

109TH CONGRESS
1ST SESSION

H. R. 2671

To provide for the expansion of Federal programs to prevent and manage vision loss, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 26, 2005

Mr. GENE GREEN of Texas (for himself, Ms. ROS-LEHTINEN, Mr. PRICE of North Carolina, and Mr. TIBERI) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for the expansion of Federal programs to prevent and manage vision loss, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Vision Preservation
5 Act of 2005”.

6 **SEC. 2. FINDINGS.**

7 The Congress finds as follows:

1 (1) An estimated 80 million Americans have a
2 potentially blinding eye disease. Three million Amer-
3 icans have low vision, 1.1 million Americans are le-
4 gally blind, and 200,000 Americans are more se-
5 verely visually impaired. Visual impairment is one of
6 the 10 more frequent causes of disability in the
7 United States.

8 (2) While it is believed that half of all blindness
9 can be prevented, the number of Americans who are
10 blind or visually impaired is expected to double by
11 2030.

12 (3) Vision is critical to conducting activities of
13 daily living and affects developmental learning, com-
14 municating, working, health, and quality of life.

15 (4) Vision problems affect 1 in 20 preschoolers
16 and, if untreated, can affect learning ability, person-
17 ality, and adjustment in school.

18 (5) It is estimated that blindness and visual im-
19 pairment cost the Federal Government more than \$4
20 billion annually in benefits and lost taxable income.

21 (6) The four leading eye diseases affecting older
22 Americans are age-related macular degeneration,
23 cataract, diabetic retinopathy, and glaucoma.

24 (7) Age-related macular degeneration is the
25 most common cause of low vision and legal blindness

1 in older Americans. More than 1.6 million Ameri-
2 cans age 50 and older live with late stage age-re-
3 lated macular degeneration. It is recommended that
4 individuals age 60 or older have their eyes examined
5 at least once a year to detect age-related macular
6 degeneration.

7 (8) The Federal Government spends more than
8 \$3.4 billion each year treating cataract through the
9 Medicare program. Cataract affects nearly 20.5 mil-
10 lion Americans age 40 and over. By age 80, more
11 than half of all Americans have cataract.

12 (9) Diabetic retinopathy affects over 5.3 million
13 Americans age 18 or older and can affect anyone
14 with diabetes. The Centers for Disease Control and
15 Prevention estimate that 10.3 million Americans
16 have diagnosed diabetes, while an additional 5.4 mil-
17 lion have undiagnosed diabetes. Because the number
18 of Americans with diabetes is expected to grow sig-
19 nificantly as the number of older Americans con-
20 tinues to increase, more people will be at risk for di-
21 abetic retinopathy.

22 (10) Glaucoma affects more than 2.2 million
23 Americans age 40 and older. Glaucoma cannot be
24 prevented, but most cases can be controlled and vi-
25 sion loss slowed or halted with treatment. Glaucoma

1 disproportionately affects minorities, affecting more
2 than 10 percent of Black men and Hispanic women
3 age 80 or older.

4 (11) Vision rehabilitation helps people with a
5 serious vision loss learn to safely navigate within
6 their home environs, avoid medication errors, cook
7 and use kitchen implements safely, and avoid burns,
8 falls, and other injuries. Vision rehabilitation pro-
9 motes safety and independence for the vision-im-
10 paired elderly, and prevents injuries and further dis-
11 abilities.

12 (12) Recognizing that the Nation requires a
13 public health approach to visual impairment, the De-
14 partment of Health and Human Services dedicated
15 a portion of its Healthy People 2010 initiative to vi-
16 sion. The initiative set out as a goal the improve-
17 ment of the Nation's visual health through preven-
18 tion, early detection, treatment, and rehabilitation.

19 (13) Greater efforts must be made at the Fed-
20 eral, State, and local levels to increase awareness of
21 vision problems, their impact, the importance of
22 early diagnosis, treatment, and rehabilitation, and
23 effective prevention strategies. It is the sense of the
24 Congress that the Nation must have a full-scale pub-

1 lic health effort on vision problems that includes the
2 following:

3 (A) Communication and education.

4 (B) Surveillance, epidemiology, and preven-
5 tion research.

6 (C) Programs, policies, and systems
7 change.

