Dental Benefits
A Guide to Managed Plans
Third Edition

PREVIOUSLY AUTHORED BY DONALD S. MAYES

International Foundation
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Chapter 2

Dental Plans—
A Compendium

Cathye L. Smithwick and Donald S. Mayes

The terms dental benefits, dental benefit plans, dental plans and dental insurance are often used interchangeably to describe the institutional mechanism most frequently used by employers for helping employees pay for a portion of the cost for dental care services or facilitate access to employee-paid benefits at a group rate.

On one end of the spectrum, dental benefits may be structured in a clinically focused manner known as defined benefits. Due to dental's unique characteristics, nearly all commercial dental benefit programs are provided using a defined benefit approach. Defined benefit dental plans are designed to encourage maintenance of oral health by specifying a market basket of services that each member is allowed to receive over a specific period, typically the plan year. Common elements of defined benefits include:

- **What is covered**—an itemized list of eligible dental services and supplies, by procedure code and/or procedure description
- **What is not covered**—exclusions
- **Limitations on coverage**—common limitations are by frequency of the procedure, age of patient, clinical criteria necessary for service to be covered, and so forth.
- **Financial rules**—cost sharing through deductibles, copayments/coinsurance, and annual and lifetime maximums.

At the other end of the spectrum, dental benefits can be as simple as a defined contribution program whereby employers agree to pay up to a certain pre-tax dollar amount per employee (and dependents, if applicable) each year for eligible dental expenses. Today, with few exceptions, the vast majority of dental benefits are provided using the defined benefits approach. Defined contributions are most commonly relegated to the pension/retirement plan arena, along with certain high-deductible medical plans provided with a health savings account (HSA) or health reimbursement arrangement (HRA).

While the term dental insurance is often used in the same context as dental benefits and benefit plans, for something truly to function as insurance it must involve the transfer of an insurable risk. This concept involves a continuum with complete insurable risk at one end and no possible insurable risk at the other. Many products sold as insurance fall somewhere in between these two extremes.
Insurable risks generally share these properties:\(^1\)

- The chance of occurrence is random, uncertain and beyond the control of the insured.
- The financial consequences to the insured should be catastrophic or nearly catastrophic, but non-catastrophic to the provider of insurance.
- The consequences should be irreversible and involve something that does not disappear spontaneously.
- The loss should be definite, measurable and statistically predictable.
- The loss should involve a pool of units sufficiently large to allow the insurer to predict the losses based on the law of large numbers, resulting in an affordable average premium rate.

Does dental care/disease meet the test of an insurable risk? See Exhibit 2.1 for a summary.

**Exhibit 2.1 | Dental Benefits and Insurable Risk**

<table>
<thead>
<tr>
<th>Characteristics of Insurable Risk</th>
<th>Does This Apply to Dental?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random, unpredictable occurrence</td>
<td>Not generally. Dental disease is nearly universal, rarely random and often within the control of the insured. The obvious exception would be accident-related dental injury.</td>
</tr>
<tr>
<td>and out of control of the insured</td>
<td></td>
</tr>
<tr>
<td>Large financial loss to the insured</td>
<td>Not generally. Dental disease and its treatment is rarely, if ever, catastrophic. The perception of a catastrophic financial loss, however, is relative and varies across consumers. The financial loss due to dental accident or oral pathology (e.g., cancer) can be significantly large when compared to routine services.</td>
</tr>
<tr>
<td>Irreversible consequences that do not disappear spontaneously</td>
<td>Mixed. Early decay and periodontal disease may be reversed, but there is a point where they become irreversible and must be treated with restorative or surgical procedures. Some symptoms such as “TMJ pain” (pain in the “jaw joint”) may disappear spontaneously.</td>
</tr>
<tr>
<td>Definite, measurable, statistically predictable loss</td>
<td>Yes</td>
</tr>
<tr>
<td>Large number of units to allow pooling of risk</td>
<td>Yes</td>
</tr>
</tbody>
</table>

For the purpose of this book, it is assumed that dental is an insurable risk, albeit a modest one. For definition purposes, the broadest term is used. Dental benefits—in the context of defined benefits—encompasses a broad spectrum of possibilities in financing, administration and delivery of dental services under a third-party payer system.

**Summary of Common Terms**

The dental benefits industry is laden with terminology that can be confusing to the uninitiated. While some terms are commonly used interchangeably, others have been borrowed from the managed medical care system where the same term may have a different meaning when used in a dental setting. The following dental benefit terms are an attempt to simplify and clarify the numerous words and acronyms used in the dental benefits realm. These are not meant to be definitive, but to serve as a guide for readers. (For more details, see the Glossary in Appendix H.)

- **Administrator**—business entity that administers dental benefits programs. An administrator may be an insurance company or purely a third-party administrator (TPA) organization. Administrators coordinate eligibility, pay claims, and perform various customer service and billing functions. Administrator is synonymous with vendor, third-party payer, insurer and insurance company.

- **Balance billing**—billing patients for fees that exceed the amount approved by the third-party payer. Most commonly applies to fee-for-service dental programs such as indemnity plans (no network, but third-party payers may still limit the maximum amount allowed by the plan) and PPO plans involving payment to non-network dentists. PPO network dentists are generally prohibited from balance billing for covered services, creating an incentive for beneficiaries to seek treatment from network dentists.

- **Beneficiary**—individual receiving benefits through a dental program. Beneficiary is synonymous with patient, enrollee, eligible, user, subscriber and member.

- **Benefit differential**—PPO plan design feature with benefits greater when members see a network dentist.

- **Capitation**—reimbursement methodology used in dental health maintenance organizations in which dentists provide covered services to members on a contract basis in return for a periodic per capita payment, usually monthly. Dentists receive payment whether or not they ever see the patient. Members are charged a fixed copayment (expressed in dollar terms), depending on the service provided. Some services such as exams, x-rays and cleanings often have a copayment of zero.

- **Capitation plan**—see Dental health maintenance organization.

- **Dental discount “plan”** (sometimes called an access or referral plan)—dental product that arranges for individuals to have access to a panel of dentists who have agreed to provide services for the amount listed in a fee schedule,
presumably at a discount off of their retail fees. No payment is made by the plan to the dentists; dentists are paid directly by the enrollee. Plan sponsors or members are charged a nominal monthly fee similar to a membership fee in exchange for access to participating dentists.

- **Dental health maintenance organization (DHMO)**—also referred to as capitation or prepayment. Dentists are reimbursed on a fixed per capita basis, usually monthly, for each covered individual or family for a defined set of benefits. Payment is not based on the number or type of services rendered or the patients seen. The dentist is financially at risk for some, if not all, services. Ideally, it is a dental plan that encourages and rewards disease prevention. Many DHMOs today include supplemental payments, beyond pure capitation, under certain circumstances. The prevalence of DHMOs that pay providers based on pure, 100% capitation (separate from patient copayments) continues to decline in an effort by carriers to share in some of the financial risk, yielding a more fair arrangement for dentists.

