



Dental and Optometric Care Access Act of 2021 (DOC Access Act)

S. 1793/H.R. 3461

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) and the American Student Dental Association (ASDA), along with the American Optometric Association (AOA), support the Dental and Optometric Care Access Act (DOC Access Act), S. 1793/H.R. 3461, introduced by Sens. Joe Manchin (D-WV) and Kevin Cramer (R-ND) and Reps. Yvette Clarke (D-NY), Buddy Carter (R-GA), Darren Soto (D-FL) and David McKinley (R-WV). 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:** 41 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 44 state governments have taken action, many dental and vision 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:** S. 1793/H.R. 3461 closes this loophole and 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.

S. 1793/H.R. 3461 also establishes 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;
- Preserves doctors’ freedom of choice in laboratories; and
- Provides a private right of action (injunctive relief and damages) for a person adversely affected by a violation of the above provisions.

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 reduce them.

