



Statement for the Written Record  
from the

**Independence Through Enhancement of Medicare and  
Medicaid (ITEM) Coalition**

**Special Committee on Aging  
United States Senate**

Hearing on:

“Eyes, Ears, and Teeth: Expanding Medicare to Cover Whole  
Person Care”

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## *Chairman Casey, Ranking Member Scott, and Members of the Senate Special Committee on Aging:*

On behalf of the Independence Through Enhancement of Medicare and Medicaid (ITEM) Coalition, and particularly our members serving individuals with visual impairments and the providers who treat them, we appreciate the opportunity to submit this statement for the record regarding the Committee's upcoming hearing on expanding the Medicare program. We are grateful for the Committee's attention to the important issue of addressing gaps in basic health coverage for Medicare beneficiaries. **As your offices and the rest of Congress continue to develop future legislation regarding Medicare expansion, we urge you to consider the needs of individuals with low vision and to include specific language advancing coverage for important assistive technology to address these conditions.**

The ITEM Coalition is a national consumer- and clinician led coalition advocating for access to and coverage of assistive devices and technologies for persons with injuries, illnesses, disabilities, and chronic conditions of all ages. Our members represent individuals with a wide range of disabling conditions, as well as the providers who serve them, including such conditions as low vision and visual impairments, hearing and speech impairments, multiple sclerosis, paralysis, spinal cord injury, cerebral palsy, brain injury, stroke, spina bifida, myositis, limb loss, and other life-altering conditions.

### **Low Vision among Medicare Beneficiaries**

Low vision and blindness significantly impact Medicare beneficiaries, as well as the general population. In fact, low vision has been noted as one of the most prevalent causes of disability across the country. Low vision is typically defined (using the World Health Organization's International Classification of Functioning, Disability, and Health) as a best-corrected visual acuity (BCVA) of less than 20/60.<sup>1</sup> Legal blindness is defined as a BCVA of 20/200 or less.<sup>2</sup>

Recent analyses of data from the National Health and Nutrition Examination Survey (NHANES) demonstrate the breadth of the impact of low vision in the United States. Among older adults, there were 1.48 million individuals with low vision or worse in 2017. When examining populations of all ages, there were nearly 1.85 million individuals with low vision in the same year.<sup>3</sup> This represents a significant burden among the Medicare population, and it is critical to take into account the significant portion of the Medicare population that is under 65 (approximately 15% of all beneficiaries), including those with long-term disability and beneficiaries dually eligible for Medicare and Medicaid coverage; as well as the nation's seniors enrolled in the program.<sup>4</sup>

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<sup>1</sup> World Health Organization. International classification of impairments, disabilities, and handicaps: a manual of classification relating to the consequences of disease. Geneva, Switzerland: World Health Organization, 1980.

<sup>2</sup> US Social Security Administration. Disability evaluation under Social Security. 2.02 *Loss of central visual acuity*.

<sup>3</sup> Chan T; Friedman S; Bradley C; Massof R. Estimates of Visual Impairment, Low Vision, and Blindness in the United States. *JAMA Ophthalmol*. Doi: 10.1001/jamaophthalmol.2017.4655. Published online Nov. 2, 2017.

<sup>4</sup> Medicare Payment Advisory Commission (MedPAC): Health Care Spending and the Medicare Program: A Data Book, p. 22 (July 2020). [http://www.medpac.gov/docs/default-source/databook/july2020\\_databook\\_entirereport\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/databook/july2020_databook_entirereport_sec.pdf?sfvrsn=0).

Of course, the visually impaired population is not static; the prevalence of low vision and blindness is growing quickly, with approximately 480,000 new cases of mild low vision or worse, 180,000 cases of moderate low vision or worse, and 134,000 newly legally blind individuals each year.<sup>5</sup> By 2030, there are expected to be 2.45 million cases of low vision or worse; this number will continue to grow to nearly 3.3 million by 2050. The projected exponential growth in these conditions makes clear the growing need for services to treat low vision in the future, especially as the Medicare population continues to age.

