

NONGOVERNMENTAL THIRD PARTY VISION CARE PAYMENT PLANS

OPT 532: Socioeconomic, Legal and  
Professional Aspects of  
Optometry

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Definition:

"The term party payor refers to a 'third party' - other than the provider or the receiver of the service - who assumes responsibility for payment for part or all of the services rendered."<sup>1</sup>

Introduction:

Third party vision care payment plans have become increasingly more popular in recent years, especially since the inclusion of such benefit plans in the UAW benefit packages in 1977. Since their introduction, these benefit packages have had a dramatic effect on the optometric profession and its established mode of practice. The initial reaction to these plans was generally negative as many optometrists considered third party plans to be an intruder between the O.D. and his patient. However, it is becoming more evident that third party plans may become a boon to optometry.

The vision care industry now amounts to over \$4 billion annually, of which about \$1.745 billion are for optometric services and materials. About 20 percent of optometric practice is through third party care.<sup>2</sup> This means approximately \$350 million per year goes to optometry via third party. As more people become eligible for vision care benefits, this amount can be expected to rise dramatically.

The major push for vision care benefits has come from organized labor. There are two main reasons for this push. First, vision care benefits offer a unique service to the union member, and second, the benefit can be financially rewarding to both the member and the employer.

Vision care plans are unique for to utilize this health care benefit, one need not get sick or die. Since vision problems are among the most prevalent of all health disorders, it is a benefit which can be used by nearly all members. "The number or percentage of the population requiring vision care to maintain vision performance increases from approximately 12% at age 6 to 96% at age 70 -- for an overall 58 percent."<sup>3</sup> Since vision affects almost all aspects of life, vision care may improve one's ability to function in society. It is estimated that approximately one in every

four school-aged children require some form of vision care.<sup>4</sup> With the advent of vision care plans, many of these children, who might not otherwise receive the required care, may now, through professional vision care, be able to function in society at a higher level.

Vision care plans have financial rewards for both the employee and employer. The employee benefits by having vision care at little or no charge, while the employer benefits by tax-free benefits to the employee and increased productivity. Inadequate vision may prevent the worker from seeing well enough to do their tasks effectively or lead to fatigue causing loss of attention and alertness. A study by a major manufacturing company showed accidents were 20% higher in companies where employees did not receive vision care than in companies with regular professional vision care.<sup>5</sup> The prevention of accidents leads to lower Workman's Compensation premiums and lower operating costs to the company.

#### Third Party Care and the Optometrist:

Despite the initial complaints, third party vision care plans may prove to be a real advantage to the optometrist. One advantage is an increased patient load. In discussing a similar third party care plan, the American Dental Association found that pre-payment got more people into dental offices on a regular basis. There is no reason to believe the same would not happen in optometry.

Another advantage of third party care plans is increased cash flow in the office. By collecting benefit payments as the service is performed, the optometrist has access to those funds for investments or interest earnings. Also, since many plans pay the optometrist directly, the chances of nonpayment are reduced.

Third party payment plans also have several disadvantages. "Many optometrists, prospering in their individual practices denounce the concept as socialism, an encroachment on their practice and infringement of their freedom."<sup>6</sup> Indeed, many programs provide for program administrators to review patient records and limit the types of services and materials that may be provided. A second major disadvantage is that these plans often pay less for a service than the optometrist would receive otherwise. An optometrist with a busy practice may actually lose revenue as more patients become eligible for third party payment plans. It appears then, that the optometrist who is not working to capacity may benefit by an increased patient load at lower fees, while the busy optometrist may suffer from a decrease in income.

#### Vision Care Benefits:

Vision care plans differ in their scope and intent. To provide the best possible care to patients, a vision care plan should not restrict the optometrist in using any optometric service available. To do so would be a disservice to the patient. Unfortunately, many programs do limit the optometrist in practicing the full scope of optometry. It is important then that the optometrist understand each program prior to treatment and attempt to change those programs which go against the principles of professional optometry.

