AMERICAN OPTOMETRIC ASSOCIATION

Local Patients, Doctors, and Communities Urge Congress to Address Costly, Controlling, and Care-Limiting Vision Benefit Manager (VBM) Steering and Self-Dealing

Key Provisions of the DOC Access Act (H.R. 1521)/Vision Lab Choice Act (S. 1716) Target VBM Mandates Requiring Patients Purchase VBM-Owned Optical Lab Products and Services, Would Push VBMs to Compete on Cost, Quality, and Wait Times

The Issue: Millions of American families and their local communities are suffering under an abusive vision benefits market - rising prices, diminishing access to needed care, and a loss of health care decision-making stemming from a vision benefits market that is highly concentrated and vertically integrated. Two dominant Vision Benefit Managers (VBMs) control more than 85% of vision coverage in America and are housed within larger vertically integrated conglomerates that manufacture nearly all eyeglass frames and lenses – nearly all of it made in China, own, operate, or direct most optical laboratories, control a vast network of optical retail and vision services outlets, are quickly acquiring independent eye care practices, and much more. These VBMs use their coverage dominance to force lopsided agreements on local doctors - setting prices, limiting patient and doctor choice to only the products the VBM makes and the services the VBM owns and operates, and are increasingly using their market power to dominate and eventually acquire the one source of competition the dominant VBMs still face - local eye care practices.

What Would Key Provision of H.R. 1521/S. 1716 Do: Based on provisions of the widely supported DOC Access Act (H.R. 1521) and mirroring the full language of the Senate's broadly supported Vision Lab Choice Act (S. 1716), VBM reform language Congress is advancing is solely focused on steering and self-dealing abuses of vision benefit plans. This language complements VBM reform laws in nearly 25 states and is needed because those state laws do not apply to federally regulated plans. VBM reform language would:

- ✓ **Prevent VBM steering and self-dealing** by giving patients and their doctors the freedom to choose the optical laboratory that works best for them, based on cost, quality, and timeliness. Right now, dominant VBMs require that patients and doctors pay to use the optical lab owned or controlled by the patient's VBM, leading to higher prices, inferior production, and longer than necessary wait times. Patients and doctors would still have the option of choosing the VBM-owned lab if that proved the better option.

- ✓ **Addresses Never-Ending "Evergreen" Agreements.** Most VBM-doctor agreements are not renegotiated after first being signed and then are considered "evergreen" – meaning the agreement never expires. The plans often add new requirements via an addendum, but the doctor rarely has an opportunity to renegotiate. Advancing VBM reform language would set plan-doctor agreements to two years, unless the doctor agrees to extend as-is. This provision is needed to ensure application of the lab freedom of choice provision to the original agreement, otherwise any new lab choice provision would only apply to new agreements.

- ✓ **Preserves state authority** by maintaining state jurisdiction over health insurance issuers and limited-scope vision benefit plans directly governed by state law and preserves applicable state requirements where they conflict with the federal provisions.

Why It Matters: The vision benefits market is highly concentrated and vertically integrated. Two vertically integrated Vision Benefit Managers provide vision coverage to nearly 200 million Americans while also maintaining significant interests across eyewear manufacturing, optical laboratories, retail optical locations, and vision care delivery. **Vertical integration creates opportunities for anti-competitive steering and self-dealing.** Dominant vision plans can use their position administering benefits to direct patients and providers toward affiliated laboratories, products, and services—limiting competition, consumer choice, and raising prices. **Patients deserve greater choice and affordability.** Allowing patients and their doctors to select laboratories and suppliers based on cost, quality, and convenience can promote competition, improve service, and help address higher costs and unnecessary delays in receiving prescription eyewear. **Communities deserve doctors fighting for what's best for patients, not controlled by corporate middlemen mandates.** VBM reform language helps ensure doctors have greater freedom to make decisions that serve their patients rather than being locked into a vision plan's affiliated supply chain or long-term contractual arrangements.

