Analysis of Dental and Vision Plan Non-Covered Services and Materials Mandates

2021 Update to 2016 Report

December 7, 2021

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EXECUTIVE SUMMARY

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. This legislative effort provides an opportunity to measure the impact, if any, state non-covered services laws have had on patient costs. This report provides insight into whether state non-covered services laws, some in place for over a decade, impact patient costs.

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 the maximum fee a doctor may charge for a non-covered service. The study found that allowing insurers to set the fees doctors can charge for non-covered services actually led to higher costs for dental and vision patients in the U.S. Forced fee limits have had implications for dentists and optometrists, who reported increasing prices on their services by as much as 93% to subsidize their losses, harming patients who are not enrolled in plans with special discounts while patients enrolled in such plans are effectively paying a premium to the plans to access prices that may have been available previously.

Current Research. In this study, we update the 2016 study relying on the same questions to maintain comparability. We also expand the number of targeted states to 10, as many more states have passed non-covered services laws in recent years.[1] 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 are passed prohibiting insurers from setting fees on non-covered services. The DOC Access Act would extend the state-level patient protections and allow dentists and doctors of optometry more freedom to make the best decisions with their patients.

[1] Please refer to Appendix A for the list of states targeted in the 2021 survey.

1. INTRODUCTION

1.1. Two critical areas of general health care often neglected in modern insurance regulations include optometry and dentistry. Insurance coverage for dentists and optometrists is typically exclusively covered by the specialized vision and dental plans with limited benefits.

1.2. Under federal law, stand-alone dental and vision benefits are considered "excepted benefits"[2] and are not regulated in the same manner as major medical plans. Additionally, many dental and vision plans are self-funded by an employer, meaning that state laws reforming insurance may be pre-empted by the Employee Retirement Income Security Act of 1974 (ERISA).[3] These two factors mean that dental and vision plans can often avoid state and federal health care insurance reform.

1.3. Under the Affordable Care Act, people under the age of 21 are provided with some dental coverage as a required component of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. However, states are under no obligation to provide any Medicaid dental coverage to those over 21. Those states that do provide some Medicaid coverage for adults will typically limit it to emergency care, which leaves many of those unable to afford dental care without and access to preventive care or treatment.[4]

1.4. Insurance coverage for optometrists is typically divided between health plans that share risk for medical and surgical eye care, and vision plans that provide limited supplemental benefits (typically eye exams and eyewear). The Affordable Care Act requires small group health plans and health insurance coverage for individuals to include vision benefits, while Medicaid requires states cover medical eye care for all populations, and additional vision benefits in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for people under the age of 21. States are not required to provide vision benefits to those over 21 in Medicaid.

1.5. National data show that 10.3% of children aged 2-18 and 33.6% of adults do not have any dental coverage, and within those who do, many will still face challenges in paying for their dental services.[5] In the case of eye care, as of 2018, at least 33 states offered some coverage but with limitations on eye exam frequency or condition severity.[6]

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[2] "Amendments to Excepted Benefits," in *79 FR 59130*, ed. the Employee Benefits Security Administration The Internal Revenue Service, and the Health and Human Services Department (2014).
[3] B. Caballero and S. Rubinstein, "Environmental factors affecting nutritional status in urban areas of developing countries," *Arch Latinoam Nutr* 47, no. 2 Suppl 1 (1997).
[4] "Dental Benefits and Medicaid," American Dental Association.
[5] Ibid.; Villarroel M.A. Blackwell D.L., Norris T., "Regional variation in private dental coverage and care among dentate adults aged 18–64 in the United States, 2014–2017," (Hyattsville, MD2019).
[6] Katch H. and Van de Water P., "Medicaid and Medicare Enrollees Need Dental, Vision, and Hearing Benefits," (Washington, DC 2020).

1.6. The supply of providers plays a critical role in access to care. There are approximately 200,000 active dentists in the U.S., with a total dentist to population ratio of 61 per 100,000.[7] These dentists face the challenges of treating acute and chronic ailments, which severely limit the quality of life. In 2019, nearly 25% of the U.S. population, about 74 million people, did not have dental insurance. As dental care is so closely tied with employment, 60% of these people are retired or unemployed, including 16 million people who lost their employment-based dental insurance during the COVID-19 pandemic.[8] In addition, there are 24 million Medicare beneficiaries who do not have dental coverage under Medicare.[9] Dental disease is exceptionally commonplace, yet largely preventable in the general population. In fact, dental caries (tooth decay) is the most common chronic childhood disease, according to the CDC. At the same time, over 70% of those over 65 have some form of gum disease.[10]

1.7. While less prevalent than dentists, there are approximately 46,000 practicing optometrists in the U.S., with a distribution that provides approximately 99% of the U.S. population with geographical access to a local doctor in optometry.[11] Doctors of optometry have a critical role in the workforce in providing the necessary tools for the 75% of the adult population who use some form of vision correction to operate at their highest efficiency. Due to vertical integration in the vision insurance industry, laboratory, supplier, and manufacturer industries, optometry practices are often forced to act as the “middle man,” being forced to use specific laboratories and manufacturers that vision plans own to provide materials to their patients and only being reimbursed for their services at the levels the dictated by the vision plans.[12]

2. NON-COVERED SERVICES & MATERIALS

2.1. Vision and dental plans typically only cover 100 percent of preventive care benefits, such as a single annual eye exam and capped eyewear allowance, or a semi-annual dental cleaning in the case of dental coverage. Beyond preventive care, basic and major services include increased “cost-sharing” where subscribers are required to pay a percentage of the cost. Because most of these plans do not share risk for additional care nor include coverage beyond defined benefits, they are usually not included in the regulatory restrictions affecting traditional medical care plans.[13] In the U.S., up until recently, these plans were exempt from the McCarran-Ferguson Act of 1947. However, with the signing of

[7] "Workforce," American Dental Association.
[8] Delta Dental, "A quick look at people without dental insurance."
[9] Ochieng N. Freed M., Sroczynski N., Damico A., Amin K., "Medicare and Dental Coverage: A Closer Look," Kaiser Family Foundation.
[10] "Periodontal Disease," in *Oral Health Conditions* (2013).
[11] Health Policy Institute, "County Data Demonstrates Eye Care Access Nationwide," (2018).
[12] "AOA challenges VSP plan to link doctor reimbursements to certain lenses and anti-reflective coating," news release, 2020, https://www.aoa.org/news/advocacy/third-party/aoa-challenges-vsp-plan?sso=y.
[13] "Repeal of the Antitrust Exemption for Health Care Insurance a Win for Consumers and Dentists," American Dental Association.