- **Dental plan**—program providing dental benefits to a specific population using various financing, benefit, reimbursement and delivery models. Sometimes used synonymously with insurance company, carrier, vendor, or administrator.

- **Dental preferred provider organization (DPPO or PPO)**—dental plan with a network of dentists that have agreed to accept a specific level of payment for covered services. Reimbursement is on a discounted fee-for-service basis. The dentist is not financially at risk.

- **Dentist**—an individual that has graduated from an accredited dental school and obtained all of the necessary licenses to practice in one or more states. Also referred to as clinician, participating provider or provider.

- **Exclusive provider organization (EPO)**—a term rarely used in dental benefits but more common to medical plans. When applicable, this term refers to a dental plan that requires enrollees to use participating dentists to receive benefits. No benefit is provided if a patient goes to a nonparticipating office. An EPO may be a PPO or DHMO and, when created, is often used as a custom network for a particular group or region.

- **Fee for service**—reimbursement method in which a dentist charges a fee for each service provided. A dental plan may or may not be involved. If no plan is involved, this generally refers to a purely cash arrangement between an individual and their dentist. When a plan is involved, payment typically comes from both the dental plan and the patient.

- **Fee-for-service dental plan**—any dental plan where the dentist is paid on a fee-for-service basis. It may be an indemnity, PPO, or another less common type found in the industry. Except for collection of fees from the plan and patient, the dentist is not at risk financially.
• **Indemnity plan**—commonly used to refer to a dental plan that has no contract with providers and reimburses the provider (or beneficiary) a specific amount for each covered service. The administrator or insurance carrier is usually at risk if payment involves a fixed monthly premium from purchasers. If the purchaser assumes all financial responsibility for payment, the purchaser is at risk and the administrator is paid a nominal fee for processing and paying claims, along with other administrative functions. Regardless of the risk sharing arrangement, as long as a third-party administrator is involved (and no network), it is proper to use the term “indemnity plan.” The dentist is not at risk financially. Used at times interchangeably with fee-for-service plan.

• **Managed dental care**—dental plan designed to manage the cost and quality of care using various delivery systems and reimbursement models.

• **Managed indemnity plan**—dental plan with a network of contracted dentists that have agreed to accept a specific level of payment (usually considerably higher PPO reimbursement) as payment in full for covered services. Though some may view any plan that has contracts with dentists as “managed care,” managed indemnity plans are a hybrid. For reporting purposes, the National Association of Dental Plans (NADP) places managed indemnity plan data in the “indemnity” category. The dentist is not financially at risk.

• **Network**—a group of providers contracted with a third-party administrator to provide care for its members.

• **Non-participating dentist**—same as non-network or non-contracted dentist. A non-participating dentist is one that does not have a contract with the third-party payer.

• **Panel**—another word for “network.” Panels/networks can be open or closed. Closed panel networks such as DHMOs only cover treatment provided by network dentists (with some exceptions). Nearly all other networks are open panels.

• **Participating dentist**—another word for network (or contracted) dentist.

• **Payment differential**—common to PPOs, this refers to the practice of reimbursing non-participating dentists differently than participating dentists. Approaches to payment differentials vary—non-participating dentists may be reimbursed at the same, a greater or a lesser amount than network dentists. Any difference between the amount charged by the non-participating dentist and the amount allowed by the plan must be paid by the beneficiary. (See Chapter 17 for details.)

• **Purchaser or plan sponsor**—employer, association, welfare trust fund or other entity that contracts with an administrator to provide benefits for its members in exchange for payment of a premium or administrative fees.

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2. 2011 NADP and DDPA Joint Report: Network Statistics (August 2011). "The essential determinant for this distinction is the payment mechanisms which in these plans are more akin to indemnity reimbursement levels than to the discounted fee-for-service and capitation payment systems that are typical of Dental PPOs and Dental HMOs."
- **Usual, customary and reasonable (UCR)**—practice of determining provider reimbursement levels from statistical analysis of prevailing charges among all similar providers within a given geographical area for a given service or procedure. Sometimes referred to as reasonable and customary (R&C) or usual and customary (U&C).

### How Dental Plans Are Administered and Financed

Dental benefits can be administered by insurance companies, third-party administrators (TPAs), multiemployer benefit trusts or other plan sponsors such as an employer. However, it is unusual for today’s employers to self-administer their dental programs. Insurance companies or TPAs administer most dental plans. The funding usually falls into one of two general categories: (1) **Self-funded**, also known as self-insured or self-financed, and (2) **insured**, also known as **fully-insured**. The difference comes down to who is at risk financially.

- **Self-funded plans.** The sponsor assumes the risk for claims cost. A self-funded plan can be self-administered but it is more likely to have a contract for administrative services only (ASO). In this situation, the plan pays an administrator a small monthly fee—usually on a per-employee-per-month (PEPM) basis—to manage the plan by overseeing the provider network, paying claims, providing customer service support, client reporting, account management and all of the usual functions associated with dental benefit programs. The administrator pays claims using funds set aside by the sponsor in a dedicated bank account. Although claims cost will fluctuate monthly, self-funding dental plans is not especially risky, as long as the appropriate plan design is in place—with the annual and lifetime benefit maximums being the most important for limiting financial liability.

- **Fully-insured plans.** The sponsor pays a fixed monthly premium PEPM and in exchange for this, the administrator assumes the financial risk of claims cost and all of the functions described above.

### What Is a Managed Dental Plan?

Managed dental plans are designed to manage the cost and quality of care through the use of various delivery systems and reimbursement methods. There was a time when managed dental care was synonymous with DHMOs. Today, virtually any network-based plan administered by a third-party payer and providing defined benefits that include some level of oversight regarding provider fees, utilization, quality of care and other such matters could be considered a managed dental plan.

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Managed Dental Plans: Enrollment Snapshot

- In 1994, 70% of participants were enrolled in indemnity (non-managed) plans.
- In 2010, just 16 years later, indemnity plans’ market share had dwindled to just 11%, with the remaining majority, 74%, enrolled in PPOs.
- Over the same time period, DHMO (capitated plans’) market share fell from 15% to 8%. Members in the remaining 10% are enrolled in discount products (technically not considered managed care).

What Are the Goals of Managed Dental Care?

Ideally, managed care programs include the following goals:

- Reduce/manage cost (compared to non-managed alternatives)
- Ensure real access to care—participating dentists conveniently located and with reasonable appointment availability
- Encourage members to improve oral health and maintain it through regular diagnostic and preventive services and necessary restorative treatment
- Monitor and employ resources designed for ensuring quality of care
- Provide value-added services to members (e.g., prompt, accurate claims payment; customer service; grievance and appeals resolution) and to purchasers (e.g., account management, underwriting, reporting)
- Deliver maximum value for dollars spent.