"Most plans provide for an examination once a year, lenses and frames either every year or every two years. Sunglasses are usually excluded, but are sometimes added, especially in construction industry plans because of the outdoor work. Besides these basic benefits, some vision care plans provide for the additional benefit of contact lenses, vision therapy and the correction of such conditions as strabismus and amblyopia."<sup>7</sup>

Fees:

In all types of vision care programs the benefit is usually limited to usual, customary and reasonable fee (UCR). The usual fee is that fee the optometrist charges most frequently for a given procedure. The customary fee is computed from the range of fees charged by other optometrists in a given locale. This fee is usually computed to include 90% of the fees charged in the given locale. The reasonable fee is that which differs from the usual or customary charges because of unusual circumstances. In essence, the UCR method provides for three possible amounts for covered services; the provider's charge, his usual charge as recorded from prior claims, and the customary charge determined by a provider's charge and those of his local peers. Generally, the amount paid is the lowest of the three.

Types of Third Party Vision Care Plans:

There are four basic types of third party care: (1) group practice, where a group of doctors contract to provide services on a stipulated fee for service or some type of monthly payment, (2) government care through federal, state, or local programs, (3) indemnity programs and (4) panel participation. The first two types are beyond the scope of this paper and will be discussed in other students' papers.

Indemnification Plans:

This type of plan is usually underwritten by insurance companies and at this time is the most popular of the non-governmental third party care plans. The most common method of payment is to reimburse the patient the optometrist's fee up to a maximum amount for the examination, an amount towards the cost of the lenses and a third amount towards the cost of the frame. The patient is required to pay the difference between the benefit

and the optometrist's fee.

Many optometrists like this method for they receive their usual and customary fees. This method also has the advantage of free choice for the beneficiary who can seek services from any optometrist and forward the bill to be reimbursed.

However, this plan may be short lived for several reasons. Under this plan, there are no standards for materials or professional services. The insurance companies underwriting indemnity programs are strickly in the business of writing a contract and paying a claim. If any problems arise, it is the patient's problem, not the company's. A second problem with indemnity programs is that often, if not always, the patient is required to pay the balance between the benefit amount and the actual fee. This may irritate some patients and one may find billings unpaid. This possibility may be reduced, however, by keeping records of the various plans, and then computing the difference between the benefit and the actual cost at the time the service is rendered. By requesting that the benefit payment be sent directly to the optometrist and billing the patient the computed difference, losses may be kept to a minimum. It is extremely important, however, that the patient realize adjustments may be necessary in case of error.

#### Vision Service Corporations:

"Vision Services Groups (VSG) or Vision Service Plan (VSP) are corporations or foundations designed to provide prepaid vision care to identifiable groups of people."<sup>8</sup> The group has a board of directors, most of whom are usually optometrists, and a paid manager who oversees the operation full-time. The service plan offers services as opposed to dollars. The vision service group is made up of a panel of optometrists who negotiate with some large groups of

people such as labor unions or school districts to provide vision services at an agreed monthly fee. When a member utilizes the service, the panel optometrist accepts the payment from the service plan as payment in full. The patient has no out-of-pocket expenses.

Any doctor licensed to practice may be on the panel of the Vision Service Corporation providing he meets the professional standards, agrees to abide by a very strict code of ethics, contracts to provide complete examinations and specific services of the highest quality, and completes a participating agreement binding him to: (1) abide by strict rules of practice; (2) use only top quality materials at laboratory costs approved by the Corporation's Standards Committee; (3) fulfill the clauses of prepaid contracts signed on his behalf; and (4) accept and adhere to the fee schedule established.<sup>9</sup>

Patients covered under such plans, wishing to utilize the service do so by filling out a pre-paid postcard in their benefit brochure and mailing it to the appropriate administrative office. The office mails the member a benefit form and a list of panel doctors in the patient's geographical area. The member selects a panel doctor and makes an appointment. The doctor verifies the identity of the patient and provides service in accordance to the contract. Payment is made by sending the completed benefit form to the appropriate administrative office. No money is collected from the patient. A percentage of the fee is withheld from the doctor's payment to maintain the administration of this non-profit organization.

This type of third party payment has several advantages over other programs. The vision service plan offers regular periodic examinations, thereby providing an avenue for preventative vision care. The panel list of doctors are from a wide geographic area making it easy for the patient to find a participating member near his home or business. Also, by providing



a list of panel optometrists the patient is free to choose the optometrist to provide the service. Since materials are provided at lab cost, there is no incentive to make the program an "Eye Glass" program. Finally, and perhaps most important to the patient and the profession, the program allows for peer review to maintain the highest quality of service.

