

Vision Benefits

Background

Vision care is one of the less common employer-sponsored health benefits. Hospital and physician care is provided to virtually all full-time employees, prescription drugs to over 90%, substance abuse coverage to 85% and dental coverage to about 70%. In contrast, various surveys indicate that only 35% of full-time employees have vision care benefits.

Vision is a relatively inexpensive benefit. The cost is also stable because utilization is restricted, usually one benefit per year or every two years. However, many health benefit funds have been virtually drained by the continued escalation of health care costs combined with decreased contributions.

The purpose of vision care coverage is to provide benefits for expenses incurred as the result of prescribing, fitting or changing eyeglasses or contact lenses for refractive errors.

Errors of refraction are imperfections of the refractive power of the eye with the simple result that images are not properly focused on the retina.

Conditions classified as errors of refractions are:

- Astigmatism - seeing imperfect images.
- Myopia (nearsightedness) - seeing distinctively at short distances only.
- Hyperopia (farsightedness) - seeing distant objects better than near objects.

Eye examinations, lenses or frames for treatment of conditions such as accidental

injuries, cataracts, glaucoma and strabismus are not covered under vision care expense coverage.

Sunglasses would not be covered except for albinism, or where medically required to be worn most of the time.

Vision testing examination means an examination including history; testing visual acuity; external examination of the eye; binocular measures; ophthalmic examination; tonometry when indicated; medication for dilating pupils and desensitizing the eye for tonometry, if applicable; summary and findings; a determination as to the need for correction of visual acuity, prescribing lenses, if needed, and confirming the appropriateness of eyeglasses obtained under the prescription.

Plan Design

The simplest way to provide any benefit, including vision, is to reimburse the recipient for the cost of the care: a fixed amount, a percentage of the billed amount or the total cost.

Since the cost of routine vision care almost always exceeds the indemnity maximum, the program might seem more like a bonus than a health benefit. Other basic management activities absent in an indemnity plan include assurances that noncovered services (e.g., non-prescription sunglasses) were not provided and that noneligible persons (e.g., ineligible relatives) were not the beneficiaries.

Discount. A discount program attempts to reduce the cost of care to members without direct funding. There are a number of vision PPOs that market discount programs for professional services and materials. Since a discount program is presented as a member benefit made available by the fund, some accountability is assumed. The problem is ascertaining that discounts are truly given and that good quality care and materials are provided.

Vision PPO. By contracting with a vision PPO, a fund can provide high quality care at a reasonable cost. The benefit can be clearly defined and fully funded, and true savings can be realized without shifting costs to beneficiaries. If vision care is included as an employee benefit, and the logical decision is made to use a PPO panel, there are five areas of concern: quality assurance, materials, administration, cost management and panel formation.

Cost Coverage Through Benefit Design

The scope of coverage of a vision plan is fairly well defined. One variable is the type of lenses included. The more enhancements included, the greater the cost. Contact lenses, photosensor (darken in sunlight) lenses, no line bifocals and fashion tints are some of the cost-related lens features.

Restrictions should not include vision-related features such as strong prescriptions or large (oversized) lenses. Some plans include coverage for multiple pairs of glasses with a related cost effect.

The cost paid per service (examination, lenses, frame) is obviously going to affect the overall program cost. Examinations should be available from a PPO at about 75% of the prevailing rate in the area. Lenses and frames should be purchased at wholesale prices with a fixed fee paid to the provider for dispensing the eyeglasses and supplying subsequent frame adjustments.

Limiting the benefit to every 12 or 24 months utilization is a reasonable and effective means of containing program cost. Depending upon member characteristics, including average age, the utilization rate of a biennial benefit will be about 25% and an annual benefit about 31%. Some biennial plans permit annual benefits for children.

Other factors that are cost related are risk assumptions, administrative costs and the ability to coordinate benefits. Most groups self-fund vision coverage because of its relatively low cost and its cost predictability. The decision to self-administer or contract

with a PPO or a third party administrator depends upon many factors, including cost, but a PPO should be able to provide complete administrative services.