### **Impact of Low Vision**

Reduced visual function impacts individuals' lives in myriad ways, reducing participation in activities of daily living, employment, and the community; decreasing individual safety and function, and reducing ability to manage other health conditions.<sup>6, 7, 8</sup> Clinical literature also suggests significant association between visual impairment and a variety of physical and mental comorbidities, including depression, social isolation, incidence of falls, and dementia.<sup>9, 10</sup> Appropriate vision rehabilitation, *along with effective devices and device training*, can mitigate much of this negative impact.<sup>11, 12, 13</sup> One recently published study noted the “significant” functional difficulty associated with age-related macular degeneration, a prevalent condition often addressed with low vision aids, resulting in physical impairment even when controlling for comorbidities.<sup>14</sup>

The safety risks of low vision include an inability to properly manage medications; patients with low vision are more than twice as likely to require assistance to manage prescribed medications. Difficulty with reading labels can also lead to misuse of products and difficulty with meal preparation.<sup>15, 16</sup> Low vision also seriously impacts independence, as difficulty with reading can

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<sup>5</sup> Chan, et al. Estimates of Visual Impairment, Low Vision, and Blindness in the United States.

<sup>6</sup> Hong T, Mitchell P, Burlutsky G, et al. Visual impairment and subsequent use of support services among older people: longitudinal findings from the Blue Mountains Eye Study. *Am J Ophthalmol* 2013;156:393-9.43.

<sup>7</sup> West SK, Munoz B, Rubin GS, et al. Function and visual impairment in a population-based study of older adults. The SEE project. *Salisbury Eye Evaluation. Invest Ophthalmol Vis Sci* 1997;38:72-82.44.

<sup>8</sup> Weih LM, Hassell JB, Keeffe J. Assessment of the impact of vision impairment. *Invest Ophthalmol Vis Sci* 2002;43:927-35.28.

<sup>9</sup> See, e.g., Court H, McLean G., et al. (2014). Visual Impairment is Associated with Physical and Mental Comorbidities in Older Adults: A Cross-Sectional Study. *BMC Med.* 12:181. Doi: 1001186/s12916-014-0181-7.

<sup>10</sup> Wood. J., Lacherez, P. et al. (2011) Risk of Falls, Injurious Falls, and Other Injuries Resulting from Visual Impairment among Older Adults with Age-Related Macular Degeneration. *Invest Ophthalmol & Vis Sci* 52 (5088-92). Doi: 10.1167/iavs.10-6644.

<sup>11</sup> Van Nispen RMA, Virgili G, Hoeben M, Langelan M, Klevering J, Keuen JEE, van Rens G. Low vision rehabilitation for better quality of life in visually impaired adults. *Cochrane Database of Systematic Reviews*. 2020.

<sup>12</sup> Lamoureux EL, Pallant JF, Pesudovs K, Rees G, Hassell JB, Keeffe JE. The effectiveness of low-vision rehabilitation on participation in daily living and quality of life. *Invest Ophthalmol Vis Sci*. 2007;48(4):1476-82.

<sup>13</sup> Binns AM, Bunce C, Dickinson C, Harper R, Tudor-Edwards R, Woodhouse M, et al. How effective is low vision service provision? A systematic review. *Surv Ophthalmol*. 2012;57(1):34-65.

<sup>14</sup> Mitchell W, Resnick H, Zebardast N. Age-related Macular Degeneration and Visual and Physical Disability in a Nationally Representative Sample from the United States. *Trans. Vis. Sci. Tech.* 2020;9(13):42.

<sup>15</sup> Feinberg JL, Rogers PA, Sokol-McKay D. Age-related eye disease and medication safety. *Ann Longterm Care* 2009;17:17-22.

<sup>16</sup> McCann RM, Jackson AJ, Stevenson M, et al. Help needed in medication self-management for people with visual impairment: case-control study. *BR J Gen Pract* 2012;62:3530-750.

decrease the ability to manage one's finances, for example, or conduct other crucial activities.<sup>17</sup> Appropriate vision rehabilitation can assist individuals with low vision to utilize devices to allow them to remain in or re-enter the workforce or participate in volunteer activities to support their communities.

