



Dental and Optometric Care (DOC) Access Act

S. 1424/H.R. 1385

Currently, patients are being adversely impacted by provisions in dental and vision plans that dictate how much a doctor may charge a plan enrollee, even though the services provided to the enrollee are not “covered” (i.e., paid for) by the plan.

The American Dental Association (ADA) along with the American Optometric Association (AOA) support S. 1424/H.R. 1385, the Dental and Optometric Care Access Act (DOC Access Act), which was introduced by Senators Joe Manchin (D-WV) and Kevin Cramer (R-ND) and Representatives Buddy Carter (R-GA), Yvette Clarke (D-NY), and Pete Sessions (R-TX). The legislation would prohibit dental and vision plans from setting the fees network doctors may charge for services not covered by the insurers.

- **National trend:** 42 states have already passed laws that limit interference with the dentist-patient relationship when the dentist delivers services not covered by insurers. Three additional states have limited the interference for optometrists and their patients.
- **Close a loophole:** Even though 42 state governments have taken action, many dental plans are federally regulated, so insurers claim they are exempt from having to follow state laws. This insurer loophole means some enrollees and doctors face undue confusion in how their plans work.
- **Narrowly drawn:** The DOC Access Act is narrowly drawn to apply only to dental and vision plans regulated by the federal government. This legislation would not interfere with the states’ abilities to maintain and enforce their own insurance regulations and laws; instead, it complements the work already done by most state legislatures across the country.

It would also establish some “rules of the road” for provider network participation:

- Prevents plans from establishing nominal payments for otherwise non-covered services in an effort to have such services considered covered inappropriately.
- Limits network agreements to two years for each contract extension unless the doctor agrees to accept a longer contract extension; and
- Preserves doctors’ freedom of choice in laboratories.

Non-covered services provisions in dental and vision plans disadvantage enrollees, doctors and the public at large because they interfere with the patient-doctor relationship, skew the pricing charged to non-subscribers, and encourage the consolidation of the dental and vision insurance industries, resulting in higher premiums overall.

Consolidation occurs because larger plans leverage their greater market share to push doctors into accepting provisions, such as non-covered services, as part of their “take it or leave it” contracts. These practices place the smaller dental and vision carriers at a competitive disadvantage and shift costs rather than reducing them.

The result is a dental plan market dominated by only a few national players in many states, and a shifting of costs to patients who are paying for their coverage out of their own pockets or whose dentist or optometrist is out of network. The ADA and the dentists we represent are not opposed to dental plans building strong networks and seeking discounts for their subscribers. But in the case of non-covered services provisions, the scales are tipped too far in the favor of large dental plans. Keep in mind, these plans aren’t paying for the services, but they still