"The Competitive Health Insurance Reform Act of 2020," some restrictions on anti-trust practices were put in place to protect consumers and providers.[14]

2.2. Nevertheless, the lack of regulation of vision and dental plans has led vision and dental plans to exercise market power to fix price discounts for certain "non-covered services."[15] These mandates seek to increase the profitability and marketability of insurance plans by forcing providers to discount their normal fees on services insurers pay no benefit. This leads to cost-shifting, which artificially inflates the prices of essential services that make treatment for the uninsured less affordable and pushes those who would not otherwise require coverage into more intensive plans.[16] Dentists and optometrists are often compelled to accept the conditions of these non-covered services terms in provider-plan agreements. Not doing so would result in restricting access to large local patient populations.[17] Problems associated with this pricing model affect both those with and without dental or vision coverage.[18]

2.3. In our previous report completed in 2016, titled "Analysis of Dental and Vision Plan Non-Covered Services and Materials Mandates and the Projected Role of H.R. 3323 in the Vision and Dental Markets," we conducted a survey-based study of doctors of optometry and dentists located in North Carolina and Texas to determine how pricing of non-covered services may be affected by laws prohibiting plans from forcing providers to adhere to non-covered services mandates. Both states enforce state laws which prevent state-regulated dental and vision plans from mandating provider fee limits on non-covered services. We analyzed data from 212 dentists and 53 doctors of optometry and determined that these non-covered services mandates led to higher costs for dental and vision patients in the U.S. Forced fee limits have had implications for dentists and optometrists, who reported corresponding increased prices on their services by as much as 93% to subsidize their losses, harming patients who are not enrolled in plans with special discounts and patients enrolled in such plans who pay a premium to avoid the resulting price.

3. PROPOSED LEGISLATION

3.1. The American Optometric Association (AOA) and the American Dental Association (ADA) oppose insurers' fee limitations on non-covered services and limits on a doctor's choice of laboratory forced by insurance plans, and many states have enacted laws to end these practices by state-regulated insurers. However, currently there is no federal law that could similarly end non-covered services mandates and laboratory choice restrictions nationwide. In response, bipartisan legislation has been introduced in the U.S. House of Representatives and the U.S. Senate to prevent these harmful practices on a national level. Upon reintroducing the Dental and Optometric Care (DOC) Access Act in May of 2021,[19]

[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] HR 3461; S 1793

Senator Joe Manchin stated "my bipartisan DOC Access Act would put the control of health care choices in the hands of patients and doctors themselves instead of insurance companies. This legislation would provide more options and better access to care for patients while also allowing doctors, especially those who operate their own practices as small businesses, more control of decisions."[20]

3.2. The Dental and Optometric Care Access Act of 2021 (S. 1793/H.R. 3461 or "DOC Access Act") in part seeks to protect doctors' bargaining positions with large vision and dental plans, address anti-competitive practices in the health care marketplace, and improve overall access to and quality of patient care. The DOC Access Act of 2021 follows similar bills introduced in the House of Representatives dating back to 2015, and the growing interest and momentum led to the first companion bill in the Senate introduced in November 2020.[21]

3.3. The DOC Access Act states that "the plan or coverage shall provide that, with respect to a doctor of optometry, doctor of dental surgery, or doctor of dental medicine that has an agreement to participate in the plan or coverage and that provides items or services that are not covered services under the plan or coverage to a person enrolled under such plan or coverage, the doctor may charge the enrollee for such items or services any amount determined by the doctor that is equal to, or less than, the usual and customary amount that the doctor charges individuals who are not so enrolled for such items or services."[22]

3.4. The DOC Access Act would bar vision and dental plans from fixing price discounts doctors provide to their enrollees on services that the plan does not pay more than a nominal amount and also prohibit them from restricting a doctor's choice of laboratory or supplier. The bills would also establish other rules relating to the insurance contracting process including limiting network agreements to two years without the doctor's prior acceptance of extension.

3.5. The reforms in the DOC Access Act would apply specifically to vision and dental plans as "excepted benefits" and also apply to self-funded employer coverage, i.e., ERISA plans that are administered by dental and vision insurance companies on behalf of employers.

3.6. More than 40 states have already passed laws that prohibit either vision or dental plans (or both) from fixing price discounts for services and materials not covered by the vision or dental plan.[23] The DOC Access Act, in part, was introduced to complement these state laws by prohibiting this practice on the part of plans regulated at the federal level, but the legislation would not supersede any state-level laws governing vision and dental plans.

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[20] "AOA-backed DOC Access Act reintroduced to combat anti-competitive vision plans," news release, May 27, 2021, 2021.

[21] *Dental and Optometric Care Access Act of 2021*, 117th Congress First Session, H.R.3461; *Dentist and Optometric Care Access Act of 2021*, 117th Congress First Session, S.1793.

[22] *Dental and Optometric Care Access Act of 2021*.

[23] "AOA-backed DOC Access Act gains U.S. Senate companion," news release, 2020, https://www.aoa.org/news/advocacy/federal-advocacy/aoa-backed-doc-access-act-gains-us-senate-companion?sso=y.

4. CONCEPTUAL FRAMEWORK

4.1. *Monopsony in insurance plan markets*. “Monopsony” is an economic term for the demand-side version of a monopoly: a single or concentrated buyer.[24] In a market where there is one or only a few firms with substantial market power, these firms may be able to act like a monopsony and leverage their position to influence prices. This contrasts with a market with perfect competition, where market forces determine equilibrium price and quantity, and no single buyer can exert market power to set prices. In a perfectly competitive market, buyers are “price takers,” but a monopsony can act as a “price setter.”[25] A monopsony, like a monopoly, generally acts in a way that increases its own economic surplus (i.e., profits), but reduces total economic welfare, compared to a perfectly competitive market.[26]

