

Guide to Dental Benefit Plans



What are Dental Benefit Plans?

Dental benefit plans are benefit plans provided by employers to help defray the cost of dental care. The term “dental insurance” is also used, but it is misleading because of the much more limited scope of dental benefits compared to medical insurance.

How are Dental Benefits Different From Medical Insurance Coverage?

Medical benefits protect patients from catastrophic and unpredictable loss due to illness or accident. This is accomplished with policies that require some cost sharing through annual deductibles and co-payments, but then provide coverage for the majority of costs incurred during the year after the deductible is met. There is typically an annual out-of-pocket maximum, meaning that patients are not personally responsible for any covered expenses above that amount.

Dental care is not an “insurable risk” because the average dental care cost per-person per-year is well under \$1,000. This is not considered a risk of catastrophic financial loss. Because most oral disease can be prevented by personal dental hygiene and regular cleanings, dental benefit plans are designed to encourage regular check-ups. In addition, because maintenance of teeth for oral disease requires active participation of the patient, dental plans believe that if patients share the cost of expensive treatment, this will increase the likelihood of compliance in maintaining oral health.

Therefore, dental benefit plans are designed to make available a finite amount of money (the “total maximum benefit”—typically \$1,000-1,500 per year) to help cover dental care. The average benefit amount has not increased significantly in 30 years.

The “total maximum benefit” adds a layer of complexity to claims submission and payment. For example, if a dental plan requires preauthorization for a procedure, the plan does not review the request with regard to the amount remaining in the patient’s benefit package. Likewise, verifying a patient’s eligibility before providing services does not guarantee payment from the benefit plan.

Dental benefit plans also may limit the frequency of coverage for certain services for a given year, including examinations, radiographs and root canal retreatments. Some benefit plans only pay for “least expensive alternative treatments.” The most common example of “least expensive alternative” in general dentistry is a plan that will pay for a filling but not a crown.

What are the Implications for Endodontists?

Because the dental benefit is small, and endodontic care is expensive, it is rare for a patient’s dental benefit plan to cover the entire cost of the endodontic care. One endodontic procedure on a single tooth can surpass the total maximum benefit. By the time patients see an endodontist, they have used some of the benefit on care provided by the general dentist.

Therefore, patients are likely to have significant out-of-pocket responsibility for endodontic services rendered. Because endodontists see most patients on a one-time basis, they do not have the option of collection at future visits. A study by McKinsey & Co. found that once a patient leaves a physician’s office, physicians typically collect about half of what patients owe.

The practice must be prepared to discuss payment options with all patients, whether the patient self-pays or has dental benefits, and the practice must have systems in place to manage accounts receivable.

How do I Talk to Patients About Limits to Their Insurance?

Patients often assume that dental coverage is similar to medical insurance, and they are shocked and angry to learn that they may be responsible for some or all of the cost of what they perceive as an expensive dental procedure.

For that reason, it is important for an endodontic practice to train staff to discuss payment with patients at the time of the visit. By providing fair warning, the practice establishes payment expectations up-front. It is the patient's responsibility to understand the terms and limits of the dental benefit plan.

Many practices send new patients a "welcome letter" before a scheduled appointment. Some include informed consent forms and a patient health history form to complete beforehand. Including a payment policy form is a very effective way to communicate this information ahead of an office visit. [A sample financial policy form can be found on page 9.](#)

What are the Different Types of Dental Benefit Plans and How do They Impact Billing?

There are four general categories of dental benefit plans:

- Direct reimbursement plans
- Fee-for-service (indemnity) plans
- PPO plans
- HMO plans

In addition, patients who contribute to health savings accounts or flexible spending plans have access to those funds to pay for dental care.

Direct Reimbursement Plans

In a direct reimbursement plan, an employer puts aside a set amount of money that is available to an employee for dental care annually (\$1,000-1,500). Direct reimbursement plans are straightforward. The patient pays the dentist, the dentist provides a receipt and the patient submits the receipt to the employer for reimbursement. Under direct reimbursement, the entire responsibility for paying the dentist rests with the patient, just as it does with a patient who is not insured (self-pay). It is reasonable for a practice to require full payment at the time of service.

Inevitably, there will be patients who have complex dental issues, have exhausted the funds in the direct reimbursement plan and who may have trouble paying the entire sum at the time of service. If a patient indicates such challenges, then the practice can discuss financing options before providing services. However, this should be the exception and not the rule.

The American Dental Association strongly supports direct reimbursement plans. The ADA has a number of resources for dentists who want to create a dental reimbursement plan for their employee (www.ada.org/2655.aspx).

Traditional Fee-for-Service (Indemnity) Plans

Fee-for-service plans allow patients to go to the dentist of their choice without incurring any financial penalty. Under fee-for-service, the patient will have a deductible. After the deductible is met, the plan will pay a set percentage of either 1) the dentist's fee; or 2) the so-called "usual customary and reasonable" (UCR) fee, whichever is less. The patient is responsible for the remainder.

