DENTAL
BENEFITS

Introduction to Dental Benefits

Dental Benefits: An Introduction

By ADA Staff

A. Types of Dental Plans

1. Preferred Provider Organizations (PPO)

In 2022, preferred provider organizations accounted for 86% of the total dental benefit market which makes PPOs the most popular type of dental plans in the United States.[1] A PPO plan is regular indemnity insurance combined with a network of dentists under contract to the insurance company to deliver specified services for set fees and according to the provisions of the contract. Contracted dentists must usually accept the maximum allowable fee as dictated by the plan, but non-contracted dentists may have fees either higher or lower than the plan allowance. Patients can usually see either a contracted dentist or another dentist, but may be penalized by receiving a smaller benefit when they receive treatment from a non-contracted dentist.

The following is a typical plan design for a PPO plan:

100% coverage for preventive and diagnostic services*
$50 annual deductible applies to all services except preventive and orthodontic
80% coverage for basic restorative services
50% coverage for major restorative services
50% coverage for orthodontics subject to separate lifetime maximum of $1,000
$1,500 annual maximum for all services except orthodontics
(*percentages are applied to the maximum allowable fees as determined by the insurance carrier)

Utilization review (UR) is a major control mechanism in PPOs. It is used to monitor the treatment patterns of participating dentists, to help the PPO and the purchaser evaluate the benefit. In those instances where dentists' utilization of a procedure goes above the "norm" established by the payer, the dentist might be notified by the payer regarding performing more of one type of procedure than other dentists in the area. The dentist has a choice to continue the current practice pattern, work with the PPO to explain and justify potential differences in practice patterns or to change practice patterns to conform to the payer's UR norm. Dentists who choose not to change their practice patterns might be dropped from the plan. The dentist may have the right to appeal if an appeal process is included in the contract. Thus, UR may have an impact on clinical care and may also interfere with the dentist-patient relationship.

[1] 2023 NADP Dental Benefits Report: Enrollment December 2023

2. Dental Health Maintenance Organizations (DHMO)/Capitation Plans

A dental health maintenance organization is a common example of a capitation plan. In 2022, DHMOs accounted for 4% of the dental benefits market in the US.[2] Under a capitation plan, contracted dentists are "pre-paid" a certain amount each month for each patient that has been designated or assigned to that dentist. Dentists must then provide certain contracted services at no-cost or reduced cost to those patients. The plan usually does not reimburse the dentist or patient for individual services and therefore patients must generally receive treatment at a contracted office in order to receive a benefit.

The following is typical for a patient presenting with a capitated plan:

- Preventive and diagnostic services require no co-payment by the patient
- Other covered services require the agreed upon patient co-payment
- With a capitated plan there are no dental claim forms to submit

Profit from a capitation plan depends on how efficiently the dental office can conduct this function. Since a dentist receives payment regardless of whether services are rendered, the practice receives a predictable cash flow and income source. The trade-off is that when a dentist enters a capitation plan, the dentist assumes the financial risk of the cost of the patient's care. Profitability under this system is higher with increasingly healthier groups who need less care.

3. Indemnity Plans

An indemnity dental plan is sometimes called "traditional" insurance. Indemnity plans accounted for 2% of the dental benefits market in 2022.[3] In this type of plan an insurance company pays claims based on the procedures performed, usually as a percentage of the charges. Generally an indemnity plan allows patients to choose their own dentists, but it may also be paired with a PPO. Most plans have a maximum allowance for each procedure referred to as "UCR" or "usual, customary and reasonable" fees. A common misperception is that the terms usual, customary and reasonable are interchangeable; they are not. Dentists determine their own usual fees. The insurance company's fee schedule is called customary, but it may or may not reflect the fees that area dentists charge. Insurance companies usually do not disclose how their fee schedules are determined. Reimbursement is made according to the patient's plan of benefits, usually a percentage of the insurance company's fee schedule.

[2]2023 NADP Dental Benefits Report: Enrollment December 2023

[3]2023 NADP Dental Benefits Report: Enrollment December 2023

The following is a typical plan design for an indemnity dental plan:

100% coverage for preventive and diagnostic services*
$50 annual deductible applies to all services except preventive and orthodontic
80% coverage for basic restorative services
50% coverage for major restorative services
50% coverage for orthodontics subject to separate lifetime maximum of $1,000
$1,000 annual maximum for all services except orthodontics
(*percentages are applied to the customary fees as determined by the insurance carrier)

4. Direct Reimbursement (DR®)

Benefits in this type of plan are based on dollars spent, rather than on the type of treatment. Direct Reimbursement is a self-funded plan that allows patients to go to the dentist of their choice. Depending on the plan, the patient pays the dentist directly (or the benefit may be directly assigned to the dental office) and then submits a paid receipt or proof of treatment. The administrator then reimburses the employee a percentage of the dental care costs. With some plans there are no insurance claim forms to complete and no administrative processing to be done by the dental office or an insurance company. DR is the ADA's preferred method of financing dental treatment.

