary must periodically review the essential health benefits and provide a report to Congress specifying how the essential health benefits will be modified to address "gaps in access." Furthermore, subparagraph (H) states that the Secretary must periodically update the essential health benefits to address these gaps in access to coverage. This implies that the Secretary, when establishing the essential health benefits, should to the extent possible ensure that the essential benefits package does not create such access gaps in the first place. The statute reflects that the exchanges are to foster consumer choices and competition, see, e.g., ACA Sections 1311 and 1312. Further, both employers and individuals are to have choices both inside and outside exchanges (e.g., under the section headed "Empowering Consumer Choice", ACA Section 1312(d) provides that health insurers shall not be prohibited from offering coverage outside the exchanges to qualified individuals and employers, a qualified individual shall not be prohibited from enrolling in coverage outside an exchange and a qualified employer shall not be prohibited from selecting for its employees coverage offered outside an exchange).

VSP appreciates the opportunity to comment on the Proposed Regulations. We would be happy to answer any questions you may have. Please feel free to contact me or Cecil Swamidoss, VSP's Director of Federal Affairs, (202.239.3788 or cecil.swamidoss@vsp.com) if you have any questions or comments regarding this issue.

Sincerely,



J. Robinson Lynch

cc: Donald Berwick, Administrator, Center for Medicare and Medicaid Services
cc: Steve Larsen, Director, Center for Consumer Information and Insurance Oversight