VISION CARE BENEFITS IN CANADA & THE CASE FOR REFORM

DON'T LOSE SIGHT
of Vision Care Benefits

CONTENTS

This report, commissioned by the Canadian Association of Optometrists (CAO), was conducted and reported independently by PDCI Market Access with support from Connex Health.

EXECUTIVE SUMMARY

Background: Spending on vision care in Canada accounts for 5.9% of all private healthcare spending.[3] While three out of four Canadians insured under a private group benefit plan have some vision care coverage included, plan members pay the majority of vision care expenses out-of-pocket.[3] This leads to high levels of dissatisfaction with vision care benefits plans in Canada and suboptimal utilization of the vision care services that can preserve vision and contribute to improved health outcomes for Canadians.

Objective: Representing 85% of optometrists across Canada, the Canadian Association of Optometrists (CAO) is the national voice of optometry, dedicated to collaboratively advancing the highest standards of primary eye care through the promotion of optimal vision and eye health, in partnership with all Canadians.[5] In Spring 2019 the CAO commissioned PDCI to report on the state of eye health and vision care benefits provided to the Canadian workforce through the insurance industry. PDCI worked collaboratively with the CAO, optometry leaders and insurance industry stakeholders to:

1. Report on the current state of vision benefits in Canada: identify gaps between the standard of care and plan offerings, and understand why these gaps exist; and
2. Recommend a course of action to modernize vision care plans, to enhance their value for money for both plan members and sponsors.

Methods: PDCI completed this research between March and May 2019. Methods included both quantitative and qualitative research on the private payer marketplace, including discussions with insurers (payers), plan advisors (benefit consultants and insurance brokers), and plan sponsors (employers, industry associations and trusteed plans).

Results: Research indicated there are notable gaps in vision care coverage. In particular, few plans cover new diagnostic services and interventions (which can both preserve vision and improve other health outcomes as well), many offer inadequate benefit levels (particularly for beneficiaries with higher levels of need), and most reflect an outdated understanding of best practices in vision care. These coverage gaps have persisted largely because of preoccupation with other cost pressures on group benefit plans, and result in measurable dissatisfaction with vision care benefits from both plan members and plan sponsors.

In summary, there are two main barriers hindering Canadians' access to vision care consistent with the standard of care:

1. **Vision care is significantly underfunded** by plan sponsors compared to other privately insured extended health benefits, so the out-of-pocket burden for Canadians to access vision care is substantially higher than for other medical professional services.
    a. According to the Canadian Institute for Health Information (CIHI), in 2016 74% of private vision care expenditures were incurred by Canadians out-of-pocket, versus 37% for drugs and 44% for dental.[3] As cost is a factor for 71% of Canadians when deciding to access vision care[6], the high out-of-pocket burden may contribute to many Canadians foregoing the routine and preventative care which would ensure their eye health and preserve vision.

b. Most vision care plans allow for reimbursement of a limited list of covered services within prescribed benefit maximums just once every 24 months. Because the need for vision care services can vary substantially from one plan member to another current vision plan design standards place some plan members at risk for substantial out-of-pocket costs and unplanned expenses, particularly those with additional requirements because of declining visual acuity or chronic diseases. Faced with substantial out-of-pocket costs, plan members who need vision care services the most may face growing financial hardship or choose to forego needed examinations and prescription changes.

2. **Plan designs for vision care benefits are outdated and inadequate for today's workforce**. Most private drug plans in Canada have not kept pace with the important clinical- and cost-effective advancements in optometric modalities, diagnostics, treatments and interventions which can improve health outcomes, preserve vision and delay or earlier diagnose other impairments. Advances in vision care clinical services mean diagnosing and treating eye conditions much earlier, with the real potential of avoiding vision loss. Vision impairment in the workplace will become more pervasive both as our workforce ages and as screen use makes up a greater portion of our workday. This ageing population has increasing vision care needs, as some form of vision correction is required in 80% of those over 50 years versus just 57% in the population over 20 years of age. Additionally, rates of chronic diseases that can affect vision health (e.g. type 2 diabetes), continue to rise within Canada's aging working population. Plan designs not incorporating coverage for advanced care result in plan members sub-optimally accessing vision care or incurring high out of pocket costs for services consistent with the standard of care, while plan sponsors experience higher-than-necessary direct and indirect costs, including lost productivity, presenteeism, and higher rates of disability.