Make no mistake about it, cost management was, and still is, a key driver behind the growth of managed dental care, as witnessed by the dominant market share today when compared to dental benefits of the past. The importance of controlling cost, especially the rate of increase (inflation), is an outgrowth of serious financial constraints facing purchasers today, as well as their desire to continue offering this popular benefit. It is quite startling to see how far managed care has come in just two decades. Exhibit 2.2 illustrates the relative market share for the most common types of plans offered today.

Exhibit 2.2 | Market Share by Type of Plan, 2010

![Market Share by Type of Plan, 2010](image_url)
In today’s globally competitive marketplace, purchasers must carefully control rising expenditures on health care and other benefits, or risk losing business to competitors. Purchasers also want easy access to quality care for participants. Properly structured managed care systems can give purchasers these important ingredients in ways that indemnity plans never could. Also, note that the degree of management and oversight is inversely related to the cost of care. All else held constant, non-managed indemnity plans are the most expensive while tightly-managed DHMOs are the least costly. There are a variety of choices between these two extremes, and these are shown in Exhibit 2.3. Each type of plan is explained later in this chapter and throughout the book.

Exhibit 2.3 | Managed Dental Plan Continuum by Type of Plan and Network, Based on Cost and Management Level

Why Network-Based Plans?

In today’s managed care system, more than any other attribute, the network defines the product, creates the greatest value for purchasers, and defines the relationship between dentists and administrators. Stated differently, a dental plan is only as good as the dentists that participate in its networks. Since networks are based on contractual agreements between providers and administrators, managed care would not be possible without the existence of such relationships, which, if handled correctly, can benefit all parties involved: providers, patients, employers, administrators and even regulatory bodies.
Network size is inversely related to the level of provider reimbursement: the higher the level of reimbursement is, the larger the network will be, all else held constant. We begin by defining the different types of network-based plans and their sub-categories, based on how providers are reimbursed.

**Types of Network-Based Dental Plans**

There are myriad dental plans available as vehicles for providing benefits. At one time, they were distinct and mutually exclusive. During the past three decades, the distinctiveness has blurred and many hybrid plans have evolved. Since each type of plan has advantages and disadvantages, there is no universally “best” type of plan meeting the needs of all stakeholders. The type of plan chosen should be based on the group’s particular needs.

There are two broad categories of network-based plans defined by the principal method of reimbursement for services and who is, or is not, at risk.

- **Fee for service (FFS).** In fee-for-service plans, the dentist is not at risk. The principal plans in this category are managed indemnity plans and preferred provider organizations (PPOs). Dentists are paid a fee for each covered service. Dental discount products and direct reimbursement programs could also be included in this category. Since they do not fit the definition of managed care plans, however, they will be discussed elsewhere.

- **Capitated.** The dominant plan in the capitated category is the DHMO. In a DHMO, dentists individually assume all or a portion of the financial risk. The administrator may assume a portion of the risk, and, by doing so, may increase the size and stability of the network.

**Fee-for-Service Plans**

Dentists are paid a fee for each covered service provided. Managed indemnity plans and PPOs are commonly referred to as fee-for-service plans. Commercial insurance carriers, third-party administrators or non-profit service corporations usually administer them. Managed indemnity plans and PPOs include participating provider agreements (contracts) between the intermediary and the dentist that limit the amount a participating dentist may collect for each covered service. Most well-recognized plans today include oversight activities such as utilization review and quality assessment. Under these plans, the dentist does not bear the financial burden for utilization. From a product perspective, PPOs dominate the fee-for-service landscape, though managed indemnity networks are larger and more attractive to dentists due to the higher reimbursement levels and reduced degree of oversight.

**Managed Indemnity**

Managed indemnity generally refers to a plan with a very large network and small fee discounts. Unlike PPOs, which typically employ fee schedules to display provider
reimbursement, most managed indemnity plans base reimbursement on the concept of usual, customary and reasonable. UCR is used to set a maximum fee level, and is expressed as a percentile per given region and specialty. Some managed indemnity contracts may express the provider’s fees in dollar terms, but these are usually limited to those contracts that are individually negotiated. Individually negotiated fees are quite common in some managed indemnity networks, depending on the state and carrier involved, although some administrators are trying to move away from this approach. The contract primarily focuses on the fee arrangement. Providers agree to accept the plan fee allowance as payment in full for covered services; they are not allowed to balance-bill the member above this amount. When a network includes about 70% or more of practicing dentists nationally or up to 95% in large metropolitan areas, it is in all likelihood a managed indemnity network.

From a product perspective, managed indemnity networks are rarely sold as a separate product. For market share reporting purposes, they are counted as indemnity plans. The high level of reimbursement, which may be at or near indemnity levels, and other characteristics make them dissimilar to PPOs. Most managed indemnity networks today are used as secondary networks that “run in the background” of a PPO network/product. This structure effectively creates a three-tiered structure that permits members to see (1) a PPO dentist, (2) a dentist in the larger, managed indemnity network or (3) a non-contracted dentist that does not participate in either network.

Pros

- **Largest networks.** Provides largest networks possible thus maximizing access to care.
- **Fee oversight.** Though not tightly managed, there are strict contractual agreements regarding the maximum reimbursement level providers can obtain and they are not allowed to balance-bill patients.
- **Direct claims submission.** Unlike non-network-based plans, participating dentists complete and submit claim forms directly to the plan on behalf of the patient.
- **Recourse for members and providers.** Plan beneficiaries and providers both have recourse in the event of a dispute regarding payment, quality of care and other matters. This is one of the most important, distinguishing attributes of managed indemnity programs, which, in many other respects, lack the tighter controls and cost savings of PPOs.
- **Freedom of choice.** Patients may see any dentist they choose, but if they see a network dentist, they may save money and benefit from administrative oversight activities. In both cases, these are less than exist in PPO networks.

Cons

- **Small discounts, potentially highest cost.** With the highest provider reimbursement of the network-based plans, this is the primary reason managed indemnity plans are not considered PPOs. When used as a secondary network
alongside a PPO, net savings may in fact be greater than some pure PPOs. This depends on the effective discount that reflects the interaction of the average discount and utilization of each type of in-network provider. When functioning in this manner, the combination of PPO discounts and managed indemnity access can be highly attractive to purchasers.

- **Incentive to overtreat.** Because of the fee-for-service reimbursement, there is an incentive for dentists to overtreat. Remember, dentists are not paid unless they do something.
- **Less oversight.** Managed indemnity plans involve less oversight and contractual requirements than do PPOs or DHMOs.

