



Dental is Different

To better understand the options available to employers in providing a dental benefit plan to their employees, it is important to understand the differences between dental and medical care. These differences drive the design of dental benefit plans, and create a distinction between approaches to dental and medical benefit coverage.

Unlike general medical disease, dental disease is not an insurable risk.

- There is near-universal incidence of dental disease – everyone has it, and hence, everyone needs and will utilize dental care.
- Apart from trauma and pain, the patient has complete control over when, or even if, treatment will be given. The nature and amount of that treatment has considerable effect on the outcome of treatment.
- Although the need for dental care varies between individuals, the dental needs of an employee group are highly predictable. Hence, a dental plan can often be self-funded and self-administered.
- Unlike general medical disease, dental disease is generally not acute or life-threatening; hence, the financial implications of dental treatment are not catastrophic.

Unlike many diseases, dental disease does not heal without therapeutic intervention; it is chronic, progressive, and destructive, becoming more severe over time.

Much of dental disease is preventable, at a minimum of cost and effort. Hence, dental coverage should always have a preventive orientation.

Dental disease generally progresses slowly. Hence dental treatment can be postponed and accumulated without symptoms for a considerable length of time.

The onset of dental disease occurs early in childhood. Hence, coverage extended to children is important in terms of a lifetime of satisfactory oral health.

The dental profession is organized differently than medicine:

- 80% of dentists are general practitioners and primary dental care providers
- The greatest percentage of dental care is rendered by one practitioner at a single site
- Almost all dental care is done on an out-patient basis
- There is a relatively small number of categories of dental auxiliary personnel [and probably a relatively small number of auxiliaries per dentist]
- There is no central facility, like a hospital, where dentists interact on a daily basis
- Dentists own, equip and operate their own "hospital," i.e., their dental office, without public subsidy

"High-tech" advances in dental care generally are not very costly, add to the efficiency and capability of care, and have not resulted in severe inflation of dental costs.

Competition exists in the dental marketplace, since most dental care is not of an acute nature, enabling patients to seek out the best value in dental care

The average annual amount of money spent per person for dental care in the United States is relatively small, even if restorative work is necessary.

Dental care amounts to about 5% of annual healthcare expenditures in the United States

Unlike the cost of medical care, the costs associated with dental care remain relatively stable; increases in the cost of dental care in the United States have been moderate

In summary:

There are significant differences between dentistry and medicine. These differences need to be taken into consideration when designing a dental benefit plan. A dental plan should not be designed as if it were a medical plan, and should not cover medical services. Ignoring the inherent differences between dentistry and medicine will result in costly mistakes in providing dental coverage to a group.



Types of Dental Benefit Plans

In many ways, the coverage of dental care mirrors the benefit plans used to cover medical care.

Commercial Plans

Commercial benefit plans fall into two categories: managed care, and fee-for-service.

Managed Care Plans

Preferred Provider Organization (PPO) programs are plans under which patients select a dentist from a network or list of providers who have agreed, by contract, to discount their fees. In PPOs that allow patients to receive treatment from a non-participating dentist, patients are penalized with higher deductibles and co-payments. PPOs can be fully insured or self-insured. They are usually less expensive than comparable indemnity plans and are regulated under the appropriate insurance statutes in the company's state of domicile and operation.

Type of Plan

Group PPO/DPO Plan

Benefits

PPO plans are less expensive than indemnity plans. Employer may be able to customize plan's benefit levels and covered services. Similar to an indemnity plan, however, plan contracts with dentist to provide service for a reduced rate. PPO plan can limit the co-payment the dentist is allowed to charge, thus reduce employee's out-of-pocket expenses. Plans regulated by state laws. Private employer-sponsored plans protected under ERISA.

Limitations

Limited to panel of participating dentists. Employee may be required to change dentists. This could discourage patients from seeking care. Reduced benefit if patient is seen by a non-participating dentist. Exclusive Provider Organization (EPO) does not cover any expenses when a patient is seen by a non-participating dentist. Annual calendar maximum.

Dental Health Maintenance Organization (DHMO)/Capitation Plan

Dental Health Maintenance Organizations or capitation plans pay contracted dentists a fixed amount (usually on a monthly basis) per enrolled family or individual, regardless of utilization. In return, participating dentists agree to provide specific types of treatment to the patient at no charge (for some treatments a co-payment may be required). Theoretically, the DHMO rewards dentists who keep patients in good health, thereby keeping costs low.

Type of Plan

Group HMO/DHMO

Benefits

Least expensive dental plan. Predictable co-payments or no co-payments. Preventative care generally provided at no cost to patient. Incentives for preventative treatment. Early diagnosis and preventative treatment keeps costs down. HMO plans are regulated by the Department of Managed Health Care. Plans are mandated by law to establish internal review processes for quality assurance.

Limitations

Employee must select Primary Care Provider (PCP) from a list of participating dentists. Employee may be required to change dentists. This could discourage patients from seeking care. No benefit paid if patient does not seek treatment from PCP. Non-routine or major services require substantial patient co-payments, or may not be covered by plan. Dentist assumes financial risk. Dentist receives a monthly "capitation" fee (per head) for each patient assigned to practice, regardless of actual service performed. Treatment may be discouraged and quality of care could be compromised. Practice may limit number of patients seen each month, thus limit patient's access to care. Patient removed from actual cost of dental care; may not understand the value of the service provided. Annual calendar maximum.



Fee-for-Service Plan

An indemnity plan is a fully insured or self-insured plan where an assigned payment is provided to dentists for specific services, regardless of the actual charges made by the provider. Payment may be made to enrollees in the form of reimbursement payments, or directly to dentists.

