



# Dental and Optometric Care Access Act

## “DOC Access Act”

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). 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 45 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:** DOC Access 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.

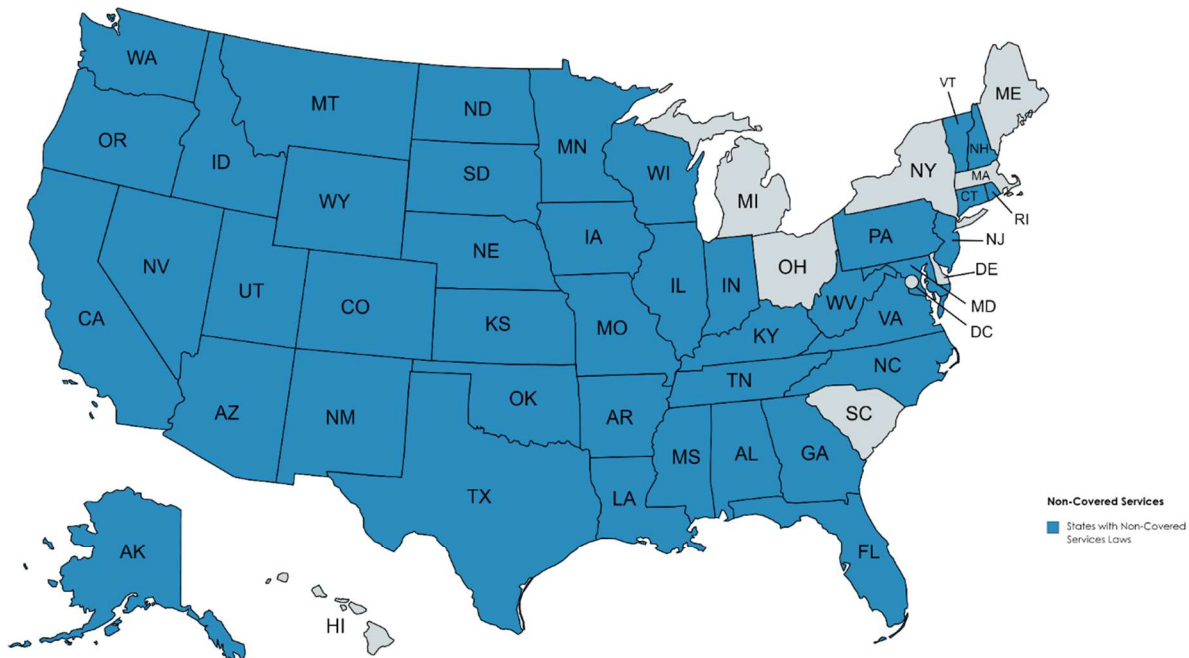
Consolidation occurs because larger plans leverage their greater market share to push doctors into accepting provisions, such as non-covered services, as part of their “take it or leave it” contracts. These practices place the smaller dental and vision carriers at a competitive disadvantage and shift 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 seek to dictate fees. Nearly all states have worked to correct this plan overreach. To ensure all patients in the country are protected, no matter how their plans are regulated, action is needed at the federal level. Passage would balance the scales, protect patients, and bring needed equity to insurer/provider contracting.

**As dentists and dental students, we ask that you co-sponsor the DOC Access Act when it is reintroduced.**

## States with Dental Non-Covered Services Laws



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