These negative impacts of low vision also have far-reaching ripple effects on individuals with low vision. Multiple studies have demonstrated a strong relationship between visual impairment and falls, a notable risk for older Medicare beneficiaries, often contributing to nursing home and other institutional placements, as well as costly hospitalizations and other medical treatments.<sup>18</sup> Furthermore, difficulty participating in society, maintaining independence, accessing information, and ambulating safely and without falls can contribute to poor quality of life and diminished mental health.<sup>19, 20, 21</sup> It has been clearly established that individuals with vision loss have greater social isolation and increased depressive and anxiety disorders.<sup>22, 23</sup>

### **Use and Impact of Low Vision Aids**

Despite the wide-ranging impacts of low vision on individuals with visual impairments, there are in fact clinically indicated treatments that can improve individuals' functional capacity and address the effects of vision loss. Low vision devices are a separate and distinct category of assistive technology from traditional eyeglasses and contact lenses. Eyeglasses and contact lenses are used to correct or improve the vision of people with nearsightedness, farsightedness, presbyopia, and astigmatism. The lenses used in these more common items work to focus light more precisely on the retina to clear the field of vision as much as possible and are typically worn consistently throughout users' active time to assist in a variety of daily activities. Importantly, the ocular tissues of those who exclusively use conventional eyeglasses can be completely healthy.

In contrast, low vision devices are used specifically by individuals with visual impairments (visual disability) that *cannot* be corrected by conventional eyeglasses. These may include, but are not limited to, such devices as hand-held monitors, video monitors, magnifiers, minifiers, prisms, head-borne devices, and other items, as well as emerging technologies, that may alter the image size, contrast, brightness, color, or directionality of an object to enhance its visibility to the user. These tools are typically task-specific and often essential for individuals with low vision to live independently, productively, and safely. Users of low vision devices generally

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<sup>17</sup> Hassell JB, Lamoureux EL, Keeffe JE. Impact of age-related macular degeneration on quality of life. *Br J Ophthalmol* 2006;90:593-6.27.

<sup>18</sup> Wang JJ, Mitchell P, Cumming RG, Smith W. Visual impairment and nursing home placement in older Australians: the Blue Mountains Eye Study. *Ophthalmic Epidemiol.* 2003;10(1):3-13.

<sup>19</sup> White UE, Black AA, Wood JM, Delbaere K. Fear of falling in vision impairment. *Optom Vis Sci* 2015;92:730-5.38.

<sup>20</sup> Wang MY, Rousseau J, Boisjoly H, et al. Activity limitation due to a fear of falling in older adults with eye disease. *Invest Ophthalmol Vis Sci* 2012;53:7967-72.39.

<sup>21</sup> Ramulu PY, van Landingham SW, Massof RW, et al. Fear of falling and visual field loss from glaucoma. *Ophthalmology* 2012;119:1352-8.40.

<sup>22</sup> Chan EW, Chiang PP, Liao J, et al. Glaucoma and associated visual acuity and field loss significantly affect glaucoma-specific psychosocial functioning. *Ophthalmology* 2015;122:494-501.

<sup>23</sup> Wang JJ, Mitchell P, Smith W, et al. Incidence of nursing home placement in a defined community. *Med J Aust* 2001;174L271-5.42.

utilize the device only when participating in the activity that the device assists. The other ocular tissues of individuals with low vision are most often not healthy, that is, there is typically an eye disease creating the impairment or disability.

