

DENTAL CARE BENEFIT PROGRAMS*

Need for Dental Benefit Programs

Dental and oral diseases may well be the most prevalent condition affecting Americans. Millions suffer from tooth decay, periodontal diseases, and other oral conditions. Yet dental diseases are mostly preventable, and dental care has produced a success story in the prevention and control of tooth decay, gum disease, and other oral diseases. Today people are maintaining their teeth better and retaining them longer through a combination of preventive activities that includes better oral hygiene (brushing and flossing), the use of fluoride in water supplies and as a treatment, and routine dental exams. Indeed, it is estimated that dental exams provide the first diagnosis for more than half of individuals with oral cancers and more than a quarter of those with diabetes and bulimia.

American Dental Association statistics show that cavities and extractions are declining while periodic visits to the dentist for checkups and cleanings are increasing. In a 10-year period, regular oral checkups increased by more than 10 percent, whereas the number of fillings declined by more than half. Extractions declined by more than 40 percent. Tooth decay for children is a declining problem. As a result, although the amount the nation spends on dental care increases each year, dental expenses as a share of total health spending, currently at approximately 4.5 percent of personal health expenditures, have declined from the levels of two decades ago.

Ironically, the success in maintaining and retaining teeth longer actually extends the lifetime risk for dental disease. Tooth decay and periodontal disease are becoming diseases of mature adulthood, with more than half of this population having some decay and a third having severe periodontal disease. As a result, the increased need for adult dental care offsets by many times the decreased need for children's dental care. Consequently, the need for dental care and the financial resources to pay for it will continue to increase.

Status and Growth of Dental Benefit Programs

Dental care benefit programs are a major factor in improving America's dental health and have contributed to the shift in dental care from treatment to prevention. There is a direct correlation between low rates of tooth decay and oral disease and the prevalence of dental insurance coverage. Dental insurance encourages people to visit the dentist by lowering or removing financial barriers for routine care and providing resources to pay for needed treatment. Dental benefits provide coverage for treatment, but they focus on primary and preventive care—the checkups, cleanings, and services that help patients avoid dental disease or detect it early when it is more easily and

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affordably treated. More than 70 percent of those with dental coverage see their dentist at least once a year compared with only half of those without dental coverage. Conversely, studies show that population groups with the highest rate of untreated dental problems lack dental coverage.

In earlier decades, dental care was considered a budgetable expense and traditionally was left uncovered in health insurance plans. In the 1970s, dental care was added to employee benefit plans with increasing frequency as it became popular with employees and a priority for unions. Certainly, dental care cost increases and the development of more sophisticated dental technology are factors. Women, who are greater users of dental services, achieved greater representation in the workforce and strongly influenced their children to seek dental care. As the population becomes more educated, individuals will more frequently seek dental care. As a result, dental plans have been one of the fastest-growing types of employee benefit.

In the last 30 years, the number of persons with some type of dental coverage has increased from 6 million to about 159 million; although this represents over half of the population, dental insurance obviously has not yet reached its full market potential. Of those with dental benefits, approximately three-quarters are under private insurance programs, with the balance consisting of Medicaid, military, and other government programs. As more employers try to attract and maintain a quality workforce, the dental insurance market is expected to grow by an estimated 2 percent per year.

Almost all of those covered for private dental expense benefits receive their coverage through a group policy. Only 3 percent of those with dental benefits have individual coverage. Surveys indicate that more than 95 percent of the nation's largest employers provide employment-based dental care programs to their employees. This drops to approximately 60 percent if medium-sized employers are added. By contrast, less than half of small employers provide dental programs for their employees. Nine out of 10 large employer programs require the employee to pay some part of the premium for the employee and dependents.

Benefits for orthodontia, largely excluded in early programs, are now becoming the norm. More than three-fourths of large employers report that they cover orthodontia benefits. Indeed, orthodontia benefits, formerly limited to children under age 19, are now increasingly available for adults as well.

The updated results of a survey of group dental plans indicates that current employee-only monthly premiums average approximately \$16.85 for HMOs, \$26.05 to \$31.00 for preferred-provider organizations (PPOs), and \$34.72 for indemnity plans. Comparable monthly premiums for an employee with two or more dependents were about \$50 for dental HMOs, \$81 to \$95 for PPOs, and \$104 for indemnity plans.

Dental Care Services

Dental benefit programs must be constructed with a thorough understanding of the scope and purpose of dental care services. Dental services fall into the following professional treatment categories: diagnostic, preventive,

restorative, endodontics, periodontics, oral surgery, prosthodontics, and orthodontics.

Diagnostic

Diagnostic services determine the existence of tooth decay, gum disease, and other oral diseases and evaluate the condition of the mouth. Routine diagnostic procedures include oral examinations and X rays. Other, nonroutine diagnostic services include clinical and laboratory tests, study models, and photos.

Examinations. Regular examinations reduce costs by detecting and treating dental problems early. Filling a small cavity today is much less expensive than using a crown to rebuild a neglected tooth tomorrow.

X Rays. Dentists use many types of X rays for diagnosis and treatment planning:

- bitewing—inside the mouth (intraoral) views, usually taken in sets of two or four, of the crown (coronal) portion of several upper and lower teeth and the spaces between them (permits detection of decay between teeth and around fillings and the gum line)
- periapicals—intraoral views of the entire tooth with root, surrounding tissue, and bone structure
- full-mouth—a set of intraoral views of the entire mouth
- panoramic—an extraoral view of the upper jaw (maxilla) and lower jaw (mandible) showing all the teeth on a single film
- cephalometric—an extraoral view of the skull and head

Preventive

Preventive services that preserve and maintain dental health include:

- prophylaxis—scaling and polishing of the teeth to remove plaque, calculus (tartar), and stains
- fluoride treatments—topical application of fluoride that hardens tooth enamel to prevent decay
- sealants—application of resin or plastic to cavity-prone areas to prevent decay
- space maintainer—insertion of a separation device that maintains a space between adjacent teeth when a deciduous (baby) tooth is lost until the permanent tooth begins to emerge

Restorative

Restorative procedures repair and reconstruct the form, function, and even the appearance of natural teeth affected by cavities, injury, wear, and other impairments. Restorative techniques include fillings, inlays, onlays, crowns, and veneers.

Fillings. Fillings are minor restorations of a tooth structure that use amalgam or composite materials. Amalgam is a metal alloy containing some combination of silver, mercury, tin, copper, and/or zinc that produces a repair strong enough to withstand chewing and grinding. Because of their dark color and strength, amalgam fillings are usually placed in back teeth. Composite is a resin material generally used in front teeth because it more

closely matches natural tooth color and lacks the strength required for the chewing surfaces of back teeth. Nevertheless, some plans now routinely provide benefits for composites on back teeth.