Discussion: Stakeholders interviewed for this research suggested vision care benefits have been unchanged over time in large part due to plan sponsors' preoccupation with cost containment among other benefits categories, such as drugs, dental and disability. However, this research finds it is important not to lose sight of the role vision care benefits can have in delivering value to both plan members and plan sponsors. This research finds that there would be significant value in modernizing vision care benefits, including:

1. **Improving Employee Satisfaction and Retention:** Plan members place a high value on vision benefits and are dissatisfied with their current vision benefits. Only 15% of Canadians are satisfied with their vision care benefits plan and 21% describe it as "poor" or "very poor".[1] Those plan members in need of vision care services and treatments to preserve eye health have a medical requirement for accessible levels of services. Diminishing vision care coverage relative to the cost of other benefits is counterproductive to the intentions of private health plans to prevent and treat health conditions and maintain a satisfied, engaged and productive workforce. The growing vision care cost burden placed on plan members should be of great concern to plan sponsors.
2. **Optimizing Value for Money in Vision Care Benefits:** On one hand, plan sponsors often highlight concerns that frames and lenses benefits can be used by plan members for discretionary spending on fashionable, higher priced frames to maximize their benefit. On the other hand, poor vision costs plan sponsors directly in other benefit lines and indirectly in impaired productivity, presenteeism, absenteeism and mental health. The Canadian

National Institute for the Blind estimates productivity costs related to vision loss costs the economy $4.4B annually[7], and in 2016 it's estimated that nearly 1 million Canadians missed work or school because of vision problems.[8] Ensuring plan members access vision care services consistent with the most current standard of care can mitigate direct and indirect costs of poor vision to the plan sponsor, yet vision care benefits often fall short of the standard of care. Modernizing plan designs can address both scenarios above to optimize the value of vision benefit plans for both the plan members and sponsor.

Recommendations: This research highlights opportunities for plan sponsors, insurers and advisors to collaborate with CAO to learn how standards of vision care clinical practice have changed over recent years, and how to modernize plans to optimize the value of vision care benefits for plan members and plan sponsors alike.

Insurers should collaborate with the Canadian Association of Optometrists to develop a new coverage and reimbursement framework for vision care benefits, with the following considerations:

1. The need to develop vision care benefit norms that separate vision care into the following categories:
   - Comprehensive routine examinations
   - Diagnostics and interventions
   - Frames and lenses
   - Additional medically indicated benefits (e.g. more frequent exams and corrective lenses updates, additional diagnostics and interventions) for patients with certain risk factors or conditions (e.g. stage of life, comorbidities, chronic disease etc.)
2. Vision care plan design options that result in minimal, if any, premium changes.

Plan sponsors should review their vision care benefits offerings in the context of the latest, evidence-based clinical practice guidelines and recommendations from the Canadian Association of Optometrists, and implement a vision care benefits plan that not only allows, but encourages members to:

1. Complete comprehensive routine eye examinations at the frequency consistent with CAO recommendations for their age and risk factors in provinces without public coverage (this means both allowing exams at the appropriate frequencies, and also funding exams at the reasonable and customary fee levels in each province to eliminate or substantially reduce out-of-pocket costs for plan members).
2. Access additional diagnostics and interventions at reasonable and customary amounts at least every 24-months.
3. Modify plans to include coverage for additional exam, diagnostics, interventions and vision care benefits for frames and lenses within twenty-four-months when medically indicated based on clearly identifiable criteria.
4. Provide frames and lenses benefits while considering implementing coinsurance so that members pay a portion from first dollar. In this way, those who need the benefit the most receive a higher overall percentage of reimbursement.

Recognizing that introducing fundamental change to vision benefits design will be challenging, the Canadian Association of Optometrists and its provincial partners, in collaboration with PDCI, have embarked on a Best Practices Guide to Vision Benefits. A selection of industry stakeholders will be asked to provide their input on the draft of this Guide prior to its release in Spring 2020. The Association welcomes dialogue with and input from all stakeholders as it works to facilitate fundamental reform to the vision care landscape in Canada.

INTRODUCTION

Eye health and vision care are important healthcare needs in Canada. In the next decade alone, partially due to the aging population, vision loss is expected to increase nearly 30% and is understandably the most feared disability for Canadians.[9] Employers should also be concerned: Vision loss cost the Canadian economy an estimated $19.1 billion per year in 2007[10], and this number could to rise to $30 billion per year by 2030[11]. This represents the highest direct healthcare cost of any disease category in Canada.

Despite these projections, advances in vision care diagnostics and interventions are positively changing the prognosis and outcomes for vision-impairing conditions. Since Herman Snellen developed the eye chart in 1862 revolutionary technological advances have provided optometrists a more comprehensive understanding of the eye and visual system, allowing for detailed diagnoses and provision of more tailored care for patients, raising the standard for vision care well beyond prescriptions for eyeglasses, to include enhanced treatment of diseases like diabetic retinopathy, glaucoma, age-related macular degeneration, and dry eye disease. With adequate screening and corrective measures, most impairments, including vision loss, can be prevented, delayed or better managed than in the past. The challenge to realizing these positive outcomes relates, of course, to patients' ability to access this standard of care.

This report examines the current private group benefits landscape for vision care, identifying gaps between benefits offerings and the standard of care, and opportunities for the marketplace to enhance the value of vision care benefits for plan members and plan sponsors alike in 2020 and beyond.

VISION CARE BENEFITS IN CANADA

Vision care benefits are a long-standing and highly valued core component of most extended health plans. When first introduced, vision care plans were intended to cover a basic eye exam and corrective lenses and frames. However, the maximums have not regularly been adjusted (and in some cases have stayed the same for a decade or longer) failing to account for either fundamental changes to the standard of care or updates to reasonable and customary fees across the country for vision care services, impeding the ability of plan members and sponsors to optimize value of vision care benefits spending in Canada.