4.2. Health, dental, and vision insurers have been shown to act as monopsonies when they hold a great enough market share.[27] When initiating a contract, medical providers engage in bargaining with insurance plans over the reimbursement rates they will receive for their services. When a plan has a credible threat to remove the practice from its network, and the practice is unable to replace those patients, the insurer is able to exert its market power to lower the reimbursement rates that it pays to the practice.[28] Insurers can similarly use their market power to gain other privileges in contract negotiations, such as discounts for their enrollees on non-covered services and requiring practices to use certain laboratories or suppliers for their materials. These tactics reduce efficiency in the market since these insurers have an advantage over their competitor plans due only to the fact that they have more enrollees, and not because they are more efficient or higher quality. This advantage makes it difficult for smaller insurers to compete and pushes the market to become more concentrated, making the large insurers even more powerful.[29]

4.3. When these contract negotiations come to heavily favor the insurance plans, medical practices end up being paid less for their services.[30] This may seem like a positive change for consumers, but these lower prices for care are often not

[24] Refer to Roger D. Blair and Jeffrey L. Harrison, *Monopsony in Law and Economics* (New York: Cambridge University Press, 2010), Book.
[25] See generally M. V. Pauly, "Monopsony power in health insurance: thinking straight while standing on your head," *J Health Econ* 6, no. 1 (1987); "Market power, monopsony, and health insurance markets," *J Health Econ* 7, no. 2 (1988); "Managed care, market power, and monopsony," *Health Serv Res* 33, no. 5 Pt 2 (1998).
[26] Blair and Harrison.
[27] See generally L. J. Brown, A. H. Guay, and D. R. House, "The effects of insurance carrier market power on dentists and patients," *J Am Dent Assoc* 140, no. 1 (2009); Leemore S. Dafny, "Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience," (The Commonwealth Fund, 2015); J. B. Herndon, "Health insurer monopsony power: the all-or-none model," *J Health Econ* 21, no. 2 (2002); K. Nasseh et al., "Consolidation in the dental industry: a closer look at dental payers and providers," *Int J Health Econ Manag* 20, no. 2 (2020).
[28] See generally Brown, Guay, and House; Herndon; M. V. Pauly, "Monopsony power in health insurance: thinking straight while standing on your head," ibid.6, no. 1 (1987); "Market power, monopsony, and health insurance markets."; "Competition in Health Insurance," (American Medical Association, 2021).
[29] "Market power, monopsony, and health insurance markets."
[30] Brown, Guay, and House; Nasseh et al.

passed through to consumers in the form of lower out-of-pocket expenses or lower premiums.[31] Since insurance plans that are able to leverage these tactics typically hold a large market share, they are able to act like a monopsony in their dealings with medical practices and also like a monopoly in the insurance market. Therefore, their premium prices will not necessarily adjust to lower costs, and in some cases, premiums may even increase as a result.[32] Further, patients who are insured by smaller plans or uninsured may face higher prices as the practices need to recoup lost payments.

4.4. While it is not certain how these negotiations directly impact consumers, the evidence does indicate that they lead to lower incomes for health care providers and that in response, providers may move or restructure their practices in a way that is worse for consumers. Research has shown that dentists in areas with higher dental insurer concentration provided larger discounts for their services and had lower incomes.[33] We would expect that in the long run, dentists will move to markets with lower dental insurer concentration where they would be able to make higher wages to balance out this effect. That would leave consumers in those areas with highly concentrated dental insurance plans with fewer dentists to choose from and higher prices for dental care as a result. Similarly, health care service providers may respond to the imbalance of market power between their practice and concentrated insurance plans by consolidating practices.[34] Larger practices have more bargaining leverage since insurance plans are more concerned about removing them from their care network. Higher concentration of health care providers has been shown to be associated with higher prices for medical services.[35]

4.5. Concentrated health, dental, and vision insurance plans can leverage their market power in contract negotiations with providers to gain economic surplus that directly hurts the providers and negatively impacts consumers in the long run. We will now focus on two items that vision and dental plans often include in contract negotiations with providers where it is still legal to do so: discounts on non-covered services and restriction of laboratories and suppliers of materials.

4.6. *Discounts on non-covered services*. A non-covered service is defined in HR 3461 as a service which the dental or vision plan is not “obligated to pay an amount that is reasonable and is not nominal or de minimis.”[36] During contract negotiations when plans and providers typically would negotiate the reimbursement prices the plans will pay the providers for services, dental and vision plans have also

[31] Dafny.
[32] Pauly, "Managed care, market power, and monopsony."
[33] Brown, Guay, and House.
[34] See generally Christopher S. Brunt and John R. Bowblis, "Health insurer market power and primary care consolidation," *Economics Letters* 125, no. 1 (2014); Ian McCarthy and Sean Shenghsiu Huang, "Vertical Alignment Between Hospitals and Physicians as a Bargaining Response to Commercial Insurance Markets," *Review of Industrial Organization* 53, no. 1 (2018); Nasseh et al.
[35] See generally D. R. Austin and L. C. Baker, "Less Physician Practice Competition Is Associated With Higher Prices Paid For Common Procedures," *Health Aff (Millwood)* 34, no. 10 (2015); K. Nasseh, J. R. Bowblis, and M. Vujicic, "Pricing in commercial dental insurance and provider markets," *Health Serv Res* 56, no. 1 (2021).
[36] *Dental and Optometric Care Access Act of 2021*.

pressured providers to provide discounts for their enrollees on non-covered services, even though they are not responsible for paying for these services. While this tactic may seem like it would directly benefit consumers, this is not necessarily the case. Holding providers to fees on non-covered services only helps patients *with* coverage while those *without* coverage (i.e., so-called cash-paying patients) are left to make up the difference. Further, dental and vision plans already require significant cost-sharing on major services and low annual limits. Holding providers to fees that the plans don't cover converts the plans into "discount cards" instead of true coverage; if most of the services are not paid for by the plan itself but by the subscribers, with only discounts offered, that is not true coverage.

4.7. As discussed above, large insurance plans have greater leverage to gain this advantage for their enrollees, which leads to difficulty for smaller plans to compete. In the long term, we would expect this to lead to a more concentrated marketplace for insurance plans, implying fewer options of plans for consumers to choose from and higher premiums. We would also expect dentists and doctors of optometry to receive lower incomes because of this and may move or restructure their practices in response.[37] Additionally, practices that refuse to provide these discounts may be removed from a plan's network, leaving patients with fewer practices to choose from. Decreased competition for dental and optometry practices could lead to higher prices for these services in the long run.