What Supporters Are Saying: Advancing VBM reform language is broadly supported by patient and consumer advocates. Two leading national organizations, the **National Consumers League**, the nation's oldest consumer advocacy organization, and **Patients Rising**, a leading national patient advocacy organization dedicated to advancing patient access to affordable, high-quality health care, have told Congress that "for years, our organizations have raised concerns about the growing consolidation and vertical integration occurring throughout the health care marketplace. Nowhere is that trend more evident, or more harmful than in the vision insurance market, where VBMs increasingly control nearly every aspect of the patient experience, often at the expense of transparency, affordability, competition, provider independence, and consumer choice… **For that reason, we strongly support the targeted vision insurance reforms recently offered by Representatives Buddy Carter and Yvette Clarke/S. 1716."**

What About Concerns That Changes Could Lead to Increased Premiums? The National Association of Vision Plans (NAVCP) - the VBM trade association - has touted that VBM premiums have not risen anywhere near the rate that inflation or health insurance premiums have increased. According to NAVCP's own data, vision care premiums have risen by 5% since 2016. Overall inflation is up 36% since 2015 (Bureau of Labor Statistics, CPI) and health insurance family premiums are up 54% since 2015 (KFF Employer Health Benefits Survey). **Vision plans have stayed dramatically more affordable than the rest of the health care system — even as lab choice and other VBM reform laws have addressed VBM abuses on the state level.**

Impact on Federal Spending: While the Congressional Budget Office has not yet completed its formal analysis of the advancing VBM reform language, data from similar laws passed on the state level were scored by state level legislative score keepers and nearly all **concluded that VBM reform legislation would have "no estimated fiscal impact."**

Bottom Line: This bipartisan reform promotes **transparency, competition, patient choice, and affordability** in one of the most concentrated segments of the health care market. It ensures that vision care decisions are driven by the needs of patients and their doctors—not the business interests of vertically integrated corporate middlemen.

April 16, 2026

The Honorable John Thune
Senate Majority Leader
United States Senate
511 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Schumer
Senate Minority Leader
United States Senate
322 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Mike Johnson
Speaker of the House
U.S. House of Representatives
521 Cannon House Office Building
Washington, D.C. 20515

The Honorable Hakeem Jeffries
House Minority Leader
U.S. House of Representatives
2267 Rayburn House Office Building
Washington, D.C. 20515

RE: *Vision Benefit Manager Reform is Needed Now – S. 1716 and H.R. 1521*

Dear Leader Thune, Leader Schumer, Speaker Johnson, and Leader Jeffries,

We are writing today on behalf of millions of American consumers and health care patients as respective leaders of the National Consumers League, the nation's oldest consumer advocacy organization, and Patients Rising, a leading national patient advocacy organization aimed at advancing patient access to affordable, quality health care.

We have long expressed concerns about harm to patients and consumers stemming from growing consolidation and vertical integration in the health benefits market, and we are increasingly concerned with the costly and controlling abuses of Vision Benefit Managers (VBMs) - entities which are arguably more horizontally consolidated, vertically integrated, and abusive to patients and consumers than even the Pharmacy Benefit Managers Congress has already taken action to reform.

As outlined in a 2026 Government Accountability Office report, the VBM market is highly concentrated. In some states, the three largest VBMs control as much as 95.5% of the employer-based market, with a single plan controlling more than 80% in certain states. Even at the median level nationwide, the three largest VBMs control more than three-quarters of the group market. In the individual market, concentration is even higher – reaching as much as 98.8% market control by the three largest plans in some states.

The VBM market is also increasingly vertically integrated. The two largest VBMs manufacture or license nearly all eyeglass frames and lenses on the market – all made overseas. They now own or control nearly all optical laboratories that produce finished prescription eyewear, they own and operate thousands of vision retail locations across the country that employ doctors and sell medical devices and other materials they manufacture, they operate vast patient data collection, surveillance, and marketing platforms that push patients away from independent eye care practices

and toward entities they own or fully control, and they are now acquiring independent eye care practices at an astonishing rate. VBMs use their market dominance to push contracts on eye care practices not yet under their full control that harm future practice viability and force them and their patients to buy the products the VBMs make and use the services they own and operate.

Bipartisan momentum for legislation to take back control from abusive VBMs is not only growing, it is already significant. More than 20 U.S. Senators already support S. 1716, and more than 115 U.S. House members support H.R. 1521 – representing more than a quarter of that chamber. This level of bipartisan, bicameral support places these pro-patient, pro-consumer bills among the most broadly supported healthcare policy proposals currently before Congress. The time to act on this legislation is now.

For patients and consumers, vision care should be simple and transparent. Patients should be able to access the provider of their choice, understand their benefits, and trust that care decisions are guided by medical need – not VBM dictates. However, the increasing influence of VBMs, particularly in a market increasingly dominated by consolidated and vertically integrated vision benefits behemoths, can limit choice, reduce transparency, and introduce significant barriers that patients and consumers often do not see until they are directly impacted.

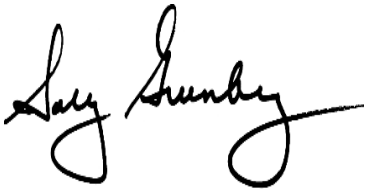
Patients and consumers are increasingly encountering restrictions on where they can receive eye and vision care services, confusion about coverage and costs, and a lack of clarity around how decisions are made within and by their VBM. These challenges are especially concerning at a time when affordability and access remain top priorities for working men and women, seniors, and families across the country.

