# In-Office Dental Plans

## Dental Membership Savings Plans or Direct Primary Care Agreements

Studies have shown that patients with a benefit plan are much more likely to seek dental care and accept treatment plans. When a practice is looking to grow without participating in a commercial dental plan, one option the office might consider is an in-office dental plan. These plans are also known as dental membership savings plans, or direct primary care agreement plans.

While there are many variants, in general, the patient pays the doctor or dental office a fixed amount of money on a monthly or annual basis. Preventive services may be covered at no charge. Procedures other than preventive are then offered at a discounted fee. The plan design is up to the office, as is the cost to the patient for participating in the plan.

When considering whether to implement such a plan, the office should consider whether revenue lost by discounting fees for existing cash patients will be offset by revenue gained through new patient acquisition or completion of treatment delayed for financial reasons. There are several commercial vendors who assist dental offices in establishing in-office plans for an administrative fee or portion of the production.

The American Dental Association (ADA) Council on Dental Benefit Programs has developed this toolkit to help dental practices begin to evaluate an in-office option. The Council appreciates the input and will continue to update this resource as needed. Please send input to dentalbenefits@ada.org.

### Step I: Legal Considerations

The ability of a dental office to set up an in-office plan depends on a variety of factors that include local and state laws, as well as existing contractual relationships between the dentist and third-party payers, especially those with a “most favored nation” clause. These factors are discussed further in the questions that follow.

Consulting with your own attorney to determine how these factors affect your business decision is an important initial step. If necessary, your local bar association may be able to help you find an attorney knowledgeable in these areas.

Some questions to consider before setting up an in-office dental plan include:

**Q. Does your state consider these types of plans to be insurance and, if so, would you have to license or register with the state accordingly?**

**A.** Your state may have its own rules that affect the establishment of an in-office dental plan. Laws vary from state to state. Appendix A is the list of states that have enacted direct primary care agreement legislation, which allows you to implement an in-office dental plan without having to register as an insurance company. Be sure to comply with any requirements.

**Q. How will any managed care contracts you have signed affect an in-office dental plan implemented by your office? For example, will the managed care plan invoke a “most favored nation” clause and require you to pass on those fees to its insured members?**

**A.** Your obligations under these contracts might present impediments to your establishing the plan, or to establishing it in the manner you wish. For example, when your contract with a third party payer

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contains a “most favored nation” clause it guarantees that the payer will receive the lowest rate that you charge for any procedure. This means that if your in-office plan fee for a procedure is less than the fee you have committed to with the payer, the payer is permitted to reimburse you at the lower fee. You will be accepting the lower fee for all patients covered by your in-office plan, plus all patients covered by the third-party payer’s plan. Also, the payer could conceivably attempt to go back to the establishment of your plan to seek partial reimbursement of the previously paid fees, or merely attempt to set that amount off against future payments to you.

**Q. What does the patient have to do to take advantage of this kind of plan?**

**A.** You will need to have a signed agreement from your patient that fully describes the terms and conditions of the in-office plan.

You should specifically describe the services that are covered by the plan (and state clearly those services that are not covered), what services will be provided at each visit, how frequently the patient may receive the covered services, any additional fees the patient might have to pay for certain services, any restrictions (e.g. limitations on refunds, the consequences of missed appointments, referrals to specialists, eligibility for enrolling in the plan, etc.).

It is critical that you fully, accurately, and unambiguously describe the terms of the plan, both in the terms of your agreement with the patient, as well as in advertisements or offers that you make to the general public (including to your patients).

A clear and unambiguous written statement in the contract of what services are and are not covered will minimize the chance of any dispute down the road.

**Step II: Implementation**

After you have conferred with your own attorney and have made the decision to proceed, where do you begin?

- Calculate the annual fixed dollar amount to be paid by the patient.
- Determine which preventive services will be covered at no additional charge. You will need to be very specific in defining those procedures and the frequency with which they will be covered.
- Decide the percentage discount you will give to the other covered procedures and remember that you determine those fees.

Besides the financial aspects of the plan, you need to set some policies about your plan.

- What do you plan to do if a patient cannot receive all the benefits? For example, what if a patient moves after having only one exam covered by the plan. Can the patient receive a refund for unused services? All the terms and conditions of the plan must be clearly stated in the agreement.
- Is specialist care included in the plan? If so, you will need to get an agreement from specialists to whom you refer to provide a discount. Keep in mind that these specialists can leave the plan at their discretion. You may also elect to not include this as a feature of your plan.

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As noted above, there are several commercial vendors who assist dental offices in establishing in-office plans for an administrative fee or portion of the production.