**Preferred Provider Organization (PPO)**

A preferred provider organization (PPO) is a network of dentists created through a contractual agreement between a dental program administrator and providers for the delivery of services to defined patient populations. Reimbursement is based on predetermined, discounted fees. Today, PPOs are the dominant dental delivery system. About three quarters of individuals with dental benefits are enrolled in PPO plans. Key attributes include the following:

- Provider reimbursement is commonly based on a fee schedule and usually varies by geographic location to account for differences in the general cost of living, the dental consumer price index and, as a matter of practical importance, the degree of market power possessed by either dentists or purchasers.
- PPO dentists agree to other requirements and administrative oversight provisions such as maintaining an active license to practice; having a minimum level of liability insurance; and cooperating with audits, quality assessment/ utilization management functions, dispute resolution and other activities that may be necessary from time-to-time.
- Beneficiaries may see the dentist of their choice, whether or not the dentist is in the network. Costs are usually less when in-network dentists are used since an in-network dentist has agreed to a maximum allowed fee. A non-network dentist is allowed to balance-bill the beneficiary the difference between the plan allowance and his or her charge.
- Structure allows for steerage to network dentists with higher benefit levels for in-network care.

**Pros**

- **Financial oversight and recourse.** The dentist signs a contract agreeing to accept a specific allowance as payment in full, and to abide by certain utilization and office protocols. The beneficiary and the administrator have recourse to address problems that may arise because of this arrangement. Although quality assurance is usually not as far-reaching as in well-managed DHMOs, it is far better than plans that do not have the dentist under contract.
Cost savings through discounted fees. The purchaser/member can usually obtain services at a discount well below the dentist’s usual charge. Typical discounts are in the 15% to 25% range from the community average. If fee allowances are too low, there may be too few dentists to treat the population. It is, therefore, important for purchasers to realize that for a PPO to be successful, there must be something in it for both providers and members.

Direct claims submission. Unlike in a non-network-based plan, participating dentists will complete and submit claim forms directly to the plan on behalf of the patient.

Advantages to participating dentists are patient volume and cash flow. This type of plan can increase patient volume—helping to fill empty chair time (if there is any) and serving as a source of referrals. For the dentist just starting practice, it can be a real “practice booster” if enough beneficiaries decide to frequent his or her office. Participation also helps providers become known through practice listings in the PPO’s online directories. In addition, some PPO plans allow assignment of benefits for network dentists (the plan pays dentists directly). This can save substantial time and resources for dental office billing staff, and it provides immediate cash flow to the dentist. (Some states prohibit plans from singling out network dentists for this special service.)

Larger networks with greater access to care. Due to the unobtrusive nature of PPO oversight and the attractiveness of fee-for-service reimbursement, PPO networks are much larger than DHMO networks.

Freedom of choice. Dentists, purchasers and patients view PPOs as less intrusive than DHMOs since patients can still see any dentist they choose—they just must see a network dentist to receive negotiated discounts and to obtain some of the administrative oversight advantages.

Cons

Incentive to overtreat. Unlike DHMOs, PPOs have an incentive for dentists to overtreat in order to make up for the discounts taken. Dentists can increase their revenue by increasing the number and intensity of services provided, and “selling” elective services. Remember, dentists are not paid unless they do something.

Less oversight. Monitoring quality is rarely as thorough as in DHMOs. Site visits are almost unheard of in PPOs, which, given the nature of their structure, is perfectly understandable and in keeping with industry standards. Quality oversight is also, generally speaking, reactive rather than proactive; that is, the plan responds and will investigate when complaints are received from members. Dentists that lack patient volume may temporarily sign up with this type of program as a stopgap measure, without really being committed to working with the plan. This behavior is especially true during economic downturns, yet it may be next to impossible for plans to determine this in advance of contracting with the dentist.
Capitated Plans

Dental Health Maintenance Organization (DHMO)

The distinguishing characteristic of DHMOs is that dentists assume all, or a significant portion of, the financial risk. Terms used interchangeably with DHMO include capitated plan and prepaid dental plan. Some early DHMOs were known for shifting all of the risk to dentists. This created numerous problems for providers and purchasers. As a result, most DHMO administrators today use a variety of methods to share a portion of the risk.

Dentists are paid on a per capita basis at a fixed rate—usually monthly—for each individual or family member enrolled. Dentists are paid irrespective of the number or types of services provided or the number of beneficiaries seen. Additional compensation comes from members through nominal copayments paid at the time of the visit.

DHMOs have the potential for being either a very good or a poor choice for providing benefits—depending on how the many variables involved are handled. Unless the administrator provides a safety net, a guaranteed minimum income, or uses some other form of financial protection and supplemental payments, the dentist is individually at risk in a DHMO. If the dentist is fully at risk and the cost to provide services is greater than payments received, it is the dentist’s loss. If payment exceeds cost, the dentist gains financially. As a consequence, there are two principal ways for a dentist to make money in dental HMOs: (1) make sure beneficiaries are provided the services necessary to bring them to a state of good dental health and keep them there and manage office overhead efficiently, or (2) do as little as possible (see Chapter 19 for details).

Pros

- Potentially cost-effective and prevention-oriented. Less incentive to overtreat. DHMOs have the potential for being one of the most cost-effective, prevention-oriented and quality-monitored dental plans available. Intrinsic to DHMOs are incentives for dentists not to overtreat, not to overuse expensive services or to misreport and to provide preventive services and necessary treatment to as many covered individuals as possible. Preventive services are cost-effective. It is far less costly to keep people in a state of good dental health than it is to repair neglect in a stable population. In theory, DHMOs also might lend themselves well to evidence-based dentistry—especially those that adopt the most sophisticated IT systems (a difficult task unless all patient encounter data can be captured) and take advantage of the various risk assessment tools now available to the dental industry.

- Steady cash flow to dentists. Capitation payments offer a steady cash flow, regardless of whether or not patients visit the dentist. During poor economic times, this may be attractive to dentists that may not otherwise consider...
participating in a DHMO. Evidence has shown that on average, even those individuals with dental benefits (fee-for-service in particular) visit the dentist less often and postpone needed care during economic downturns, especially for services that require cost sharing.

**Cons**

- **Incentive to undertreat (ration care).** Depending on the administrator, level of oversight and ability to capture accurate utilization information, DHMOs can create incentives for dentists to do as little as possible. For the DHMO provider, controlling cost may be the only way to maximize revenue. This means rationing care by providing as few services as possible and discouraging beneficiaries from visiting the dentist.

- **Less access.** Beneficiaries generally have fewer offices to choose from and, consequently, access may be a problem. Beneficiaries may have to take a double hit on access if care is also rationed once they are able to get an appointment.