This legislation offers a targeted and pragmatic path forward. It is designed to restore transparency, reinforce patient choice, and ensure that clinical decisions remain centered on patients and their providers rather than influenced by conglomerate structures that may not align with patient and community interests.

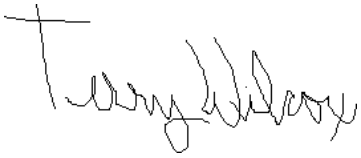
Importantly, Congress has already done the hard part by building substantial bipartisan support. What remains is the willingness to act on that support. Failure to advance legislation that has garnered this level of consensus risks sending a message that even broadly supported, patient-focused reforms cannot move forward.

We therefore urge congressional leadership and the relevant committees to prioritize these reforms and move them forward without delay, including consideration as part of any forthcoming health care legislative package. The breadth of support in both chambers makes clear that this issue is ready for action. Patients and consumers across the country expect a health care system that is transparent, fair, and centered on their needs. We stand ready to work with you to ensure these reforms are enacted.

Sincerely,



Sally Greenberg
Chief Executive Officer
National Consumers League



Terry Wilcox
Co-Founder & CEO
Patients Rising

119TH CONGRESS
1ST SESSION

S. 1716

To amend title XXVII of the Public Health Service Act to improve health care coverage under vision plans, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 12, 2025

Mr. CRAMER (for himself, Mr. MURPHY, and Mr. MULLIN) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To amend title XXVII of the Public Health Service Act to improve health care coverage under vision plans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Vision Lab Choice Act of 2025''.

SEC. 2. IMPROVING HEALTH CARE COVERAGE UNDER VISION PLANS.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act is amended by inserting after section 2719A (42 U.S.C. 300gg–19a) the following new section:

"SEC. 2719B. IMPROVING COVERAGE UNDER VISION PLANS.

"(a) IN GENERAL.—With respect to a group health plan or individual or group health insurance coverage that provides benefits for items and services relating to vision care (including such a plan or coverage that offers limited scope vision benefits), the following shall apply:

"(1) DURATION OF LIMITED SCOPE VISION PLANS.—In the case of a doctor of optometry who has an agreement or is the beneficiary of an agreement with respect to a group health plan or health insurance coverage that offers limited scope vision benefits—

"(A) the term of the initial agreement shall be not longer than 2 years;

"(B) the agreement may be extended with the prior acceptance by such doctor for each such term extension, and any such extension may be for a term not longer than 2 years; and

"(C) the agreement may be extended for unlimited terms, subject to subparagraph (B).

''(2) NO RESTRICTIONS ON CHOICE OF LABORATORIES AND SOURCES AND SUPPLIERS.—A group health plan or health insurance issuer offering such coverage may not, directly or indirectly, restrict or limit a doctor of optometry described in paragraph (1) with respect to choice of laboratories, or choice of source or supplier of services or materials provided by the doctor to an individual who is enrolled under the plan or coverage.

''(b) NOTIFICATION.—The Secretary shall on an annual basis notify each State of the State's authority to enforce the provisions of subsection (a) against a group health plan or a health insurance issuer offering health insurance coverage described in subsection (a) pursuant to section 2723(a)(1) and request confirmation from the State whether or not the State will enforce the provisions of subsection (a). If a State notifies the Secretary that the State will not enforce the provisions of subsection (a) or fails to respond within 90 days of the Secretary's request, the Secretary shall treat such State as failing to substantially enforce such provisions for purposes of subsections (a)(2) and (b) of section 2723.

''(c) DEFINITION.—In this section, the term 'doctor of optometry' means a doctor of optometry who is legally

authorized to practice optometry by the State in which the doctor so practices.''.

(b) CONFORMING AMENDMENT.—Section 2722(c)(1) of the Public Health Service Act (42 U.S.C. 300gg–21(c)(1)) is amended by inserting ''(other than the requirements under section 2719B)'' after ''section 2791(c)(2)''.

(c) EXCLUSIVE APPLICABILITY OF STATE LAW.—Notwithstanding any amendment made by this Act, State law that directly affects any standard or requirement relating to health insurance issuers and vision benefit plans, shall have exclusive application and the amendments made by this Act shall not apply to the extent that such State law conflicts with such amendments. The State shall retain exclusive jurisdiction over health insurance issuers and limited scope vision benefit plans that are directly governed by such State.

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