The “Dental and Optometric Care Access Act” (DOC Access Act) eliminates basic consumer protections and would mean higher costs for consumers with dental benefits. The bill is inconsistent with laws in the majority of states and sets up different standards for fully insured/self-funded plans and interferes with private contracts between dentists and carriers.

The bill includes significant restrictions on dental (and optometric) provider contracts which increase the administrative complexity of plans and result in unexpected costs to the consumer.

**How Do Negotiated Discounts Work?**
Dental plans cover a wide array of dental services; however, most have an annual maximum benefit per plan year. After the annual maximum amount is met, consumers can continue to benefit from insurance coverage through discounts that have been negotiated between the dental plan and that plan's contracted dentists.

The DOC Access Act would prohibit carriers from offering discounts to their consumers unless the plan is reimbursing the provider for that specific service. This approach denies insureds the benefit of discounts negotiated for both covered and non-covered services which negates one of the primary values of insurance.

**Contracted Fees Minimize Out-of-Pocket Consumer Costs**
Minimizing American’s out-of-pocket health costs is one of the primary goals of federal health care reform. Dental plans and consumers can better calculate the expected costs of care up front when a single fee schedule is adopted for all services, covered or not. This helps avoid “sticker-shock” and surprise costs that might otherwise result from non-contracted fees for dental services suddenly appearing on a patient’s dental bill.

Dental plans and dentists have a responsibility to work together to offer competitive costs for dental services. Under current law, consumers receive the contracted fee even if the service is delivered after the annual maximum or a frequency limit is met, for example. Without the contracted fees, consumer costs for non-covered services are generally higher and can put significant financial strain on individuals and families. Cost savings realized when consumers receive non-covered services at a contracted fee encourages them to seek treatment in a timely manner and not delay their care due to cost restraints.

**How Contracted Fees Save Consumers Money**
If a dental plan covers the cost of two cleanings a year and the consumer wants or needs a third cleaning, the policy and provider contracts would require the provider to charge the same price to the consumer as they would have charged the carrier for that service. Most states protect discounts for services covered by dental plans for those consumers who have reached a plan maximum or frequency limitation.

**Contracted Fees Help Increase the Scope of Benefits**
The design of the dental policy selected by the employer dictates what services are covered under a plan. This allows the employer to offer a plan at an affordable cost to both the employer and the consumer. A dental plan’s ability to offer a single contracted fee schedule for all services under a group employer dental plan increases the scope of benefits without increasing premiums, thereby increasing the overall value of the program for employees. The DOC Access Act would limit employer flexibility and reduce product choices.

**DOC Access Interferes With Private Contracts**
Dentists have the choice to join a dental plan’s network and those dentists have agreed to contracts with negotiated discounts in return for referrals of patients by the dental plan. The DOC Access Act interferes with agreed upon contracted fees and other terms of private contracts between carriers and providers, legislating changes in contractual agreements that are confusing and financially harmful to consumers.