The following are typical plan designs for DR plans:

Plan A
100% of the first $200 of dental expenses
80% of the next $250 of dental expenses
50% of the next $2,200 for an annual maximum of $1,500

Plan B
100% of the first $100 of dental expenses
80% of the next $1,750 for an annual maximum of $1,500

DR offers the following advantages for **dentists**:

- Freedom of choice for patients
- No fee restrictions
- Treatment decisions are made between the dentist and patient
- Preserves dentist-patient relationship
- No need to submit x-rays or pre-determinations
- Typically all services are covered (except cosmetic)
- No waiting periods

DR offers the following advantages for **patients**:

- Freedom to choose any dentist for treatment
- Easy to understand

- Reimbursement based on dollars spent, not on the type of treatment received
- No pre-authorization requirements
- Typically all services are covered (except cosmetic)

DR offers the following advantages for **employers**:

- Cost control through the use of co-payments and annual maximums
- No premiums. Instead, payment is made for those employees who actually visit the dentist.
- Fewer employee complaints
- Simple to administer and easy to understand

Remember, when a patient presents with a DR plan, please make sure your staff understands that this is not a managed care patient and that this is basically a cash paying patient.

5. Point of Service Plans

Point of service options are arrangements in which patients with a managed care dental plan have the option of seeking treatment from an "out-of-network" provider. The reimbursement to the patient is usually based on a low table of allowances; with significantly reduced benefits than if the patient had selected an "in network" provider.

6. Discount or Referral Plans

Discount or referral plans are technically not insurance plans. The company selling the plan contracts with a network of dentists. Contracted dentists agree to discount their dental fees. Patients pay all the costs of treatment at the contracted rate determined by the plan and there are no dental claim forms to file. Originally these plans were sold to individuals; however, more and more employers are purchasing these types of plans as the dental plan for the company's employees. In 2022, these plans accounted for 4% of the dental benefits market.[4]

7. Exclusive Provider Organizations (EPO)

Exclusive provider organization plans require that subscribers use only participating dentists if they want to be reimbursed by the plan. These closed panel groups limit the subscriber's choice of dentists and also can severely limit access to care.

8. Table or Schedule of Allowances Plans

These types of plans are indemnity plans that pay a set dollar amount for each procedure, irrespective of the actual charges. The patient is responsible for the difference between the carrier's payment and the charged fee. The plan may also be paired with a PPO that limits contracted dentists to a maximum allowable charge.

[4]2023 NADP Dental Benefits Report: Enrollment December 2023

B. Financing of Dental Plans

1. Self-Funded Plans

In a self-funded plan, the employer generally has more flexibility. The employer can determine what dental expenses will be covered and it also has responsibility for plan decisions. The employer pays its employees' claims with its own money, as the claims are incurred. For those employers that do not want to process the claims themselves, they may choose to sign an agreement with a third-party administrator (TPA), or an administrative services only (ASO) agreement with an insurance company to process the claims. However, in an ASO agreement the insurance company's standards and procedures will usually determine what benefits are covered, even though the plan is self-funded. A federal law known as the Employee Retirement Income Security Act of 1974 (ERISA) sets rules for most self-funded plans. ERISA plans are governed by the US Department of Labor and exempt from many state insurance laws.

2. Paid Premium Plans

Paid premium dental plans are typically business arrangements between an insurance company and an employer. Most plans are designed to pay only a portion of the patient's dental expenses. In a paid premium plan the employer pays a "fixed" (usually on a monthly basis) premium to an insurance carrier. The insurance carrier assumes all of the risk associated with the claims of the employees, no matter how many claims are incurred. Premium dollars not used at the end of the plan year become assets of the insurance company and not the employer. In a paid premium group plan, the insurance carrier agrees to provide coverage to the employees subject to various conditions. The carrier is responsible for all plan decisions and any legal actions are directed to the carrier. In addition, paid premium plans are generally governed by state insurance statutes.

3. Medicaid

The Medicaid program, Title XIX of the Social Security Act, provides optional dental services for adults age 21 and older. On the other hand, dental services are required for the majority of Medicaid-eligible individuals under the age of 21.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is Medicaid's comprehensive child health program. The goal of the program is to concentrate on prevention and early diagnosis and treatment of medical conditions. This is a requirement under any state's Medicaid program.

The state will consult with recognized dental organizations involved in children's health to determine when dental services must be provided in accordance with reasonable standards of dental practice. At a minimum, services must include restoration of teeth, maintenance of oral health and relief of pain and infections. Individuals eligible for EPSDT may not have dental services limited to emergency procedures.

An oral screening provided by a physician does not substitute for a dental examination performed by a dentist as a result of a dental referral. The state will determine the schedule for direct dental referrals, which are required for every child. The Centers for Medicare and Medicaid Services (CMS) does not specify what dental services must be provided, however, EPSDT requires that all covered services under the Medicaid program must be provided to EPSDT recipients if determined to be medically necessary. States determine medical necessity under Medicaid programs.

