Chapter 22

Dental Care Plans

Introduction

Nearly all large employers offer dental health benefits to their employees. A survey of employers with 1,000 or more employees found that 99 percent had a dental plan in 2005 (Hewitt Associates LLC, 2005). Another study indicates that 96 percent of employers with 500 or more employees offered a comprehensive dental plan in 2005 (Mercer Human Resources Consulting, 2006). Only 17 percent of employers provide dental coverage through their medical plan. Most dental benefits are offered in a freestanding plan. Although smaller employers are less likely than large employers to offer dental benefits, 66 percent of employers with 10–499 employees offered dental insurance in 2005 (Mercer Human Resources Consulting, 2006).

Dental benefit costs are rising and, as is the case with medical plans, employers are shifting a greater percentage of the costs to employees. In 1988, 63 percent of large employers required employee contributions. By 2005, that portion had increased to 94 percent (Hewitt Associates LLC, 2005).

A sound dental insurance plan has two primary objectives: to help pay for dental care costs and to encourage people to receive regular dental attention, which can prevent serious dental problems while identifying potential medical problems that first manifest as dental health issues.

The three major dental care plan benefit structures are the traditional indemnity plans, network plans, and dental health maintenance organizations (DHMOs). Employers may combine these options. Overall, 48 percent of large employers offered traditional indemnity dental plans, 56 percent offered network plans, and 29 percent offered DHMOs in 2005 (Hewitt Associates LLC, 2005). Direct reimbursement and discount/referral plans are usually grouped with indemnity plan models.

Services

A dental insurance plan should specify the types of services that are and are not covered. Preventive services (i.e., examinations and x-rays) are commonly covered up to 100 percent of the usual, customary, and reasonable amount. Depending on the type of plan, other services typically provide less coverage. For example, indemnity plans commonly cover 80 percent of restorative services such as fillings, endodontics, periodontics, and dental

surgery, and likely cover 50 percent of major restorative services (i.e., crowns, prosthetics, and orthodontia). Orthodontia coverage is an optional feature, with services typically reimbursed at 50 percent up to a separate lifetime maximum. Participants in an indemnity plan have the choice of using any licensed dentist.

A network plan is typically structured similarly to an indemnity plan except that the allowable charge for network-provided services is contractually negotiated by the network with the dentist. There may also be a higher reimbursement percentage and/or lower deductibles for use of network providers. While participants have the choice of using any licensed dentist, they can usually reduce out-of-pocket costs by using a provider who is in the network.

A DHMO benefit plan typically has specified copayments for all covered services, ranging from zero for some preventive services to hundreds of dollars for major restorations. Unlike a network plan, participants in a DHMO usually are required to use dentists in the network in order to receive any benefit.

Benefit Limitations

Services that are usually not covered by any type of dental plan include hospitalization due to necessary dental treatment (though this is often covered by the medical plan as inpatient care); cosmetic dental work (e.g., whitening); cleaning and examinations performed more often than twice a year; and services covered by workers' compensation or other insurance programs.

Indemnity and network plans typically include annual deductibles ranging from $25 to $100, annual maximums ranging from $500 to $2,000, and lifetime maximums for services such as orthodontia of $500 to $2,500. In 2005, 70 percent of plans had a deductible, with $50 being the most common (Hewitt Associates LLC, 2005). Dental plans will frequently not apply a deductible to diagnostic and preventive services in order to encourage appropriate utilization of these services. Other cost management features are typically used as well, such as:

a) Frequency limitation (e.g., reimbursement for cleanings is limited to two times per year).

b) Copayments (participant's share of the dentist's fee after the benefits plan has paid). Copayments for preventive care may be as low as $5 or $10 per procedure. As the procedures become more expensive, the copayment increases.

c) Predetermination of benefits—Before beginning dental treatment, a plan participant may want to know how much he or she will be charged for the treatment and how much the plan will pay. The dentist can complete a predetermination-of-benefits form describing the proposed treatment and its cost. After review, the dental plan will advise the participant and the dentist of the amount the plan would pay. Some dental plans require this procedure when anticipated charges exceed a stated amount (e.g., $200).