Inlays. Inlays are metal fillings shaped to fit a cavity space inside or between the points of a tooth's grinding surface (cusps) and are cemented into place.

Onlays. Onlays are restorations of the cusp or cusps of a tooth with extreme structural loss. While similar to an inlay, the metal casting of the onlay covers or caps the cusps and strengthens the entire tooth.

Crowns. Crowns replace the entire enameled portion of the tooth that projects above the gum (gingival margin) with a cast or otherwise fabricated prosthetic. Crowns are required when a remaining tooth structure is broken or severely weakened by decay or extensive fillings. Crowns may also be used to provide or restore proper bite and for appearance reasons. The most common crown materials are gold, porcelain, nonprecious metal, semiprecious metal, resin, and porcelain fused to various metals.

Veneers. Veneers are a laminate of porcelain or similar material. The veneering process strengthens the tooth by bonding the veneer material to the acid-etched tooth surface; this procedure is more conservative than use of a crown.

Endodontics

The specialty of endodontics is the diagnosis and treatment of diseases of the tooth pulp and associated areas around the end of the root. Endodontic therapy provides a successful and well-accepted treatment for saving broken, painful, and infected teeth. Root canal therapy, the most widely known endodontic procedure, involves removal of the blood vessels and nerves from the pulp chamber and root canal inside the tooth. When the source of infection has been removed and the area treated and allowed to drain, the canal is filled with an inert material prior to restoration, often in the form of a crown.

Periodontics

Periodontics, another specialty, is the diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth, including bones, gums, and other structures. Although periodontal or gum disease affects most adults and is the major cause of adult tooth loss, it is largely preventable by regular brushing and flossing.

Oral Surgery

Oral surgery is a specialty that involves diagnosis and surgical treatment of diseases, injuries, deformities, defects, and aesthetic deficits of the teeth,

jaw, and face. Removal of teeth, which is the most commonly performed oral surgery, includes ordinary extractions, surgical removal, and removal of impacted teeth.

Prosthodontics

Prosthodontics is the replacement of natural teeth missing because of extraction, surgery, accident, or congenital defect through the construction, replacement, and repair of artificial teeth and similar devices. Bridges and dentures are prostheses included in this category. A prosthesis is complete (in contrast to partial) if it replaces all of the upper or lower teeth; it may be removable, as in the case of dentures, or permanent, as in the case of an implant or fixed bridgework.

Orthodontics

Orthodontics involves the interception and treatment of abnormal bite (malocclusion) by repositioning natural teeth to achieve proper alignment and pleasing facial contour. Certain malocclusions left uncorrected may adversely affect dental health through abnormal wear, speaking ability, and general health as well as erode self-confidence due to an unattractive smile.

Orthodontic treatment may protect normal occlusion (preventive), mitigate developing problems (interceptive), or correct malocclusion (comprehensive). Repositioning of the teeth is achieved by functional or mechanical means, largely through the use of braces, bands, retainers, and space maintainers.

Dental Benefit Plan Service-Level Groupings

Dental benefit programs typically aggregate the previous professional treatment categories into service-level groups for plan design purposes. The following four service level groups are commonly used.

- service level I—preventive care, including routine exams, cleaning, X-rays, fluoride treatment and sealants
- service level II—minor restorative procedures including fillings, inlays, onlays, and veneers
- service level III—major restorations, including crowns, bridges, and implants, as well as other major services involving endodontics, periodontics, and oral surgeries
- service level IV—orthodontic services (may include procedures to correct temporomandibular joint [TMJ] dysfunction)

Service levels are key to designing plans in which members have focused financial incentives to seek routine services to prevent future expenses and have a greater stake in more costly major services decisions. Thus, for example, a typical dental plan provides its most complete payment for level I services and somewhat less complete payment for level II services, while

providing the least complete benefit for level III and level IV services (if covered).

Insurers and other providers of dental benefit programs use differing arrays of procedures that are identified here in service levels II and III. Such arrays are more procedure specific and may extend the number of groupings to five or more.

Benefit Plan Design Features

Effectively designed dental plans take into account many features. Some are generally consistent with those found in most health benefit plans, such as duplication of benefits and termination provisions. But others are unique to managing dental insurance risk, including least expensive treatment alternatives, prior authorization, the use of benefit maximums, service-specific limits, and program phase-in options. Because of their expense potential, temporomandibular joint (TMJ) dysfunction, overlap with medical services, and orthodontia require special attention. The following discussion covers these and related plan design features. It begins with a review of some guiding principles, then discusses the most significant dental plan design features. (These features should also be highlighted in plan description summaries and detailed in the plan document.)

Guiding Principles

Dental care has a wide range of professionally effective treatment options. Moreover, many of the more expensive options proposed by a dentist are attractive to the patient because of their cosmetic enhancements. Therefore good dental plan design aims to maintain reasonable plan costs while seeking to promote the efficient use of resources for needed and effective dental care and treatment. Diagnosis and preventive treatment services actually save money for the program by avoiding the greater costs resulting from nontreatment.

Least Expensive Professionally Acceptable Treatment

Because dental problems can often be successfully treated in more than one way, plans usually focus their benefits on the least expensive professionally acceptable alternative treatment. For example, a plan will pay for the cost of an amalgam filling that effectively repairs a tooth but not for a gold inlay or crown, which would also be effective but much more expensive. If the more expensive option is used, then the member pays the difference between the amalgam filling and the gold inlay or crown.

Thus the member has a substantial incentive to support the plan's objective. Nevertheless, if the member proceeds with the more expensive treatment, the patient cost sharing encourages the member to ensure the success of the treatment. Having completed the more costly treatment, the patient will also wish to protect the investment by practicing good oral hygiene and taking advantage of routine diagnostic and preventive services, usually provided at little or no out-of-pocket cost.

Prior Authorization

A plan frequently requests the member's dentist to complete a preauthorization-of-benefits form for major services and orthodontia that describes the dental diagnosis, the proposed treatment, and the cost. This process is called *prior authorization* (also frequently referred to as *predetermination* or *pretreatment estimate*), and consists of filing a claim form in advance of treatment when anticipated charges exceed a stated amount, such as \$300. The member or the dentist sends the completed form to the plan's claim office. X rays, photographs, and models for orthodontia may be submitted to the plan's claim office to substantiate the required treatment and to avoid delaying benefit payment pending a subsequent request.