4.8. If dental and optometry practices are originally overcharging for services, then forcing them to discount services is beneficial to the consumers receiving these discounts, if there are no externalities. However, if the 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. For example, our 2016 report found that dentists and doctors of optometry reported having to increase prices of other services in response to forced discounts on non-covered services, leading to higher overall costs for patients.[38]

4.9. *Restriction of laboratories and suppliers of materials*. In a free and competitive market, dental and optometry practices are incentivized to choose the most efficient, high-quality laboratories, manufacturers, and suppliers of materials for their patients since this will keep their patients happy and make them likely to return to their practices in the future. It also allows practices to set lower prices for their services if the fees they pay laboratories, manufacturers, and suppliers is lower. In a competitive market, practices must make the most efficient choices, or

[37] Brown, Guay, and House; Nasseh, Bowblis, and Vujicic.
[38] John E. Schneider, Robert L. Ohsfeldt, and Cara M. Scheibling, "Analysis of Dental and Vision Plan Non-Covered Services and Materials Mandates and the Projected Role of H.R. 3323 in the Vision and Dental Markets," (Avalon Health Economics LLC, 2016).

they will be unable to compete.[39] Therefore, any restriction of choice of laboratories, manufacturers, and suppliers of materials will not improve outcomes for patients, from the view of economics. However, the vertical integration of insurance plans, particularly vision plans, has led to plans forcing practices to use the laboratories, manufacturers, or suppliers that the plan owns, all without transparency by the plans to their enrollees.[40]

4.10. Vertical integration occurs when a company owns more than one stage of production in a supply chain. Vertical integration in health care can lead to efficiency gains in some instances, such as with managed care organizations, because it aligns the incentives for hospitals and insurers to provide efficient care.[41] However, in the case of the vision industry, vision plans profit by forcing potentially inefficient choices on the middleman in the supply chain: independent optometry practices. Since vertically integrated vision plans profit from practices choosing certain laboratories, manufacturers, or suppliers, they have an incentive to force the practices to make these decisions through contract agreements, even though this leads to worse outcomes and higher prices for patients.

4.11. Forcing practices to use plan-owned laboratories and suppliers also implies that these laboratories and suppliers no longer face the same level of competitive pressures as when practices have free choice. This may lead to these laboratories and suppliers increasing their prices and providing worse quality products than when they had to compete with other firms for their services. Additionally, patients may have to wait much longer to receive their products because plan-owned laboratories may not produce them as quickly as when practices complete the work in their back offices.

5. CURRENT STUDY

5.1. To better understand how regulations regarding the pricing and production of non-covered services by dental and optometry practices may impact consumers of these services, we designed surveys for dentists and doctors of optometry to provide information on how state-wide non-covered services laws have impacted the amounts they charge and receive for providing non-covered services. Many of the survey questions were adopted from our previous study completed in 2016, with the aim that we would be able to see if our results were consistent with the results in the 2016 report.[42] However, in this study we were able to expand the number of targeted states to 10 (see **Appendix A**) rather than only North Carolina and Texas, as several additional states have passed non-covered services laws in recent years.

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[39] See generally Carol Propper and George Leckie, "Increasing Competition Between Providers in Health Care Markets: The Economic Evidence," in *The Oxford Handbook of Health Economics* (USA: Oxford University Press, 2011).
[40] David Lazarus, "Column: Vision insurers have rigged the market to get you to buy their glasses," *Los Angeles Times* 2019.
[41] B. B. Wang et al., "Managed care, vertical integration strategies and hospital performance," *Health Care Manag Sci* 4, no. 3 (2001).
[42] Schneider, Ohsfeldt, and Scheibling.

5.2. The survey questions aimed to assess how dental and optometry providers changed their behavior based on state-level non-covered services laws. Surveys were administered using Alchemer®, an online survey tool. There were separate surveys administered to dentists and doctors of optometry. Most questions were similar in the two surveys, with the main difference being the specific non-covered services that were included. The full list of survey questions is shown in **Appendix B**. Surveys were sent to all member emails from the statewide dental and optometry associations in the 10 target states, beginning on May 10, 2021. Both surveys were closed on October 2, 2021. Survey respondents were informed that their responses would be kept confidential and only aggregate data from the surveys would be reported.

5.3. There were 746 responses to the dental survey and 131 responses to the optometry survey when the survey was closed. Observations were excluded from the analysis if they came from states outside of the 10 target states, contained illogical responses, or were missing a large portion of the data. Statistical outliers were also removed from the data, as they were assumed to be due to misinterpreting the survey question (e.g., reporting total annual charges instead of average charges). A large portion of the responses that were excluded from the analysis were from dentists or doctors of optometry that either did not accept any type of insurance or noted that they did not perform any of the services in the survey as non-covered services, therefore leading to most of the survey questions being unanswered. After excluding these observations, 496 responses to the dental survey and 102 responses to the optometry survey remained and were included in the analysis.

6. RESULTS

6.1. Average responses to several key survey questions are reported below in **Table 6-1**. For both dental and optometry surveys, we asked about the practitioners' pricing decisions regarding five specific services that are typically not covered by dental and vision plans. Respondents were asked to report their average full (non-discounted) charges for each of the five services that they provide, as well as their average voluntary discounted charges (i.e., discounts not fixed by dental or vision plans) and their average charges after discounts mandated by dental or vision plans. Additionally, the survey included questions regarding whether they increased their base charges for the services once plans required them to provide their members discounts on them, and how much payment they received on average for each service.

Table 6-1.
Summary survey data

Dentists					
Survey Question	D03050 2D oral/ facial image	D1206 fluoride varnish	D2960 labial veneer	D9944 occlusal guard	D9972 external bleaching
Avg non-discounted charges (Q2b)	$62	$41	$1,219	$565	$364
Avg charges after voluntary discount (Q2b)	$50	$27	$772	$365	$273
Avg charges after required plan discount (Q2ci)	$28	$22	$646	$299	$240
Percent by which charges were increased (Q3a)	44%	36%	20%	28%	36%
Avg net payment (Q4)	$43	$27	$893	$412	$318
Doctors of Optometry					
Survey Question	Eyeglasses (second pair, etc.)	Eyeglasses lens features	Contact lens fitting/ evaluation	Digital Imaging and Machine-based tests	Low Vision/ Vision Therapy
Avg non-discounted charges (Q3)	$384	$203	$99	$81	$201
Avg charges after voluntary discount (Q3)	$279	$132	$72	$56	$127
Avg charges after required plan discount (Q4a)	$208	$99	$53	$39	$87
Percent by which charges were increased (Q5a)	21%	30%	34%	38%	57%
Avg net payment (Q6)	$172	$73	$57	$45	$126

6.2. The results indicate that dental and optometry practices often provide substantial discounts on these services without being required to by insurance plans, but the discounts fixed by insurance plans are often larger than these voluntary discounts. However, dental and optometry practices often accept lower payments than their posted prices, as is indicated by the average net payments reported in Table 1. Therefore, it is unclear whether the enrollees of the plans requiring the discounts benefit due to this practice.

