

## Analysis of Dental and Vision Plan Non-Covered Services and Materials Mandates: An Update

**Background.** In the last decade, most states have enacted limitations on dental and vision plans' ability to set fees on non-covered services and require materials be provided by specific laboratories or manufacturers. However, federally regulated plans take the position that they are exempt from these state laws, despite the enactment of many state-level prohibitions. As a solution, the DOC Access Act would align federally regulated plan law with existing state non-covered services laws to provide greater consistency.

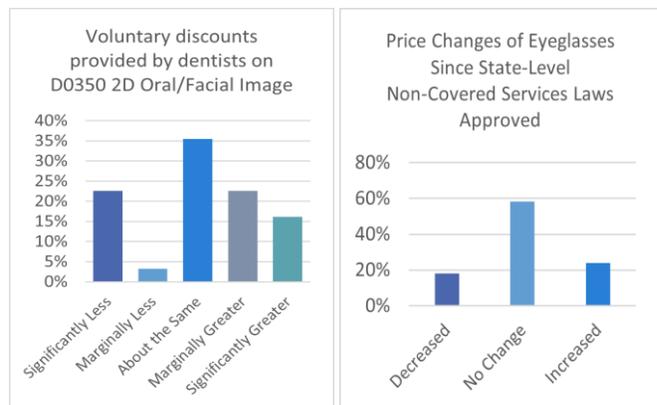
**Economics.** The practice of plans setting prices on non-covered services is an example of monopsony, which is an economic term for the demand-side version of a monopoly: a single or concentrated buyer. In the case of non-covered services, the plans are essentially using their market power to dictate pricing structures on items and services for which they bear no financial responsibility. This practice is mostly inconsequential from a consumer perspective, but only if there are no negative externalities. If practices are *not* overcharging patients and are faced with providing discounts for non-covered services from patients with certain insurance plans, they may need to increase charges for these or other services to make up for the losses. This results in cost-shifting to enrollees of other insurance plans or to those who are uninsured and may even lead to overall higher expenses for the enrollees of the plan receiving the discount.

**Past Research.** In 2016, we conducted a survey-based study of optometry and dentistry in North Carolina and Texas to determine the impact on fees charged in states with laws prohibiting insurers from setting fees for non-covered services. The study found that allowing insurers to set the fees doctors can charge for non-covered services led to *higher* costs for dental and vision patients in the U.S.

**Current Research.** In this study, we update the 2016 study relying on the same survey design to maintain comparability. We also expand the number of targeted states to 10. The survey questions aimed to assess how

dental and optometry providers changed their behavior based on state-level non-covered services laws. There were 496 responses to the dental survey and 102 responses to the optometry survey that were included in the analysis.

**Results.** Consistent with the 2016 research, our findings clearly suggest that dentists and doctors of optometry are not charging unreasonable prices for non-covered services after state-level laws passed prohibiting insurers from setting fees on non-covered services. In fact, many dentists and doctors of optometry reported having increased their prices in response to plan-required discounts when regulations preventing this practice were not in place.



**Conclusions.** Allowing federally regulated dental and vision plans to set fees for non-covered services and require materials be provided by specific laboratories results in cost-shifting and worse outcomes for patients. The DOC Access Act would end these practices that are harming patients and allow dentists and doctors of optometry more freedom to make the best decisions for their patients.

The full report is available for viewing and download on the [Avalon Health Economics website](#). –John E. Schneider, PhD, Kenna D. Garrison, MA, Cara M. Scheibling, MBA, Karen Beltran