**Step III: Example**

This example is for illustration purposes only. Dentists will need to determine the annual fees, percentage discounts and covered procedures.

| Covered Procedures | Frequency | Cost |
|---|---|---|
| D0120 – Periodic Oral Evaluation<br>D1110 – Prophylaxis<br>D0274 – Bitewings | 2 times per plan year<br>2 times per plan year<br>1 time per plan year | $400 or $300 or $150 annually |
| All other dental procedures | No limit | 20% or 15% or 10% discount off dentist’s full fee |

**Step IV: In-Office Dental Plan Calculator**

Accurately predicting the financial impact of your in-office dental plan is essential to its success. Our in-office dental plan calculator is designed to help you determine potential impact on your practice income with different plan designs.

The calculator will allow you to estimate the total annual revenue from your in-office dental plan and compare it to the total amount of revenue you are currently generating from patients without dental benefits. In addition, you will be able to estimate the financial impact of bringing new patients, who are interested in this type of program, into your office.

**Step V. Your In-Office Dental Plan**

Before you put your in-office plan in place, it is imperative you have the plan and accompanying agreement reviewed by a competent attorney.

There are several commercial vendors who assist dental offices in establishing in-office plans for an administrative fee or portion of the production.

**Step VI: Summary**

- Determine the annual fixed dollar amount to be paid by the patient.
- Determine the preventive procedures that will be covered at no additional charge.
- Determine the percentage discount for other procedures.
- Be sure to have your own attorney review your plan and accompanying agreement.

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## Additional Resource Materials

**Dental Benefit Information**

- ADA.org/dentalinsurance

**Appendix A: Direct Primary Care Agreements In-Office Health and Dental Plans**

- This may not be a complete listing of all states with direct primary care agreement legislation, but is provided to help dentists in those states comply with any laws pertaining to direct primary care agreements.

**Appendix B: General Contract Considerations**

**Appendix C: Checklist and Considerations for Your In-Office Dental Plan**

**Appendix D: Marketing and Promotional Letter**

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# Appendix A: Direct Primary Care Agreements

## In-Office Health and Dental Plans

Direct Primary Care Agreement (DPCA) laws provide guidance and restrictions for health care providers that establish private agreements with their patients providing specified scope of services for an established periodic fee. The laws generally establish the following:

- Contracting requirements
- Restrictions on billing or filing claims with carriers
- Exemptions from state insurance authority regulation or oversight
- Certain patient notification requirements

## Direct Primary Care Agreement Legislation

**States That Include Dental**

Twenty states *include dental* in the definition of health care provider authorized to engage in DPCA. (*Two states are *dental specific*.)

## Direct Primary Care Agreements – In-Office Plans

*June 13, 2022*

Direct Primary Care Agreement (DPCA) laws provide guidance and restrictions for health care providers that establish private agreements with their patients providing specified scope of services for an established periodic fee. The laws generally establish: contracting requirements; restrictions on billing/filing claims with carriers; exemptions from state insurance authority regulation/oversight; and certain patient notification requirements.

### 20* States *Include Dental* in the Definition of Health Care Provider Authorized to Engage in DPCA; (* *2 are Dental Specific*)

**See Washington for note on interpretation issue**

| 20 States | **Select Provisions**<br>*See state law for full review of requirements & restrictions* |
|---|---|
| **ALABAMA<br>SB 94<br>2017** | • Cannot bill a third party any additional fee for services for patients covered under a dental agreement<br>• No license required to offer, market, sell or enter into DPCAs<br>• Periodic fee does not count toward deductible or out-of-pocket max<br>• Urge consult with health insurer. Insurer may cover services also covered in DPCA |
| **ARIZONA<br>SB 1105<br>2019** | • Prohibits DPCPs from submitting a claim to patients' health care insurer for DPCA services |