SPENDING ON VISION CARE BENEFITS

Extended health benefit plans have often been described with the standard core components of "Drugs, Vision and Dental". With between 57% and 80% of plan members requiring corrective lenses, vision benefits are widely used. However, as a share of private healthcare expenditures, the total cost of vision care is much smaller than other categories of spending such as prescription drugs (25%), and dental services (20%), as shown in Figure 1.

Additionally, spending on vision care as a proportion of private health expenditures has remained fairly constant over time. As shown in Figure 2, compared to drugs and dental, vision is a much lower cost benefit offering for plan sponsors, accounting for only 5% of private health insurance spending among the three core components.[3]

Figure 1: Shares of Private Health Expenditure, 2019[12]

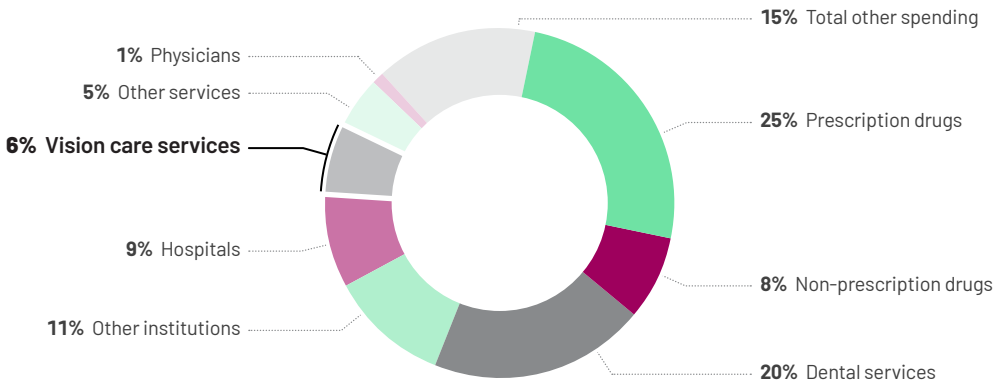


Figure 2: Private Insurance Spending by Core Component[3]

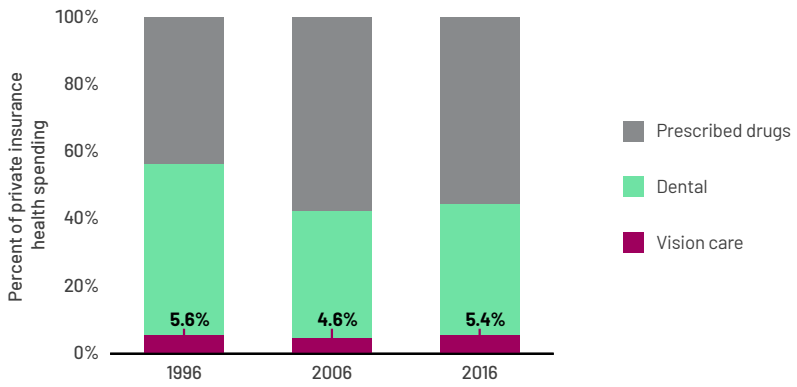
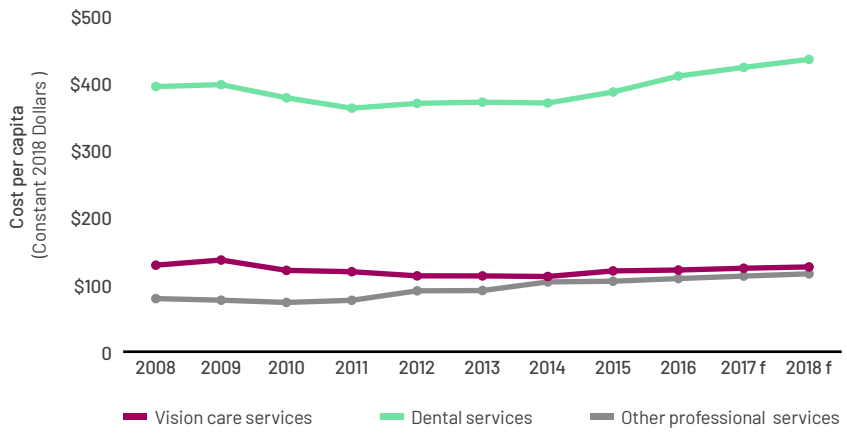


Figure 3: Cost Per Capita for Vision, Dental and Other Professional Services, 2008–2018f[2]



Historical analysis of private vision care expenditures by CIHI shows a peak in 1997 when 8.4% of private health care expenditure was spent on vision care. Vision care remained between 7%–8% of private expenditures for the next decade before declining to 6% in more recent periods.

Additionally, in the 10-year period between 2008 to 2018, the per capita cost of vision care benefits has remained relatively constant, as shown in Figure 3, while spending on each dental and other professional services have increased. In 2018, per capita costs for dental care, vision care and other professional services were forecasted to be $434, $116 and $116 respectively.[12] On a per capita basis, only $28 dollars of vision care spending comes from private health insurance reimbursement while the rest is paid out-of-pocket to the plan member. Considering the substantial out-of-pocket costs of vision care, private insurance for vision care has failed to keep pace with reimbursement of other private health benefits.

