

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

## Review Council

Council on Clinical Affairs

## Latest Revision

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, subscriber/patient, and provider.

### Methods

This policy originally was developed by the Council on Dental Benefits Programs and adopted in 2012. This document is an update of the previous version and included a review and analysis of state laws and pending legislation prohibiting the capping of non-covered services by third party providers, related federal legislation, and the American Dental Association's Policy on Maximum Fees for Non-Covered Services<sup>2</sup>.

### Background

The American Dental Association (ADA) defines covered service as "any service for which reimbursement is actually provided on a given claim" and noncovered 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. 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 may refuse to contract with smaller plans making this requirement, they are 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 that 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 individuals 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>4</sup> Legislation to prohibit a dental insurer or dental service plan from limiting fees for services not covered under the plan, is the law in 35 states<sup>4</sup> and has been introduced in most other states. Such legislation allows the dentist to utilize the usual and customary fee for services not covered by the plan.

#### ABBREVIATIONS

**ADA:** American Dental Association. **AAPD:** American Academy Pediatric Dentistry.

### 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.

### References

1. American Academy of Pediatric Dentistry. Policy on the dental home. *Pediatr Dent* 2017;39(6):29-30.
2. American Dental Association. Maximum Fees for Non-covered Services (2015:112). In: American Dental Association Current Policies Adopted 1954-2015. American Dental Association, Chicago, Ill.; 2015:112.
3. American Dental Association. Health Care Reform Legislation: Side-by-side Comparison. Available at "<http://www.aapd.org/assets/news/upload/2010/3827.pdf>". Accessed January 22, 2017. (Archived by WebCite® at: "<http://www.webcitation.org/6niQHIMUM>")
4. American Academy of Pediatric Dentistry. Non-covered benefits legislation. *Pediatric Dentistry Today*. Available at: "<http://www.pediatricdentistrytoday.org/2016/March/L1/2/news/article/535/>" Accessed January 22, 2017. (Archived by Website® at: "<http://www.webcitation.org/6niRwFAVk>")