In addition, if a condition requiring treatment is discovered during a screening, the state must provide the necessary services to treat that condition, even if the services are not included in the state's Medicaid plan.

It is up to individual states to determine if their adult Medicaid-eligible population is eligible for dental services. Many states do provide emergency dental services for adults at a minimum; however, less than half provide comprehensive dental care. There are no minimum requirements for adult dental coverage.

4. Medicare

Medicare will only pay for dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury) or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. In certain instances, Medicare will make payment for oral examinations, but not treatment preceding kidney transplantation or heart valve replacement. Such examination would be covered under Part A if performed by a dentist on the hospital's staff or under Part B if performed by a physician.

Section 1862 (a)(12) of the Social Security Act states, "where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services."

The dental exclusion was included as part of the initial Medicare program. In establishing the dental exclusion, Congress did not limit the exclusion to routine dental services, as it did for routine physical checkups or routine foot care, but instead it included a blanket exclusion of dental services. Congress has not amended the dental exclusion since 1980 when it made an exception for inpatient hospital services when the dental procedure itself made hospitalization necessary.

Coverage is not determined by the value or the necessity of the dental care but by the type of service provided and the anatomical structure on which the procedure is performed.

The following two categories of services are excluded from coverage under Part B:

A primary service (regardless of cause or complexity) provided for the care, treatment, removal, or replacement of teeth or structures directly supporting teeth (e.g., preparation of the mouth for dentures, removal of diseased teeth in an infected jaw).

A secondary service that is related to the teeth or structures directly supporting the teeth unless it is incidental to and an integral part of a covered primary service that is necessary to treat a non-dental condition (e.g., tumor removal) and it is performed at the same time as the covered primary service and by the same physician/dentist. In those cases in which these requirements are met and the secondary services are covered, Medicare does not make payment for the cost of dental appliances, such as dentures, even though the covered service resulted in the need for the teeth to be replaced, the cost of preparing the mouth for dentures or the cost of directly repairing teeth or structures directly supporting teeth (e.g., alveolar process).

An exception to an excluded service is the extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease. Another example is an oral or dental examination performed on an inpatient basis as part of comprehensive workup prior to renal transplant surgery or performed in a RHC/FQHC prior to a heart valve replacement.

Structures directly supporting the teeth means the periodontium, which includes the gingivae, periodontal membrane, cementum of the teeth and the alveolar bone (i.e. alveolar process and tooth sockets).[5]

5. Medicare Advantage Plans

Medicare Advantage plans are health plans that are part of the Medicare program. Generally, all Medicare covered health care can be obtained through this type of plan which can include prescription drug coverage. Medicare Advantage plans include:

- Private Fee-for-Service Plans
- Medicare Health Maintenance Organizations
- Preferred Provider Organizations
- Medicare Special Needs Plans

Medicare Advantage plans use the health insurance cards that patients get from their medical plans. Many of these plans offer enhanced benefits and possibly even lower copayments than in the original Medicare plan. However, your patients may have to see participating dentists or go to certain hospitals to receive benefits.

In order to join a Medicare Advantage plan, a patient must have Medicare Part A and Part B. The patient will need to pay a monthly Medicare Part B premium to Medicare. In addition, the

[5] Accessed from http://www.cms.hhs.gov/MedicareDentalCoverage/, September 23, 2009

patient will need to pay a monthly premium to the Medicare Advantage plan for the extra benefits provided. [6]

C. Plan Designs

1. Traditional

Traditional plan designs are commonly used in indemnity and PPO plans which consist of 100% coverage for preventive and diagnostic services, 80% coverage for basic restorative services, 50% coverage for major restorative services and 50% coverage for orthodontics.

2. Dollar-Based

Dollar-based plans are plans in which benefits are stated as a maximum dollar limit per year per eligible individual, or a percentage thereof. Reimbursement is based on the dollars spent rather than on the type of treatment received. Unlike conventional plans, there are typically few exclusions or limitations on specific treatments. Direct Reimbursement is a type of dollar-based dental plan.

3. Preventive Only/Limited Benefit

Employers wishing to have low premium payments may wish to purchase plans that provide preventive services only. This would typically include an oral examination, prophylaxis and certain combinations of radiographs. In addition, employers wishing to spend a little more in premium could add basic restorative services to the preventive services.