The benefits of low vision aids in aggregate are apparent and supported by longstanding clinical evidence. In 2009, researchers conducted a well-regarded review of the existing literature on the effectiveness of assistive technologies for low vision rehabilitation. The authors concluded: “The findings of our review indicated that optical devices (electronic and nonelectronic) are effective and accessible rehabilitation options. Moderately strong evidence indicates that electronic stand-mounted or handheld CCTVs can improve reading performance and are generally preferred by persons with low vision over standard nonelectronic optical devices. Simple nonelectronic magnifiers are still preferred by individuals when portability and cost may be an issue.”<sup>24</sup>

An array of clinical studies indicates the various benefits of the utilization of low vision devices, when paired with effective, evidence-based low vision rehabilitation services. One trial noted that integrating mental health services with low vision interventions, including the use of relatively inexpensive (< \$350 per person) low vision devices, was able to halve the incidence of depressive disorders in patients with age-related macular degeneration (AMD).<sup>25</sup> Another study demonstrated that visual rehabilitation, including device prescription and training, improved patients’ health-related quality of life, self-esteem, and mental health.<sup>26</sup>

It is clear that the provision of low vision aids, along with necessary training and services, can significantly impact the health of Medicare beneficiaries, and reduce the incidence of injuries and other conditions that are major common drivers of both negative health outcomes and high costs to the Medicare program. Unfortunately, many Medicare beneficiaries are unable to access these devices due to the longstanding gap in coverage that prohibits Medicare payment for these aids.

### **Current Status of Medicare Coverage for Low Vision Aids**

As outlined above, individuals with low vision and other vision-related impairments face significant obstacles in carrying out activities of daily living (ADLs). Despite the availability of low vision devices and the numerous benefits to health and function they can afford beneficiaries with visual impairments, the Medicare program currently denies coverage of any technology that uses “one or more lenses for the primary purpose of aiding vision,” under a 2008 regulation.<sup>27</sup> This restrictive policy goes far beyond congressional intent in defining the Medicare benefit and denies critical and medically necessary assistive devices for an entire diagnostic category of

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<sup>24</sup> Jeffrey W. Jutai, J. Graham Strong, and Elizabeth Russell-Minda. Effectiveness of Assistive Technologies for Low Vision Rehabilitation: A Systematic Review. *Journal of Visual Impairment and Blindness* 2009; Vol 103, No 4.

<sup>25</sup> Rovner BW, Casten RJ, et al. Low Vision Depression Prevention Trial in Age-Related Macular Degeneration: A Randomized Clinical Trial. *Ophthalmology* 2014;121:2204-11.

<sup>26</sup> Kuyk, T, Liu L, et al. Health-related Quality of Life Following Blind Rehabilitation. *Qual Life Res* 17:497-507 (2008).

<sup>27</sup> Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; and Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); Final Rule, 73 Fed. Reg. 224, p. 69909-69910 (Nov. 19, 2008).

beneficiaries with specific medical and functional needs. This regulatory interpretation was finalized even though the Centers for Medicare and Medicaid Services (CMS) recognized the fact that several prior court decisions found that the Medicare law does not prohibit payment for video magnifiers, one example of a low vision device.

As the Committee is well aware, the Medicare statute does not provide for general vision, dental, and hearing benefits, a gap that significantly impacts beneficiaries. However, the current policy surrounding low vision aids is inconsistent with the treatment of other devices related to statutorily excluded benefits. For example, despite the ban on Medicare payment for hearing aids and related examinations, CMS has determined that payment for cochlear implants is allowable, correctly noting that while these devices improve hearing, they are separate and distinct from the broader hearing aid benefit prohibited in the statute. Equivalently, CMS does provide payment for the Implantable Miniature Telescope (IMT), an intraocular lens intended to treat vision loss stemming from macular degeneration, and (when it was available) for the Argus Retinal Prosthesis for severe vision loss from Retinitis Pigmentosa. As a result, the determination that all other low vision devices, equivalent in their therapeutic intent, are prohibited by the statutory language we believe is simply an overreach.