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|---|---|
| | • Allows health care insurers or other third parties to pay for the periodic fee and any additional fees for ongoing care under the agreement |
| **ARKANSAS HB 2240 2017** | • Prohibits the healthcare provider from charging or receiving additional compensation for healthcare services included in the periodic fee<br>• Allows health care insurers or other third parties to pay for the periodic fee |
| **FLORIDA HB 7 2019** | • Provider may not submit a claim for DPCA services<br>• Provider allowed to market, sell, or offer to sell a direct medical care agreement |
| **IDAHO SB 1062 2015** | • Provider or patient prohibited from billing insurer for DPCA services<br>• Urge consult with health insurer<br>• Video of Senate Committee hearing |
| *** ILLINOIS SB 174 2019** | • DPCA law is dental-specific<br>• Dentist and patient prohibited from billing insurer for DPCA services<br>• Urge consult with health insurer<br>• Dentist *MAY* refund unearned direct fees associated with the covered services in the agreement<br>• Establishes restrictions on transfer of agreements |
| **INDIANA SB 303 2017** | • Prohibits billing a third party that provides coverage to the patient for the primary care health services |
| **IOWA HF 2356 2018** | • Dentist may not bill insurance<br>• A direct patient may submit a request for reimbursement to an insurer if permitted under the direct patient's policy of insurance<br>• Contract must specify any additional costs for primary care health services not covered by the direct service charge for which the direct patient will be responsible<br>• Urge consult with health insurer for DPCA services<br>• Allows periodic fee/additional fees to be paid by insurer or 3rd party |
| *** LOUISIANA SB 127 2019** | • DPCA law is dental-specific<br>• Periodic fee does not count toward deductible or out-of-pocket max<br>• Urge consult with health insurer for DPCA services<br>• Dentist allowed to market, sell, or offer to sell a direct medical care agreement<br>• Patients wouldn't forfeit their insurance, Medicaid, or Medicare benefits by purchasing a direct primary care agreement<br>• Allows a direct dental practice to accept payment of periodic fees for a direct primary care agreement directly or indirectly from third-parties, including employers |
| **MICHIGAN SB 1033 2014** | • Provider and patient prohibited from billing insurer for DPCA services<br>• Provider allowed to market, sell, or offer to sell a direct medical care agreement |
| **MISSOURI HB 2168 2022** | • Declares In-Office Plan contract is *not* business of insurance<br>• Dentist is not required to obtain a certificate of authority or license to market, sell, or offer to sell In-Office Plan products<br>• Agreements must meet specified standards |
| **MONTANA SB 101 2021** | • Prohibits provider from submitting claim for services in direct patient care agreement;<br>• Allow for the direct fee and any additional fees to be paid by a third party |

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|---|---|
| | • Exempts direct patient care agreements from state insurance authority oversight<br>• Insurers may not prohibit, interfere with, initiate a legal or administrative proceeding against, or impose a fine or penalty against a health care provider solely because the provider provides direct patient care solely because the person pays a direct fee for direct patient care. |
| **NORTH CAROLINA HB 471 2020** | • Provider may not bill any third parties on a fee for service basis<br>• Provider and their agent[s] shall not be required to be licensed or certified to market, sell, or offer to sell direct primary care agreements |
| **OKLAHOMA SB 560 2015** | • Prohibits provider from billing third parties on a fee-for-service basis<br>• Any per-visit charges under the agreement will be less than the monthly equivalent of the periodic fee<br>• DPCA patient does not forfeit coverage under a health benefit plan<br>• No certification of authority or license required to market, sell or offer to sell a direct primary care agreement<br>• A direct primary care membership agreement is not a medical discount plan |
| **TENNESSEE SB 2317 2020** | • Prohibits billing third party payers<br>• Charges under the agreement must be less than the monthly equivalent of the periodic fee<br>• Periodic fee does not count toward deductible or out-of-pocket max<br>• Urge consult with health insurer<br>• DPCA patient does not forfeit coverage under a health benefit plan<br>• Specifies DPCA is not a discount plan<br>• Provider not required to obtain certification of authority or license in order to market, sell, or offer to sell a direct medical care agreement |
| **UTAH HB 240 2012** | • Provider may not submit a claim for DPCA services<br>• A person or a professional corporation agrees to provide *routine health care services* to the individual patient for an agreed upon fee and period of time<br>• “Routine health care services” are screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury |
| **VIRGINIA SB 800 HB 2053 2017** | • Provider may not bill insurance<br>• Urge consult with health insurer/In-surer may cover services also covered in DPCA |
| **WEST VIRGINIA HB 2301 2017** | • DPCA patient does not forfeit coverage under a health benefit plan<br>• Specifies DPCA is not a discount plan<br>• Provider allowed to market, sell, or offer to sell a direct medical care agreement |
| **WYOMING SB 49 2016** | • Allows periodic fee/additional fees to be paid by insurer or 3rd party<br>• Prohibits the provider from charging or receiving additional compensation for health care services included in the periodic fee |

*Though dental is included in definitions, State insurance authority interprets dental is not included.*

| | |
|---|---|
| **WASHINGTON SB 5958 2007** | • Provider may not bill and insurer or submit a claim for DPCA services<br>• Urge consult with health insurer/In-surer may cover services also covered in DPCA<br>• Allows periodic or other fee to be paid by a 3rd party |

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| | |
|---|---|
| | • Provider allowed to market, sell, or offer to sell a direct medical care agreement<br>• NOTE: State insurance authority currently rules dentists are not eligible to engage in DPCAs |

## 12 States *Do Not Include Dental* in the Definition of Health Care Provider Authorized to Engage in DPCA

| Colorado HB 1115 2017 | Georgia SB 18 2019 | Kansas HB 2225 2015 | Kentucky SB 79 2017 | Maine SB 472 2017 | Mississippi SB 2687 2015 | Missouri HB 769 2015 | Nebraska L 817 2016 |
|---|---|---|---|---|---|---|---|
| New Hampshire HB 508 2019 | Ohio HB 166 2019 | Oregon SB 86 2011 | Texas HB 1945 2015 | | | | |