The claim office reviews the information to determine exactly how much the dental plan will pay if the services are rendered. Selected claims are referred to the carrier's dental consultant to assess the appropriateness of the recommended treatment. If there are any questions, the dental consultant discusses the treatment plan with the dentist before the services are performed. The claim office will advise both the member and the dentist of its authorization decision, and if the treatment is approved, the benefit is paid upon the return of the signed dated claim form verifying the completion of treatment. If treatment extends over a period of time, such as orthodontia, payment is usually made in installments over the course of treatment.

Prior authorization promotes better quality care and reduces costs by identifying unnecessary expenses, treatments not expected to last, coverage duplication, and charges higher than the plan benefits allow. However, even if the member disregards the prior-authorization provision, any benefits provided would not be reduced. Nevertheless, it gives the plan some control over the performance of procedures; both the dentist and the member should understand that benefits are limited or that services are not covered before extensive and expensive work begins. The process also encourages the member to be a better health care consumer. Prior authorization applies to indemnity and preferred-provider plans, but it is usually not used in DHMO programs.

Duplication-of-Benefits Provisions

Like all group programs, group dental contracts contain provisions to avoid duplicating benefits paid under another plan. While coordination of benefits is common to all group programs, avoiding duplication with medical benefits is uniquely important to dental plans.

Medical Expense Programs. Dental procedures may duplicate medical-surgical procedures in such areas as excision of oral cysts, treatment of fractured facial bones, and facial surgery when these services can be performed legitimately by physicians, oral surgeons, and dentists. Contract language that distinguishes between medical and dental procedures is explicit to ensure that claims are appropriately classified. For example, surgeries to remove bony growths to prepare for dentures and procedures to reorient the alignment of the upper and lower jaws (teeth), and to improve function

(chewing) and appearance (cosmetic) may be classified as dentistry in some plans. Other dental plans may require that such services be paid as a medical-surgical benefit, however. Surgeries to the jaws for malignancies, fractures, and cleft palate are almost always classified as medical-surgical claims.

Clear contract language also controls the practice of representing dental services as medical services in order to avoid the dental plan's payment and frequency limits, maximums, and least costly effective alternatives. In addition, medical utilization and claims review processes normally take steps to deal with this problem. Medically coded claims filed by dentists are often marked for review because medical plans are improper vehicles to pay for dental services.

Coordination of Benefits. In addition to avoiding duplication of benefits with medical plans, standard coordination of benefits (COB) between primary and secondary plans also applies. Thus the primary plan pays benefits as if there were no secondary plan, and the secondary plan pays the balance of the claim up to the amount of its stated benefit based on the plan's allowable expense. (HS 325 Group Benefits provides a complete discussion of applicable COB rules.)

Benefit Maximums

Except for DHMO plans, which provide service benefits rather than reimbursement, virtually all other dental plans feature a calendar-year maximum benefit. Although the median amount is \$1,200, the typical range for a calendar-year plan maximum is \$800 to \$2,000, with \$2,500 becoming more commonly available, especially in high-cost areas. Calendar-year maximums encourage members to seek less costly care, and they may help to spread out the impact of accumulated dental needs over the plan's early years.

If annual benefits paid are below a minimum threshold level, some plans permit a portion of the unused calendar year maximum to be rolled over and used in subsequent years, if needed. Thus, for example, if a member has a \$2,500 calendar year maximum, but receives less than \$900 in total annual dental benefits, \$450 may be rolled over to any future year in which the benefits paid reach the plan's calendar-year maximum. Accumulated rollover amounts are subject to a limit, however, such as \$1,500.

Although few plans have only a lifetime maximum (such as \$1,000 or \$5,000), many plans contain both a calendar-year maximum and a lifetime maximum. Lifetime maximums may apply to all dental expenses, or they may apply to all expenses except those that arise from orthodontic (and occasionally periodontic) services. Today, most plans limit the use of a lifetime maximum to orthodontia and temporomandibular joint (TMJ) treatment benefits and provide annual maximums for all other services.

Frequency Limitations

The frequency with which covered services may be received varies from plan to plan. Table 7-4 illustrates the prominent limitations in a typical plan.

TABLE 7-4
Illustrative Frequency Limitations in a Typical Dental Plan

Diagnostic	Examinations—two times per year
X rays	Bitewings—one set per year (6 months if under age 18) Periapicals—two per year Full-mouth surveys—one in any 60 consecutive months Panoramic—one in any 60 consecutive months Cephalometric—one every 3 years for TMJ and orthodontia
Preventive	Prophylaxis—two times per year Fluoride treatment—one per year for dependent children) Sealants—one in any 36 consecutive months (for dependent children) Space maintainers—applicable only to dependent children
Restorative	Filling replacements—covered only after 24 consecutive months have passed since initial filling Inlays/onlays/crowns/veneers—covered only if the tooth cannot be restored by a filling; replacements if at least 96 consecutive months have passed since the last restoration
Prosthodontics	Bridges and dentures—covered only if the teeth being replaced were not missing prior to the effective date of dental insurance; replacements are covered only if the existing bridge is more than 96 consecutive months old
Periodontics	Varies from 3 months to 36 months depending on the procedure and quadrant of the mouth

Other Limitations and Exclusions

Plans generally exclude coverage for all cosmetic services and for services covered by workers’ compensation insurance. However, with the recent emphasis on cosmetic services by dentists, some plans are beginning to provide benefits for certain cosmetic services or offer access to discounted pricing for them.

Plans also frequently limit or exclude coverage for temporomandibular joint (TMJ) dysfunction and orthodontia. These topics require special attention.

TMJ Dysfunction. Dental procedures that treat the temporomandibular joint and associated musculature may be considered treatment of TMJ dysfunction. Treatment usually consists of conservative and noninvasive therapy such as splints. Invasive therapy, such as surgery, is usually only considered after all conservative treatment has been tried. TMJ dysfunction is difficult to diagnose, and there is little professional consensus on its appropriate treatment; the possibilities range from the simple to the drastic. As a result, TMJ dysfunction claims can be costly and subject to abuse.

Some carriers consider TMJ a medical condition and completely exclude it from dental plan coverage. Others consider it a dental program service but limit the benefit. Because TMJ dysfunction constitutes an important concern, it is often addressed in both medical and dental plans. Many states have passed legislation requiring coverage of TMJ dysfunction as a mandated benefit under medical expense plans.