6.3. In response to plan-required discounts, 12% of dentists and 54% of doctors of optometry who completed the surveys reported increasing their prices for these services. Those who increased their prices did so by an average of 20%-57%, depending on the service. This indicates that while some consumers who enroll in the plans that fix these discounts may appear to benefit from the required discounts, the consumers who do not enroll in these plans may be forced to pay more for the services as a result. This type of arrangement hurts patients who are uninsured, insured by smaller plans, or insured by plans that are required to follow state-level non-covered services laws. In addition, even those patients who are insured may have their "discounts" applied to higher prices than would exist without plans fixing the price discounts.

6.4. After state laws were passed banning forced discounts on non-covered services, many dentists and doctors of optometry reported that they continued to offer discounts on at least some of the non-covered services specified. Most of these respondents described their new voluntary discounts as only marginally less or about the same as those previously mandated by plans (**Figures 6-1** and **6-2**).

Figure 6-1.
Size of voluntary discounts provided by doctors of optometry after state-level non-covered services laws (Q7a)

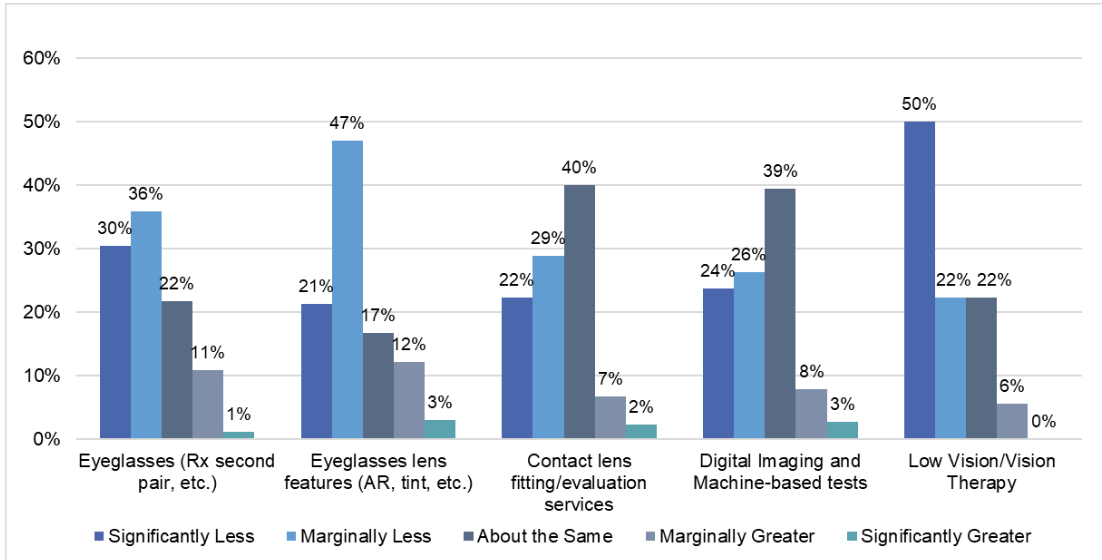
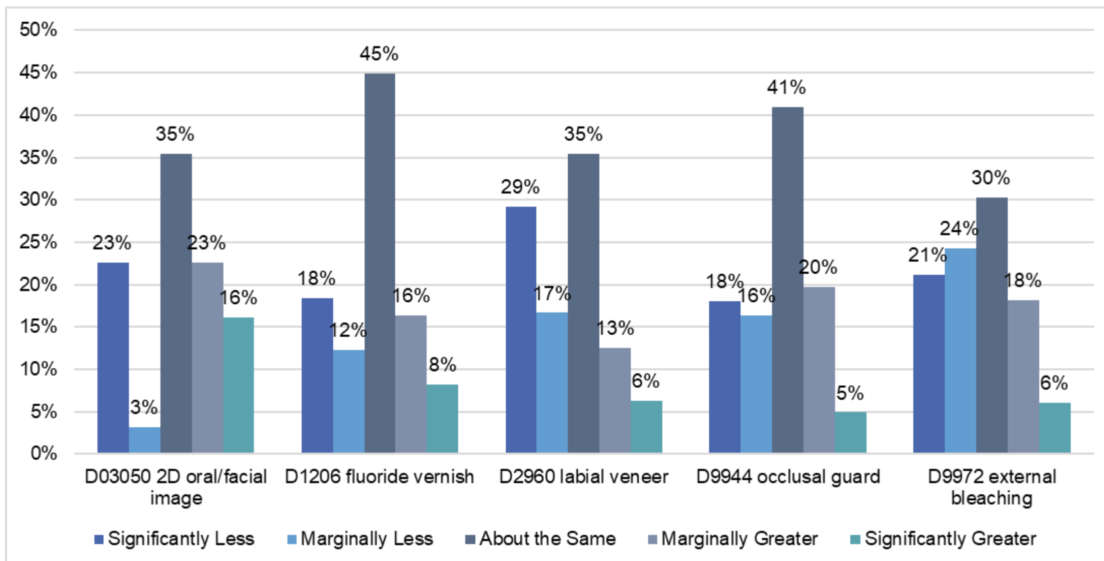


Figure 6-2.
Size of voluntary discounts provided by dentists after state-level non-covered services laws (Q5a)



6.5. Moreover, most respondents indicated that their prices for these services have not increased at a rate higher than inflation since their state approved a law banning discounts on non-covered services (**Figures 6-3** and **6-4**). These results imply that the passage of state-level laws banning plans from requiring discounts on non-covered services have not led to significant increases in the prices that consumers of these services face.

