



**Prevent  
Blindness**

**Our Vision Is Vision.**

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26 June 2020

The Honorable Lamar Alexander  
Chairman  
United States Senate  
Committee on Health, Education, Labor, and Pensions  
Washington, DC 20510

Dear Chairman Alexander:

As the nation's leading nonprofit, voluntary organization committed to preventing blindness and preserving sight, Prevent Blindness appreciates the opportunity to respond to the Committee's white paper *Preparing for the Next Pandemic*. We stand ready to work with the Committee to address the unique challenges that people currently living with blindness or vision impairment have faced throughout this pandemic and could face in future public health emergencies (PHE).

Before the pandemic occurred, vision and eye health remained on the margins of important national health care conversations related to disparities in access, health inequities, and the public health infrastructure. A 2016 report from the National Academies of Sciences, Engineering, and Medicine (NASEM), [Making Eye Health a Population Imperative: Vision for Tomorrow](#), acknowledged that **for too long vision and eye health have not received the attention and investment they warrant, given their importance to public health**. Unfortunately, due to chronic underfunding of our nation's public health infrastructure—including surveillance and response capacity at state and community levels—as a nation, we were not prepared to respond to the novel coronavirus and safeguard the health and well-being of patients who live with low vision, disease-related progressive vision loss, disabling vision loss, or blindness. The results of the [Flatten Inaccessibility](#) survey, which was co-managed by fifteen organizations (including Prevent Blindness) that were interested in gauging the effects of COVID-19 on adults with visual impairment, indicates that we are failing to address the needs of those who live with visual impairment and eye disease.

We appreciate that Congress has legislated several aspects of a national response quickly, but we know that more work is necessary to implement lessons learned. Below are our recommendations for a comprehensive response to this and future pandemics as it relates to vision and eye health.

#### **Vision and Eye Health and COVID-19**

*Recommendation: To achieve effective implementation on the ground, a national response strategy must take into account such factors as underlying chronic health conditions (including vision impairment, eye disease, or visual disability), disparities across racial and ethnic populations, impact of disease based on age, socioeconomic circumstances, and barriers in access to care to mitigate impacts on various populations. As such, data collection on disease impact should include population*



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*health data and current health status, including whether the patient has vision loss or visual impairment.*

Vision and eye health enables many aspects of daily living no matter your age, racial and ethnic background, or socio-economic status. Many of the circumstances that surround vision loss and eye disease—including the presence of chronic disease, disparities along racial and ethnic lines, socioeconomic circumstances, and age—are at the intersection of COVID-19 and its most serious consequences. In addition, several conditions that are associated with the most serious complications of COVID-19 are analogous to vision and eye health, including diabetes, heart problems, depression and social isolation, longer hospitalization and readmission<sup>1</sup>, and need for long-term care.

Early COVID-19 surveillance data<sup>2</sup> from the CDC indicates that 30% of patients with COVID-19 also had diabetes and 4.8% of patients had a neurologic or neurodevelopmental disability (including visual impairment). This same study also indicates that people over the age of 50 represented the highest prevalence of COVID-19 and, based on available data, 33% of COVID-19 patients are Hispanic, 22% are black, and 1.3% are Native American/Alaska Native, illustrating the intersection between vision and eye health, underlying health indicators, and COVID-19.

In the future, we recommend that demographic data, including race, gender, and disability status (including visual impairment), is included in data collection on testing. We also recommend data on primary outcomes (such as mortality, hospitalization, ventilator use or equipment used in extreme, life-saving measures, and recovery) and secondary outcomes (such as unemployment, food insecurity, non-COVID or disease health implications like mental health impacts) are collected and reported. Doing so will allow us to address the underlying conditions of health that could put populations at risk, assess the impact on different populations, and compare data with existing population health and disease prevalence data and respond proactively to protect those most vulnerable.

