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114TH CONGRESS
1ST SESSION

H. R. 3323

To amend title XXVII of the Public Health Service Act to improve health care coverage under vision and dental plans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 29, 2015

Mr. CARTER of Georgia introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend title XXVII of the Public Health Service Act to improve health care coverage under vision and dental plans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Dental and Optometric Care Access Act'' or the ''DOC Access Act''.

SEC. 2. IMPROVING HEALTH CARE COVERAGE UNDER VISION AND DENTAL PLANS.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act is amended by inserting after section 2719A (42 U.S.C. 300gg–19a) the following new section:

"SEC. 2719B. IMPROVING COVERAGE UNDER VISION AND DENTAL PLANS.

"(a) IN GENERAL.—Under a group health plan or individual or health insurance coverage (including such a plan or coverage offering limited scope dental or vision benefits), the following shall apply:

"(1) PAYMENT AMOUNTS FROM COVERED PERSONS.—

"(A) IN GENERAL.—The plan or coverage shall provide, 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 furnishes items or services that are not covered by the plan or coverage to a person enrolled under such plan or coverage, that 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.

"(B) ITEMS AND SERVICES CONSIDERED COVERED BY A PLAN.—For purposes of subparagraph (A), an item or service shall be considered, with respect to a plan or coverage, to be covered by the plan or coverage only if the

negotiated rate agreed to by such plan or coverage and the doctor for such item or service, without regard to any cost sharing obligation of the enrollee, is an amount that is reasonable and is not nominal or de minimis.

''(2) CHANGES TO PLANS.—The terms of an agreement between such a plan or coverage and such a doctor (including, in the case of a plan or coverage that provides for a provider network, the negotiated rate for providers that participate in the network of such plan or coverage), may be changed only pursuant to a subsequent agreement signed by the doctor that documents the acknowledgment and acceptance of the doctor (as applicable) to such changes.

''(3) DURATION OF LIMITED SCOPE VISION AND DENTAL PLANS.—In the case of an agreement between such a doctor and such a plan or coverage that offers limited scope dental or vision benefits, the agreement may not be for a period that is greater than two years.

''(4) TERMS AND CONDITIONS FOR ANCILLARY SERVICES AND PROCEDURES.—Such plan or coverage may not deny such a doctor participation in the plan or coverage or remove such a doctor from participation in the plan or coverage for the sole rea-

son of the failure of the doctor to accept the terms and conditions under such agreement for any ancillary service or procedure.

''(5) CONDITION TO JOIN A PROVIDER NETWORK.—The plan or coverage may not require that such a doctor must participate with, or be credentialed by, any specific plan or coverage offering limited scope dental or vision benefits as a condition to participate in the provider network of such plan or coverage.

''(6) NO INTERFERENCE WITH EXISTING RELATIONSHIPS AND REQUIREMENTS.—Unless otherwise required by law or regulation, such plan or coverage may not directly communicate with an individual enrolled in such plan or coverage in a manner that interferes with or contravenes any State or Federal requirement, or doctor-patient relationship in existence at the time of such communication.

''(7) NO RESTRICTION ON CHOICE OF LABORATORIES.—The plan or coverage may not, directly or indirectly, restrict or limit, such a doctor's choice of laboratories or choice of source and suppliers of services or materials provided by the doctor to an individual who is enrolled under the plan or coverage.

''(b) PRIVATE RIGHT OF ACTION.—In addition to any other remedies under State or Federal law, a person adversely affected by a violation of this subsection may bring action for injunctive relief against a plan described in subsection (a) and, upon prevailing, in addition to such injunctive relief, shall recover monetary damages of no more than $1,000 for each day found to be in violation plus attorney's fees and costs. The district courts of the United States shall have exclusive jurisdiction of civil actions brought under this subsection.

''(c) RELATIONSHIP TO EXCEPTION FOR LIMITED, EXCEPTED BENEFITS.—Section 2722(c)(1) shall not apply with respect to the requirements of this section.

''(d) DEFINITIONS.—In this section:

''(1) The terms 'doctor of dental surgery' and 'doctor of dental medicine' mean a doctor of dental surgery or of dental medicine, as applicable, who is legally authorized to practice dentistry by the State in which the doctor performs such function and who is acting within the scope of the license of the doctor when performing such functions.

''(2) The term 'doctor of optometry' means a doctor of optometry who is legally authorized to practice optometry by the State in which the doctor so practices.''.

(b) CONFORMING AMENDMENT.—Section 2722(c)(1) of the Public Health Service Act (42 U.S.C. 300gg–21(c)(1)) is amended by striking ''The requirements'' and inserting ''Subject to section 2719B, the requirements''.

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