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
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.

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.

<table>
<thead>
<tr>
<th>Covered Procedures</th>
<th>Frequency</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120 – Periodic Oral Evaluation</td>
<td>2 times per plan year</td>
<td>$400 or $300 or $150 annually</td>
</tr>
<tr>
<td>D1110 – Prophylaxis</td>
<td>2 times per plan year</td>
<td></td>
</tr>
<tr>
<td>D0274 – Bitewings</td>
<td>1 time per plan year</td>
<td></td>
</tr>
<tr>
<td>All other dental procedures</td>
<td>No limit</td>
<td>20% or 15% or 10% discount off dentist's full fee</td>
</tr>
</tbody>
</table>

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. Visit Success.ADA.org for the calculator.

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.
Additional Resource Materials

Dental Benefit Video Series
- Success.ADA.org/en/dental-benefits/dental-benefit-videos

Dental Benefit Information
- ADA.org/dentalbenefits
- Is an in-office dental plan right for your practice?

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
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

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

<table>
<thead>
<tr>
<th>19 States</th>
<th>Select Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>(See state law for a full review of requirements and restrictions.)</td>
<td></td>
</tr>
</tbody>
</table>

**ALABAMA**

- SB 94
- 2017

- Cannot bill a third party any additional fee for services for patients covered under a dental agreement.
- No license required to offer, market, sell, or enter into DPCAs.
- 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.

**ARIZONA**

- SB 1105
- 2019

- Prohibits direct primary care providers (DPCPs) from submitting a claim to patients’ health care insurer for DPCA services.
- 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 health care provider from charging or receiving additional compensation for health care services included in the periodic fee.
- Allows health care insurers or other third parties to pay for the periodic fee.
<table>
<thead>
<tr>
<th>State</th>
<th>Bill/HB</th>
<th>Year</th>
<th>Relevant Information</th>
</tr>
</thead>
</table>
| COLORADO   | HB 1115  | 2017 | • Prohibits the provider from submitting a fee-for-service claim for payment to a health insurance issuer for primary care services covered under the agreement.  
• Allows periodic fee or additional fees to be paid by insurer or third party.  
• Urge consult with health insurer. |
| FLORIDA    | HB 7     | 2019 | • Provider may not submit a claim for DPCA services.  
• 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.  
• Urge consult with health insurer. |
| ILLINOIS   | SB 174   | 2019 | • DPCA law is dental-specific.  
• Dentist and patient prohibited from billing insurer for DPCA services.  
• Urge consult with health insurer.  
• Dentist may refund unearned direct fees associated with the covered services in the agreement.  
• 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       | HF2356   | 2018 | • Dentist may not bill insurance.  
• A direct patient may submit a request for reimbursement to an insurer if permitted under the direct patient’s policy of insurance.  
• 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.  
• Urge consult with health insurer for DPCA services.  
• Allows periodic fee or additional fees to be paid by insurer or third party. |
<table>
<thead>
<tr>
<th>State</th>
<th>Bill Number</th>
<th>Year</th>
<th>Key Points</th>
</tr>
</thead>
</table>
| Louisiana     | SB 127      | 2019 | - DPCA law is dental-specific.  
- Periodic fee does not count toward deductible or out-of-pocket maximum.  
- Urge consult with health insurer for DPCA services.  
- Dentist allowed to market, sell, or offer to sell a direct medical care agreement.  
- Patients would not forfeit their insurance, Medicaid, or Medicare benefits by purchasing a DPCA.  
- Allows a direct dental practice to accept payment of periodic fees for a DPCA directly or indirectly from third parties, including employers. |
| Michigan      | SB 1033     | 2014 | - Provider and patient prohibited from billing insurer for DPCA services.  
- Provider allowed to market, sell, or offer to sell a direct medical care agreement. |
| North Carolina| HB 471      | 2020 | - Provider may not bill any third parties on a fee-for-service basis.  
- 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.  
- Any per-visit charges under the agreement will be less than the monthly equivalent of the periodic fee.  
- DPCA patient does not forfeit coverage under a health benefit plan.  
- No certification of authority or license required to market, sell, or offer to sell a DPCA.  
- A direct primary care membership agreement is not a medical discount plan. |
| Tennessee     | SB 2317     | 2020 | - Prohibits billing third party payers.  
- Charges under the agreement must be less than the monthly equivalent of the periodic fee.  
- Periodic fee does not count toward deductible or out-of-pocket maximum.  
- Urge consult with health insurer.  
- DPCA patient does not forfeit coverage under a health benefit plan.  
- Specifies DPCA is not a discount plan.  
- Provider not required to obtain certification of authority or license in order to market, sell, or offer to sell a direct medical care agreement. |
<table>
<thead>
<tr>
<th>State</th>
<th>Bill Number</th>
<th>Year</th>
<th>Regulations</th>
</tr>
</thead>
</table>
| UTAH        | HB 240      | 2012 | - Provider may not submit a claim for DPCA services.  
- 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.  
- "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      | 2017 | - Provider may not bill insurance.  
- Urg consult with health insurer. Insurer may cover services also covered in DPCA. |
| WASHINGTON  | SB 5958     | 2007 | - Provider may not bill and insurer or submit a claim for DPCA services.  
- Urg consult with health insurer. Insurer may cover services also covered in DPCA.  
- Allows periodic or other fee to be paid by a third party.  
- Provider allowed to market, sell, or offer to sell a direct medical care agreement.  
- State insurance authority ruled dentists are not eligible to engage in DPCAs.* |
| WEST VIRGINIA | HB 2301    | 2017 | - DPCA patient does not forfeit coverage under a health benefit plan.  
- Specifies DPCA is not a discount plan.  
- Provider allowed to market, sell, or offer to sell a direct medical care agreement. |
| WYOMING     | SB 49       | 2016 | - Allows periodic fee or additional fees to be paid by insurer or third party.  
- Prohibits the provider from charging or receiving additional compensation for health care services included in the periodic fee. |
States That Do Not Include Dental

Eleven states do not include dental in the definition of health care provider authorized to engage in DPCA.

<table>
<thead>
<tr>
<th>State</th>
<th>Bill Number</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgia</td>
<td>SB 18</td>
<td>2019</td>
</tr>
<tr>
<td>Kansas</td>
<td>HB 2225</td>
<td>2015</td>
</tr>
<tr>
<td>Kentucky</td>
<td>SB 79</td>
<td>2017</td>
</tr>
<tr>
<td>Maine</td>
<td>SB 472</td>
<td>2017</td>
</tr>
<tr>
<td>Mississippi</td>
<td>SB 2687</td>
<td>2015</td>
</tr>
<tr>
<td>Missouri</td>
<td>HB 769</td>
<td>2015</td>
</tr>
<tr>
<td>Nebraska</td>
<td>L 817</td>
<td>2016</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>HB 508</td>
<td>2019</td>
</tr>
<tr>
<td>Ohio</td>
<td>HB 166</td>
<td>2019</td>
</tr>
<tr>
<td>Oregon</td>
<td>SB 86</td>
<td>2011</td>
</tr>
<tr>
<td>Texas</td>
<td>HB 1945</td>
<td>2015</td>
</tr>
</tbody>
</table>

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 third party.** **Prohibits dentist from charging or receiving additional compensation for services in the periodic fee.** **Allows periodic fee or additional fees to be paid by insurer or third 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.**
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.
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.
- 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.
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.