Orthodontia. Orthodontic problems are usually not the result of a disease, generally involve no acute symptoms, and are often more a matter of aesthetics (akin to cosmetic surgery). Some form of malocclusion (faulty spacing or meeting of teeth) occurs in many people. Therefore, an orthodontia benefit may be cost prohibitive for many plans and may be excluded. Nevertheless, an increasing number of plans provide this benefit, and it is becoming common. Because orthodontia problems can rarely be categorized as emergencies, the benefits are well suited to separate controls. Orthodontic benefits are never written without other dental coverage. Orthodontic services, unlike nonorthodontic dental procedures, generally are rendered only once in an individual's lifetime. Specific orthodontic maximums and sometimes deductibles typically are expressed on a lifetime basis. Because the best time for orthodontic work is during adolescence, many plans limit orthodontic coverage to persons under age 19. However, an increasing number of plans include adult orthodontics as well.

The orthodontic benefit level is commonly the same as that for major restorative procedures (for example, 50 percent under a percentage-of-charge program.) Orthodontia benefits may be subject to prior authorization, and benefits often are paid in installments instead of at the treatment's conclusion, because the treatment program frequently extends over several years.

Termination

Coverage under dental insurance plans typically terminates for the same reason it terminates under medical expense coverage. Rarely is there any type of conversion privilege for dental benefits, even when the coverage is written as part of a major medical contract. Voluntary dental benefit programs usually are not portable when the employment relationship ends.

Benefits for a dental service received after termination may still be covered as long as (1) the charge for the service was incurred prior to the termination date, and (2) treatment is completed within 60 or 90 days after termination. For example, the charge for a crown or bridgework is incurred once the preparation of the tooth (or teeth) has begun, even though the actual installation of the crown or bridgework—and the billing—does not take place until after the coverage terminates. Similarly, charges for dentures are incurred on the date the impressions for the dentures are taken, and charges for root canal therapy are incurred on the date the root canal is opened. The root canal treatment must be successfully completed, however, before full payment is made.

Remaining Underwriting Issues

All of the plan design features just discussed help to manage the unique nature of dental insurance risk; however, additional important underwriting concerns remain.

When an employer introduces a new dental program, employees who have been lax in proper dental hygiene often seek correction of accumulated major problems. The situation may be even worse when an employer announces a new dental plan many months before the effective date and employees postpone all but emergency care until then. This pent-up demand can lead to extraordinarily high use of the plan in its early years, which is a major concern to an underwriter. Depending on the group's characteristics, the number of first-year claims for a new plan can be expected to run between 20–50 percent higher than long-term annual claims. To counter this situation, an insurer or any provider of dental benefit programs attempts to build in a number of safeguards.

These safeguards begin with efforts to enroll a high percentage of a group's employees in the dental plan. This explains why many dental plans are noncontributory, meaning that all employees are members because the premium is paid in full by the employer. Enrolling all employees eliminates a fundamental element of adverse selection against the plan.

However, as overall employer health benefit costs continue to rise, more contributory and voluntary programs are being written. Under these programs, employees pay part or all of the premium and may decline enrollment, thereby substantially increasing the potential for adverse selection. Although there is evidence that the adverse selection created is not as great as was once anticipated, some insurers continue to discourage contributory plans.

One of the simplest ways to ensure employee participation in a contributory situation is to tie the dental plan to enrollment in the medical plan and eliminate the option of enrolling in the dental plan alone. So if the employee turns down the dental plan, the medical plan must also be turned down. However, even that requirement has become muted as marketing efforts have expanded and caused dental benefit programs to operate independently of any existing medical benefit program. Most insurers in this market insist on a specific percentage of participation that may range from 80 percent to as low as 50 percent of eligible employees. Even these percentages are flexible and can decrease as the number of eligible employees increases. Indeed, some voluntary plans will accept as few as five participants in an under-100-life group. Some insurance companies insist on writing other business with an employer in addition to dental coverage whenever enrollment in the dental program is at the employee's option.

A number of additional provisions counter high first-year claims and limit the effects of adverse selection that accompany the first-time installation of a group's dental program.

Evidence of Insurability. An insurance company might require any person seeking dental plan coverage to undergo a dental examination. If major dental problems are disclosed, the person must have them corrected before insurance

coverage will become effective. Alternatively, coverage may be excluded for treatment of conditions identified in the exam. Evidence of insurability is rarely required in today's market.

Preexisting Conditions. Preexisting conditions are treated in a number of ways: They may be excluded, treated as any other condition, covered on a limited basis (perhaps one-half of the normal reimbursement level), or subject to a lifetime maximum.

The most common preexisting condition relates to the expense associated with replacing teeth extracted before the coverage date. Many plans will not pay for replacement of a tooth unless it is extracted while the insured is covered under the plan. Such plans, however, would likely provide a benefit for a bridge or denture that would include such a tooth if an adjacent tooth or teeth are removed while coverage is in place.

Program Phase-in. Program phase-in can occur in a number of ways, as discussed below.

Participation Levels. Employee participation may drive the level of benefits. Using this approach, a plan may feature four coverage steps, each based on the percentage of eligible employees enrolling in the plan. The following illustrative example is taken from an existing voluntary program:

- step 1, at 35–49 percent employee enrollment—coverage for preventive care at 100 percent and minor services at 50 percent, but no coverage for major treatments and orthodontia
- step 2, at 50–69 percent employee enrollment—coverage for preventive care at 100 percent, minor services at 60 percent, and major services at 20 percent
- step 3, at 70 percent or more employee enrollment—coverage for preventive care at 100 percent, minor services at 70 percent, major services at 40 percent, and orthodontia at 25 percent
- step 4, for employees staying with the plan for a specified number of years—coverage for preventive care at 100 percent, minor services at 80 percent, major services at 50 percent, and orthodontia at 25 percent

A common alternative is to simply set the benefits and premium using a target participation range over a contract period. If actual participation deviates from the target at the end of the period, benefits and premium are adjusted at renewal. Some insurers are willing to guarantee benefits and rates if the employer agrees to take certain steps, such as mandatory enrollment meetings designed to maximize plan participation.

Probationary or Waiting Periods. Some plans may use a longer probationary period for dental benefits than for medical expense benefits. Other plans may have the same probationary period for both types of coverage but impose waiting periods before certain types of dental expenses are covered. For example, there may be no coverage for major dental

services (level III) until the plan's second year. Orthodontic benefits (level IV), if included, would be payable after the third year begins.

Opinions on the use of probationary periods differ. Many believe they must be long enough, such as 12–18 months, to deter participants from postponing needed services until the probationary period expires. Others caution that extended probationary periods, though they keep claims low initially, may actually lead to increased claims later; existing but non-urgent dental conditions will only become more severe and will then require more expensive treatment.