d) Alternative benefits—Dental problems can often be successfully treated in more than one way to achieve the same outcome. When this situation occurs, many dental plans base payments on the least expensive treatment that is customarily used for the condition in question. For example, a decayed tooth may often be satisfactorily repaired with a crown or a filling. In this case, a dental plan with an alternative benefit provision bases its payment on the less costly filling. The participant and the dentist may proceed with the more expensive crown only if the participant agrees to pay the difference.

DHMOs have fewer benefit limitations. Premium costs are managed through provider discounts, limitations on access to specialists, and by pre-approval of high-cost services. Dentists in DHMOs typically receive a monthly capitation from the plan to provide basic services for each member. Although access to dentists is more restricted in this type of plan, DHMOs appeal to some plan participants because of their lower premiums and richer benefits.

Claims Payment

Payment of claims under an indemnity or network dental plan generally follows the same procedure as payment of claims under a group medical plan. The participant and/or the dentist fills out and submits claim forms. Payments for covered services may be sent to the dentist or to the participant. Increasingly, this claim submission process occurs electronically through the Internet.

Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with dental plans to offer continued access to group dental insurance for former employees and their dependents.

Deciding on a Dental Care Plan

Ultimately, an employer offers a dental plan for the same reason it offers any benefit plan. The design and selection of a dental plan must balance the employer's financial limitations with its desire to offer an appealing benefit to current and prospective employees.

To balance cost and employee appeal, employers need to consider the following factors:

- Type of plan: indemnity, network, or DHMO.
- Benefit cost sharing: deductibles, copayments, and coinsurance.
- Reimbursement percentage for various services: e.g., 100 percent, 80 percent, 50 percent.
- Access to network dentists: how many dentists are near participants' homes and how many are accepting new patients?
- Maximums: annual and lifetime.
- Exclusions and limitations such as cosmetic services and age limitations for specific services such as sealants.
- Covered services: for example, orthodontia.
- Participant contributions to the premiums.

Employers electing a network dental plan also need to decide whether they want to create a plan design incentive for employees to choose in-network services over out-of-network services. Incentives could include lower deductibles and/or higher reimbursement amounts for in-network benefits.

Bibliography

Brown, Christopher. "Dental Benefits: Setting Objectives, Picking a Plan." *Employee Benefit Plan Review* (March 1995): 30–33.

Hewitt Associates LLC. *Salaried Employee Benefits Provided by Major U.S. Employers: 2005–2006*. Lincolnshire, IL: Hewitt Associates LLC, 2005.

McDonnell, Ken, and Paul Fronstin. *EBRI Health Benefits Databook*. Washington, DC: Employee Benefit Research Institute, 1999.

Mercer Human Resources Consulting. *National Survey of Employer-Sponsored Health Plans: 2005 Survey Report*. New York: Mercer Human Resources Consulting, 2006.

William M. Mercer. *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2001: Report on Survey Findings*. New York: William M. Mercer, 2002.

Additional Information

American Academy of Dental Group Practice
5110 N. 40th Street, Suite 250
Phoenix, AZ 85018
(602) 381-1185
www.aadgp.org

American Board of Quality Assurance and Utilization Review Physicians
890 W. Kennedy Boulevard, Suite 260
Tampa, FL 33609
(813) 286-4411
www.abqaurp.org

American Dental Association
211 E. Chicago Avenue
Chicago, IL 60611
(312) 440-2500
www.ada.org

Aon Corporation
200 E. Randolph Street
Chicago, IL 60601
(312) 381-4844
www.aon.com

Hewitt Associates LLC
100 Half Day Road
Lincolnshire, IL 60069
(847) 295-5000
www.hewitt.org

Mercer
1166 Avenue of the Americas
New York, NY 10036
(212) 345-7000
www.mercer.com