8 **TITLE I—PUBLIC HEALTH**
9 **PROVISIONS**

10 **SEC. 101. VISION LOSS PREVENTION.**

11 Part B of title III of the Public Health Service Act
12 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
13 tion 317S the following:

14 **“SEC. 317T. PREVENTIVE HEALTH MEASURES WITH RE-**
15 **SPECT TO VISION LOSS.**

16 “(a) COMMUNICATION AND EDUCATION.—

17 “(1) IN GENERAL.—The Secretary, acting
18 through the Centers for Disease Control and Preven-
19 tion, the Health Resources and Services Administra-
20 tion, and the National Institutes of Health, shall ex-
21 pand and intensify programs to increase awareness
22 of vision problems, including awareness of—

23 “(A) the impact of vision problems; and

1 “(B) the importance of early diagnosis,
2 management, and effective prevention and reha-
3 bilitation strategies.

4 “(2) ACTIVITIES.—In carrying out this sub-
5 section, the Secretary may—

6 “(A) conduct public service announcements
7 and education campaigns;

8 “(B) enter into partnerships with eye-
9 health professional organizations and other vi-
10 sion-related organizations;

11 “(C) conduct community disease preven-
12 tion campaigns; and

13 “(D) conduct testing, evaluation, and
14 model training for vision screeners based on sci-
15 entific studies.

16 “(3) EVALUATION.—In carrying out this sub-
17 section, the Secretary shall—

18 “(A) establish appropriate measurements
19 for public awareness of vision problems;

20 “(B) establish appropriate measurements
21 to determine the effectiveness of existing cam-
22 paigns to increase awareness of vision problems;

23 “(C) establish quantitative benchmarks for
24 determining the effectiveness of activities car-
25 ried out under this subsection; and

1 “(D) not later than 12 months after the
2 date of the enactment of this section, submit a
3 report to the Congress on the results achieved
4 through such activities.

5 “(b) SURVEILLANCE, EPIDEMIOLOGY, AND HEALTH
6 SERVICES RESEARCH.—

7 “(1) IN GENERAL.—The Secretary shall expand
8 and intensify activities to establish a solid scientific
9 base of knowledge on the prevention and control of
10 vision problems and related disabilities.

11 “(2) ACTIVITIES.—In carrying out this sub-
12 section, the Secretary may—

13 “(A) create a national ongoing surveillance
14 system;

15 “(B) identify and test screening modalities;

16 “(C) evaluate the efficacy and cost-effec-
17 tiveness of current and future interventions and
18 community strategies;

19 “(D) update and improve knowledge about
20 the true costs of vision problems and related
21 disabilities; and

22 “(E) require the Surgeon General to assess
23 the state of vision care and vision rehabilitation
24 in the United States.

25 “(c) PROGRAMS, POLICIES, AND SYSTEMS.—

1 “(1) IN GENERAL.—The Secretary shall expand
2 and intensify research within the Centers for Dis-
3 ease Control and Prevention on the prevention and
4 management of vision loss.

5 “(2) ACTIVITIES.—In carrying out this sub-
6 section, the Secretary may—

7 “(A) build partnerships with voluntary
8 health organizations, nonprofit vision rehabilita-
9 tion agencies, Federal, State, and local public
10 health agencies, eye health professional organi-
11 zations, and organizations with an interest in
12 vision issues;

13 “(B) work with health care systems to bet-
14 ter address vision problems and associated dis-
15 abilities; and

16 “(C) award grants for community outreach
17 regarding vision loss to national vision organi-
18 zations with broad community presence.”.

19 **SEC. 102. EXPANSION OF VISION PROGRAMS UNDER THE**
20 **MATERNAL AND CHILD HEALTH SERVICE**
21 **BLOCK GRANT PROGRAM.**

22 Section 501(a)(3) of the Social Security Act (42
23 U.S.C. 701(a)(3)) is amended—

24 (1) by striking “and” at the end of subpara-
25 graph (E);

1 (2) by striking the period at the end of sub-
2 paragraph (F) and inserting “, and”; and

3 (3) by adding at the end the following new sub-
4 paragraph:

5 “(G) introduce core performance measures
6 on eye health by incorporating vision screening
7 standards into State programs under this title,
8 based on scientific studies.”.

9 **SEC. 103. PREVENTION AND TREATMENT FOR UNDER-**
10 **SERVED, MINORITY, AND OTHER POPU-**
11 **LATIONS.**

12 (a) **EXPANSION AND INTENSIFICATION OF VISION**
13 **PROGRAMS.**—The Secretary of Health and Human Serv-
14 ices (in this section referred to as the “Secretary”) shall
15 expand and intensify programs targeted to prevent vision
16 loss, treat eye and vision conditions, and rehabilitate peo-
17 ple of all ages who are blind or partially sighted in under-
18 served and minority communities, including the following:

19 (1) Vision care services at community health
20 centers receiving assistance under section 330 of the
21 Public Health Service Act (42 U.S.C. 254b).

