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## Policy on Third Party Fee Capping of Non-Covered Services

Originating Council

Council on Dental Benefit Programs

Review Council

Council on Clinical Affairs

Adopted

2012

Revised

2017

### Purpose

The American Academy of Pediatric Dentistry (AAPD) supports dental benefit plan provisions designed to meet the oral health needs of patients by facilitating, beginning at birth, the delivery of diagnostic, preventive, and therapeutic services in a comprehensive, continuously accessible, coordinated and family-centered manner<sup>1</sup>. A well-constructed dental benefit plan respects and meets the needs of the plan purchaser, ~~plan~~ subscriber/patient, and ~~plan~~ provider.

### Methods

This policy is an update of the previous document adopted in 2012. The update included based upon a comprehensive review and analysis of state laws and pending legislation prohibiting the capping of non-covered services by third party providers, a review of federal legislation, and a review of the American Dental Association's Policy on Maximum Fees for Non-Covered Services<sup>2</sup> (ADA 2012) and proposed federal legislation.

### Background

The American Dental Association (ADA) defines covered service as “any service for which reimbursement is actually provided on a given claim” and non-covered service as “any service for which the third party provides no reimbursement”. Capping of non-covered services occurs when an insurance carrier sets a maximum allowable fee for a service ineligible for third-party reimbursement.

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While most contractual matters between insurers and providers are those of a private business relationship, this particular business practice is contrary to the public interest for the following reasons:

- Larger dental benefit carriers with greater market share and more negotiating power are favored in this arrangement. While dentists ~~typically~~ may refuse to contract with smaller plans making this requirement, dentists are ~~while~~ unable to make the same decision with larger plans controlling greater numbers of enrollees. Eliminating this practice levels the playing field for all insurers and encourages greater competition among dental plans. If smaller plans and insurers are unable to survive, the group purchaser and subscriber are ultimately left with less market choice and potentially higher insurance cost.
- It is unreasonable to allow plans to set fees for services in which they have no financial liability, and ~~which furthermore~~ may not cover the overhead expense of the services being provided. When this provision precludes dentist participation in a reimbursement plan, subscribers realize less choice in their selection of available providers. In many cases, especially in rural or other areas with limited general or specialty practitioners, this adversely affects access to care. This is particularly true for vulnerable populations, including ~~children~~ patients with special health care needs.
- For dentists forced to accept this provision, the artificial pricing of uncovered services results in cost- shifting from those covered under a particular plan to uncovered patients. Thus, the uninsured and those covered under traditional indemnity or other plans will shoulder the costs of these provisions. Capping of non-covered services is not cost saving; it is cost-shifting — often to the most vulnerable populations and to those least able to afford healthcare.
- The ability to cap non-covered services allows insurance plans to interfere with the patient-doctor relationship.

The House of Delegates of the ADA in 2009 adopted Resolution 59H which opposed third party contract provisions that establish fee limits for non-covered services and called for state and federal legislation to prohibit such practices<sup>3</sup>. ~~(ADA 2012).~~

~~Federal legislation prohibiting all group health plans (including stand-alone dental plans and medical plans with dental benefits) from applying the plan's fee schedule to services for which no benefit or reimbursement is provided was introduced in 2010 (US House of Representatives 2010).~~

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Legislation to prohibit a dental insurer or dental service plan from limiting fees for services not covered under the plan, ~~as contrary to public policy, was~~ is the law in over half of the states in 2011 (~~Soderlund 2011~~) 35 states<sup>4</sup> and has been introduced in most other states. ~~Where eventual passage of most is generally assumed (ADA Government Affairs 2011).~~ Such legislation allows the dentist to utilize the usual and customary fee for services not covered by the plan.

## Policy statement

- The AAPD believes that dental benefit plan provisions which establish fee limitations for non-covered services are not in the public's interest and should not be imposed through provider contracts.
- The AAPD encourages dental societies and membership organizations to work for the passage of state and federal legislation to prohibit insurance plans from applying such provisions.

## References

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