## **Vision and Eye Health Surveillance**

*Recommendation: Congress should invest in public health surveillance efforts of vision loss and eye disease. Understanding our national vision and eye health burden will improve our ability to develop strategies that will protect patients who are currently living with blinding eye disease, low vision, or vision loss.*

We agree with the Committee that surveillance is a critical component of a national public health and community health strategy. It is essential for identifying vulnerable populations and understanding the conditions and diseases that could needlessly put them in harm's way in future

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<sup>1</sup> Morse AR, et al. *JAMA Ophthalmol.* 2019;doi:10.1001/jamaophthalmol.2019.0446. Accessed 20/01/23 from: <https://www.ncbi.nlm.nih.gov/pubmed/30946451>

<sup>2</sup> Coronavirus Disease 2019 Case Surveillance – United States, January 22 – May 30, 2020. [https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e2.htm?s\\_cid=mm6924e2\\_w](https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e2.htm?s_cid=mm6924e2_w)



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outbreaks. With updated surveillance data, we can work with state and community leaders to develop cross-sector, multilevel collaborations and interventions on vision and eye health that ensure individuals living with vision loss can continue to safely function in their own communities while taking necessary precautions against COVID-19 and future pandemics.

The [Vision Health Initiative](#) at the CDC measures rates of eye disease that lead to vision loss, and uses this information to develop evidence-based public health interventions designed to complement state and community health and response efforts. However, due to a consistent lack of resources allocated for this work, **our best-known estimates of our national vision loss and eye disease burden is over a decade old with current state and community interventions based on data that dates as far back as 1999.** We cannot respond to the needs of patients who are living with blinding eye disease, low vision, or vision loss during this or future disease outbreaks using data that predates such trends as our rapidly aging population, skyrocketing rates of chronic disease, new stresses to our eye health such as technology, and rising costs of health care. As well, surveillance is necessary to understand how COVID-19 and future infectious diseases affect people who live with vision loss, blinding eye disease, or a disabling visual impairment. In the long term, not having this critical information base will create gaps in our knowledge of COVID-19 and other infectious diseases, the consequences of which may include gaps in research at the National Institutes of Health.

In addition, national surveillance of children's vision and eye health is a significant public health challenge as **there is currently no system in place to track children's vision screenings, follow-up eye exams, treatment, or outcomes of care;** thus, making it difficult to measure progress and facilitate coordinated care across systems. Efforts to slow the spread of the virus have largely required Americans to transition their work and education environments to digital platforms, which has led to a significant increase in digital device use for children ages 6 to 12 years.<sup>3</sup> Alarming, children younger than six years are increasingly becoming reliant on devices. Children who spend many hours doing close visual work, such as learning via electronic devices, have a higher risk of developing myopia. If left uncorrected, myopia causes far-away objects such as a classroom board to appear blurry and can cause headaches, discomfort, or behavioral problems related to a child's inability to focus and concentrate. Severe myopia can also lead to sight-threatening complications such as glaucoma, cataract, and retinal detachment in addition to problems seeing clearly in adult life. As schools and school systems implement approaches for safely returning to classes in the fall, children's vision and eye health may face competing demands for school-based health services including personnel to conduct vision screenings and coordinate care, safe administration protocols, and protective equipment. Left unaddressed, all of these conditions and others such as amblyopia, which could develop before age 7, could lead to difficulties in learning, compound disparities in health care and academic success, and permanent damage to vision.

Improved vision and eye health data will advance health and clinical outcomes, both related and unrelated to disease outbreaks. This data will also certainly contribute to policies that seek to

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<sup>3</sup> <https://www.axios.com/kids-screen-time-coronavirus-562073f6-0638-47f2-8ea3-4f8781d6b31b.html>



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improve telehealth and achieve accessible technology for use in virtual working and learning environments. If we are unwilling to plan and conduct this essential work outside of a PHE, we cannot expect to have a plan ready to ensure those with vision loss can access essential services during a PHE. This data is critical to ensuring access to pandemic-related services such as sites of care for disease screening, testing, and treatment (including hospital transportation if needed) as well as social or support services to those with visual impairment or disability including public transit use, paratransit or ride-sharing availability, accessible voting methods, food and meal delivery services, or access caregiving services under social distancing requirements.

## **Coverage and Access to Vision and Eye Health Care**

*Recommendation: Patients need the assurance of continued health care coverage during a PHE, not only in case they contract illness, but also so that they can continue receiving needed care for existing eye disease or chronic illness. Congress should enact these policies before a declared PHE so that patients are empowered to work with their providers to continue their care safely.*

As we transition from emergency response, we are concerned about the potential long-term impacts on our national vision and eye health if patients cannot access timely eye care treatments. The economic consequences of this pandemic has caused millions of people to lose not only their economic livelihoods but also their access to health care coverage through employer-sponsored health plans.