Covered Services Levels. Some plans phase in the benefit level for covered services with a lower coinsurance factor, with increasing percentages in each subsequent year to encourage members to spread out claims. For example, the preventive benefit may be initiated at 100 percent to encourage routine care, but benefits for major services (level III) could be 30 percent of expenses in the first year, increasing to 40 percent in the second, and finally to 50 percent thereafter. Benefit level phase-in must also be used judiciously to avoid delaying needed dental services, which will likely necessitate more extensive and expensive treatment later.

Some plans may implement these increments only if the member receives required care and treatment annually. Although the intent of an annual service requirement is to avoid delaying more serious dental problems until the benefits are richer, some insurers believe it makes the dental plan more difficult to understand.

Incremental Annual Maximums. The annual maximum can be introduced at a lower level and incremented annually, limiting the plan's financial risk in the early years of the program while still encouraging diagnostic and preventive services.

Single Plan Option. In the early years of a new program, a single plan offering avoids the effects of adverse selection between plan options. The availability of options could generate significant adverse selection against the higher benefit plan in its initial years, as members sign up, delay their entry, or drop out based on the extent of their planned dental services. Requiring participants to remain in a selected plan for a specified minimum period before being eligible to drop or change coverage is advisable, particularly if optional plans are available through more than one insurer and there is a large difference in benefits.

Late Entrants. The problem of adverse selection in contributory plans can be particularly severe when a person desires coverage after the date on which they were initially eligible to participate. Employees may delay entering the plan until they know that anticipated dental services for themselves or family members will cost more than their contributions to the plan. Subsequently, they may drop the plan or move to a less costly plan, if available.

Many group plans today may simply require the employee to wait for the next annual enrollment period. Even then, dental insurance contracts may contain additional provisions that try to minimize the adverse selection by late entrants, including one or a combination of the following:

- reducing benefits (usually 50 percent) for a period of time (such as one year) following the late enrollment
- reducing the maximum benefit to a low amount (such as \$100 or \$200)
- excluding some benefits for a certain period (such as one or 2 years) following the late enrollment period; this exclusion may apply to all dental expenses except those that result from an accident, or it may apply only to certain benefits (such as those for orthodontics and prosthetics)

The late-entrant limitations for group plans are quite similar to the standard limitations placed on enrollees in individual (nongroup) dental benefit programs.

Special Rating Factors

In general, insurers compute dental plan rates in a manner similar to premium rates for other health care expense coverages. Included in these considerations are all the factors that require the plan design features presented above.

When writing group insurance—especially for small groups—and individual (nongroup) dental programs, many insurers also look at various considerations when they develop rates. Unless constrained by state regulation, these considerations may include the experience under previous dental coverage and the following demographic characteristics of the population that affect dental expenses.

Age

The increased incidence of high-cost dental procedures at older ages generally makes coverage of older groups more expensive.

Gender

Women tend to have a higher cost and utilization rate than men because they typically access dental services more frequently than men.

Location

Charge levels, practice patterns, utilization rates, and the availability of dentists vary considerably from one area to another. Even the presence of fluoride in the water supply is an important determinant affecting the prevalence of tooth decay.

Income

Several reasons may account for income being a key factor: (1) the higher the income level, the greater the likelihood that the individual already has an established program of dental hygiene; (2) in many areas, accessibility to dental care is greater in the high-income neighborhoods; (3) there is a greater tendency on the part of higher-income individuals to elect higher-cost procedures; and (4) dental fees are higher in higher-income neighborhoods.

Occupation

Salaried groups, possibly because of income factors, generally have greater dental expenses.

Benefit Payment Methods

The benefit payment methods are (1) percentage of charge, (2) scheduled maximum payment, or (3) service benefits. A benefit payment method is typically identified with each plan type. Nevertheless, a plan type may utilize more than one benefit payment method. The reading presents the benefit payment methods first, followed by a discussion of the plan types with which they are associated.

Percentage of Charge

Percentage of charge is the most common method of dental benefit payment. The heart of the percentage-of-charge method is the use of two cost-sharing provisions: coinsurance and deductibles.

Coinsurance. As in a major medical program, the plan's coinsurance level, usually in conjunction with a deductible, requires that the member pay a portion of the charges for dental services. However, in most dental plans, the coinsurance is uniquely structured to reduce spending on optional dental care while promoting cost-effective dental practices by varying the benefits for the different service levels.

- level I—While preventive care expenses (such as those for examinations and cleanings) generally are reimbursed between 80–100 percent of charges, the 100 percent benefit is by far the most common.
- level II—The reimbursement level for minor restorative procedures generally is lower than for preventive care, typically 80 percent.
- level III and level IV—Major restorations, other major services, and orthodontics usually have the lowest reimbursement levels. In many instances, the plans reimburse no more than 50 percent of the reasonable and customary charges for these procedures. In some plans, the reimbursement for specified major restorations and oral surgeries may be higher. (The concept of reasonable and customary charges is covered in detail in HS 313 Individual Health Insurance Planning and HS 325 Group Benefits.)

Deductibles. A deductible is an initial amount a member must pay for the expenses of covered services before receiving any benefit payments and is usually included as an integral part of the percentage-of-charge plan design. A deductible typically is written as a single amount applicable to the total of expenses for all covered services received on a calendar-year or lifetime basis, with the calendar-year approach by far the more common. Annual plan deductibles for an individual range from \$25 to \$100. Deductibles help control claim administration costs by eliminating frequent payment for small claims that can be readily budgeted and accumulated for subsequent filing. Because insurers believe the best way to promote early detection and lower dental claim costs over the long term is to pay virtually all of the cost for preventive services, they are typically not subject to a deductible.

Some insurers apply lifetime deductibles to all services to lessen the impact of accumulated dental needs at the initiation of a plan or new member enrollment. Lifetime deductibles present an alternative to leaving preexisting conditions uncovered or covering these conditions but cutting back elsewhere on the plan's benefits. The theory behind the lifetime deductible is to encourage the member to make a significant investment in dental health first, with the plan paying benefits to maintain that investment. However, there are problems with this theory. If the lifetime deductible is set at a level high enough to affect claim costs and premiums, it may present a financial barrier to obtain needed care promptly, when it can be the most cost effective. On the other hand, if it is low, overutilization may arise from those anxious to take full advantage of the plan. As a result, lifetime deductibles are not common, although they may appear in individual dental programs.

Advantages. There are two major advantages to percentage-of-charge plans. In addition to using standard financial incentives to promote the cost-effective use of dental services, the percentage-of-charge method has the additional advantage of a uniform reimbursement percentage; while the payment may vary by area and dentist, the percentage reimbursed is uniform for each service level. In addition, the percentage-of-charge method adjusts not only for inflation but also for the variation in the relative value of specific procedures.