Furthermore, the Medicare program does provide coverage for vision rehabilitation services for beneficiaries with visual impairments ranging from low vision to total blindness. Vision rehabilitation under Medicare encompass several services covered for other conditions, including therapies to enhance mobility, ability to perform activities of daily living, and other medically necessary rehabilitation goals. Additional criteria define the limits of coverage for these services, similar to coverage conditions for other rehabilitation services, including clear and defined goals, potential for restoration or improvement of lost functions, and provision by qualified physicians or therapists.<sup>28</sup>

In the intervening years since the finalization of the rule, the needs of Medicare beneficiaries have persisted. The body of evidence supporting the use of low vision devices, and conversely, the consequences and complications of unaddressed low vision, has grown significantly. Low vision technology has continued to proliferate with new and improved assistive devices, while access to care has continued to be impeded. The current discussion surrounding broad gaps in Medicare coverage and the momentum in Congress to address these benefits provides an important opportunity to help ensure that Medicare beneficiaries with low vision are able to access the care they need.

### **Congress Must Act to Extend Coverage of Low Vision Aids in Medicare**

For too long, Medicare beneficiaries with low vision have been prevented from accessing medically necessary assistive technology to enhance the health, independent function, and quality of life. Additionally, given the distinct needs of beneficiaries with low vision and visual impairment, simply directing Medicare to cover eyeglasses and contact lenses, while a major

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<sup>28</sup> Centers for Medicare and Medicaid Services. Provider Education Article: Medicare Coverage of Rehabilitation Services for Beneficiaries with Vision Impairment. Transmittal AB-02-078, May 29, 2002. Accessed December 13, 2020.

step forward, will not address the current barriers faced by this population. We urge Congress not to leave these individuals behind.

**Therefore, we strongly support the low vision language included in H.R. 4187, the Medicare Vision Act of 2021 and encourage you to replicate this language in any legislation creating a Medicare vision benefit or otherwise expanding the Medicare program.**

This legislation, introduced in June 2021 by Reps. Kim Schrier (D-WA), Tom O’Halloran (D-AZ), Suzan DelBene (D-WA), and Elissa Slotkin (D-MI), would lift the low vision aid exclusion by repealing the statutory ban on Medicare coverage for eyeglasses. Further, it would direct the Secretary of Health and Human Services (HHS), working through the Centers of Medicare and Medicaid Services (CMS), to undergo a “review and analysis” of low vision aids that are appropriate for Medicare coverage and advance coverage for devices identified by the Secretary. The relevant language is excerpted below:

**§ 2(h):** *“Repeal of Ground for Exclusion. – Section 1862(a)(1) of the Social Security Act is amended by striking ‘, eyeglasses (other than eyewear described in section 1861(s)(8)) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes.”*

**§ 2(i):** *“Low Vision Aids. – Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall, in consultation with relevant stakeholders –*

- (1) undergo a review and analysis of clinically indicated magnifiers, spectacles, and other similar vision enhancement devices used to assist individuals with low vision and visual impairments;*
- (2) based on such review identify such specific devices that are not, but which pursuant to administrative action could be, covered under the Medicare program under title XVIII of the Social Security Act coverage; and*
- (3) take such administrative actions as are necessary to provide for such coverage of such devices so identified as the Secretary determines appropriate.”*

It is important to recognize that there are numerous low vision aids currently available, that address a wide range of functional needs and some with varying degrees of evidence supporting their use. Therefore, **this language does not provide a blanket mandate of coverage for this entire product category**; rather, it directs CMS to work with relevant stakeholders to review existing clinical evidence, beneficiary needs, and provider perspectives to determine which devices are most appropriate for Medicare coverage. Thus, we do not expect that this language will substantially contribute to the fiscal impact of a Medicare expansion bill – though it will have a major impact for individuals who need access to these devices to live healthy, independent lives.

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We appreciate the opportunity to provide the Committee with our perspective on the importance of appropriate access to low vision aids and devices. These devices, when paired with medically necessary vision rehabilitation services and device training, can dramatically improve the health, independent function, and quality of life for individuals with visual impairments. The ITEM Coalition looks forward to working with Congress to advance coverage for this critical assistive technology and to furthering public policy for individuals with injuries, illnesses, disabilities, and chronic conditions.

If you have any questions or if we can be of any assistance, please do not hesitate to reach out to Joe Nahra, ITEM Coalition co-coordinator, at [Joseph.Nahra@PowersLaw.com](mailto:Joseph.Nahra@PowersLaw.com). Thank you for your consideration.