The panel optometrist agrees to provide services at a predetermined fee. Almost always this fee is less than what he would normally receive for non-service plan patients. The panel optometrist is compensated for these lower fees by delivery of patients without recruiting expense, and assurance of payment without any credit or billing expenses or losses.

Information regarding the Vision Service Corporation may be obtained by writing to: Jack Gregory, 3583 Washenaw, Ann Arbor, MI 48104, telephone number 313-971-1990.

Local vision corporations are organized through the Vision Institute of America (VIA). This organization was formed in 1964 by optometrists as a non-profit corporation to bring vision care to the public on a group basis. The VIA does not provide vision care but acts as a national coordinating organization for local service corporations. It is panel members in these local service corporations who provide vision care services. The main objective of the VIA is to increase the availability of vision care to the public by promoting vision care pre-payment plans administered through non-profit service corporations. Recently the VIA has directed its efforts towards marketing and administration and functions to acquaint labor leaders, employers and other groups to the full service plan and its advantages.

#### Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan (BCBSM) recently began a vision care

plan which also promotes service. Under this plan, participating providers agree to accept payment from BCBSM as payment in full. The subscriber has no out-of-pocket expenses other than a co-payment as specified in his vision care certificate. All payments are made to the providers directly.

To be a participating provider the optometrist must agree to the following:

1. Charges made to BCBSM subscribers must be uniform with those charges made to the majority of provider's patients/customers for similar services/materials.
2. Accepts the reimbursement made by BCBSM for covered services as payment in full. This does not include subscriber liabilities for optional services and/or materials. The subscriber must be advised in advance of any extra expense for which he may become liable.
3. Submits BCBSM claim forms promptly on behalf of the covered person.
4. Makes available to BCBSM for pre-or post-payment review all relevant books, records, facilities, and equipment which BCBSM deems necessary to assure the appropriateness of its payment to the provider.
5. Maintains records of all claims submitted to BCBSM for a period of at least three years after date of claim payment.
6. Notifies BCBSM of any major changes in operation including, but not limited to, changes in location, services, ownership,

legal status, licensure, registration, or certification.

7. Does not advertise or otherwise hold himself as a participating provider, except as approved by BCBSM. BCBSM will provide a decal designating participation in the Vision Care Program for participating providers which may be displayed. In addition, if it is your practice to advertise, you may specify your participation with BCBSM but only by using the following statement: "          (name)           participates in the BCBSM Vision Care Program."
8. Accepts the concept of Peer Review and agrees to work within the recognized guidelines of its profession to assure self-regulation with respect to billing practices and quality care.
9. Must always collect the 20 percent subscriber co-pay on Vision Testing examinations in accordance with the contract specifications.

Optometrists not wishing to become participating providers may examine BCBSM subscribers and bill patients directly. The patient is in turn reimbursed by BCBSM but at only 60% the reasonable and customary charge for services and the lesser of 50% the usual charge or 75% the average benefit paid for covered lenses and frames to participating providers. This means the patient will be required to pay more for examinations performed by nonparticipating providers.

For participating providers, Blue Cross Blue Shield of Michigan provides benefits to cover 80% the usual and customary charges for examinations. The subscriber is responsible for the 20% co-payment to be collected by the

provider at the time the service is performed. Each exam shall include, but is not limited to:

1. History
2. External examination of the eye
3. Test visual acuity
4. Binocular measure
5. Ophthalmoscopic examination
6. Tonometry when indicated
7. Medication for dilating the pupils and desensitizing the eyes for tonometry, if applicable
8. Summary and finding.

This benefit is payable only once every 24 months.

Benefits under BCBSM provide for 80% of the dispensing and net acquisition costs for lenses and frames. Once again the subscriber is responsible for the 20% co-payment. The dispensing fee is the fee, predetermined by BCBSM, that compensates providers for dispensing lenses and/or frames and is determined by local surveys, local shopping programs, and discussions with optical labs, retail chains and the professions. The net acquisition costs consists of the total cost of the lens and/or frame to the provider charged by the lab. In the case of frames, however, a maximum net acquisition cost of \$12.50 will be covered. Other benefits covered by BCBSM include contact lenses when conditions exist such that spectacle lenses won't improve vision better than 20/70, and tints for therapeutic reasons. Once again, the subscriber must pay the 20% co-payment.

Information about the Blue Cross Blue Shield of Michigan may be obtained by writing to: Blue Cross and Blue Shield of Michigan, Providers Inquiry Services Department 1106, 600 Lafayette East, Detroit, MI 48226 or telephone 1-800-482-5141.