Disadvantages. This approach also has disadvantages. First, because benefit levels adjust automatically for increases in the cost of care, cost control can be a problem in periods of rapidly escalating prices. The employer receives no credit from employees for keeping the benefit current. When used with an indemnity plan—except for claims receiving prior authorization—rarely is it clear in advance of treatment what the specific payment for a particular service will be, either to the patient or the dentist. However, in a managed care dental plan, this is less of a problem because the percentage of charge is applied to the negotiated charge that represents payment in full.

Scheduled Maximum Payment

The scheduled maximum payment (SMP) method is similar to that found in surgical expense plans, in which benefits are paid up to the amount

specified in the fee schedule for an all-inclusive list of services. For example, the plan may pay \$50 for a cleaning and \$400 for root canal therapy. If a service is not on the list, it will sometimes be covered, but only at the listed rate for a suitable substitute. An unlisted service might also not be covered, however. Most SMP plans provide benefits on a first-dollar basis and contain no deductibles or specified coinsurance percentage. In order to encourage diagnostic and preventive services, dental schedules are designed so that the fees for these services are more completely covered, while benefits for other dental services are paid at a lower level.

SMP plans have three major advantages:

- cost control—Benefit levels are fixed and therefore less susceptible to inflation.
- uniform payment—In certain instances, it may be important to provide the same benefit regardless of regional cost differences. Collectively bargained plans occasionally may take this approach to ensure the “equal treatment” of all members.
- ease of understanding—It is clear to both the member and the dentist what the benefit payment is for each procedure.

These plans also have disadvantages. First, benefit levels as well as the value relationships between procedures must be examined periodically and changed when necessary to maintain reimbursement objectives. Second, when members are dispersed geographically, plan reimbursement levels will not vary according to the cost of dental care in a particular area unless multiple schedules are utilized.

The SMP benefit method, found almost exclusively in traditional indemnity plans, usually sets the maximum benefit for each service lower than prevailing charge levels. Consequently, members are forced to pay a portion of the costs of their dental services. Although once common, this benefit payment method is now used less frequently.

Service Benefits

Service benefits are different from benefits that pay claims to indemnify beneficiaries for expenses incurred. With service benefits, a member is assured of receiving the services listed in the plan of benefits, not just payment for them. However, there must be a contractual relationship between the dental plan and the dentist to provide a guarantee of service. Service benefits are typically, though not exclusively, provided by DHMOs and an increasing number of PPOs. Delta Dental plans, for example, have historically had service benefit contracts even for their traditional dental products.

The cost-sharing provisions under the service benefit method are limited to copayments, which, depending on the specific service, may be as low as \$10 (minor services) or over \$1,000 (orthodontia). Thus, plans using a service benefit may not have deductibles, coinsurance, or annual or lifetime maximums. As a result, members with service benefits know that their out-of-pocket costs are limited to the copayment amounts.

Combination Plans

Combination plans contain two or more features from scheduled-maximum-payment, percentage-of-charge, or service-benefit methods. A typical combination plan would cover preventive services on a percentage-of-charge or copayment basis, but use a scheduled maximum payment for other dental services. Plans using the service-benefit method frequently incorporate a percentage-of-charge approach for certain services.

Major Plan Types

Generally speaking, dental benefit plans can be classified as indemnity or managed care types. Managed care plans are provided by either PPOs or DHMOs. Different plan types may be available at enrollment as multiple options or at the point that the service is actually received.

Approximately 23 percent of current dental program members are covered under traditional fee-for-service indemnity plans; 54 percent are enrolled in dental PPOs and 14 percent in DHMOs. An additional 7 percent are estimated to be participants in noninsured discount dental programs. Managed care is by far the fastest-growing type of dental benefit plan, and this growth has been at the expense of indemnity plans. Within managed care, PPOs have overtaken and surpassed DHMOs, which are the more structured and integrated managed dental care option.

Indemnity Plans

A traditional indemnity plan pays full benefits without regard to the dental provider selected by the member. Benefits are paid following the submission of claims for each dental service by either the member or the dentist with an assignment of benefits. As discussed earlier in the benefit payment methods section, the benefit could take the form of a scheduled maximum or a percentage of charge, with the percentage-of-charge method being much more common.

The member will have out-of-pocket expenses under either method, primarily because there is no agreement on charges for services between the plan and the dentist. The scheduled maximum amounts are always pegged at levels lower than prevailing charges, and the member is responsible for the difference. Under the percentage-of-charge method, the member has cost sharing through deductibles and coinsurance requirements as well as responsibility for charges by the dentist that exceed reasonable and customary charges as determined by the plan. For an illustration of a typical indemnity plan's benefits, see table 7-5.

Even in the absence of a negotiated agreement with dentists, traditional indemnity plans can claim some managed care features. In dentistry, a gatekeeper concept already exists. Eighty percent of dentists are in general practice, in contrast to their medical colleagues, where only a third are engaged in primary care. Dental patients rarely "self refer" to a dental specialist. Patients usually develop a close relationship with a family dentist, visiting frequently for routine check-ups and seeking referral only when the

**TABLE 7-5
Dental Indemnity Plan Benefits Summary**

Service Level	Benefits
Level I—Preventive	100% of R & C*
Level II—Minor	80% of R & C*
Level III—Major	50% of R & C*
Level IV—Orthodontia	50% of R & C*
Deductible†	\$50 (individual) \$150 (family)
Orthodontia Lifetime Maximum	\$1,500
Annual Maximum for Other Benefits	\$1,500
<p>* Reasonable and customary—charge determined by the plan based on prevailing fees charged by dentists in the area † Not applicable to level I</p>	

dentist believes the services of such specialists as endodontists or oral surgeons are required. The basic plan design features reviewed earlier are present in all indemnity plans. For example, the structuring of coinsurance benefits to encourage routine examinations and other preventive services is almost a standard provision, and prior authorization provides an additional level of control.

Managed Care Dental Programs

Managed care in medical benefit programs, which has played a significant role in the evolution of group dental insurance, is covered in other assignments of this course and in HS 344 Advanced Topics in Managed Care.

There are two basic dental managed care plan structures: the PPO and the DHMO. Multiple-option plans give the insured additional choices. Recently, dental service organizations have developed to support the management of dental practices.