Figure 6-3.
Optometry price changes since state-level
non-covered services laws approved (Q8)

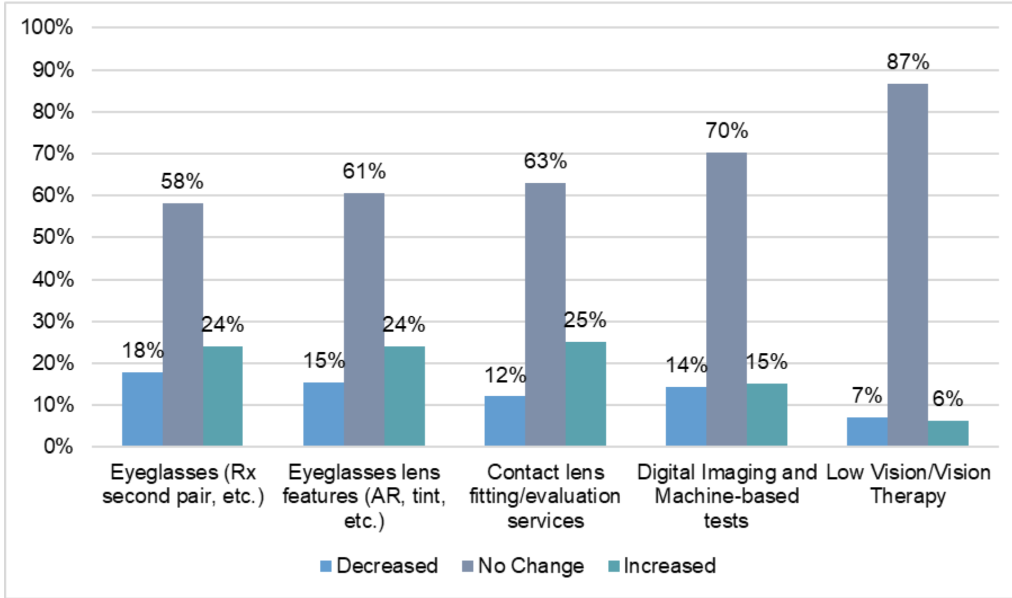
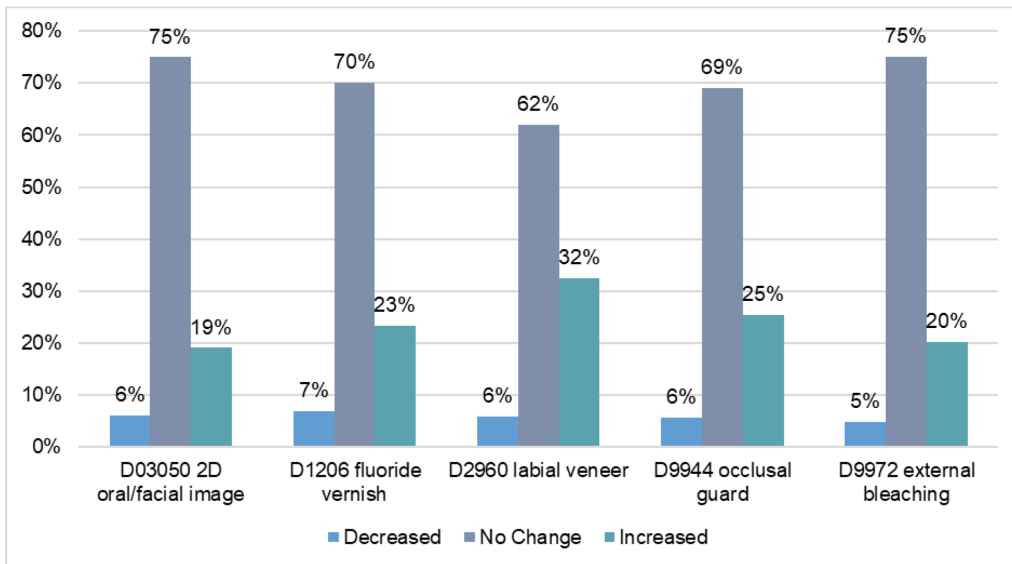


Figure 6-4.
Dentistry price changes since state-level
non-covered services laws approved (Q6)



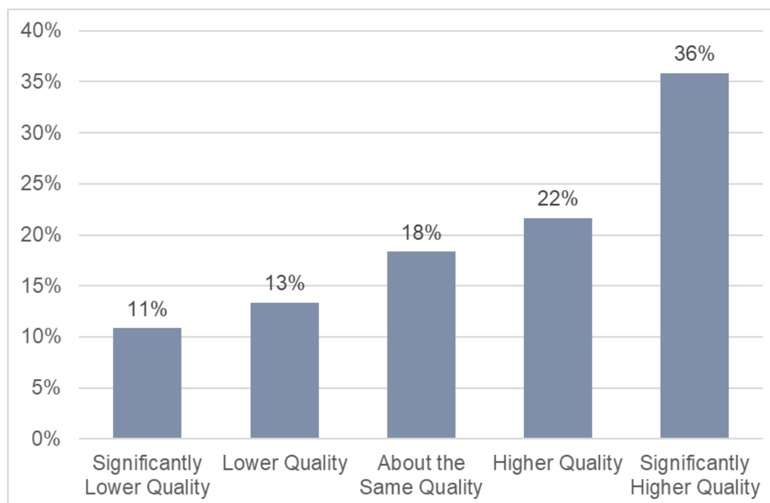
6.6. These findings are consistent with the results of our 2016 report, and our conclusions remain unchanged: dental and optometry practices are not overcharging patients for these services when plans are unable to fix price discounts for their enrollees.[43] In fact, there is evidence to support the claim that many patients are better off when plans do not mandate discounts on non-covered services for their enrollees: particularly those who are not covered by those plans, since dental and optometry practices are forced to increase prices for other patients or services as a result of required discounts.

6.7. The survey administered to doctors of optometry included some additional questions regarding the common practice of vision plans requiring optometry practices to provide eyeglasses or related supplies at certain laboratories or manufacturers, often those that the plan itself owns. As previously described in this report, economic theory would suggest that restricting the options for laboratories can only reduce the ability of the doctor to make the most efficient choice and is likely to lead to worse outcomes for patients. We focused on three outcomes that patients are likely to be interested in: costs, wait times, and quality. The results are reported in **Table 6-2** and **Figure 6-6** below.

Table 6-2.
Average charges and wait times for laboratories vision plan-required vs. laboratories of choice

	Avg charge for eyeglasses	Avg wait time for eyeglasses
Laboratories that plans required (Q9c)	$231	15 days
Laboratories of choice (Q9d)	$240	7 days

Figure 6-6.
Quality of eyeglasses and/or supplies from laboratories of choice relative to laboratories required by plans (Q10)



[43] Ibid.