4. Cafeteria Plans/Section 125 Plans

A cafeteria plan is an employee benefit program established by an employer for employees that meets the specific requirements of and regulations of section 125 of the Internal Revenue Code. A cafeteria plan allows employees to pay for certain qualified expenses (such as health insurance premiums) on a pre-tax basis, thereby reducing the employee's taxable income and increasing the employee's take-home pay. The funds that are placed in these accounts are not subject to federal, state or Social Security taxes.
A qualified benefit does not defer compensation and is excludable from an employee's gross income under a specific provision of the Code, without being subject to constructive receipt principles. Examples of qualified benefits include:

- Dependent care assistance
- Adoption assistance
- Certain accident and health benefits
- Health savings accounts
- Group-term life insurance coverage

[6] Accessed from http://www.medicare.gov/choices/advantage.asp, January 11, 2010

The plan must specifically describe all benefits and establish rules for eligibility and elections. A section 125 plan is the only means by which an employer can offer employees a choice between taxable and nontaxable benefits without the choice creating taxable benefits. A plan offering choices between taxable benefits only is not a section 125 plan.[7]

5. Health Savings Accounts (HSA)

Health savings accounts were created to provide tax-advantaged alternatives to traditional medical plans. In essence, a health savings account is a savings account that permits employees to pay for necessary medical care and expenses with tax-free dollars. Employees must obtain coverage through a high deductible health plan (HDHP) in order to participate in an HSA. Due to the high deductible, an HDHP is usually substantially lower in price compared to premiums associated with a typical medical insurance plan and these cost savings could be transferred into the employee's HSA.

Employees own and are responsible for the funds in their health savings account. Therefore, decisions on how to utilize the funds are made by the employee without interference from an insurance company. In addition, employees are responsible for making all investment decisions.

Some employers have implemented HDHPs that encourage preventive care by providing first dollar coverage (deductible waived) and applying higher out-of-pocket limits, including co-payments and coinsurance for services received by non-participating providers.

6. Health Reimbursement Arrangements (HRA)

A health reimbursement arrangement is an employer funded account set up for employees. The money in an HRA can be used to pay for qualified medical expenses not covered by a healthcare plan. Qualified medical expenses are those as defined in Section 213(d) of the IRS Revenue Code. These expenses include doctor's visits, laboratory tests, dental work, prescription drugs, eye care and hospitalizations as well as many over-the-counter medicines. In addition, employers may further limit the types of expenses that are reimbursable.

Employers determine if the money rolls over into the next plan year and employers can set caps. Expenses eligible for the plan are those that are incurred during the plan year. An expense is incurred on the date the employee receives the service or treatment, not on the date the employee is billed or when payment is made. If an employee leaves the company, the money in the account is usually forfeited; however, that decision is made by the employer.

[7] Accessed from http://www.irs.gov/govt/fslg/article/0,,id=112720,00.html#1, September 16, 2009

7. Flexible Spending Accounts (FSA)

A flexible spending account is one of several tax-advantaged financial accounts that can be established through a cafeteria plan of an employer. An FSA allows an employee to set aside a portion of his or her earnings to pay for qualified expenses as determined by the cafeteria plan, most often for health care expenses but also for dependent care or other expenses. The money deducted from an employee's pay into an FSA is not subject to payroll taxes, which could also create a huge savings in payroll taxes for the employer.

The medical expense flexible spending account is the most popular FSA and is similar to a health reimbursement arrangement or a health savings account. Typically, health savings accounts and health reimbursement arrangements are commonly used as components of consumer driven health care plans and medical FSAs are usually offered with traditional medical plans. The current trend is to have FSA plans administered by using an FSA debit card (Flexcard); however, some employers may still use traditional paper claims.

The majority of cafeteria plans offer two different types of FSAs; one is for dependent care expenses and the other is for qualified medical expenses. Some plans offer other types of flexible spending accounts, usually when the employer offers a health savings account.

The prevalent type of flexible spending account is used to pay for health care expenses not paid for by insurance; this includes coinsurance, copayments and deductibles from the employee's medical plan, but can also include expenses not covered by the medical plan, such as over-the-counter drugs, vision and dental expenses. A medical FSA cannot pay for cosmetic surgery and items, controlled substances (not allowed by federal law), medical insurance premiums or items that improve one's overall health. All items must be necessary for the treatment or prevention of specific medical conditions; this can be as serious as diabetes, or as minor as skin lacerations.

Employers have the ability to set their own annual maximums for medical FSAs. The IRS does not place annual maximums on medical FSAs; however, employers will often limit the amount each employee may contribute annually, in an effort to help lessen the risk of pre-funding. If the employee terminates employment with the employer and thus no longer pays in to the plan, the employer cannot recapture the pre-funding from the employee's payroll deduction.

Many employers are now taking advantage of flexible spending account debit cards which allow for the automatic electronic transfer of pre-tax dollars from an employee account when paying for qualified expenses. Employees can receive immediate reimbursement of dependent care, commuter and health care expenses just by using the card at the point of service. Lost receipts are no longer a problem as the traditional paper claims process is obsolete.[8]

[8] Accessed from http://en.wikipedia.org/wiki/Flexible_spending_account, September 23, 2009

D. Management of Dental Plans

1. Insurance Companies

Insurance companies are some of the most common administrators of dental benefit plans. Whether it is a fully-insured or self-funded plan, insurance carriers can provide many services for clients including: marketing, underwriting, claims payment and risk management services.