22 (2) Vision rehabilitation programs at vision re-
23 habilitation agencies, eye clinics, and hospitals.

24 (b) **VOLUNTARY GUIDELINES FOR VISION SCREEN-**
25 **ING.**—The Secretary, in consultation with eye-health pro-

1 fessional organizations and other vision-related organiza-
2 tions, shall develop voluntary guidelines to ensure the
3 quality of vision screening.

4 **SEC. 104. NATIONAL INSTITUTES OF HEALTH.**

5 (a) IN GENERAL.—The Director of the National In-
6 stitutes of Health (in this section referred to as the “Di-
7 rector”) shall expand, intensify, and coordinate programs
8 for the conduct and support of research with respect to
9 vision loss prevention and vision rehabilitation.

10 (b) COORDINATION.—The Director shall coordinate
11 vision-related activities in consultation with Federal offi-
12 cials, voluntary health organizations, medical professional
13 societies, and private entities as appropriate.

14 (c) RESEARCH.—In carrying out this section, the Di-
15 rector shall expand the following research activities:

16 (1) translational research within the National
17 Eye Institute;

18 (2) diabetes and glaucoma related programs of
19 the National Eye Institute;

20 (3) creation of an age-related macular degen-
21 eration public education program within the Na-
22 tional Eye Institute to—

23 (A) increase awareness of age-related
24 macular degeneration in selected high-risk tar-
25 get audiences in the United States;

1 (B) increase awareness of the importance
2 of early detection of age-related macular degen-
3 eration in preventing vision loss;

4 (C) increase health care providers' aware-
5 ness of the need for regular comprehensive di-
6 lated eye examinations for those at risk for age-
7 related macular degeneration and other eye dis-
8 eases, with the ultimate goal of early detection
9 of eye disease and the linkage of patients to ap-
10 propriate medical treatment and rehabilitation
11 services; and

12 (D) encourage at-risk populations to take
13 appropriate action based on their increased
14 awareness.

15 **TITLE II—MEDICARE**
16 **PROVISIONS**

17 **SEC. 201. IMPROVEMENT OF OUTPATIENT VISION SERV-**
18 **ICES UNDER PART B.**

19 (a) COVERAGE UNDER PART B.—Section 1861(s)(2)
20 of the Social Security Act (42 U.S.C. 1395x(s)(2)) is
21 amended—

22 (1) in subparagraph (Y), by striking “and”
23 after the semicolon at the end;

24 (2) in subparagraph (Z), by adding “and” after
25 the semicolon at the end; and

1 “(III) A vision rehabilitation professional
2 (as defined in paragraph (2)) while under the
3 general supervision (as defined in subparagraph
4 (D)) of a qualified physician.

5 “(B) In the case of vision rehabilitation services fur-
6 nished by a vision rehabilitation professional, the plan of
7 care may only be established and reviewed by a qualified
8 physician.

9 “(C) The term ‘qualified physician’ means—

10 “(i) a physician (as defined in subsection
11 (r)(1)) who is an ophthalmologist; or

12 “(ii) a physician (as defined in subsection (r)(4)
13 (relating to a doctor of optometry)).

14 “(D) The term ‘general supervision’ means, with re-
15 spect to a vision rehabilitation professional, overall direc-
16 tion and control of that professional by the qualified physi-
17 cian who established the plan of care for the individual,
18 but the presence of the qualified physician is not required
19 during the furnishing of vision rehabilitation services by
20 that professional to the individual.

21 “(2) The term ‘vision rehabilitation professional’
22 means any of the following individuals:

23 “(A) An orientation and mobility specialist (as
24 defined in paragraph (3)).

1 “(B) A rehabilitation teacher (as defined in
2 paragraph (4)).

3 “(C) A low vision therapist (as defined in para-
4 graph (5)).