2018 CIHI: At just 6% of total private health expenditure, vision care spending is at its lowest since 1975.

CURRENT PLAN DESIGNS

Today, more than 150 life and health insurers operate throughout Canada and provide varying levels of coverage to 25 million Canadians. Three large national group insurance carriers collectively manage approximately 60% of all insured lives.[2, 13]

Private extended health plans provide various combinations of vision care reimbursement for eligible expenses. In most cases, vision care benefits are limited to a single maximum benefit every 24 months for adults, ranging from $100 to $500. Data from one major Canadian payer shows their plans most frequently cover a maximum of $200-$250 (39%), 10% of plans have unlimited vision benefits and 13% do not cover vision care services at all.[14]

In most cases, plans reimburse eye examination fees only once within the 24-month benefit period, and often to a maximum amount that is well below reasonable and customary fees for eye exam services. Advanced examinations and diagnostics, when they are eligible for

reimbursement, are often reimbursed within the standard examination benefit maximum or as part of the overall maximum vision care benefit, meaning access to newer diagnostic tools are extremely limited, and typically paid by the patient out of pocket if and when they are performed.

Recently, some insurers have tried to contain costs by leveraging web-based referral tools that inform and guide plan members to lowest cost providers. Their success has been limited by plan members preferences to visit the medical professional with whom they've established a relationship and are unlikely to change medical professionals strictly because of cost. Such an approach diminishes the importance and value of the patient-provider relationship in vision care. In PDCI's research, insurers mentioned web-based tools as a way to improve vison care benefits, but plan sponsors and benefit advisors did not.

PDCI's research suggests that little has changed with regards to vision benefits coverage in the last 10 years, only modest changes in the vision care plans of today can be observed compared to those of ten or even twenty years ago. For example, a small number of plans have recently allowed the frames and lenses maximum to be allocated for laser surgery instead, however broader changes to the plan designs or maximum coverage amounts have remained the same in most cases. Benefit levels have been infrequently reviewed or adjusted over time, failing to reflect changes in new optometric technologies and modalities, or changing workplace demographics and needs.

Although most plans routinely cover eye exams, PDCI research indicates that it is still outside the norm to find vision care plans that provide an additional allowance for new diagnostic services and interventions.

The approach to offering vision care benefits to a maximum dollar amount within each 24-month period leads to some unintended consequences which inhibit both plan members and sponsors from optimizing value in vision care benefits plans. These include:

- **Patients with high out-of-pocket costs may delay or avoid updates to their prescription corrective lenses, thereby hastening their own vision loss.** Some patients who require complex prescription lenses that are very costly or who experience frequent changes in their vision (within a 24-month period), may forego prescription updates, or choose lower quality lenses in order to reduce their out-of-pocket burden. This may lead to accelerated vision loss, additional prescription requirements in the future, and additional out-of-pocket costs. Their suboptimal vision may also have an impact on job performance, presenteeism, and safety in the workplace, particularly for those in safety sensitive positions.
- **The "use it or lose it" model may drive unnecessarily high claims volumes for frames and lenses:** Plan members may choose to update frames and lenses in order to make use of their benefit allowance even if they have not had a prescription change within the 24-month period as patients don't want to "lose the benefit".
- **A patient-focused approach to vision care based on each plan member's medical needs can be impeded by inconsistent access to exams:** For those insured under group plans in provinces where public coverage for exams does not exist, their plan may include the exam fee as part of the overall vision care benefit with a set maximum every 24 months. Only some plans have a reasonable and customary allowance for exams, and these tend not to reflect current, provincially appropriate fees. This can contribute to the significant out-of-pocket expenses for patients to access comprehensive exams consistent with the standard of care.

- **Many plans have insufficient benefit levels for medically indicated advanced vision care diagnostics and interventions**. This further contributes to plan member out-of-pocket burden. More concerning is that some patients will decline important diagnostics and interventions due to affordability leading to potentially significant long-term impacts on their eye health and vision.

When asked about reasons for the gaps between benefit offerings and the current standard of care, stakeholders identified the following barriers to moving away from the historical approach:

- **Stakeholders perceive vision care to be a cost driver in benefit plans.** However, the high out-of-pocket burden for plan members, along with claims data trends, suggest vision care is increasingly underfunded within benefit plans, which in turn drives high utilization of vision care benefits. Even with improvements, vision care could remain relatively low cost in the overall benefit budget. The evolution of vision care services, the increasing needs of an aging workforce and the relatively low benefit levels under many benefit plans contribute to poor vision care practices and low satisfaction rates amongst plan members with vision care benefits.
- **The perception that vision care benefit improvements would result in dollar-for-dollar extra costs for the plan.** Vision care benefits are highly utilized, with significant additional out-of-pocket costs incurred by plan members. It is perceived that incremental benefits will result in a near dollar-for-dollar increase in benefit costs. However, novel plan designs can address this concern and enhance value for both plan members and plan sponsors alike.
- **Some stakeholders reported plan sponsors' perception that their vision care benefits plans are already quite effective and, in some cases, cover 100% of costs.** However, coverage of 100% of costs up to an insufficient maximum amount does not equate to full coverage as they implied, and instead leads to the high out-of-pocket costs or foregone essential medial care and the low levels of satisfaction observed for vision care benefits. Other stakeholders highlighted Healthcare Spending Accounts (HSAs) as an opportunity to cover additional vision care services, however these represent an inadequate solution for improving access to vision care (see HSA call-out box for more details).
- **Plan sponsors and advisors reported being largely unaware of the clinical and personal value today's vision care services can offer plan members.** Most private drug plans in Canada do not recognize the important clinical- and cost-effective advancements in optometric modalities, diagnostics, treatments and interventions which improve health outcomes, preserve vision and delay or earlier diagnose other impairments and disability. The large share of out-of-pocket expenses demonstrate the importance plan members place on these vision care services.

"Every time I have an employee meeting … when we get to vision care, I'll say, 'Vision care is covered at 100% up to $200 for a pair of glasses and we cover an eye exam' and there's always someone that says, 'Well, it's not at 100% — when was the last time you got a pair of glasses for $200?'"

Benefit Advisor

HEALTHCARE SPENDING ACCOUNTS:
An Inadequate Tool for Improving Access Vision Care Services

Increasingly popular in health benefits offering are Healthcare Spending Accounts (HSAs) which provide plan members the ability to use a fixed pool of HSA dollars towards additional extended health services that are over an above what is covered by the member's plan. According to the 2018 Sanofi Canada Healthcare Survey, approximately one-third of plan sponsors offer HSAs, and they are more common in large groups and those with flex plans.[4] HSAs are a mechanism for plan sponsors to offer plan members flexibility in how they may choose to spend their healthcare dollars. For the one-third of plan sponsors offering HSAs, vision care services would compete for a fixed pool of additional dollars (e.g. $100 to $500 every 12 or 24 months according to PDCI's research) alongside other extended healthcare services and providers. HSA allowances at the lower end of this range will not provide plan members with basic vision care needs, let alone access to the advanced diagnostic services and interventions that have been demonstrated to clinically- and cost-effectively preserve and protect their vision.

While their intent is to offer choice, HSAs do not address fundamental shortcomings of private health plans that have failed to update coverage for current clinical standards of vision care in Canada. In the end, HSAs are provided by the minority of plan sponsors and when they are available, they offer an inadequate solution to the need for reforming vision care coverage.

THE CASE FOR VISION CARE BENEFITS REFORM

Vision care benefits are often inadequate for plan member and sponsor needs and are often overlooked when renewing benefit programs. They must, however, be modernized to address vision care needs of the workforce in 2020 and beyond and to optimize value for both plan members and sponsors alike.

IMPROVE PLAN MEMBER & SPONSOR SATISFACTION

Plan members place a high value on vision care coverage within group benefit plans, with 91% reporting vision care to be "somewhat" or "very" important in the 2016 Sanofi Healthcare Survey. However, only 15% of Canadians reported being satisfied with their vision care benefits plan and 21% described it as "poor" or "very poor".[1] Additionally, 21% of plan members said they would choose an increase in the vision care benefit if only one area of their benefit plan could be increased, and this was second only to major dental services.[15]

In the 2016 Sanofi Healthcare Survey, 91% of plan members reported vision care coverage to be very or somewhat important yet 21% of plan members reported their current coverage to be poor or very poor.[1]

Plan sponsors similarly named vision care is the benefit they are most likely to be dissatisfied with (15%).[1] The most frequent reasons expressed for this dissatisfaction were:

- Delivering inadequate value
- High costs for plan members and plan sponsors, and
- Negative feedback from plan members.

Given the high importance assigned to vision care by plan members, and low levels of satisfaction with existing vision care benefits among both members and sponsors, sponsors acknowledged the value in revisiting vision care benefits as a way to improve member satisfaction.

"We had a plan where you would have people who need their glasses changed, they get their glasses or lenses every two years. For people who don't have a change, their frequency goes from two years to four years. So, plan members were all unhappy."