2. Third-Party Administrators (TPA)

A third-party administrator is a claims payer who assumes responsibility for administering health benefit plans without assuming any financial risk. Some commercial insurance carriers and Blue Cross & Blue Shield plans also have TPA operations to accommodate self-funded employers seeking administrative services only (ASO) contracts.

E. Relationships with Third-Parties

1. Contractual

When you sign a participating provider agreement with a dental benefit carrier, you make promises that will be legally binding on you. If you fail to do what you promise, the other party may be able to terminate the contract or may initiate legal action against you for breach of contract. **It is therefore, essential that you review any contract carefully before you sign it.**

By signing the contract, what are you promising to do? Are you able and willing to do it? What promises is the other party making to you? What remedies will you have if something goes wrong? Are you aware that by signing a contract you may also be agreeing to policies and procedures that can be changed unilaterally by the plan?

For these reasons, you are strongly urged to consult your personal attorney before signing any contract.[9] In addition, the ADA offers a contract analysis service for dentists that wish further assistance.

The ADA Contract Analysis Service was established in 1987 and is currently housed in the ADA Division of Legal Affairs. This is a popular member benefit. The Service is authorized to analyze the following:

- dental provider contracts
- dental management service organization contracts and
- contracts that offer dental school students scholarships or loans in exchange for commitments for future employment

[9] What Every Dentist Should Know Before Signing a Dental Provider Contract", American Dental Association

Members may submit a contract to their state or local dental societies who will forward it to the Service. The Service provides a plain language explanation of contract terms of each agreement analyzed. The Service does not provide legal advice or recommend whether a contract should or should not be signed. The analysis will be subsequently sent to the member at no charge. Members may send a contract directly to the Service and will be charged a fee of $50 for each contract analyzed.

The Service remains committed to the following goals: meeting the current demand in a timely manner; developing new informational material regarding dental provider contracts; and working closely with state and local societies to address member dental provider contracting concerns.

The Service will present seminars and workshops concerning the legal implications of dental contracts upon request or respond to members' telephone calls requesting information.

2. Non-contractual

Regardless of whether a dentist has signed a participating provider agreement with a dental benefit carrier, the dentist should always submit his or her full fee to the carrier. The terms and conditions of a signed participating provider agreement do not pertain to a non-contracted provider. In some states, certain carriers will not honor assignment of benefits to non-participating providers and they may not submit explanation of benefit statements to these offices. These are just a few of the payment challenges faced by out-of-network dentists.

Employers have traditionally offered dental benefit programs to their employees as an ancillary benefit to improve the oral health of the employees and to help retain and attract new employees. Recent human resources and employee benefits surveys have shown that dental benefits are one of the most highly desired benefits packages that employees are seeking. Typically, dental benefit plans are not designed to cover all dental procedures at 100%; instead, dental plans are designed to have employees participate in the cost of treatment by allowing for deductibles, co-payments, co-insurance and annual maximums. Therefore, it is very important for dental offices to explain to their patients that dental coverage is not based on dental necessity and that it is based on what the employer or plan purchaser is willing to pay in terms of dental plan premiums.

This section is devoted to explaining the types of payment challenges faced by dentists that choose not to participate in network programs and thus how these offices are handled differently by the payers and how the dentists' reimbursements may be affected.

a. Failure to Recognize Assignment of Benefits

Some carriers will not honor the patient's request for assignment of benefits to non-participating providers even though the patient has signed the appropriate section of the dental claim form. Instead payment is sent directly to the patients. The carriers claim it is their prerogative to honor assignment of benefits and that it is a benefit for network providers. This can pose problems for a dental office as many times the patients simply cash the checks

and subsequently do not pay the dental office. An out-of-network dentist should always bill for the full fee unless the patient or insurance company have already paid part of it. Fortunately and as of July 2024, there are approximately 23 states that have passed legislation basically requiring a dental benefits plan to honor assignment of benefits if the patient has authorized assignment to the dentist on the dental claim form. Consult ADA.org for the most up-to-date listing. Dentists in states without this type of legislation are encouraged to work closely with state dental societies to lobby lawmakers in these states to pass similar legislation. Remember, these laws generally apply only to fully insured plans which are governed by state insurance statutes. Self-funded plans are exempt from state insurance statutes and are governed by federal legislation known as ERISA.