5 “(3) The term ‘orientation and mobility specialist’
6 means an individual who—

7 “(A) if a State requires licensure or certifi-
8 cation of orientation and mobility specialists, is li-
9 censed or certified by that State as an orientation
10 and mobility specialist;

11 “(B)(i) holds a baccalaureate or higher degree
12 from an accredited college or university in the
13 United States (or an equivalent foreign degree) with
14 a concentration in orientation and mobility; and

15 “(ii) has successfully completed 350 hours of
16 clinical practicum under the supervision of an ori-
17 entation and mobility specialist and has furnished
18 not less than 9 months of supervised full-time ori-
19 entation and mobility services;

20 “(C) has successfully completed the national ex-
21 amination in orientation and mobility administered
22 by the Academy for Certification of Vision Rehabili-
23 tation and Education Professionals; and

24 “(D) meets such other criteria as the Secretary
25 establishes.

1 “(4) The term ‘rehabilitation teacher’ means an indi-
2 vidual who—

3 “(A) if a State requires licensure or certifi-
4 cation of rehabilitation teachers, is licensed or cer-
5 tified by the State as a rehabilitation teacher;

6 “(B)(i) holds a baccalaureate or higher degree
7 from an accredited college or university in the
8 United States (or an equivalent foreign degree) with
9 a concentration in rehabilitation teaching, or holds
10 such a degree in a health field; and

11 “(ii) has successfully completed 350 hours of
12 clinical practicum under the supervision of a reha-
13 bilitation teacher and has furnished not less than 9
14 months of supervised full-time rehabilitation teach-
15 ing services;

16 “(C) has successfully completed the national ex-
17 amination in rehabilitation teaching administered by
18 the Academy for Certification of Vision Rehabilita-
19 tion and Education Professionals; and

20 “(D) meets such other criteria as the Secretary
21 establishes.

22 “(5) The term ‘low vision therapist’ means an indi-
23 vidual who—

1 “(A) if a State requires licensure or certifi-
2 cation of low vision therapists, is licensed or certified
3 by the State as a low vision therapist;

4 “(B)(i) holds a baccalaureate or higher degree
5 from an accredited college or university in the
6 United States (or an equivalent foreign degree) with
7 a concentration in low vision therapy, or holds such
8 a degree in a health field; and

9 “(ii) has successfully completed 350 hours of
10 clinical practicum under the supervision of a physi-
11 cian, and has furnished not less than 9 months of
12 supervised full-time low vision therapy services;

13 “(C) has successfully completed the national ex-
14 amination in low vision therapy administered by the
15 Academy for Certification of Vision Rehabilitation
16 and Education Professionals; and

17 “(D) meets such other criteria as the Secretary
18 establishes.

19 “(6) The term ‘vision impairment’ means vision loss
20 that constitutes a significant limitation of visual capability
21 resulting from disease, trauma, or a congenital or degen-
22 erative condition that cannot be corrected by conventional
23 means, including refractive correction, medication, or sur-
24 gery, and that is manifested by 1 or more of the following:

1 “(A) Best corrected visual acuity of less than
2 20/60, or significant central field defect.

3 “(B) Significant peripheral field defect includ-
4 ing homonymous or heteronymous bilateral visual
5 field defect or generalized contraction or constriction
6 of field.

7 “(C) Reduced peak contrast sensitivity in con-
8 junction with a condition described in subparagraph
9 (A) or (B).

10 “(D) Such other diagnoses, indications, or other
11 manifestations as the Secretary may determine to be
12 appropriate.”.

13 (c) PAYMENT UNDER PART B.—

14 (1) PHYSICIAN FEE SCHEDULE.—Section
15 1848(j)(3) of the Social Security Act (42 U.S.C.
16 1395w-4(j)(3)) is amended by inserting “(2)(AA),”
17 after “(2)(W),”.

18 (2) CARVE OUT FROM HOSPITAL OUTPATIENT
19 DEPARTMENT PROSPECTIVE PAYMENT SYSTEM.—
20 Section 1833(t)(1)(B)(iv) of such Act (42 U.S.C.
21 1395l(t)(1)(B)(iv)) is amended by inserting “vision
22 rehabilitation services (as defined in section
23 1861(bbb)(1)) or” after “does not include”.

1 (3) CLARIFICATION OF BILLING REQUIRE-
2 MENTS.—The first sentence of section 1842(b)(6) of
3 such Act (42 U.S.C. 1395u(b)(6)) is amended—

4 (A) by striking “and” before “(G)”; and

5 (B) by inserting before the period the fol-
6 lowing: “, and (H) in the case of vision rehabili-
7 tation services (as defined in section
8 1861(bbb)(1)) furnished by a vision rehabilita-
9 tion professional (as defined in section
10 1861(bbb)(2)) while under the general super-
11 vision (as defined in section 1861(bbb)(1)(D))
12 of a qualified physician (as defined in section
13 1861(bbb)(1)(C)), payment shall be made to (i)
14 the qualified physician or (ii) the facility (such
15 as a rehabilitation agency, a clinic, or other fa-
16 cility) through which such services are fur-
17 nished under the plan of care if there is a con-
18 tractual arrangement between the vision reha-
19 bilitation professional and the facility under
20 which the facility submits the bill for such serv-
21 ices”.