The split varies. It is typically 80-20, but some plans include a 50-50 split for more expensive treatment that requires significant patient compliance for maintenance. The total maximum benefit available for all annual dental care often is capped in the range of \$1,000-1,500 per year.

Traditional Fee-for-Service (Indemnity) Plans (continued)

The use of UCR by benefit plans adds complexity to billing and collections. UCR is always less than the dentist's fee and often significantly less. Benefit plans in the same market will set a UCR for the same service at very different rates, and dentists have no way to determine this ahead of time or to substantiate the basis for the fee.

With a fee-for-service plan, there is no contract between the dentist and the plan. Consequently, as with a nonparticipating dentist in a PPO, the dentist must decide whether to request an assignment of benefits from the patient and file the claim directly with the insurer on behalf of the patient. [Assignment of benefits is discussed further on page 6.](#)

If a dentist accepts assignment and submits the patient's claim, he/she he must wait until the claim is processed before billing the patient for his/her copay and the difference between billed charge and the amount paid by the plan.

PPO Plans

Preferred provider organization dental plans use a network of dentists who have contractually agreed to provide care to patients at a discounted rate. Like all dental benefit plans, they have a low total maximum benefit (\$1,000-1,500) and may exclude certain services.

If a patient goes to an in-network dentist, the plan pays the dentist directly according to the discounted fee schedule, and the patient is responsible for any co-payment or deductible. If a patient goes to a nonparticipating dentist (out-of-network) his/her benefit is reduced. General dentists who are in-network are required to refer to in-network dentists for specialty care.

The out-of-network dentist must decide whether to accept an "assignment of benefit" from the patient. If the dentist secures a written assignment of benefit, then he/she will receive the patient's reduced benefit under the plan and can then bill the patient for the difference between the payment and the dentist's billed charge (also called "balance billing"). [The pros and cons of being an in-network participant with a PPO are discussed further on page 6.](#)

To maximize the likelihood of collection of the full amount for services provide under a PPO plan it is important for the front office to predetermine the following, if possible:

- Does the patient have any benefits left? If so, how much?
- Does the plan cover the endodontic services you will be providing?
- Are there any other terms that could limit the patient's benefit? Examples are:
 - 1) least expensive alternative treatment provisions; and
 - 2) pre-existing condition clauses that may deny coverage for endodontic treatment that was started elsewhere.

HMO Plans

HMOs pay contracted dentists a fixed per-member per-month amount for providing patients a defined set of treatments. HMOs favor coverage for routine dental care and “least expensive alternative treatments,” and also have a total maximum benefit ranging from \$1,000-1,500. Dental HMOs have not made significant inroads into most markets, but some companies do offer them as an option.

Dentists who participate in an HMO do not receive additional payment when they provide the treatments covered under the plan, other than any required co-payment. Also, general dentists who contract with an HMO are required to refer to in-network specialists. If an endodontist is not “in-network,” then the patient will receive no benefit for the services provided, and the patient will be responsible for the entire fee.

Flexible Spending Accounts

A flexible spending account allows employees to put a portion of their pre-tax income into an account that can be used during the course of the year to pay for “qualified medical expenses” not paid for by insurance. Noncosmetic dentistry is a qualified medical expense under IRS regulations. People who have a history of dental problems and have access to an FSA may choose their contribution rate in anticipation of incurring dental costs.

FSAs are limited in the following aspects:

- Employers must limit each employee’s contribution to not more than \$2,500 a year.
- The employee can only use the amount accrued in the FSA on the date the expense was incurred.
- Use it or lose it—there is no rollover of funds in FSAs from year-to-year.

From the dental practice standpoint, patients with FSAs are similar to patients in direct reimbursement plans. Patients provide the plan administrator with an invoice from the provider and the plan reimburses the patient directly for the cost of services. Many FSAs provide patients with a debit card that can be used to reimburse the provider at the point-of-service. If the practice is equipped to process credit cards, accepting the debit card is the most efficient collection method.

The entire responsibility for paying the dentist rests with the patient, and it is reasonable for a practice to require full payment at the time of service. However, as with direct reimbursement plans, patients with FSAs may not have accrued enough in their account to cover an expensive service or they may have exhausted funds in the FSA because of other medical or dental problems.

Assignment of Benefits

What is an Assignment of Benefits?

When a patient participates in a dental benefit plan, the “benefit” (payment for certain services) belongs to the patient. If a provider does not participate in the plan, he/she is not entitled to receive payment from the plan for services rendered unless the patient “assigns the benefit” to the provider.

An “assignment of benefits” is a legal document signed by a patient that transfers the benefit to the dentist. It is common for patients to sign an “assignment of benefits” as part of the registration process. [A sample assignment of benefits form can be found on page 8.](#)

What Happens After a Patient Executes an Assignment of Benefits?

The dentist files the claim with the dental plan, along with the assignment form and any required documentation. The dental plan will then pay the dentist for the services provided under the terms of the contract.

Along with the payment, the dentist will receive an “explanation of payment” from the dental plan setting forth 1) the dentist’s billed charge; 2) the amount of benefit paid under the plan; and 3) the amount the patient may owe the dentist.