Thus, it is possible to treat a patient whose dental plan is fully insured and if the state has passed such legislation, the carrier must honor assignment of benefits. However, if the plan is self-funded and not subject to state insurance statutes that same carrier may choose not to honor assignment of benefits and pay the patient directly – even though it is required by law to honor assignment of benefits for fully insured plans. This is confusing for dental offices because some patients are being paid directly and some dental offices are being paid directly by the same carrier and most of the time the dental office is not going to know whether the patient's dental benefit plan is fully insured or self-funded. It would behoove carriers to be consistent and honor direct assignment requests for all dental plans including self-funded plans in states that have passed assignment of benefits legislation.

b. Reduced Levels of Reimbursement

Another method carriers use to steer patients to offices of participating providers is to reduce the percentage of reimbursement the patient receives for services from non-participating providers. For example, instead of reimbursing 100% for preventive and diagnostic services, the plan may reimburse 90% if the patient receives treatment from a non-participating provider, 70% instead of 80% for basic services and 40% instead of 50% for major services. This has the tendency to steer many patients to seek care from participating providers so that these patients may reduce out-of-pocket expenses. Thus, the non-participating provider may be entrusted with the unpopular responsibility of having to explain to patients why their out-of-pocket expenses are higher for treatment performed by his or her office.

c. Higher Deductibles and Lower Annual Maximums

Some carriers have even implemented higher deductibles and lower annual maximums for patients seeking treatment from non-participating providers. Once again, the intent of these policies is to steer patients to offices of participating providers by shifting a higher burden of the dental treatment costs on the patient instead of the dental benefit plan. For example, a plan that has a $50 deductible for basic and major services may increase that deductible to $100 if treatment is provided by a non-participating provider. The same holds true for annual maximums. A plan that has a $1,500 annual maximum may decrease that maximum to $1,250 if treatment is provided by a non-participating provider. The non-participating provider is at a distinct disadvantage compared to the participating provider because of the patient's

potential added out-of-pocket expenses due to the higher deductible and lower annual maximum.

d. Failure to Receive Explanation of Benefits Statements

Many carriers will not send explanation of benefits statements to non-participating providers. These carriers will only send EOBs to patients and to participating provider offices. Once again, the carriers claim that this is a benefit of being a participating provider. This can cause problems for the non-participating dental office because the dental office does not receive a copy of the explanation of benefits and it makes it harder to assist the patient when the patient has a question regarding his/her reimbursement by the plan. Again, an out-of-network dentist should always bill for the full fee unless the patient or insurance company have already paid part of it.

Some carriers offer what is called “fax back” service meaning that the carrier will fax a copy of the EOB to the dental office if the dental office provides a fax number and requests that the carrier fax the EOB to the office. This is time consuming and non-participating dental office staff have to constantly remember to do this in addition to all of their other duties and responsibilities.

e. Faster Payment for Out-of-Network Dentists Allowing Discounts

Dental offices may be contacted by third party organizations that have been hired by carriers to persuade dental offices to accept a discounted or decreased fee in return for faster payment of the claim. Dental offices should determine if this is a one-time arrangement or if the organization will continue to apply the discount to future patients without the dental office providing additional consent. Dental offices are encouraged to use the ADA’s contract analysis service to receive a free written analysis of the contract which includes information on whether this applies to future claims submitted by the dental office for that patient or other patients.

Many times there is considerable confusion by dentists and their staff about contracts they have signed and where they might apply. “Stacking” refers to the practice of a dental plan administrator using more than one contracted network for a specific employer plan or even the administrator’s entire book of business. A dentist might have just one signed contract or more than one contract with a “provider network”. The plan administrator can use the contracted fees from any dentist network they are using or their own, if they have one. Generally speaking, the plan administrator will apply the lowest contracted fee a specific dentist has agreed to when determining benefits for a specific group dental plan. If a dentist has more than one signed contract with “provider networks” that a specific administrator utilizes, the lowest fee the dentist has agreed to is generally applied. A dentist doesn’t even have to have a signed agreement with the plan administrator (such as XYZ Company), but can have it with any provider network XYZ Company has an agreement with.

Another form of stacking involves a dentist having more than one contract with the same administrator. In this case, it is possible that the administrator asked the dentist to sign

another contract to treat a different group of patients. A dentist may choose to sign this additional agreement in order to have access to and obtain new patients. A challenge can develop for the dental office when more groups are offered this second, smaller network. It is possible that some of the patients seen under the first and higher fee agreement may convert to the lower fee agreement. The dentist essentially must now provide the same level of care for a reduced fee. This can impact significantly on the bottom line if a number of patients convert to the lower fee network.

Another aspect of provider contracts that again confuses dental offices is when a plan administrator starts processing claims or "leasing" their network to other plan administrators. For example, a dentist may have a signed contract with Dental PPO "A" and see several patients from this PPO. PPO "A" may make an arrangement with TPA "B". A patient (and perhaps one that this office has seen regularly) presents with a membership card to TPA "B". The dentist may think they have no contractual arrangement with this patient through PPO "A". When the office gets an EOB, they will notice that TPA "B" has reduced the dentist's full fee to the contracted fee agreed to between the dentist and PPO "A". They may also note that they can no longer balance bill the patient up to their full fee, but only to their contracted fee with PPO "A". This form of network leasing seems to be increasingly common.

Another method carriers may use to entice out-of-network dentists to accept a discounted fee is to send a check with a decreased payment with language that says something similar to final payment or payment in full. It is recommended that dental offices check with their personal attorneys before cashing a check with this type of language to determine what options are available to them.