- **Dentists may inherit a high-risk group.** From the dentist’s perspective, unstable groups (i.e., groups with a high turnover of eligibles) are not good candidates for DHMOs unless reimbursement is adjusted for increased care needs. The dentists may never be able to get all patients to a maintenance level and, unless steps are taken to protect them from financial loss, may be at great financial risk and/or fall victim to declining participation from eligibles. At some point, a financial breaking point may be reached.

- **Lack of accountability.** A poorly managed DHMO could have virtually no monitoring of the care that is provided and little or misleading data available for review. In this case, purchasers may be unable to assess accurately the level, value and the quality of the care provided.

These major types of plans and their characteristics are summarized in Exhibit 2.4.

**Exhibit 2.4 | Major Types of Dental Plans and Their Characteristics**

<table>
<thead>
<tr>
<th>Element</th>
<th>Indemnity/Managed Indemnity</th>
<th>PPO</th>
<th>DHMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>How dentists are paid</td>
<td>UCR/R&amp;C or table of allowances/UCR or negotiated maximum allowable fees</td>
<td>Fee schedule or UCR/R&amp;C (less common)</td>
<td>Capitation, and in many cases, supplemental payments for select procedures</td>
</tr>
<tr>
<td>Potential for managing</td>
<td>Least/Low, but depends on contract</td>
<td>Fair to Good</td>
<td>Good*</td>
</tr>
<tr>
<td>Financial incentives for prevention</td>
<td>Moderate/High</td>
<td>Fair to Good</td>
<td>Good</td>
</tr>
<tr>
<td>Element</td>
<td>Indemnity/ Managed Indemnity</td>
<td>PPO</td>
<td>DHMO</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------------------------</td>
<td>----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Financial incentives to overtreat</td>
<td>High/High</td>
<td>High to Moderate</td>
<td>Low*</td>
</tr>
<tr>
<td>Financial incentives to undertreat</td>
<td>Low/Low</td>
<td>Low</td>
<td>Moderate to High</td>
</tr>
<tr>
<td>Ability to manage quality of care</td>
<td>Low/Low to Fair</td>
<td>Fair to Good</td>
<td>Fair to Good</td>
</tr>
<tr>
<td>Cost/benefit potential</td>
<td>Least/Low to Moderate</td>
<td>Moderate to Good</td>
<td>Good to Excellent</td>
</tr>
<tr>
<td>Utilization controls</td>
<td>None or Few/Few</td>
<td>Moderate to Good</td>
<td>Moderate to Good*</td>
</tr>
<tr>
<td>Robust contractual provisions</td>
<td>None/Fair, but least of</td>
<td>Yes, Moderate to Good</td>
<td>Yes, Good to Excellent</td>
</tr>
<tr>
<td>Potential for fraud/abuse</td>
<td>High/Moderate</td>
<td>Moderate</td>
<td>Low to Moderate*</td>
</tr>
<tr>
<td>Management of fee increases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– UCR/R&amp;C/U&amp;C</td>
<td>Poor/Poor to Fair</td>
<td>Fair</td>
<td>NA</td>
</tr>
<tr>
<td>– Fee Schedule</td>
<td>Good**/Good</td>
<td>Good</td>
<td>NA</td>
</tr>
<tr>
<td>– Capitation</td>
<td>NA/NA</td>
<td>NA</td>
<td>Good</td>
</tr>
<tr>
<td>Patient access to providers (freedom of choice) and to appointments</td>
<td>Excellent/Good to Excellent</td>
<td>Varies Widely</td>
<td>Poor to Fair, Limited to a small network of dentists***</td>
</tr>
<tr>
<td>Patient satisfaction (highly dependent on patient assessment of the relative importance of access versus cost)</td>
<td>Poor to Good (&quot;On their Own&quot;)/ Fair to Very Good</td>
<td>Good/Excellent</td>
<td>Good/Excellent</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Assumes the administrator is able to capture accurately all services provided (100% accurate reporting of patient encounters).

**Traditional Indemnity: Fee schedules are less common, but when they do occur, they may be presented to patients as a table of allowances (maximum fee that will be paid to the provider per procedure), with members making up the difference between the billed and the allowed amount. Managed indemnity: May involve fee schedules with the administrator having a fair degree of control over reimbursement by individually negotiating fee schedules and determining how frequently dentists are allowed fee increases. Dentists are contractually prohibited from balance-billing patients.

***Out-of-network care is not covered, except in cases of approved specialty referrals and some dental emergencies.
Other Types of Network-Based Plans

Exclusive Provider Organization (EPO)
In dental benefits, the term exclusive provider organization (EPO) denotes custom-designed networks, often regional, that may be created for a particular employer with a large or highly concentrated employee population. EPOs are much less common in dental benefits than in medical plans. To receive benefits, members are normally required to utilize a network dentist, except in the case of dental emergencies, for which some allowance may be made for out-of-network care. EPOs are an extremely small part of the market, therefore, industry resources do not break out enrollment data.

Point-of-Service (POS) Plan
Definitions of point-of-service (POS) plans vary. For this book, a POS plan is any program that involves a combination of networks that allows members to choose any dentist (including out-of-network), and the benefit level and provider reimbursement vary accordingly. The most distinguishing feature of POS plans is that members do not have to choose any particular dentist or network during annual open enrollment—they are free to switch at will depending on their needs and preferences, with the benefit available being determined at the point of service. The most common POS program in dental benefits involves combinations of PPO and DHMO networks. As with EPOs, dental POS enrollment is not separately reported.

Independent Practice Association (IPA)
An IPA, by most definitions, is a hybrid dental HMO. The IPA model combines the risk sharing of an HMO with fee-for-service reimbursement. The dentists are collectively at risk, as opposed to DHMOs in which they are individually at risk. Large, group practices that are dentist owned might be considered one type of IPA.

The purchaser pays the IPA entity a capitation fee and the IPA pays participating dentists on a fee-for-service basis. However, the dentists can be at risk if payout to the IPA exceeds capitation payments it receives. If this occurs, fees to the dentists may be reduced or the dentists may not be paid for treatment beyond a certain threshold amount. This type of dental plan is not as widespread as it is in medical benefits, but, with sophisticated management, may show promise in the future, as large, group practices continue to proliferate. The question remains: Is being at risk collectively sufficient to deter overutilization by individual practices?

Other Types of Products
Two other types of dental products are worth mentioning, although neither is considered managed dental plans or defined benefits in the traditional sense. They are discount products and direct reimbursement (DR).
Discount Products

Fairly new on the national scene, discount products (sometimes called *access* or *referral products*) should not be considered in the same light as traditional dental benefits, so they have been placed under the category of “other.” This variation on a PPO may best be described as a marketing strategy for carriers seeking to retain at-risk accounts (employers), dentists who are seeking new patients, or providing some level of access and savings for little or no cost to the sponsor. These programs cost the purchaser very little because they involve what is generally referred to as a discounted fee dental product based on a monthly or annual membership fee. There is no third-party payer involved in financial or treatment transactions. Discount programs work similarly to having a “Costco® card” or other retail buying club membership. In exchange for a nominal monthly fee (generally $5 to $9 per member/per month), participants are allowed access to a limited network of dentists who agree to provide a defined set of services to members at a discount.