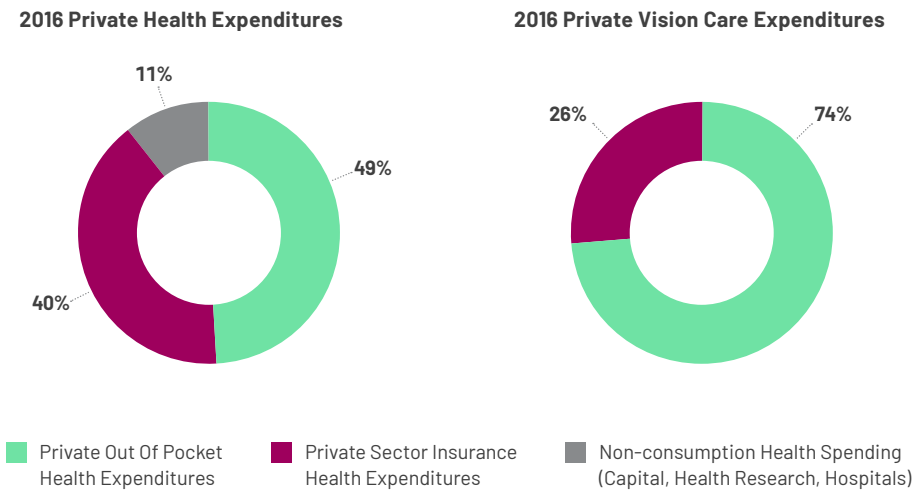
Insurer

MITIGATE HIGH OUT-OF-POCKET EXPENSES

In contrast to the substantial funding of both dental care and pharmaceuticals through group benefit plans, funds for vision care lag behind, representing a growing coverage gap in the Canadian benefits environment. Although most group benefit plans provide some coverage for eye exams and prescription eyewear, a significant gap exists between the expenses incurred by plan members and the amount eligible under their vision care benefit coverage. This makes vision care the largest out-of-pocket healthcare expense for most Canadians, with 74% of all private spending on vision care expenses being out-of-pocket (versus 37% for drugs and 44% for dental).[3] National Health Expenditure data from the Canadian Institute for Health Information (CIHI) highlights the share of private health spending paid by insurers versus by Canadians out-of-pocket, as shown in Figure 4. Additionally, this may be an underestimate of the share paid out of pocket as some claims may never be submitted (e.g. when plan maximums have already been reached, plan members pay out-of-pocket for medically needed vision care and do not submit claims they know will be declined).

As cost is a factor for 71% of Canadians when deciding to access vision care services[16], the high out-of-pocket burden likely causes some Canadians to forego the routine and preventative care which would ensure their eye health and preserve vision. For example, vision care problems

Figure 4: Private Health Spending by Source of Funds (2016)[3]



such as refractive errors are easily correctable, yet uncorrected refractive errors account for 53% of moderate and severe visual impairment globally,[17] suggesting the important role adequate vision care benefits can have to ensure sufficient screening and correction.

Case Studies

To illustrate the gaps in vision care benefits and the opportunity for change, three patient case studies are presented. Each case represents an actual patient's treatment plan, demonstrating how plan members often face significant out-of-pocket costs to access clinically necessary vision care services. The expenses described were not associated with elective or discretionary expenses and rather represent situations where optometric services were required to ensure appropriate vision accommodations in the workplace. Reforms to vision care benefits to reduce potential out-of-pocket costs, particularly for specialty diagnostic services and non-elective interventions, while balancing increases to benefit costs must be explored to alleviate the burden on plan members illustrated by these examples. Payers and plan sponsors should be encouraged to implement vision care benefits reform to accommodate these, and similar situations where deteriorating eye health requires timely and appropriate interventions and ongoing monitoring and care. Such an approach can ensure plan members remain productive, healthy and safe in the workplace.

About

A.L. is a bus driver living in New Brunswick with type 2 diabetes. As a condition of his Class 1 license, he must undergo an annual eye examination. A full dilated fundus exam and refractive assessment is carried out yearly to ensure he has not had diabetes-related changes in the blood vessels at the back of his eyes (diabetic retinopathy) and that he is seeing properly.

Case Study 1
MANAGING COMPLICATIONS OF DIABETES

Examination — A.L.'s private insurance includes 80% coverage for one eye examination every 2 years, up to a maximum of $110. His exam fees were $119 for a dilated fundus examination with optical coherence tomography (OCT) in each year:

Year 1: $119 x 80% = $95.20 paid by insurance; $23.80 paid by A.L.

Year 2: $119 x 0% = $0 paid by insurance; $119.00 paid by A.L. In year 2, an additional $49 was incurred to monitor a small hemorrhage to determine risk to vision and whether to refer A.L. for treatment. $49 x 0%= $0 paid by insurance; $49.00 paid by A.L.

Frames and Lenses — A.L.'s insurance includes 80% coverage for frames and lenses, up to a maximum of $220 per 24-month period. A.L. was developing cataracts (common for patients with diabetes), so his prescription was changing and new eyeglasses were needed within the 24-month period. A.L. chose frames from the economy line for $119 and scratch-coated progressive lenses were needed with a non-glare coat (since he drives for work) for a total lens cost of $309.

Total Cost: $428 = $180 paid by insurance; $248 paid by A.L.

Out-of-pocket costs — For exams, supplemental tests (not covered in NB) and frames and lenses, A.L. incurred $715 in total costs: $275 (38.5%) paid by insurance; $440 (61.5%) paid by A.L.

About

B.D. is a 63-year-old female who visited her optometrist due to blurred vision in the past 3 months.

Case Study 2
CHANGING PRESCRIPTION DUE TO CATARACTS

B.D.'s optometrist diagnosed B.D. with cataracts and tested her vision, recognizing that the cataracts were causing B.D.'s prescription to change rapidly. The optometrist determined B.D. was not eligible for cataract surgery but would need new lenses in order to be safe to drive. B.D. received new prescription lenses at her last exam one year ago but chose to update her prescription again to maintain her independence.