PPOs. A PPO is an arrangement between a plan and a panel of dental service providers whereby the providers agree to accept a certain payment (usually less than their customary fees) in anticipation of a higher volume of patients. Typically, the agreement between the plan and the providers in the network requires the participating dentists to take part in utilization review and quality assurance programs. However, these programs are usually not as extensive as those found in DHMOs.

The higher volume of patients results from a benefit structure that gives the member financial incentives to use providers from the panel. These incentives typically come in the form of reduced cost sharing or richer benefits. The method of benefit payment is almost always percentage of charges, usually with a deductible.

Members are not required to use participating providers, but they receive more liberal benefits if they do. At the very least, members who go outside

the network are responsible for payment of dental fees that exceed the plan's determination of the levels prevailing in the area. Some plans create an even greater incentive to use the network by increasing the indicated deductible and/or lowering the benefit levels for those using network providers, as indicated in table 7-6, which compares benefits in a typical PPO network with those that would be provided outside the network.

Service Level	In-Network Benefits	Out-of-Network Benefits
Level I—Preventive	100% of negotiated charge*	100% of R & C†
Level II—Minor	85% of negotiated charge*	75% of R & C†
Level III—Major	50% of negotiated charge*	50% of R & C†
Level IV—Orthodontia	50% of negotiated charge*	50% of R & C†
Deductible‡	\$50 (individual) \$100 (family)	\$75 (individual) \$100 (family)
Orthodontia Lifetime Maximum	\$2,000	\$1,500
Annual Maximum for Other Benefits	\$2,000	\$1,500

* Negotiated charge—fee that the dentist participating in the network accepts as payment in full
† Reasonable and customary—charge determined by the plan based on prevailing fees charged by dentists in the area
‡ Not applicable to level I

However, traditional PPO features are changing. Some employers are requesting modifications to their existing plans to obtain additional savings by restricting out-of-network benefits to the amounts paid to network dentists, which are generally lower than the prevailing (reasonable and customary) fee levels. The extent of any available rollover of unused benefits from one calendar-year maximum to a subsequent-year maximum may be greater for in-network services. In addition, PPO plans are adopting a service-benefit approach for network services, as employers seek to limit their employees' out-of-pocket expenses to defined amounts through the use of copayments for services.

PPOs typically do not take on any insurance risk but are simply vehicles for bringing providers and plan subscribers together. The insurers that set up or contract with PPOs and enroll members are taking the insurance risk.

DHMOs. A DHMO is a prepaid health plan that provides dental care services to members in a defined geographic area, accepts responsibility for delivery of services (not just the payment), pays a fixed periodic payment to dentists based on the number of insureds, and is organized under state law as a dental HMO. The payment to the dental providers, called a per capita or capitation rate, is usually paid monthly for each individual or family without regard to the number or types of services rendered or the number of members seen. Thus the dentist or dental group is at financial risk for the members'

utilization and has every incentive to encourage dental health and avoid unnecessary procedures.

Because DHMOs provide service benefits, in contrast to indemnity and PPO plans, they typically have no deductibles and no maximum level of benefits. Flat copayment amounts may be associated with major restorative, endodontic, oral surgery, and orthodontia services, such as \$250 for a crown. (For an example, see table 7-7.) Some DHMOs, however, use coinsurance for certain major procedures and orthodontia. Typically, benefits are available only for the services received from the providers participating in the DHMO plan. This distinguishes the DHMO from the PPO, where the subscriber is free to use nonparticipating providers, albeit at a reduced level of benefits. Members are rarely required to fill out claim forms or other paperwork.

TABLE 7-7 DHMO with Point-of-Service (POS) Option Plan Benefits Summary		
Service Level	DHMO Benefits	POS Benefits
Level I—Preventive	Fully paid	100% of R & C*
Level II—Minor	\$10 copay	80% of R & C*
Level III—Major	\$50 to \$250 copay†	50% of R & C*
Level IV—Orthodontia	50% of negotiated charge‡	50% of R & C*
Deductible	Not applicable	\$75 (individual)‡‡ \$150 (family)‡‡
Orthodontia Lifetime Maximum	Not applicable	\$1,500
Annual Maximum for Other Benefits	Not applicable	\$1,500

* Reasonable and customary—charge determined by the plan based on prevailing fees charged by dentists in the area
† Amount varies depending on treatment or service; consult plan document for specific amounts
‡ Negotiated charge—fee that the DHMO-participating dentist accepts as payment in full
‡‡ Not applicable to level I

Many DHMOs use a gatekeeper model of managing care, and each member chooses or is assigned a dentist to oversee his or her dental health. All specialist dental work (except emergencies) must be arranged through that dentist to help control utilization of major services. Participating providers are normally required to take part in utilization management and quality assurance programs sponsored by the DHMO; these programs are more stringent than those found in PPOs.

There are four common models of HMOs, including DHMOs: individual practice, group practice, staff, and mixed. The models are distinguished primarily by the relationship between the plan and its participating dentists.

Individual Practice Model. In this model (the most common type), the plan contracts for dental services with multiple independent individual dentists, who continue to practice in their offices and see nonplan patients. Often this arrangement is formalized by establishing an organization—

frequently by the individual dentists themselves—to provide services to the plan as an entity under a single contractual arrangement.

Group Practice Model. In this model, the plan contracts with dental groups that are usually incorporated. These groups have multiple offices, and although dentists are not employees of the plan, they sometimes limit their practice to DHMO patients.

Staff Model. A staff model DHMO actually hires its participating dentists and pays them a salary to treat patients in the DHMO facility. Staff and group practice models with only DHMO members are referred to as *closed panels*.

Mixed Model. Plans that use more than one model type are often referred to as mixed-model DHMOs.

Multiple-Option Plans. Some plans are now giving the insured a choice between two or more plan types at the time of enrollment.

Dual-Option Plan. A typical dual-option plan offers the member a choice between two types of plans—most frequently, a PPO plan and DHMO coverage. The subscriber must select one of the two plans before coverage begins and typically may not switch to the other option until the next open enrollment period. The DHMO plan usually provides more generous benefits for a premium equal to or less than the indemnity plan. On the other hand, the PPO plan does not restrict the subscriber to a limited number of providers.

Triple-Option Plan. A triple-option plan offers the subscriber a choice between three coverages: a traditional indemnity plan, a PPO, or a DHMO. Again, the choice must be made during the open enrollment period.

Point-of-Service (POS) Plan. Point-of-service coverage is a more recent development; it refers to the ability of a DHMO member to use an out-of-network provider. Under a POS plan, the member determines whether to use the DHMO network or go outside of it each time services are delivered.