*Common DPCA Statutory Themes*:
**Contract provision requirements: scope, periodic fee, termination etc. ** Maximum number of months fees can be collected ** Periodic fee does not count toward deductible or out-of-pocket maximum ** Urge consult with health insurer/Insurer may cover services also covered in DPCA ** Dentist may decline patient for cause ** Allows periodic or other fee to be paid by a 3rd party ** Prohibits dentist from charging or receiving additional compensation for services in the periodic fee ** Allows periodic fee/additional fees to be paid by insurer or 3rd party ** DPCA patient does not forfeit coverage under a health benefit plan ** Specifies DPCA is not a discount plan ** Per-visit charges in agreement must be less than monthly periodic fee ** Provider allowed to market, sell, or offer to sell a direct medical care agreement**

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# Appendix B: General Contract Considerations

These are some overarching considerations and are neither meant to be an all-inclusive list nor legal advice. Legal counsel should be consulted to develop a contract based on the plan design developed by the practice and can vary between practices. "Member" in the clauses below references the dental practice patient seeking to enroll in the in-office dental plan. Consider stipulating that:

- The dental practice retains the right to interpret any program stipulations.
- No refunds will be given in the event Member terminates the plan prior to the end of the plan year.
- The annual membership fee must be paid in full prior to treatment.
- Membership benefits are not transferable, have no cash value and may not be redeemed for cash.
- This is not an insurance plan and is not subject to regulation by the state department of insurance.
- Plan membership cannot be combined with current dental insurance plans.
- No insurance claim will be filed for Members under this plan.
- The plan is for individual use only. It is not a group benefits plan.
- Each additional family membership must be paid at the time of the initial membership or at renewal time.
- Membership fee may be adjusted annually.
- Members are responsible for notifying dental practice of any address or contact changes.
- Missed appointment fees/penalties are ineligible for the membership discount.
- Total payment amount is due at the time services are provided. If full payment is not received at the time of service, fee discount will be void.

In addition to these general contract considerations, it is important that the contract clearly lay out the payment requirements to maintain membership in the plan. Some considerations include:

- Membership fee payment schedule.
- Consequences of missed payments.
- Guarantees for treatment fee related to membership plan year.
- What services will be provided as part of the membership plan.
- What services will be provided at a discounted rate and what level of discounts will apply.
- Whether the patient can cancel the plan and the consequence.
- Whether the practice can cancel the plan and the consequence.
- Whether there will be annual maximums on discounts.

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# Appendix C: Checklist and Considerations for Your In-Office Dental Plan

Use this checklist to help determine all of the key steps necessary to consider before you implement your own in-office dental plan.

Addressing these items is a good way to begin the development of your plan.

- ☐ Consult your own attorney to determine how the implementation of this plan will affect your business is an important initial step.
- ☐ Send a promotional letter to patients without dental benefits.
- ☐ Determine the effective date for implementation of your new plan.
- ☐ Check with your state to determine if it considers these types of plans to be insurance and make sure that your plan is compliant with any state law.
- ☐ Review all your signed managed care agreements to determine if any clauses may affect your in-office plan, e.g., most favored nation clauses.
- ☐ Determine the annual fees, percentage discounts and covered procedures.
- ☐ Have your attorney review your plan and the accompanying patient agreement.
- ☐ Start marketing your plan to the public and your uninsured patients. You may want to consider using social media or local radio and television advertisements as well as direct mail. You may also want to contact your local Chamber of Commerce for additional promotional opportunities.

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# Appendix D: Marketing and Promotional Letter

Date

XX
XX
XX

Dear:

At XX dental, we are always looking for ways to make our dental practice better for our patients. To make that possible, we are now offering our own in-office dental plan* for patients that do not have a dental benefits plan from their employer or for patients who do not have an individual dental plan. This type of dental program has recently been gaining popularity and has been successful for other dental offices.

Effective {date} my office will offer an in-office dental plan for patients without a dental plan for an annual fee of $XXX. This fee includes two examinations and cleanings and one set of bitewing x-rays per year.

All other dental procedures will be given a discount of XX% off of my regular fees. There is no limit on how much money you can save by using the program.

I strongly urge you to ask my staff about this program and how it may benefit you and I hope that you will give this serious consideration.

It is our sincere privilege to have you as our patient and please let us know of any questions you have regarding this new program or how we may serve you better.

We look forward to continue providing you with the dental care you expect and deserve.

Sincerely,

Name

**Consider using your own terminology for the plan name. Examples include direct primary care agreement or dental membership savings plan.*

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