F. Typical Plan Benefits and Limitations

1. Pre-existing Conditions

Some group health plans restrict coverage for dental conditions present before an individual's enrollment in the plan, such as missing teeth. These restrictions are known as "preexisting condition" exclusions. If a plan imposes pre-existing condition exclusions, the length of the exclusion must be reduced by the amount of any prior creditable coverage. A certificate of creditable coverage will indicate the time the employee has been continuously covered under a plan and allows waiver of any waiting period to a pre-existing condition. Most coverage can be considered creditable coverage, including group dental coverage, COBRA continuation coverage or coverage under an individual dental policy. If 63 days or more have passed without any coverage (called a break in coverage) a plan may not have to count the coverage before the break as creditable coverage.

2. UCR – Three Different Concepts, Not One

Dental plans may use the terms “usual, customary and reasonable” (UCR) to determine the portion of the dental treatment fee they are willing to pay for a particular procedure. As noted earlier the terms usual, customary and reasonable are not interchangeable and “UCR” is a misleading acronym. Usual fees are determined by the dentist. An insurance company creates its own “customary” fee schedule. There is no universally accepted method for determining the customary fee schedule, which may vary a great deal among plans – even when those plans operate in the same area. The fee the insurance company determines to be “customary” may be lower than the area dentists’ usual or reasonable fees for the same service.

The benefit paid will generally be based on a percentage of the insurance company’s customary fee schedule. Patients often do not know what their out-of-pockets costs will be because third-party payers generally do not release these customary fee schedule maximums to the public.

3. Annual Maximums

Many dental plans feature a *total annual maximum* – a maximum dollar amount that may be reimbursed each year, even if the patient’s dental costs exceed that limit. A common annual maximum is $1,000 or $1,500, but it is not uncommon to see plans with much higher annual maximums of $2,000 or $3,000 to match the rising costs of dental treatment. These totals can be based on individual or family maximums.

4. Managed Care Cost Containment Features

Cost containment measures are features of a dental benefit program or of the administration of the program designed to reduce or eliminate certain charges to the plan. Cost containment measures are used throughout the healthcare industry and are used to determine the payment for services that have been provided. Health care plans should disclose information on how cost containment measures are used, or how they will affect the claim being considered. Any limitations, exclusions and applied cost containment measures should be described and the application of deductibles, co-payments and coinsurance factors explained to the patients by the third-party payers and employers before
the services are performed.
Managed care dental plans are health plans that integrate the financing and delivery of health care services to covered individuals by means of some or all of the following:

- arrangements with selected providers to furnish services to members
- defined criteria for the selection of health care providers
- significant financial incentives for members to use contracted providers
- procedures associated with the plan, subject to limitations and exclusions
- formal programs for quality assurance and utilization review

a. Least Expensive Alternative Treatment Provisions (LEAT)

A dental plan may not allow benefits for all treatment options. A least expensive alternative treatment provision is a limitation found in many plans which reduces benefits to the least expensive of other possible treatment options as determined by the benefit plan, even when the dentist determines that a particular treatment is in the patient's best interest. For example, the dentist may recommend a fixed bridge, but the plan may allow reimbursement only for a removable partial denture. The patient may not always understand the payer's least expensive treatment policy, and what the out of pocket costs are, until the explanation of benefits is received.

b. Bundling of Dental Procedures

Claims bundling is the systematic combining of distinct dental procedures by third-party payers that results in a reduced benefit for the patient/beneficiary. The ADA considers bundling of procedures to be potentially fraudulent.

Many dentists want to know what the purpose of developing a procedure coding system with separate codes for distinct dental procedures is when third-party payers simply ignore it. Although there are some instances of bundling due to improper filing of the claim, the instances of concern to dentists are when procedures which are legitimately separate are bundled either inappropriately, or due to contract provisions without explanation.

One of the most common examples of bundling issues pertains to radiographs. Several radiographs will be combined and recoded as a full mouth series and are then subjected to dental benefit plan frequency limitations (many plans will only pay for one full mouth series of radiographs in a five-year period). Usually the number or type of radiographs taken would not constitute a full mouth series.[10]

c. Downcoding

Downcoding is a practice of third-party payers in which the benefits code has been changed to a less complex and/or lower cost procedure than was reported except where delineated in contract agreements.

When a third-party payer downcodes a procedure, it may be understood by the patient that the payer is making a determination that a lower level of care was needed or should have been provided. Dentists feel that the determination of the level of care necessary for the treatment of their patients should be made by them, not the insurance company. Unless the purely business reason for the payer decision is explained, this may wrongfully interfere with the doctor-patient relationship.

Many carriers typically do not disclose their bundling or downcoding policies, even during the contract negotiation process. Dentists and patients have no way of knowing what the reimbursement will be until the explanation of benefits is received. When the dentist has a

[10] *ADA News,* **ADA/NADP share views on bundling and downcoding, June 20, 2007**

contractual arrangement with the carrier, and procedures are bundled or downcoded, a greater dollar amount than what was anticipated may have to be written off. If the dentist is not contracted with the carrier, the patient's coinsurance may also be greater than what was expected.