The patient is responsible for payment of all fees. There is no reimbursement to either the dentist or the beneficiary by the plan administrator (other than the membership fee). The dentist agrees to accept a fee schedule as payment in full and signs an agreement to this effect. The transaction is a cash-based one, strictly between the patient and dentist—which can sometimes make it difficult for members to determine if they are being charged the correct fee, and, if so, whether it amounts to any real cost savings over what they would have paid if going direct.

The majority of discount products are sold to individuals rather than groups. They are often distributed through direct-to-consumer channels via the web or other advertising vehicles.

**Pros**

- **Low cost, no risk.** Discounts products are low cost for purchasers. In essence, these plans offer a network of dentists who agree to charge a set—usually discounted—fee for defined services to those enrolled in the program.
- **Easy to purchase and enroll.** This is one of the few types of dental products that can be purchased by individuals and may permit enrollees to disenroll without being locked in for a specific time period.
- **Fees known in advance by members.** One of the major advantages of this type of program is that the beneficiary receives a brochure (or web link) listing covered services and associated fees in advance. It is often offered on a limited free-trial basis or with a limited money-back guarantee. Plans have varied billing scenarios from monthly to annual.

**Cons**

- **No utilization management.** Of all types of products offered, these and direct reimbursement plans have no utilization management or review.
- **No mechanism for oversight.** There are no claim or encounter forms, no data collection or audit trail, and no one reviews the services provided. If
beneficiaries have problems other than with fees, they are usually on their own. The primary safeguard against poor quality or mistreatment is the complaint resolution process by the network administrator; the ability to do so may be extremely limited due to the nature of the contract.\(^4\)

- **Potential to confuse employees, who may think it is insurance.** If discount products are offered through the workplace to employees accustomed to traditional employer-sponsored dental benefits, employees are more likely to expect the discount card—regardless of what the fine print says—to function like traditional dental benefits. Some states now require all marketing and communications materials to include disclaimers saying “this is not insurance.”

**Direct Reimbursement (DR)**

Direct reimbursement is a method of providing financial assistance for dental services based on the concept of defined contribution. Under DR, the beneficiary receives care from the dentist, pays the bill (usually at the time of the visit), and receives a receipt, which is then submitted to the sponsor for reimbursement. DR has a nominal market share, estimated to be about 1%, and when offered, is often self-administered by the plan sponsor (usually a small employer). Occasionally, plan sponsors may use a third party to process payments to beneficiaries. There are no claim forms, no utilization review, no quality assurance and no external limitations on what the services are provided or fees charged.

DR, in its most common form, pays for a portion of dental expenses based on a sliding scale that is dollar-driven. For example, 100% of the first $100, 80% of the next $200 and so forth. Annual maximums are highly recommended and are usually lower than traditional plans, say, in the range of $500 to $750 per year. This type of program has been promoted by the American Dental Association as an alternative to managed dental plans.

**Pro**

- **Simplicity.** DR programs are simple to set up and to understand. Direct reimbursement can be particularly attractive to small companies or businesses that wish to offer some type of dental benefit but are too small to be able to purchase an affordable plan from a carrier (largely due to the adverse selection problem). Direct reimbursement may also be a viable option if cafeteria-type benefits are offered.

**Cons**

- **Administrative burden.** The purchaser must usually self-administer the program using scarce internal resources for purposes for which they were not intended. The law of unintended consequences is great.

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\(^4\) In some situations, patients that have a dispute with a dentist may obtain assistance through a local dental society’s complaint resolution process.
■ **Lacks plan design elements that encourage prevention.** There is no plan design—the hallmark of defined benefit plans—reimbursing preventive services at 100%, but major services at a lesser amount (e.g., 50%). DR establishes no priorities for treatment; there is no financial incentive to prefer preventive services to purely cosmetic services. Both may be reimbursed at the same level.

■ **No clinical or financial oversight.** Utilization review and quality assurance are nonexistent. Dentists can charge what they want because there are no restrictions on payment (see Chapter 23 for details).

■ **No audit trail increases potential for fraud.** Due to the absence of oversight, employers may be risking fraud on the part of employees, providers or both. This could place employers in an uncomfortable position.

### Other Options for Providing Dental Benefits

**Cafeteria Plans or IRC Section 125**

A cafeteria plan (or Section 125 plan) is not a dental plan per se; it is simply a financing mechanism. Contributions to a Section 125 plan are made by employees on a pre-tax basis. The employer may also contribute. Money that is not spent usually reverts to the employer. Money placed in a cafeteria plan may be used for dental care in two ways:

1. **Pay for premiums.** Employees can pay for eligible group insurance premiums such as medical, dental and vision using pre-tax dollars.

2. **Pay for dental care not fully funded by the plan.** Employees who anticipate major dental expenditures such as orthodontics, periodontal surgery or implants may set aside pre-tax dollars to help pay a portion of their share for these services. Often, this is done through a flexible spending account (FSA), which allows employees to use payroll deducted pre-tax dollars to pay for eligible expenses, such as coinsurance/copayments and other expenses.

In the 1980s, the Internal Revenue Service promulgated regulations for Internal Revenue Code Section 125 (synonymous with cafeteria plans). This section allows certain welfare benefits to be paid with pre-tax money through payroll deductions. Over the years, these plans have become popular with employees and employers alike because employers save on employment taxes when employees reduce their taxable wage base. Companies that offer cafeteria plans and include dental plans under the cafeteria umbrella allow employees to pay premiums with pre-tax money. Participation is voluntary.

**Voluntary Plans**

As the name implies, employee participation in a voluntary plan is voluntary. Premiums are paid in full or in large part by the employees. An underwriting and actuarial concept
in terms of plan design and financing, voluntary plans can be offered through multiple delivery systems, networks and products.

The hallmark of voluntary plans is their great potential for adverse selection; hence, many carriers consider their voluntary products to be a separate line of business. The greater the employee contribution to the premium, the greater the potential for adverse selection. From an actuarial perspective, most carriers consider a voluntary plan to be any plan to which an employee’s contribution to the premium is greater than 50%. Voluntary dental plans differ from other dental plans in several ways:

- Enrollment is voluntary (unlike plans where the employer pays 100% of the premium). Once employees must contribute to premium to participate, they have a choice to opt out.
- They contain many rules and plan design provisions to minimize adverse selection and actuarial risk, including:
  - Minimum enrollment requirements expressed as a percent of total eligibles or a minimum number of employees or both
  - Enrollment is usually for a minimum of one year, which is known as a lock-in provision.
  - Benefits/allowances sometimes improve in the second and third year of the plan to avoid people signing up, getting care and then dropping out (this behavior is typical if the plan is not well-managed).
  - If an employee discontinues the plan, he or she is not permitted to re-enroll for an extended period of time (12, 24, or 36 months with waiting periods on some services). Some voluntary plans prohibit re-enrollment, period.