Vision loss from eye diseases like glaucoma, diabetes-related eye disease, thyroid eye disease, and age-related macular degeneration is often progressive in nature and irreversible, requiring that patients adhere to clinical treatments to slow the progression of vision loss and preserve any remaining vision. Without the ability to access coverage or pay for treatments such as eye drops for glaucoma, diabetes medication, or injection and infusion services, patients may face disruptions to their vision and eye care that could result in permanent vision loss. Coupled with novel and sometimes confusing or conflicting social distancing guidelines and the majority of optometric and ophthalmic services considered “elective” or “non-essential,” patients may be more likely to forgo eye care altogether not only during the initial wake of the pandemic but for a long time thereafter until they acquire coverage elsewhere or feel safe to resume care.

We appreciate that Congress acted quickly to enact policies to protect coverage, but any uncertainty (even if short-lived) about coverage can deter patients from planning and working with their providers to continue receiving care. We believe there is opportunity to learn what policies worked during the COVID-19 pandemic that can be applicable to future pandemic responses. Specifically, we ask that Congress:

- Review and legislate policies such as special enrollment periods, subsidies to continue employer-based or private coverage, or extending public coverage options through the duration of the PHE not just in the case a person contracts the illness but to ensure continuity of care for existing conditions,



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- Work with the Centers for Medicare and Medicaid Services to ensure that Medicare beneficiaries (who are considered to be at risk due to chronic disease and age) can receive medications allowed under Part B in an alternate setting of care so that patients do not have to decide between interruptions in their care or exposing themselves and others to the serious risks of COVID-19,
- Examine the impact of suspending prior-authorization requirements in Medicaid, Medicare Part D, Medicare Advantage, and exchange plans on non-COVID-19 drug and plan administration costs, and
- Implement changes to policies governing prescription refills so that patients can access medication safely and have what they need on hand should they need to quarantine at home.

We encourage Congress to consider what coverage options are best for patients and give them the assurance that their needs will be met in a time of crisis.

## **Telehealth**

*Recommendation: A national telehealth strategy should promote access to care, not become an additional barrier through increased cost sharing or inaccessibility for patients who live with low vision or vision loss. Telehealth platforms need to comply with protections under the Americans with Disabilities Act (ADA) to ensure people with physical and sensory disabilities (including visual impairment and blindness as well as hearing loss) can access the health care they need via telehealth platforms. Telehealth should complement in-person eye examinations when appropriate, and have a strong foundation in evidence to guide its use.*

Telehealth has unquestionably become an invaluable way for patients to receive care in a safe and socially distant manner during this PHE. Telehealth provides the opportunity to expand access to eye care in communities where it is unlikely that the appropriate and necessary eye care provider(s) will be physically present. While telehealth cannot fully substitute the benefits of an in-person eye examination, if executed correctly, initial screenings via telemedical technology can be a valuable access point for the detection of serious eye diseases and ultimately preventing vision loss.

We are grateful to the Committee for its recent hearing examining the impact of telehealth flexibilities on patient access to care, especially for those with chronic diseases and disabilities. Expanded access to telemedicine alternatives in minority, low income, and rural communities may hinge on CMS' continuing implementation of PHE-related flexibilities such as permitting use of mobile telephones, including audio-only devices, which are an important access point for older adults, blind, or visually impaired patients who cannot afford smart phone technology. Of critical importance, we urge the Committee to prioritize the needs of people who live with physical and sensory disabilities (including visual and hearing impairments) by ensuring telehealth policies comply with mandates under the ADA designed to ensure health care is accessible.

We are encouraged by increased interest in expanding telehealth beyond the PHE, and we urge careful consideration of policies to ensure that it does not become an additional barrier to care.



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Given recent estimates attributing approximately \$93 billion in excess medical care costs and \$42 billion in lost productivity per year to health care disparities, we urge you to consider permanent adoption of telemedicine flexibilities that prove successful in expanding access to care during a PHE.

## **Conclusion**

Once again, we appreciate the opportunity to provide input into this important and timely white paper. Please do not hesitate to contact Sara D. Brown, Director of Government Affairs, at (312) 363-6031 or [sbrown@preventblindness.org](mailto:sbrown@preventblindness.org) if you or your staff would like to discuss these issues.

Sincerely,

Jeff Todd  
President and CEO