Involvement in Third Party Vision Care Plans:

The following guidelines were developed by the AOA to help the optometrist in making intelligent, independent decisions about being a provider to a particular plan.

1. The patient shall have freedom of choice concerning provider of service.
2. When a program provides reimbursement at the provider's charge - up to a maximum stated amount, the program should not discriminate between provider groups when payment is made for covered benefits as defined by the program. In claims administration, carriers should not develop differential screens based on provider classification.
3. Payments should provide equal payment or reimbursement to participating and nonparticipating providers as a means of enabling the beneficiaries to obtain quality care from the provider of their choice.
4. All legally qualified optometrists shall be eligible providers.
5. Provisions shall be made to assure the highest quality of both services and materials.
6. Peer review shall be the mechanism for maintaining standards.
7. Administrative requirements shall not usurp professional judgment of the practitioner in the right to render optimal care.
8. The cost of vision care should take into consideration accurate and current statistical data, and be subject to adjustment at reasonable intervals. Reimbursement should not act as a deterrent to high quality vision care.
9. Reimbursement policies for covered benefits shall differentiate between professional service fees and acquisition cost of materials.
10. The optimal vision care program would include the full scope of examination, diagnosis, and treatment of conditions of the visual system on an as-needed basis.
11. The optimal vision care program would provide for "paid-in-full" covered benefits.

Conclusion:

Because of rewards to both the employee and employer, third party vision care plans are one of the "hottest" benefits being offered in contract talks. Very few optometrists will escape the impact of these programs as more people become eligible for these benefits. It is important then that the optometrist understand how these programs operate. It is also important that optometry becomes involved in promoting the highest professional standards in third party vision payment plans in preparation of a national health insurance program.

1. How is payment to non-participating optometrists and ophthalmologists?
2. How is payment to participating providers?
3. How is payment to participating providers based on UCR or on a fee schedule? If so, what is the UCR fee schedule?
4. How is payment to participating providers based on UCR or on a fee schedule? If so, what is the UCR fee schedule? Is this different from item 3?
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FOR TREATMENT MATERIALS

1. How is payment to optometrists, ophthalmologists, and opticians?
2. How is payment to participating providers?
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# Third Party Payment Plan for Vision Care

## Program Profile

Program \_\_\_\_\_  
(subscriber group)

Type \_\_\_\_\_  
(service benefit or indemnity)

Administrator \_\_\_\_\_

Underwriter \_\_\_\_\_

Local Representative \_\_\_\_\_

I do \_\_\_\_\_ do not \_\_\_\_\_ participate

*FOR THE EXAMINATION* — My UCR \_\_\_\_\_

"Does it . . ."

- \_\_\_\_\_ 1. Pay similar fees for similar procedures to any provider licensed to perform those procedures?
- \_\_\_\_\_ 2. Provide payment to both optometrists and ophthalmologists?
- \_\_\_\_\_ 3. Have a panel of participating providers?
- \_\_\_\_\_ 4. Publish and/or distribute a list of names of participating providers?
- \_\_\_\_\_ 5. Pay participating providers based on UCRs or on a fee schedule?  
If so, what is the UCR \_\_\_\_\_ fee schedule? \_\_\_\_\_
- \_\_\_\_\_ 6. Reimburse subscribers for procedures performed by non-participating providers?
- \_\_\_\_\_ 7. Reimburse subscribers for procedures performed by non-participating providers on UCRs or on a fee schedule? If so, what is the UCR? \_\_\_\_\_ fee schedule? \_\_\_\_\_ Is this different from Item 5?
- \_\_\_\_\_ 8. Have a co-pay/deductible provision?  
If so, how much? Co-pay \_\_\_\_\_ deductible \_\_\_\_\_
- \_\_\_\_\_ 9. Prohibit any waiver of any applicable co-payment?
- \_\_\_\_\_ 10. Provide coverage for contact lenses? If so, how much? \_\_\_\_\_

### *FOR TREATMENT MATERIALS*

"Does it . . ."