The patient will receive an “explanation of benefit” form from the plan with the same information, including the amount he/she owes the provider. The provider may bill the patient for the balance.

What are the Benefits of Accepting an Assignment of Benefits From a Patient?

For endodontists, the main reason to accept an assignment of benefits is as a service to the patient. The assignment of benefits saves the patient the hassle of filing the claim. The patient will not be responsible for any payment (other than co-payment) until the claim is processed.

What are the Disadvantages of Accepting an Assignment of Benefits From a Patient?

The disadvantage to accepting assignment of benefits is the challenge of collecting from the patient after he/she has left the office. As noted, because of the one-time nature of endodontic procedures, practices do not have the option of collecting the amount due when the patient returns to the office.

Many patients do not understand the limits of their benefit plan, and they are unhappy when they receive the EOB stating the amount they may owe the provider. They may not understand that there is a total maximum benefit under their plan; they also may not understand why the plan’s payment amount is lower than the dentist’s billed charge. Add the fact that people tend to pay medical and dental bills last, and a practice may have a collection problem.

Participating in Dental Benefit Plans: In-Network or Out-of-Network?

The decision to sign a contract to participate with any dental benefit plan or to continue that relationship is a business decision that each practice must make based on the market where they practice, their referral relationships and their overall practice economics. The key is determining whether participation helps build and sustain a financially healthy practice.

Consider the Following Important Questions Before Signing a Contract:

- What is the fee schedule for the procedures you commonly perform?

Endodontists use a limited set of *CDT* codes, and the plan should be able to provide a fee schedule by *CDT* code so that you can determine whether total payment under the contract is adequate to cover overhead and a reasonable profit market.

- Is participation important to maintain and build your referral and patient base? Does it provide a marketing advantage? Patients build practices.

In endodontics, referrals from general dentists are key to building and maintaining a practice. General dentists who contract as in-network PPO providers are usually required to refer to in-network specialists.

In a market where one or two dental PPO plans serve a significant number of potential patients and many general dentists contract with the plan, the advantages to being in-network may outweigh the disadvantages. This scenario is more likely in markets where there are one or two dominant employers.

Ask the dental benefit plan's provider relations representative for the following information:

- What are the major businesses in the area that use the PPO plan?
- How many people does the plan cover?
- What are the standard design limitations and exclusions?
- What are the pre-authorization requirements?

Already in-Network? Monitor Performance Under the Contract

Most provider contracts are "evergreen," meaning that they automatically renew every year unless one of the parties terminates the contract. For that reason, your practice staff needs to keep an eye out for contracts that may be more trouble than they are worth. For example, does staff spend too much time addressing plan problems or administrative requirements relative to the economic value of the contract? Are the plan's payment policies hurting your bottom line by, for example, bundling procedures into a single code?

An endodontic practice is a small business and decisions on whether to continue contracts should be based on whether they are good for the bottom line so that you can provide the best care to your patients.



SAMPLE ASSIGNMENT OF BENEFITS FORM

I hereby assign to (Practice Name) my right, title and interest in and to any and all dental, medical or other benefits otherwise payable to me for treatment provided by (Practice Name).

I acknowledge that I am still responsible for paying (Practice Name) if the relevant insurer, plan or payer does not pay practice in full at its billed amount.

Policy Name:

Policy Number:

Signed:

Date:

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
(to the extent minor could not have consented to the care)
- Guardian or conservator of patient
- Beneficiary or personal representative of deceased patient

SAMPLE FINANCIAL POLICY FORM

The fee for endodontic therapy is determined by the complexity of the tooth being treated. Therefore, we cannot give you an estimate of the charges in advance of treatment. All payments are due at the time services are rendered. The only exception is if you are covered through a dental insurance plan in which we participate. You must provide valid evidence of coverage.

(Practice Name) participates in the following dental benefit plans:

- X Plan
- Y Plan
- Z Plan

If you are a member of one of these plans, please note the following:

- You are responsible for executing the attached assignment of benefits form.
- You are responsible for any co-payment amounts at the time of service.
- You are responsible for any deductibles that are not yet met.
- You are responsible for any amounts over your yearly contacted benefit amount. For example, if your total annual benefit is \$900 and you have already submitted \$900 of claims, you will be responsible for 100% of our fee.
- You are responsible for knowing the rules and regulations of your insurance policy. For example, not all dental or endodontic procedures are a covered benefit in all dental insurance plans.

If you are covered by any other dental plan, we will file an insurance claim on your behalf as a courtesy, but payment in full is due at the time services are rendered. The insurance company will pay the insurance benefit to you directly.

If your account with (Practice Name) becomes delinquent, you are responsible for paying all costs associated with the collection procedure, and we may report the status and payment history of your account to credit reporting agencies.

I have read and understand the (Practice Name) financial policy, and I consent to the policy.

Patient's Name

Date

Patient's Signature

If you have any questions about this payment policy please call (identify staff person by name) ahead of your appointment.