Dental Insurance Reform

Support the Dental and Optometric Care (DOC) Access Act to prevent insurers from interfering in the doctor-patient relationship.

Why is federal dental insurance reform legislation needed?

Insurers currently interfere with the doctor-patient relationship by dictating 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.

State laws do not apply to federally regulated plans, such as ERISA plans, preventing doctors with patients enrolled in these plans from charging reasonable fees for the services they provide. This loophole means some enrollees and doctors face undue confusion in how their plans work. Federal legislation can prohibit the same practice in ERISA plans.

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.

42 states

have passed laws to prohibit insurance companies from dictating the fees dentists may charge one of their enrollees for dental services not covered by the insurance plan.

AAOMS's ask of Congress

Co-sponsor the DOC Access Act (S 1424/HR 1385)

- The bipartisan Dental and Optometric Care (DOC) Access Act was reintroduced in the 118th Congress by Sens. Joe Manchin (D-W.Va.) and Kevin Cramer (R-N.D.) and Reps. Earl L. "Buddy" Carter (R-Ga.) and Yvette Clarke (D-N.Y.).
- The bill would allow dentists to charge reasonable and customary fees to patients who are enrolled in a federally regulated plan for quality patient care not covered by that plan.
- It also would establish other insurer guardrails that serve to encourage provider network participation, including:
  - Prohibiting insurers from providing nominal coverage – for example, at 5 percent of the provider's normal fee – thereby avoiding the non-covered services' law prohibition.
  - Preventing insurers from extending network agreements beyond two years without permission from the doctor.
  - Preserving a doctor's freedom of choice in laboratories.
- For more information, contact the office of Sen. Manchin, Sen. Cramer, Rep. Carter or Rep. Clarke.