- \_\_\_\_\_ 1. Provide payment to optometrists, ophthalmologists, and opticians?
- \_\_\_\_\_ 2. Have a panel of participating providers?
- \_\_\_\_\_ 3. Have adequate payment provisions for treatment which might be determined to be necessary as a result of the examination?
- \_\_\_\_\_ 4. Reimburse subscribers for professional services and materials received from non-participating providers?  
If so, how much? Frames \_\_\_\_\_ Lenses \_\_\_\_\_

- 5. Pay participating providers based on UCRs or on a fee schedule?  
If so, my UCRs are: Frames \_\_\_\_\_ Lenses \_\_\_\_\_  
fee schedule: Frames \_\_\_\_\_ Lenses \_\_\_\_\_
- 6. Differentiate professional service from acquisition costs?  
If so, my UCRs for: Frames \_\_\_\_\_ Lenses \_\_\_\_\_
- 7. Have a co-pay/deductible provision?  
If so, how much for frames? \_\_\_\_\_ for lenses? \_\_\_\_\_
- 8. Prohibit any waiver of any applicable co-pay/deductible?
- 9. Allow the subscriber to choose, and pay for personally, all or part of the cost of treatment materials which are not a covered benefit?  
If so, method \_\_\_\_\_
- 10. Have a list of approved laboratories?  
If so, labs in my area are: \_\_\_\_\_
- 11. Have provisions for obtaining materials from non-approved labs?

**GENERAL QUESTIONS**

"Does it..."

- 1. Have provisions for true peer review?
- 2. Have a fee grievance mechanism?
- 3. Have certain limitations on the frequency with which the examination and required treatment are covered benefits?  
If so, limit for exam?  
for materials? Frames \_\_\_\_\_ Lenses \_\_\_\_\_
- 4. Have a procedure for establishing subscriber eligibility?  
If so, how? \_\_\_\_\_
- 5. Require a participating provider to allow audits of office records?
- 6. Have a standard claim form that is easily completed?  
If so, attach to back.
- 7. Require a fee for becoming a participating provider?  
If so, how much? \_\_\_\_\_

**NOTES**

Tear out & file



**BLUE CROSS AND BLUE SHIELD OF MICHIGAN  
VISION CARE PROGRAM  
PARTICIPATION AGREEMENT**

\_\_\_\_\_ hereby registers as a Participating  
(Name) (Title)  
\_\_\_\_\_ under the service plans of Blue Cross and Blue Shield of  
(Type of Provider)  
Michigan (BCBSM) and agrees to serve its Members and to accept payment for covered  
services in accordance with the terms of the Member's contract and the BCBSM Vision  
Care Manual in force at the time of service.

This agreement may be terminated at any time by either party upon sixty (60)  
days written notice to the other party.

The office address to which all communications from BCBSM are to be sent is  
(please type or print):

_____	_____
Name	License No. (if any)
_____	_____
Street	Social Security No. or IRS Identification No.
_____	_____
City Zip County	
_____	
Signature	
_____	
Title	
_____	
Date	

\_\_\_\_\_  
Authorized Signature or Stamp to be used on all claims submitted.

NOTE: For multiple locations, authorized signatures or identification numbers please  
attach supplemental sheet.

Exhibit 2-1: BCBSM VISION CARE PROGRAM PARTICIPATION  
AGREEMENT

FOOTNOTES

1. Koch, David A., "Vision Care Benefit Programs - An Optometric Interpretation", Optometric Monthly, Vol. 69, No. 5, Feb. 78, pp. 74.
2. Myhre, Alden G., "Learning to Love Third Party Care", Optometric Management, Vol. 14, No. 11, Nov. 78, pp. 29.
3. Taylor, Paul B., Optometry in Third Party Programs, American Optometric Association, Sept. 1977, pp. 1.
4. Ibid, pp. 1.
5. Ibid, pp. 1.
6. Schmidt, Leonard J., "Progress Report in Vision Service Plans", Optometric Management, Vol. 12, No. 7, July 1976, pp. 28.
7. Atwood, Robert C., "The Case for Full Vision Insurance", Optometric Management, Vol. 12, No. 7, July 1976, pp. 24-25.
8. "Vision Service Groups", AOA Information Kit, 1977-78, pp. 50-51.
9. Beachler, Fred L., "Vision Care: America's Only Tangible Benefit", The Southern Journal of Optometry, Oct. 1969, pp. 11.

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- Bennett, Irving, "The Group Vision in Your Future", Optometric Management, Vol. 12, No. 7, July 1976, pp. 35-42.
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- "Vision Service Group", AOA Information Kit, 1977-78, pp. 50-51.