Eight months later B.D. returned to the clinic feeling her vision was poor again and affecting her ability to work on a computer. This time, even a new prescription would not sufficiently improve her vision, so she became eligible for cataract surgery, but the wait time would be 6 months. B.D. updated her lenses again so she could continue working and driving until her surgery.

Following her surgery B.D. could see to drive without glasses but required glasses for reading and working on a computer, so she had to update her lenses for a third time.

B.D's insurance covers 100% of reasonable and customary expenses every two years for an eye exam and up to $600 for prescription frames and lenses. Her expenses, including two of the eye exams and two of the sets of lenses were not covered by insurance. The third exam and prescription change fell into a new two-year window, so her expenses were covered at that time.

Out-of-pocket costs – $1,374

About

C.T. is a 50-year-old male who works in Human Resources. Despite years of dry eye therapies involving eye drops, omega-3 and hot compresses he still suffers from blurry and painful eyes when working on a computer.

Case Study 3
CHANGING VISION NEEDS IN A MODERN WORKFORCE

To diagnose and treat C.T.'s condition, an optometrist measured the osmolarity of his tear film, conducted infrared imaging of his oil glands, and analyzed tear production and video documentation of his blink rate and tear film. His optometrist identified that C.T. had poor oil gland function and treatment would require iLux treatment to heat and express the meibomian glands. This included a Blephex treatment to clean the eyelids and remove any blockages followed by the iLux device that heats end expresses oils from the upper and lower eyelids. C.T.'s vision and comfort were substantially improved by the treatment, but he may require additional treatment in 6-8 months.

Out-of-pocket costs – $600
Because C.T. had an eye examination and needed new progressive glasses the year prior, his insurance coverage was exhausted. C.T. paid $150 for his initial consultation and $450 for the Blephex and iLux treatments for a total of $600 spent 100% out-of-pocket.

Effective control of dry eye conditions often associated with extended computer use, requires regular monitoring and treatment resulting in substantial potential out-of-pocket expenses. Ensuring employees have adequate coverage to manage workplace related vision expenses requires new approaches to vision care benefits.

REDUCE COSTS OF POOR VISION TO PLAN SPONSORS

In addition to the value of improving plan member satisfaction with their vision benefits, plan sponsors should be similarly keen to enhance vision benefits. This is because poor vision costs plan sponsors directly: Plan members with sub-optimal vision incur direct costs for their plan sponsors when they access other types of claims caused by sub-optimal vision (e.g. prescription drugs, absence, short- and long-term disability, chiropractic and massage care). Studies have shown preventative care for vision loss is cost effective as patients with vision loss have higher non-eye related medical costs than those without vision loss.[18]

Poor vision also costs employers indirectly: It affects employee productivity, presenteeism, absenteeism and mental health. The Canadian National Institute for the Blind estimates productivity costs related to vision loss costs the economy $4.4B annually.[7] In 2016 nearly 1 million Canadians missed work or school because of vision problems[8] and a survey of American adults found a shocking 90% reported that visual disturbances are negatively impacting their work[19]. Employees with vision loss are likely to be less productive, have higher absenteeism and retire earlier than other employees.[18]

It is an employer's responsibility to provide a safe and comfortable workplace. Appropriate vision care can prevent workplace injuries and deterioration of vision caused by eye strain from work activities (e.g. extended screen use). Ensuring plan members access vision care services consistent with the standard of care can mitigate direct and indirect costs of poor vision to the plan sponsor, yet vision care benefits often fall short of the standard of care. Modernizing plan designs can optimize the value of vision benefit plans not only for the plan member, but for the plan sponsor as well.

CONCLUSIONS

> **Plan members and sponsors stand to benefit greatly from fundamental changes to vision care plan design. By collaborating with the CAO, private healthcare stakeholders can develop vision care plans that close the gaps with the standard of care and deliver value for both plan members and sponsors.**

Vision care has been a valuable core component of most extended healthcare plans for decades. However, current plan designs are out of step with changing needs, out of date with current clinical practice and overdue for significant change. PDCI's research indicates vision care spending through group benefit plans is significantly underfunded compared to other health benefits and there is tangible dissatisfaction with vision care coverage from both plan members and plan sponsors, in large part due to substantial out-of-pocket costs. Addressing high out-of-pocket costs and improving coverage for specialty vision care diagnostic services and non-elective interventions should be central to any reforms aimed at improving plan member satisfaction.

Achieving change and improving coverage will require innovative new plan design solutions. Plan sponsors, advisors and insurers will need to commit to fundamental changes in how plan design is approached. To be sustainable in the future, changes to vision care coverage will need to consider overall cost concerns across all benefits (such as dental, pharmaceutical, extended health) and look to reallocating existing dollars to new services. This reallocation may be achieved by implementing co-pays for some services and products, particularly frames and lenses, and providing greater access to medically necessary services, including new diagnostics and interventions. Reform efforts should engage plan members and the CAO to ensure design changes meet the changing employee needs and current standards of clinical practice mentioned earlier in this report.