<i>Type of Plan</i>	<i>Benefits</i>
Group Fully-Insured Indemnity Plan	Employee may see any dentist. Fixed premium for 6-12 months. Fee-For-Service; benefits paid off a UCR schedule. Preventative services are usually paid at 100%, basic services at 80% and major services at 50%. Basic orthodontic coverage may be included. Plans regulated by state laws. Private employer-sponsored plan protected under ERISA.

<i>Limitations</i>
Most expensive type of dental plan. Limit of calendar-year maximum of \$1,000-\$2,000 in expenses. Excluded coverage for esthetic dentistry, implants, treatment for TMJ. Annual deductible of \$50-\$150 Patient is financially responsible for the balance remaining from the UCR fee to the actual fee charged. Waiting periods may apply.

<i>Type of Plan</i>	<i>Benefits</i>
Group Self-Funded Indemnity Plan	Employee may see any dentist. Fee-For-Service; benefits paid on a UCR schedule. Less expensive than a fully-insured indemnity plan. Claims usually paid directly to dentist. Private employer-sponsored plans protected under ERISA.

<i>Limitations</i>
Employer bears sole financial responsibility; premiums are paid to a trust fund. Employer costs are not fixed, cost varies depending upon utilization. Employer responsible for selecting and paying for Third Party Administrator. Check references of TPA. Self-funded plans are regulated by state law.

Direct Reimbursement (DR)

A self-funded dental benefits plan that reimburses patients according to dollars spent on dental care, not the type of treatment received. It allows the patient complete freedom to choose any dentist. Instead of paying monthly insurance premiums employers pay a percentage of actual treatments received. Moreover, employers are removed from the potential responsibility of influencing treatment decisions due to plan selection or sponsorship.

<i>Type of Plan</i>	<i>Benefits</i>
Direct Reimbursement	Employees have freedom of choice to see their own dentist. No interference from insurance with patient-provider relationship. Employer determines benefit level. Employees have control of how they use their benefit dollars. Employees are directly involved in the payment process. Low administrative cost. Some employers may chose to self-administer or select a TPA. Almost all monies go directly to dental benefits. Private employer-sponsored plan is regulated by ERISA.

<i>Limitations</i>
Less predictable than a premium plan; costs vary month to month depending upon utilization. Plan is not regulated by state law. Employees may be required to pay dentist directly for services and are later reimbursed by the employer. This inconvenience can be avoided if employer establishes plan to directly pay dentist.



Alternative forms of dental coverage

Discount dental plans are technically not insurance plans. Discount plans offer a panel of dental providers that have agreed to offer services at a reduced rate. The patient pays for all dental expenses out-of-pocket, albeit discounted below the dentist's usual, customary, and reasonable fees, rather than a third-party insurer paying for the major portion of treatment costs. Discount dental plans are required to obtain a license from the State Department of Managed Health Care (DMHC) to ensure that discounts for services are actual, and that the statements made by in their marketing materials are truthful. If you are unsure whether the discount dental plan you are considering is licensed, you may call DMHC toll-free at 1-888-466-2219 to inquire.

Type of Plan

Discount Dental Plan

Benefits

Provides employees discounted dental services, similar to "discount membership clubs." No interference from a plan with patient-provider relationship. Membership fees predictable. Employees have complete control of what benefits or treatments to purchase. Administrative costs nonexistent for employers.

Limitations

Discounts available only through dentists in the plan's network. The amount of discounts vary from plan to plan. While treatment fees are discounted, the cost of care is still borne 100% by the patient.

Definitions

An employer group purchases and maintains insurance coverage for its employees. Premiums are paid by the employer and may require the employee to partially or fully pay for coverage with pre-tax income deductions. The employer may customize the plan with the insurance company with regard to benefits, employee deductibles/co-pays, covered treatment, and annual maximums.

Private employer-sponsored group benefit plans are regulated by the Employee Retirement Income Security Act of 1974 (ERISA), under the Pension and Welfare Benefits Administration, U.S. Department of Labor. ERISA sets standards for administering these plans, requires financial and other information to be disclosed to plan participants, and sets requirements for the processing of benefit claims.

Group and individual fully-insured indemnity and Preferred Provider Organizations (PPO) plans are regulated by state law. Consumers make seek assistance in resolving claim issues with the California Department of Insurance. Group self-funded plans are not regulated by state law.

Health Maintenance Organizations (HMO) plans and some PPO plans are regulated by the California Department of Managed Health Care. Once a consumer has exhausted the plan's internal grievance system without success, the consumer may seek assistance with the DMHC.

An individual purchases insurance offered through the employer with post-tax income deductions or purchases insurance coverage through a broker or directly from insurance company. Individual plans are not protected by ERISA. The majority of individual dental plans available are Health Maintenance Organizations.

Government Programs

Aside from commercial benefit plans, the principal publicly-funded dental program in California is the Medi-Cal Dental Program, or "Denti-Cal."

Part of the federal Medicaid program, states are required to provide dental services to children up to the age of 21 who are enrolled as beneficiaries in the Medi-Cal program. Medi-Cal's dental benefit program covers a comprehensive package of benefits including diagnostic and preventive services such as examinations and prophylaxis (cleanings), restorative services such as fillings, and oral surgery services. Some services, such as crowns, dentures and root canals, require prior authorization, and some services such as dental sealants.

Basic dental coverage for adult beneficiaries in Medi-Cal was ended by the State of California in 2009. However, federal Medicaid requires states to provide for Federally Required Adult Dental Services (FRADS) for adult beneficiaries. These services, generally, relate to diagnosis and provision of dental services on an emergency basis, such as the need for extractions and other oral surgery procedures; for pregnant women; for adult residents of skilled nursing or intermediate care facilities; and dental services rendered as necessary for medical treatments covered by Medi-Cal.