There is no disagreement about the right of a plan purchaser and the payer to decide what will be covered and what will not be covered. In some cases, limits on coverage are an industry response to what payers believe is abuse of the system by some dentists. The concern often goes back to explanation of benefits language. If payers would clearly explain that these are economic decisions between the plan purchaser and the payer in a manner that does not impact the doctor-patient relationship, it would help clear the air. Patients still might not be happy with how the benefits are administered but the dentist should not be held to blame. In the present climate, it is incumbent upon dentists and their staff to explain to patients in advance of treatment that a treatment plan should be dictated by what the doctor and patient determine is clinically appropriate, not by plan compensation.

d. Predetermination

Predetermination of benefits is an administrative procedure that may require the dentist to submit a treatment plan to the third party before treatment begins. The third party usually returns the
treatment plan indicating one or more of the following:

- patient's eligibility
- covered services
- benefit amounts payable
- application of appropriate deductible
- co-payment and/or maximum limitation

Under some programs, predetermination by the third party is required when covered charges are expected to exceed a certain dollar amount. Predetermination is not a guarantee of benefits, for example, predetermination does not consider any coordination of benefits.

Examples of situations where a previously approved pre-determination of benefits may not be honored by the carrier include:

- At the time the pre-determination was processed by the carrier, the patient was eligible for benefits; however, by the time treatment was provided, the patient was no longer employed by his/her employer and thus was not eligible for the benefits.
- At the time the pre-determination was processed by the carrier, the patient had benefits dollars available; however, by the time treatment was provided, the patient had exceeded his/her annual maximum benefit and benefit dollars were no longer available.

e. Deductibles

The amount of dental expense for which the beneficiary is responsible before a third party will assume any liability for payment of benefits. The deductible may be an annual or one-time charge, and may vary in amount from program to program.

f. Coinsurance Provisions

A provision of a dental benefit program by which the beneficiary shares in the cost of covered services, generally on a percentage basis. The percentage of a covered dental expense that a beneficiary must pay (after the deductible is paid). A typical coinsurance arrangement is one in which the third party pays 80% of the allowed benefit of the covered dental service and the beneficiary pays the remainder of the charged fee. Percentages vary and may apply to table of allowance plans; maximum allowable benefit plans and Direct Reimbursement plans.

G. Coordination of Benefits (COB)

Coordination of benefits takes place when a patient is entitled to benefits from more than one dental plan. The plans will coordinate the benefits to eliminate over insurance or duplication of benefits. When both plans have COB provisions, the plan in which the patient is enrolled as an employee or as the main policyholder is primary. The plan in which the patient is enrolled as a dependent would be secondary.
In addition, state laws and regulations often mandate coordination of benefits. Plan sponsors should be certain that the plan they select specifies its method for coordinating benefits with other plans.

1. Types of COB

a. Traditional

Traditional coordination of benefits allows the beneficiary to receive up to 100 percent of expenses from a combination of the primary and secondary plans.

b. Non-Duplication of Benefits

In the case of non-duplication of benefits, if the primary carrier paid the same or more than what the secondary carrier would have paid had it been primary, then the secondary carrier is not responsible
for any payment at all. This differs from traditional coordination of benefits in that reimbursement is limited to the greater amount allowed by the two plans rather than a total of 100 percent of the charges.

c. Maintenance of Benefits

Maintenance of benefits (MOB) reduces covered charges by the amount the primary plan has paid, and then applies the plan deductible and coinsurance criteria. Consequently, the plan

pays less than it would under a traditional COB arrangement, and the beneficiary is typically left with some cost sharing.

d. Carve out of Benefits

Carve out is a coordination method which first calculates the normal plan benefits that would be paid, then reduces this amount by the amount paid by the primary plan.

The ADA recommends that patients impacted by these policies consult with their human resources department to determine their entitled level of benefit prior to treatment.

2. Dependents

Which policy pays first for dependents depends on the rules of the insurance company or state laws. The typical rules for dependents of parents with overlapping coverage rely on the birthday rule, that is, the parent whose birthday is earlier in the calendar year is primary. In the case of divorced/separated parents, the court's decree would take precedence.

3. When Does Secondary Pay?

Usually, the secondary policy will not accept a claim until after the primary claim is paid, and then the secondary policy will often require a copy of that payment information (referred to as an EOB).

4. ADA Guidelines on Coordination of Benefits for Group Dental Plans

When a patient has coverage under two or more group dental plans the following rules should apply:

a. The coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan.
b. The aggregate benefit should be more than that offered by any of the plans individually, allowing duplication of benefits up to the full fee for the dental services received.

This publication was developed to assist dentists in understanding Dental Plans and types of Dental Benefits. It is not intended to cover every situation or offer complete advice. None of the information is to be construed as legal advice, a legal standard, or Association policy that can serve as a substitute for a dentist's own professional judgment or consultation with a personal attorney or other professional advisor.