If the subscriber uses a nonparticipating provider, benefits are reduced, as discussed earlier. Benefits are based on prevailing charges, with deductibles and coinsurance or a fee schedule and additional out-of-pocket expenses if actual dental charges exceed the allowed amounts. For an example, see table 7-7.

While POS plans have become popular for medical benefits, they have only recently been applied to dental benefits. The evidence suggests that under a dental POS option, cost savings are sharply reduced compared with those resulting from the exclusive use of the DHMO. This result and the management challenges presented by this option have severely restricted the availability of POS dental plans.

Dental Service Organizations. Over the last decade, a new type of enterprise with great significance for managed dental care has developed,

called a dental service organization (DSO) or a dental practice management company. DSOs, typically owned by dentists and entrepreneurial organizations, strive for cost efficiency and provide integrated dental network management.

The need for efficiency arises from the prevalence of solo or small group office practices among dentists, with each office required to have its own equipment and business systems. A single larger organization that consolidates the operations of these smaller practices can create significant economies. Some estimates indicate that dental care providers in a DSO can reduce overhead expenses by as much as 25–30 percent even while keeping up with state-of-the-art dental technology.

In addition to the obvious overhead savings, DSOs offer professional management. The dentist is free from management, operations, and marketing responsibilities, and can focus entirely on treating patients. DSOs may also expand the scope of services and revenues by bringing specialists into the practice.

More importantly from the managed care perspective, DSOs have developed alliances with DHMOs that have expanded managed dental care. Without an adequate dental network, DHMOs could not effectively enter certain markets. DSOs in effect provide ready-made dental networks. In fact, when professional resistance to managed care or some other difficulty in recruiting dentists is encountered, a DHMO often contracts with a DSO in its market area. Indeed, a DSO may extend its practice acquisitions to accommodate the markets that a DHMO is entering. In turn, a DHMO can ensure the patient and revenue stream required to make DSO practices profitable.

Recently, however, DHMOs have moved directly into the DSO arena by acquiring or building dental practices in areas with high patient demand. DHMOs can then generate income not only from the sale of their dental benefit programs to employers but also from the dental practices to which they channel their enrollees. DSOs have the potential to modify dentistry as practiced in traditional solo and small group offices. However, DSOs face critical challenges as they strive to organize and manage their acquired dental practices as systems that can consistently deliver quality dental services at a profit in a managed dental care environment. The growth of these organizations has slowed, however, as some DSOs encountered financial difficulties.

Other Plan Types

Direct reimbursement and discount dental programs, although distinct from the funded or insured plan designs presented above, are nevertheless relevant to a complete discussion of dental plans. In addition, consumer-directed health plans are affecting the payment of dental care services.

Direct Reimbursement

Direct reimbursement is a form of self-funded indemnity benefit plan under which an employer reimburses employees according to the dollars they

and their dependents spend on all dental care without reference to the category or type of treatment received. An employee or covered dependent visits the dentist of his or her choice, receives the dental work, and after treatment typically pays the dentist's bill directly in the office. The employee then presents the paid receipt or proof of treatment to the employer or third-party administrator and is reimbursed for all or part of the expense, depending on the plan design. (Third-party administration is discussed in the later assignments on self-funded plans.)

The design of the plan is selected by the employer as a budgeted expense amount, and therefore plan designs vary widely among companies. For example, one plan may reimburse 100 percent of the first \$200 of dental expenses and 80 percent of the next \$1,000, resulting in a total annual maximum benefit of \$1,000 per covered individual. Another company may only reimburse 75 percent of the first \$1,000 of dental expenses, resulting in a total annual maximum benefit of \$750 per covered individual. The totals can be individual or family maximums.

The American Dental Association (ADA) aggressively promotes direct reimbursement and cites several advantages, including the following:

- ease of employee understanding and employee satisfaction while avoiding service-specific exclusions and limits
- ease of administration by using a simplified percentage benefit payment structure without a detailed analysis of treatment categories
- employer cost control based on the employer's budget and the experience of the employee group

The last feature is intended to be especially attractive to smaller employers who would otherwise have to pay a premium for the purchase of an insured benefit program subject to applicable premium taxes and benefit mandates. The ADA, along with state dental societies, assists employers in designing direct reimbursement dental programs. As part of this service, the ADA supplies software free of charge to support the administration of a direct reimbursement program. However, in its purest form, direct reimbursement has no incentives for preventive services and provides no mechanism to monitor utilization, quality, or fees. Moreover, administrative costs are not significantly less than those experienced under typical benefit arrangements. As a result, direct reimbursement plans have limited popularity.

Discount Dental Programs

Discount dental plans that provide dental services at reduced prices are common in the dental service area. Their characteristics, including operation in tandem with funded benefit programs, are consistent with the earlier discussion of discount programs in the general area of ancillary benefit programs. The monthly fee for enrollment in dental discount programs is typically less than \$10, and many companies pay the fee on behalf of the employee. Some of these programs provide free initial dental examinations.

Providers of Dental Benefit Programs

Providers of dental benefit programs cover a broad spectrum that includes insurance companies, Blue Cross and Blue Shield organizations, Delta Dental plans, HMOs and independent DHMOs, and other managed dental care organizations. Delta Dental plans are nonprofit organizations that were initially sponsored by state dental associations. Medical benefit plan organizations, including HMOs, may develop their own dental plan subsidiaries and networks, or they may provide dental benefits through contracts with existing dental plans as well. For example, in some markets, Blue Cross and Blue Shield plans and HMOs market dental coverage under contract with Delta Dental plans.

With the growth of dental benefit alternatives, organizations that provide dental plans do not limit themselves to a single traditional type of plan offering, as in earlier decades. Most organizations now offer comprehensive lines of plan products that include indemnity plans, dental PPOs, DHMOs, and dual- and triple-option offerings with point-of-service (POS) features as well as administrative service arrangements for self-funded employer plans. Indeed, some third-party administrators have specialized in dental network plans for the self-insured market.

Regulation

For the most part, dental insurance is subject to the same regulation as medical insurance. However, a few points should be emphasized.

HIPAA

Dental insurance as a stand-alone product is excluded from federal regulation as an “excepted benefit” for purposes of the portability, availability, and renewability provisions of the Health Insurance Portability and Accountability Act (HIPAA). This exception has spurred unbundling of existing integrated dental plans to simplify the administrative and compliance requirements of medical plans under HIPAA.

COBRA

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

State Regulation

Like medical insurance, dental insurance is subject to legislation affecting standard individual and group contract provisions, such as those relating to the entire contract, incontestability, claims, rating, and advertising. Unlike medical insurance, however, dental insurance seldom has mandated, specific benefit provisions.