7. DISCUSSION

7.1. Our results indicate that, on average, charges for eyeglasses were slightly higher at laboratories of the doctor of optometry's choice than at the laboratories vision plans required. However, the average wait times for those eyeglasses were more than twice as long at the laboratories that vision plans required, and more than half of respondents reported that the eyeglasses from the laboratories of their choice were higher quality. This suggests that doctors of optometry are often being limited to provide lower quality eyeglasses to their patients with much longer wait times for the patients to receive them, due to the restrictions the vision plans can place on their optometry practices. Passing a law that would ban these restrictions by vision plans, such as the DOC Access Act, would allow doctors of optometry to choose laboratories that could cut wait times for eyeglasses in half and provide higher quality eyeglasses at approximately the same cost for patients.

7.2. Our survey research was limited in that it could not measure some of the long-term impacts of allowing dental and vision plans to fix price discounts for their members on non-covered services or forcing practices to use specific laboratories, as discussed above. These include harms that patients face due to the consolidation of the dental and vision insurance industries, including higher premiums, which is supported by these types of special privileges that only large plans have enough leverage to force on practices. Additionally, we are unable to capture the harm of dental and optometry practices relocating or restructuring in the long term to improve their negotiating power against insurance plans.

8. CONCLUSION

8.1. Dentists and doctors of optometry are not charging unreasonable prices for non-covered services after state-level laws banning insurance companies from imposing discounted fees on these providers are passed; nor do these providers demonstrate a tendency to raise their fees beyond the rate of inflation in response to the passage of such a law.

8.2. Federally regulated dental and vision plans are still allowed to set fees for non-covered services and require materials be provided by specific laboratories, which 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.

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Appendix A: List of States Targeted in Survey Study

1. Alabama
2. Arkansas
3. Florida
4. Georgia
5. Kansas
6. Maryland
7. New Jersey
8. North Carolina
9. Texas
10. West Virginia

Appendix B: Survey Instruments

Dentists Survey

1. What state are you located in? [ ]

2. Which of the following procedures have you performed and were not covered by at least some dental plans during the most recent fiscal year (or the year for which you have the most easily accessible data)?
   - ☐ D2960 labial veneer
   - ☐ D1206 topical application of fluoride varnish
   - ☐ D0350 2D oral/facial photographic image
   - ☐ D9972 external bleaching
   - ☐ D9944 occlusal guard – hard appliance, full arch
   - ☐ None of the above

   a. Please indicate the approximate number of times you have billed for these services for the most recent complete fiscal year (or the year for which you have the most easily accessible data).

	Estimate of Number of Times Billed
1) D2960 labial veneer	
2) D1206 topical application of fluoride varnish	
3) D0350 2D oral/facial photographic image	
4) D9972 external bleaching	
5) D9944 occlusal guard – hard appliance, full arch	

   b. Indicate the full fees for the services and list the average discounted billed charges. For this question, do not consider discounts required or “forced” by dental plans, but rather discounts you gave to patients by your own choice.

	Full Fee	Estimate of Average Discounted Billed Charges
1) D2960 labial veneer		
2) D1206 topical application of fluoride varnish		
3) D0350 2D oral/facial photographic image		
4) D9972 external bleaching		
5) D9944 occlusal guard – hard appliance, full arch		

   c. For the charges listed above, did a dental plan require you to discount any of these charges for procedures not covered by the plan?

- Yes
- No

i. Please list the average charges after the required dental plan discount. Think about the most recent complete fiscal year (or the year for which you have the most easily accessible data).

	Estimate of Average Charges After Required Dental Plan Discount
1) D2960 labial veneer	
2) D1206 topical application of fluoride varnish	
3) D0350 2D oral/facial photographic image	
4) D9972 external bleaching	
5) D9944 occlusal guard – hard appliance, full arch	

3. For these five services, would you say that you raised your fees for these services when the dental plan began requiring you to discount them?

- Yes
- No

a. If so, please indicate the amount by which your listed charges were increased in response to the plan-required discounts.

	Estimate of Average Increase in Charges in Response to Plan-Required Discounting
1) D2960 labial veneer	
2) D1206 topical application of fluoride varnish	
3) D0350 2D oral/facial photographic image	
4) D9972 external bleaching	
5) D9944 occlusal guard – hard appliance, full arch	

4. Thinking about the five services, what was your average *net payment* for each of these products or services? Think about the amount that you actually received in satisfaction of the bill or invoice. Think about the most recent complete fiscal year.

	Estimate of Average Net Payment
1) D2960 labial veneer	
2) D1206 topical application of fluoride varnish	

3) D0350 2D oral/facial photographic image	
4) D9972 external bleaching	
5) D9944 occlusal guard – hard appliance, full arch	

5. Thinking about the five services, after your state approved a law banning forced discounts, did you continue to offer a discount on non-covered services even when you were not forced to do so?
   - ☐ D2960 labial veneer
   - ☐ D1206 topical application of fluoride varnish
   - ☐ D0350 2D oral/facial photographic image
   - ☐ D9972 external bleaching
   - ☐ D9944 occlusal guard – hard appliance, full arch
   - ☐ None of the above

   a. How did your "voluntary" discount compare to that which had been required or forced by the dental plan?

	1	2	3	4	5
1) D2960 labial veneer					
2) D1206 topical application of fluoride varnish					
3) D0350 2D oral/facial photographic image					
4) D9972 external bleaching					
5) D9944 occlusal guard – hard appliance, full arch					
Note: 1 = Significantly less; 2 = Marginally less; 3 = About the same; 4 = Marginally greater; 5 = Significantly greater					

6. Consider the time since your state approved a law banning forced discounts for non-covered services. For the following procedures, have the fees for these services increased, decreased, or have had no change, relative to inflation? Check one of the boxes that apply to the service.

	Increased	Decreased	No Change
1) D2960 labial veneer			
2) D1206 topical application of fluoride varnish			
3) D0350 2D oral/facial photographic image			
4) D9972 external bleaching			
5) D9944 occlusal guard – hard appliance, full arch			

Doctors of Optometry Survey

1. What state are you located in? [ ]

2. Below is a list of five categories of common services and materials that, at times, may be treated as non-covered services or materials. For each of these categories, indicate the approximate number of times you have billed for the services or materials within that category for the most recent complete fiscal year (or the year for which you have the most easily accessible data).