There are many other variations on voluntary plan design and provisions, some of these can be found in Chapter 22.

**Dental Plan Delivery**

Dental HMOs and the other specialized plans discussed can be designed with different delivery models. These include networks, staff models and the closed panel.

**Open Access Network**

This is a dental plan that uses multiple dental offices and individual providers in various locations and employees are not required to go in-network to receive benefits. It is the most common method of delivering dental benefits for managed indemnity and PPO programs. The administrator usually contracts with private dental offices that are principally fee-for-service dental practices. With more than 187,000 professionally active dentists in the U.S. in 2006 and the average PPO reporting more than 68,000 dentists, it is no wonder establishing and maintaining a widespread network of dental offices is very costly.
**Steerage**

How do you get a patient to choose a participating provider over a nonparticipating provider? The answer is *steerage*. This is a general term used in the industry to refer to plan design or other features used to direct plan participants to network dentists. Steerage occurs in two main ways:

*Provider Directories*

Directories of network dentists are provided via the carrier’s website(s) and often on the employer’s portal as well. While patients tend to be quite loyal to their dentist and reluctant to change without strong incentives, readily available directories are important for encouraging employees to frequent network providers. Employee populations with high turnover rates are far more likely to seek network dentists since they often do not have their own dentist and/or need to find a new one if their new job requires them to relocate. The practical effect of easily accessible directories and promotion on the employer’s web portal is steerage; employees are more likely to select one of these dentists over nonparticipating dentists when faced with this decision. Steerage can be enhanced if a plan uses the term “preferred providers” instead of the more neutral terms of “participating providers,” “contracted providers” or “network providers.”

*Discounted Fees/Better Benefits*

Sponsors that offer higher benefit for a managed plan option are steering participants to an in-network option. This is the most common way sponsors influence choice of provider. If a person does not have an established relationship with a dentist and other choice factors are equal (e.g., distance to office, office hours, perceived quality), participants will choose the provider with the lower out-of-pocket cost and better benefits. If the plan design for basic services is paid at 80% of allowable charges for a network dentist versus 60% for a non-network dentist, there is a greater incentive to select the network dentist. The more costly or elective the procedure, the more effective steerage becomes.

*Closed Panel Network*

A closed panel network is a specific type of network providing beneficiaries a limited choice of offices or dentists; beneficiaries must use a network dentist to receive benefits. DHMOs are the most common closed panel networks, but EPOs and IPAs may also use this approach. If a non-network dentist renders services, the participant usually receives no benefit. The beneficiaries’ choice of dentists or access to offices can be problematic with this delivery model.

*Staff Model*

A staff model refers to a dental plan that employs dentists or contracts with one or more offices that employ staff dentists. This model has been used successfully with DHMO plans. It may be a closed panel operated by the entity providing services for
its own beneficiaries or as a contracted dental office providing services to one or more purchasers. The staff model has the potential for having the highest degree of quality assurance and the lowest cost because it is easier to manage. If it is owned and operated by the entity receiving the services, there is even more control. However, success depends on the quality of management and the providers employed. A downside of staff models is the potential for management to place production quotas on dentist-employees. Substantial experience and expertise are required to manage large, multisite dental offices.

Variations on How Dentists Are Reimbursed

Fee for Service

The more services a dentist provides under fee-for-service plans, the greater the revenue to the dentist, the higher the premium charged to purchasers and the less affordable the plan becomes. Pricing competition among administrators, and trying to maintain or grow market share, are the main factors driving the extensive amount of resources used to manage the universe known as “provider reimbursement.”

Because of the highly asymmetrical nature of the information held by providers, patients and purchasers—especially regarding quality, cost and fees—administrators have developed methods to place a ceiling on prices that will be accepted under each plan. This is done for several very good reasons:

- Purchasers and other stakeholders require and expect dental administrators to maintain predictable, stable premium rates. Failure to control both the level and volatility of rates can spell “corporate demise” for administrators or the elimination of dental benefits provided by purchasers.
- It is difficult and may be cost prohibitive for consumers to comparison shop for health care services.
- Administrators—especially the largest, national carriers—are in a good position to evaluate the reasonableness of fees given the millions of claims they process each year and their direct involvement with both purchasers and providers. This is a tough balancing act. To be fair to all, most administrators offer an array of products and prices, plan designs, networks and reimbursement levels.

The most common reimbursement methods used under fee-for-service arrangements are the maximum allowable fee (also known as usual, customary and reasonable), the PPO fee schedule and the table of allowances. When evaluating managed dental plans, it is important for the broker, consultant and purchaser to understand the nuances that can affect cost, quality and access to care. Provider reimbursement is one of the most important but least understood of these components. For purchasers that choose to self-fund, this dimension can make it quite challenging to estimate expected claims cost.
Usual, Customary and Reasonable (UCR), or Maximum Allowable Charge (MAC)

This term denotes what has been a common method used to determine maximum allowable charges (MACs). UCR is based on statistical observations of market prices arrayed by dental code, geography and specialty into a frequency distribution and broken into percentiles. An indemnity or managed indemnity plan may reimburse up to the 80th or 90th percentile. PPO fee schedules are typically based on a discount off “average area charges.” Actuarial estimates indicate that average charges are approximately equal to the 50th percentile. Note that a percentile is not the same as a percent. The 90th percentile is that fee which at least 90% of the values in the set are less than or equal to, the 80th percentile is the fee that at least 80% of the values in the set are less than or equal to, and so forth.

Reimbursement is based on the dentist’s usual charge, unless the charge exceeds certain parameters, in which case reimbursement is based on the lesser of the submitted charge or the allowable fee. For example, the plan may pay the dentist’s fee unless the fee exceeds a certain percentile threshold, such as the 70th, 80th or 90th. To illustrate, the 90th percentile is that fee at which 10% of the charges for that service in a given geographic area, usually a three-digit zip code area, are greater, and 90% are at or below. Some administrators may allow up to the 50th percentile or median charge, i.e., up to what 50% of the charges are in a given geographic area. In this case, one-half of charges, by frequency, for specific services would be greater than the allowed amount for the service.

**Pros**
- **Based on market prices.** UCR/MAC methodology is based on the prices that dentists actually submit on claim forms by region, procedure code and type of practice.
- **Flexibility.** Allows for maximum flexibility and responsiveness to market forces, which are dynamic and constantly changing
- **Meeting business goals.** Allows administrators to update reimbursement levels to achieve business goals such as network recruiting and pricing changes requested by purchasers.

