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March 4, 2026

The Honorable Pamela Beidle
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St., Annapolis, MD 21401 - 1991

Re: SUPPORT SB 795 "Health Insurance - Vision Benefits - Regulation of Insurers and Vision Benefit Managers"

The Opposition's Arguments and the Facts

VBM Argument: VBMs claim insurance premiums could go up as much as 30% if this bill passes:

Facts:

1. Texas, Oklahoma, Nevada, and Arkansas have recently passed similar legislation and there have been no reported premium increases while expanding provider networks and patient access.
2. Absolute worst case scenario – if an insurance plan premium is roughly \$10-12/month, a 30% increase is less than \$50 total for the entire year. That amount won't be a massive make or break for the average consumer.
3. The real cost driver is vertical integration allowing monopoly pricing. The threat of increased premiums is a red herring to scare legislators away from market reform. When major medical centers refuse to participate in VBM plans due to untenable contract terms, patients with complex conditions are forced to seek fragmented care across multiple uncoordinated locations, leading to duplicate testing, delayed diagnoses, and worse outcomes that cost the healthcare system far more than coordinated care would.
 - a. This bill doesn't increase premiums - it removes anti-competitive practices in an 85% concentrated market that fragments care, restricts patient access to quality providers, and drives up total healthcare spending through inefficiency.
4. It's ultimately up to the VBM how they want to absorb or pass on these costs. They have enough alternative business ventures that there should be ways for them to absorb some of the costs, but if they opt to pass the entirety onto their customers, that's their business decision. Optometrists haven't had a pay raise in the last 30 years while the Corporate entities have been massively profiting.

VBM Argument: VBMs state there is no reason that they shouldn't be able to be transparent about which practices/doctors provide discounts or better rates for their consumers on their Provider directories.

Facts: The online provider directories/doctor locators rank their doctors **not** by in-network/out-of-network and **not** by quality of care standards, but by how much you purchase annually into their company's other business ventures. All of the in-network providers have agreed to provide a certain subset of services, at a quality standard and can be kicked out of the network if not upholding, yet are underrecognized for not purchasing a certain separate line of services that is owned by the VBM.

Example: VSP has a "premier" status for providers, which ranks them higher on their doctor provider directory page. Doctors achieve this "premier provider" status PURELY by spending \$12,000 annually on the frame lines they own and using VSP's brand of lenses, Unity.



To rank a doctor as “premier” by only how much they’ve “paid to play” in support of that particular vertically integrated company is misleading to consumers about why they would choose one provider over another and decreases choice/competition as doctors are having to funnel patients to a certain subset of products just to continue being ranked higher by that plan.

This is equivalent to having a neighborhood “Best Of” ranking based on community votes, but allowing people to bypass the voting system and buy their way to the top spots.

VBM Argument: Providers can simply opt out of VBM networks.

Facts: Unlike other markets, providers cannot “just walk away.” In many Maryland communities, VBMs dominate the market. Patients have no alternative plan. Providers face ‘take it or leave it’ contracts. Providers have no realistic ability to negotiate or drop these plans without losing the majority of their patients. Opting out means patients lose access to local care. Rural clinics become financially unsustainable. This is why legislation is needed — to level the playing field and protect both patients and providers.

VBM Argument: VBMs reduce costs for patients and employers. VBMs negotiate lower prices, control utilization, and help keep premiums affordable for employers and consumers.

Facts: VBMs do not reduce the cost of care. They shift costs from insurers to providers; and from plans to patients who have copays, non-covered services and forced materials. There is no evidence that VBM savings are passed on to patients or employers in the form of lower premiums. In practice, VBMs:

- Restrict patient choice
- Mandate pricing below market value
- Increase administrative burdens and waste. SB795 streamlines contracting and communication.

Maryland employers already pay premiums; VBMs add middlemen costs, not savings. VBMs don’t lower costs – they redistribute them away from insurers and onto patients and small medical practices.

VBM Argument: Regulation will drive insurers/VBMs out of Maryland.

Facts: VBMs continue operating in states like Oklahoma, Texas, Nevada and Arkansas that have already passed legislation. Marylanders deserve the same protections.

VBM Argument: Vision care isn’t essential medical care. Vision benefits are ancillary or optional.

Facts: Vision exams detect diabetes, hypertension, glaucoma, and neurologic disease. Loss of vision directly impacts ability to work, safety, and independence. Medicare and Maryland Medicaid already recognize optometric services as “physician services” part of essential healthcare.

VBM Argument: VBMs already operate under sufficient regulation. Existing insurance laws are adequate.”

Facts: VBMs exploit regulatory gaps. They are neither insurers nor providers. Oversight is fragmented or absent. SB795 closes a known loophole. Transparency requirements exist in other benefit manager sectors.

VBM Argument: SB795 limits negotiation and removes discounts for patients.

Facts: SB795 protects open negotiation and bans deceptive ‘discounts’ only. It restores honest pricing and fair negotiations. Patients get honest, upfront pricing and more freedom of choice. SB795 doesn’t eliminate contracts – it ensures contracts don’t harm patients.

VBM Argument: SB795 eliminates data for claims.



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Facts: It only restricts unnecessary or invasive data collection. It actually protects privacy while maintaining claim efficiency.

VBM Argument: SB795 limits tiering and flexibility.

Facts: SB795 stops anti-competitive steering, not benefit design. It ensures fairness and employers keep flexibility.

VBM Argument: VBMs ensure quality and standardization. They improve care quality by setting uniform standards."

Facts: VBMs do not set medical standards – licensing boards and medical guidelines do. VBMs:

- Restrict exam time
- Dictate materials and labs
- Incentivize volume over quality

There is no evidence that VBM oversight improves clinical outcomes. Quality healthcare is delivered by licensed professionals, not benefit managers.

VBM Argument: VBMs protect against fraud and abuse. Their oversight prevents overutilization and unnecessary services.

Facts: Fraud prevention already exists through state licensing boards, insurance audits and federal Medicaid oversight. VBMs use "fraud" language to justify denials, retroactive clawbacks, and arbitrary documentation demands. These practices burden compliant providers and do not target bad actors.

VBM Argument: Restricts removing poor providers.

Facts: SB795 allows removal for material breach with due process. It protects integrity and fairness.

Truly yours,

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