22 (d) PLAN OF CARE.—Section 1835(a)(2) of the So-
23 cial Security Act (42 U.S.C. 1395n(a)(2)) is amended—

24 (1) in subparagraph (E), by striking “and”
25 after the semicolon at the end;

1 (2) in subparagraph (F), by striking the period
2 at the end and inserting “; and”; and

3 (3) by inserting after subparagraph (F) the fol-
4 lowing new subparagraph:

5 “(G) in the case of vision rehabilitation
6 services, (i) such services are or were required
7 because the individual needed vision rehabilita-
8 tion services, (ii) an individualized, written plan
9 for furnishing such services has been estab-
10 lished (I) by a qualified physician (as defined in
11 section 1861(bbb)(1)(C)), (II) by a qualified oc-
12 cupational therapist, or (III) in the case of such
13 services furnished by a vision rehabilitation pro-
14 fessional, by a qualified physician, (iii) the plan
15 is periodically reviewed by the qualified physi-
16 cian, and (iv) such services are or were fur-
17 nished while the individual is or was under the
18 care of the qualified physician.”.

19 (e) RELATIONSHIP TO REHABILITATION ACT OF
20 1973.—The provision of vision rehabilitation services
21 under the medicare program under title XVIII of the So-
22 cial Security Act (42 U.S.C. 1395 et seq.) shall not be
23 taken into account for any purpose under the Rehabilita-
24 tion Act of 1973 (29 U.S.C. 701 et seq.).

25 (f) EFFECTIVE DATE.—

1 (1) INTERIM, FINAL REGULATIONS.—Not later
2 than 180 days after the date of enactment of this
3 Act, the Secretary of Health and Human Services
4 shall cause to have published in in the Federal Reg-
5 ister a rule to carry out the provisions of this sec-
6 tion. Such rule shall be effective and final imme-
7 diately on an interim basis, but is subject to change
8 and revision after public notice and opportunity for
9 a period (of not less than 60 days) for public com-
10 ment.

11 (2) CONSULTATION.—The Secretary shall con-
12 sult with the National Vision Rehabilitation Associa-
13 tion, the Association for Education and Rehabilita-
14 tion of the Blind and Visually Impaired, the Acad-
15 emy for Certification of Vision Rehabilitation and
16 Education Professionals, the American Academy of
17 Ophthalmology, the American Occupational Therapy
18 Association, the American Optometric Association,
19 and such other qualified professional and consumer
20 organizations as the Secretary determines appro-
21 priate in promulgating regulations to carry out this
22 Act.

1 **SEC. 202. STUDY ON OBSTACLES FOR UNDERSERVED POPU-**
2 **LATIONS FOR VISION SERVICES UNDER THE**
3 **MEDICARE PROGRAM.**

4 (a) STUDY.—The Secretary of Health and Human
5 Services shall conduct a study on barriers faced by medi-
6 cally underserved populations (such as racial or ethnic mi-
7 norities) to vision services that are covered under the
8 medicare program under title XVIII of the Social Security
9 Act, including vision rehabilitation and other vision-related
10 services. In conducting the study, the Secretary shall con-
11 sider economic barriers posed by cost-sharing require-
12 ments, such as copayments and deductibles and the aware-
13 ness of medicare beneficiaries of vision services benefits
14 currently covered and those benefit for which coverage is
15 not provided under the program.

16 (b) REPORT.—Not later than one year after the date
17 of the enactment of this Act, the Secretary shall submit
18 to Congress a report on the study conducted under sub-
19 section (a). The report may include such recommendations
20 for administrative action or legislation as the Secretary
21 determines to be appropriate.

22 **SEC. 203. COMPREHENSIVE EYE EXAMINATIONS.**

23 The Secretary of Health and Human Services shall
24 enter into an agreement with the Institute of Medicine of
25 the National Academy of Sciences to conduct a study on

- 1 the cost benefit of providing a universal dilated eye exam
- 2 under the medicare program.

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