Failure to ensure vision care services keep pace with clinical needs and advances in treatment will place plan members at greater risk of poor eye health and vision impairment. It will also risk that dissatisfaction with vision care benefits will continue grow. Without new, innovative solutions to reform vision care coverage, the out-of-pocket burden on plan members who need the coverage the most is expected to rise further. This increasing cost burden on individuals raises the potential for negative health effects as plan members may avoid personal costs for services needed.

Making vision care exams, diagnostics and interventions more accessible and affordable, will have a direct positive impact on plan member satisfaction, maintaining or improving health and productivity, presenteeism. While this may increase some out-of-pocket expenses for those with less acute vision care needs, particularly those who may choose to purchase new frames and lenses without a change in prescription, those who require a change in prescription every 24 months, will be provided with a higher level of reimbursement. This shift in the balance of benefits coverage to more advanced diagnostics and interventions represents a better investment of plan sponsor vision care dollars.

The emergence of new diagnostics and interventions to treat eye conditions and the complications of chronic disease, make a strong business case for plan sponsors to review vision care benefits for these groups. Four factors need to be considered:

1. **Provincial coverage:** Some but not all provinces provide enhanced vision benefits for those with visual impairments and those with disease related vision risks

2. **Bridging the gap:** Plan members look to their benefit plan for reimbursement of medically necessary examinations, diagnostic services and treatments not covered by provincial healthcare plans

3. **Evolving standards of care**: As these evolve over time, including new diagnostics and interventions in group vision plans are part of this process

4. **Early detection and treatment** of chronic eye diseases and other chronic diseases identifiable through new diagnostic procedures, will make these diseases easier to manage and result in better long-term vision and healthcare outcomes for plan members.

Some stakeholders may see a role for HSAs to address the need for additional vision benefits, however transferring the benefits burden for vision care to an HSA, where vision would be

competing for reimbursement among other benefits, will marginalize the importance of vision care and rather than increasing it, and is likely to exacerbate already limited access to necessary services and the already low member satisfaction with overall benefit plan design.

The workplace and workforce have changed and will continue to do so and the role of vision care to address these changes has been largely overlooked. Vision impairment in the workplace will become more pervasive both as our workforce ages and as screen use makes up a greater portion of our workday. Vision benefits must also change to accommodate our workforce, the way we work today and to mitigate its ill effects on vision and eye health. In recent years vision care plans have not changed to meet the changing needs of plan members or recognize the clinical advances in vision care diagnostics and interventions but opportunities for change lie ahead.

RECOMMENDATIONS

This research has highlighted important opportunities to both reform vision benefits while also managing costs. Specific opportunities to reform vision care benefits to enhance value for both plan member and sponsors include:

1. **Ensuring coverage for comprehensive routine eye examinations** so they occur at the frequency consistent with CAO recommendations for plan member age and risk factors in provinces without public coverage (this means both allowing exams at the appropriate frequencies, and also funding exams at the reasonable and customary fee levels appropriate by province across the country to eliminate or substantially reduce out-of-pocket costs for plan members).

2. **Ensuring access to additional diagnostics and interventions** at reasonable and customary amounts by province every 24-months.

3. **Modifying plans to include coverage for additional exam, diagnostics, interventions** and vision care benefits for frames and lenses within twenty-four-months when medically indicated based on clearly identifiable criteria.

4. **Providing frames and lenses benefits** while considering implementing coinsurance so that members pay a portion from first dollar. In this way those who need the benefit the most receive a higher overall percentage of reimbursement.

It is recommended that insurers, plan sponsors and advisors work with the optometry profession to develop a new framework for vision care benefits. Recognizing that introducing fundamental change to vision care design will be challenging, the Canadian Association of Optometrists and its provincial partners, in collaboration with PDCI, have embarked on a Best Practices Guide to Vision Benefits to inform this process. A selection of industry stakeholders will be asked to provide their input to finalize the Guide prior to its release in Spring 2020. The Association welcomes dialogue with and input from all stakeholders as it works to facilitate fundamental reform to the vision care landscape in Canada that will improve value for plan members and sponsors alike.

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GLOSSARY OF TERMS

Advisor – is a consultant or insurance broker engaged by a plan sponsor to provide expert advice in the selection, ongoing management and renewal of a contract/agreement with a private payer. They are compensated on a fee for service or commission basis.

Broker – is a licensed advisor usually compensated through commissions paid by the private payer for their services.

Consultant – is a licensed advisor usually compensated on a fee for service basis by the plan sponsor.

Plan Member – individual who is enrolled and eligible for reimbursement under an employer, association or trusteed plan. This can include the primary individual enrolled under the plan, their spouse and dependent children.

Plan Sponsor – an employer, association or trusteed plan who has entered into a contract/agreement with a private payer to adjudicate claims for a list of services and products based on specific eligibility criterion.

Private Healthcare Stakeholders – is a collective term for advisors, brokers, consultants, private payers and plan sponsors.

Private Payer – is an insurance company or other third-party payer that has a contract/agreement with a plan sponsor for adjudicating claims for a list of services and products based on a specific eligibility criterion.

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