**Cons**
- **Inflationary.** Inherently inflationary due to distortions caused by presence of insurance. Dentists have an incentive to raise their fees in order to keep reimbursement as high as possible.
- **Data lags.** Because there is a lag in updating the data by insurance companies, some dentists “play games” by increasing their charges in anticipation of having them reduced. Today’s increased fee becomes tomorrow’s UCR or MAC. Major technological advancements have greatly reduced lag times and made this issue less of a factor than in the past.
Using insured reimbursement to subsidize non-insured patients. There is also a tendency for some dentists to increase their fees for those covered by a dental plan using the UCR/MAC payment methodology above what they charge their non-insured patients.

Dentists submitting their PPO discounted fees. It is becoming more difficult to statistically determine dentists’ usual fees, given the dominance of PPOs and the use of practice management software and electronic claims submission and billing transactions. Although carriers continue to request that all dentists submit their usual fees, regardless of any negotiated discounts, it is only natural that PPO dental offices would be inclined to submit their negotiated fees specific to each network that are contracted with, rather than their usual fee for all claims submissions. This can potentially create a downward bias in the statistical distribution of fees used for deriving UCR or MAC schedules. Many insurance companies prohibit this.

Table of Allowances

This method is most common for indemnity plans where there are no network or contracted providers and when members have a network-based plan but choose to use a non-network dentist.

Reimbursement is based on a table of allowances or indemnity schedule. A list of covered dental services is usually provided to beneficiaries detailing the dollar amount that will be reimbursed for each covered service. The amount listed in the schedule is usually less than the dentist's fee and the dentist may charge the difference between the allowance and his or her fee because the dentist has not agreed to accept the amounts listed in the table of allowances as payment in full.

Pros

Cost stability. A table of allowances tends to stabilize cost. There is no automatic, uncontrolled escalation in dental fees as may occur with UCR-based reimbursement. The fees are not necessarily adjusted every year, but rather, some may be updated every two to three years.

Different reporting incentives. Dentists have less incentive to report increased fees when reimbursement is based on a table of allowances.

Simple for members to understand. The patient knows what is covered and what the plan will pay.

Allows for selective adjustment of fees. Another advantage for a plan (and its customers) with fiscal constraints is that allowances (i.e., costs) can be raised selectively. For example, the allowance for diagnostic and preventive services can be increased (high-frequency, low-cost services that improve dental health) and the payment level for expensive major services (crowns, dentures, root canals—low-frequency, high-cost services) can remain at the current level of reimbursement.
Con

- **The participant may not know how much the dentist will charge.** Indemnity and non-network dentists can charge whatever he or she wishes, and the participant will typically have to pay the difference between the plan allowance and the dentist's fee. Patients in this situation would be well advised to request that their dentist submit a pre-determination or pre-treatment estimate prior to having any expensive work involving significant cost sharing. This will allow patients to know exactly what their out-of-pocket cost will be prior to having the work done (all else held constant.)

Fee Schedule

A fee schedule refers to a list of fees the dentist has agreed to accept as payment in full covered services listed in the schedule. This is the most common method used to reimburse PPO dentists, with PPO plans themselves often referred to as “discounted fee-for-service” programs. In addition to the pros listed under Table of Allowances above, fee schedules involve additional considerations.

Pro

- **The dentist agrees to accept the fees listed in the schedule as payment in full.** The patient knows exactly what is covered, what the plan will pay and what he or she will have to pay, if anything.

Con

- **If the level of payment is too low, dentists will not join the network.** This is particularly important in plans such as PPOs that depend on participating dentists to provide care.

Dental Plan Choice and Enrollment Options

If only one dental plan is available for a beneficiary, enrollment is straightforward. Increasingly, however, patients have a choice of more than one plan—especially in light of the trend toward requiring employees to pay a greater share of the premium cost. With increased cost sharing on the premium side, it makes good business sense to offer employees a choice of plans and price points from which to choose. When a choice is offered, the following terms are commonly used:

Plan Choice

Dual Choice

Beneficiaries may select between two types of plans, usually a DHMO and another dental plan. The second plan is often a PPO or other type of fee-for-service plan.
Beneficiaries have the option to enroll in either plan on an annual basis during open enrollment. Point-of-service plans may be an exception.

**Triple Choice**
Beneficiaries have three options—usually a dental HMO, an unrestricted fee-for-service plan (or passive PPO) or a PPO (often one involving steerage by providing richer benefits for in-network care).

**Enrollment Options**
Enrollment options can have a significant impact on the plans’ experience (utilization and cost), on the enrolled patients and on the dentists.

**Positive Choice**
Two or more plans are offered, and the participants must select a plan.

*Pro*
- This is the preferred method of enrollment. It encourages eligibles to analyze their options and become more familiar with their benefits. It also injects competition into the marketplace. The participating dentists wish to retain their enrolled patients, particularly if they have a large number of patients from a particular group and have brought them to a state of good dental health. When dentists know the patients can select another dental plan on an annual basis, they tend to be more accommodating. Positive choice is the most actuarially sound way to enroll participants.

*Con*
- The disadvantage of positive choice is that it requires more effort from the employer.

**Primary Enrollment**
Two or more plans are offered and eligible employees can choose which plan to enroll in during annual open enrollment. The purchaser can designate any of the plans as the “primary plan.” It may be a DHMO, a PPO or an indemnity plan. Eligibles that do not make a choice are assigned to the primary plan.

*Pro*
- This is also an acceptable method of enrollment. From a purchaser’s perspective, it encourages patients to stay enrolled in what is usually a less costly plan and they have to handle only enrollment forms of those who want to opt out of the primary plan. It can also be effective in driving eligibles to a less costly dental plan.
**Con**
- It may increase the risk of adverse selection. Cost per participant for the non-primary plan could be higher than it would be under a required positive choice arrangement because those who make a choice to change plans are far more likely to use the plan. If used, it is essential that effective quality and utilization monitoring be in place.

**Assigned or No Choice**
Usually the only plan offered is a closed panel DHMO. The eligibles are enrolled in a DHMO and have no other option unless they go to a dentist of their own choice and pay for their dental care out of their own pocket. They may or may not be automatically assigned to a particular dental office. The best practice, when eligibles do not make an active selection, is for them to be automatically assigned to a dental office. DHMO-only programs are not recommended except in special cases such as individual or group voluntary plans.

**Pro**
- If the plan is a quality closed panel dental plan, this type of arrangement may provide quality care at significant savings for the purchaser. Administration is easier when all participants are enrolled in one plan.

**Con**
- Enrollee satisfaction and access may be a problem if there are too few offices. Dentists know the enrolled patients have no (or few) choices and may act accordingly. Many of these plans feature a large-production clinic atmosphere.