	Estimate of Annual Volume
1) Eyeglasses (Rx second pair, Rx sun wear, etc.)	
2) Eyeglass lens features (AR, tint, UV, progressives, etc.)	
3) Contact lens fitting/evaluation services	
4) Digital Imaging and Machine-based tests (retinal imaging, visual field tests)	
5) Low Vision/Vision Therapy	

3. For these same services and materials, what are your average listed, non-discounted charges for materials or usual and customary for services (that is, per-product or per-service)? Also, in the adjacent column, for the same services list the average discounted billed charges. For this question, do not consider discounts required or “forced” by vision plans. Think about the most recent complete fiscal year (or the year for which you have the most easily accessible data).

	Estimate of Average, Listed Non-Discounted Charges	Estimate of Average Discounted Billed Charges
1) Eyeglasses (Rx second pair, Rx sun wear, etc.)		
2) Eyeglass lens features (AR, tint, UV, progressives, etc.)		
3) Contact lens fitting/evaluation services		
4) Digital Imaging and Machine-based tests (retinal imaging, visual field tests)		
5) Low Vision/Vision Therapy		

4. For the charges listed above, did a vision plan require you to discount any of these charges for procedures not covered by the plan?

- o Yes
- o No

a. Please list the average charges after the required vision plan discount. Think about the most recent complete fiscal year (or the year for which you have the most easily accessible data).

	Estimate of Average Charges After Required Vision Plan Discount
1) Eyeglasses (Rx second pair, Rx sun wear, etc.)	
2) Eyeglass lens features (AR, tint, UV, progressives, etc.)	
3) Contact lens fitting/evaluation services	
4) Digital Imaging and Machine-based tests (retinal imaging , visual field tests)	
5) Low Vision/Vision Therapy	

5. For these five services and materials categories, would you say that you raised your listed charges or prices for these services and materials when the vision plan began requiring you to discount them?
   - o Yes
   - o No

a. Please indicate the amount by which your listed charges were increased in response to the plan-required discounts. If you did not raise your fees one or more times in response to a vision plan's policy on noncovered services, enter a "0".

	Estimate of Average Increase in Charges in Response to Plan-Required Discounting
1) Eyeglasses (Rx second pair, Rx sun wear, etc.)	
2) Eyeglass lens features (AR, tint, UV, progressives, etc.)	
3) Contact lens fitting/evaluation services	
4) Digital Imaging and Machine-based tests (retinal imaging, visual field tests)	
5) Low Vision/Vision Therapy	

6. Thinking about the five services and materials categories, what was your average net payment for these products or services? Think about the amount that you actually received in satisfaction of the bill or invoice (net payment = vision plan payment (if any) + patient payment). Think about the most recent complete fiscal year.

	Estimate of Average Net Payment

1) Eyeglasses (Rx second pair, Rx sun wear, etc.)	
2) Eyeglass lens features (AR, tint, UV, progressives, etc.)	
3) Contact lens fitting/evaluation services	
4) Digital Imaging and Machine-based tests (retinal imaging, visual field tests)	
5) Low Vision/Vision Therapy	

7. Thinking about the five services and materials categories, after your state approved a law banning forced discounts, did you continue to offer a discount on non-covered services and materials even when you were not forced to do so?

☐ Eyeglasses (Rx second pair, Rx sun wear, etc.)
☐ Eyeglass lens features (AR, tint, UV, progressives, etc.)
☐ Contact lens fitting/evaluation services
☐ Digital Imaging and Machine-based tests (retinal imaging, visual field tests)
☐ Low Vision/Vision Therapy

 a. How did your “voluntary” discount compare to that which had been required or forced by the vision plan?

	1	2	3	4	5
1) Eyeglasses (Rx second pair, Rx sun wear, etc.)					
2) Eyeglass lens features (AR, tint, UV, progressives, etc.)					
3) Contact lens fitting/evaluation services					
4) Digital Imaging and Machine-based tests (retinal imaging, visual field tests)					
5) Low Vision/Vision Therapy					
Note: 1 = Significantly less >50%; 2 = Marginally less 20-50%; 3 = About the same; 4 = Marginally greater 20-50%; 5 = Significantly greater >50%					

8. Consider the time since your state approved a law banning forced discounts for non-covered services. For the following procedures, have the fees for these services increased, decreased, or have had no change, relative to inflation? Check one of the boxes that apply to the service.

	Increased	Decreased	No Change
1) Eyeglasses (Rx second pair, Rx sun wear, etc.)			
2) Eyeglass lens features (AR, tint, UV, progressives, etc.)			
3) Contact lens fitting/evaluation services			

4) Digital Imaging and Machine-based tests (retinal imaging, visual field tests)			
5) Low Vision/Vision Therapy			

9. Have you been under contract with vision plans to have certain laboratories provide eyeglasses or related supplies (i.e. lenses) for patients during the most recent fiscal year?
   - o Yes
   - o No

   a. If yes, is the lab owned by the vision plan?
   - o Yes
   - o No

   b. Approximately what percentage of eyeglasses that you provided were produced at plan-specified laboratories? Think about the most recent complete fiscal year (or the year for which you have the most easily accessible data).
   - o 0-10%
   - o 10%-20%
   - o 20%-30%
   - o 30%-40%
   - o 40%-50%
   - o 50%-60%
   - o 60%-70%
   - o 70%-80%
   - o 80%-90%
   - o 90%-100%

   c. What were the average charges and wait times for a patient to receive eyeglasses from laboratories that plans required?

   Average charge for [ ] eyeglasses:

   Average wait time for [ ] eyeglasses:

   d. What were the average charges and wait times for a patient to receive eyeglasses from laboratories of your choice (i.e. when a plan did not require you to have materials provided from certain laboratories)?

   Average charge for eyeglasses: [ ]

   Average wait time for [ ] eyeglasses:

10. How would you rate the quality of eyeglasses and/or supplies (i.e. lenses) provided by the laboratory of your choice, including in-house if applicable, relative to the laboratories you were required to use due to contracts with vision plans?
Note: 1 = Significantly lower quality; 2 = Lower quality; 3 = About the same quality; 4 = Higher quality; 5 = Significantly higher quality

1	2	3	4	5

11. Which vision plan covers the largest portion of your patients?
    - ○ VSP
    - ○ EyeMed
    - ○ Other: [ ]

    a. What percentage of your patients are covered by this vision plan?

    [ ]