

ONE DENTIST'S VIEWPOINT ON DENTAL INSURANCE

In my twenty plus years of practicing dentistry, I have seen the “birth” of the dental insurance policy and experienced its impact on the dental profession personally. Nowadays most employers provide some type of dental plan as an inducement to attract and hire the best employees available. The quality of the benefit package was a deciding factor for many people in choosing an employer when the economy was booming in the 1990's. However, the decline in corporate profits and massive layoffs of employees in recent years have left most people happy just to have a job. Still, it has come to be expected that dental benefits be part of an employee's compensation. So most employers continue to offer them, but the quality and generosity of many plans have declined significantly.

Ever wonder why your insurance changes from one year to the next? Many employers have reduced the benefits that their employee dental plans provide in order to reign in ever-increasing insurance premium costs. Increases in premiums have outpaced the level of benefits in most plans. But people's expectations regarding what their policies do, and do not, provide seems not to have changed accordingly. It is unfortunate, but true, that most dental plans have been reduced significantly. So much so as to make it impossible to achieve or maintain good health by depending on the coverage of the policy alone. As a result, it falls to the patient to pay a larger share out-of-pocket for one's treatment than in the past.

How much specific information about your dental plan has really been explained to you? Often it is the dentist and his staff who educate patients about the parameters of their dental plans. I find that most people do not have a clear understanding of their policies. Why is this? There are several reasons, beginning with the apparent lack of information offered to policyholders by their employers and the insurer. It is human nature, I suppose, to emphasize one's attributes and minimize one's deficiencies. Some employers play up the fact that a dental plan is being provided at all to the employee, but are vague as to the details. Perhaps it is considered good enough to “give” any benefit, so one should not be picky. Our office has seen some very poor plans in recent years. So bad, in fact, that I wonder how the insurer justifies the cost of the premium. Is management on the same plan? If they are then I'm betting that this is a company in trouble.

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Insurers have a tendency to promote the good elements of a policy in bold letters and relegate the downside of the plan to the fine print, hoping that no one will notice until after the contract for coverage is signed. Presumably the employer's main concern is to find an affordable benefit for its employees and not be burdened with the specifics. This suits the insurance underwriter just fine – after all, its purpose in selling the policy is profit, not health. Insurers can be more agile than Mohammed Ali, floating and evading like the proverbial butterfly, then stinging the policyholder whenever he finally uses the plan. It should come as no surprise that these insurance policies have more fine print to read than bold, easily understood explanations of their plan details. Believe me when I tell you “the devil is in the details”.

But you, the policyholder, are not without responsibility. After all, is it not the ultimate responsibility of the “owner” of the policy to find out what it contains? Of course it is. Just because your employer and the insurer make you dig for information does not mean it is not available. An insurance plan is a contract, and as such must spell out completely what it does and does not cover. You as the insured have a right, as well as responsibility, to know what is contained in your plan. Please exercise that right.

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* A ROADMAP TO UNDERSTANDING DENTAL INSURANCE *



Traditional dental insurance plans are essentially indemnity-type plans. These policies are group plans and therefore only available through belonging to a group such as a company or a collective of some type, for instance a professional organization. I have never personally seen a policy that was purchased by an individual through a broker without it being part of a group.

Typically there is an annual deductible which is applied to all but a few services each year and is met the first time the policy is used in that calendar year. An insurer may say that the deductible is “waived” for preventive treatment, but what

constitutes preventive under the provisions of the plan can vary greatly from policy to policy. A good example is x-rays, essential to the dentist in being able to properly ascertain a patient’s dental condition. Some plans consider x-rays as “preventive” while others categorize them as “basic” under the policy provisions. Services defined as basic by the insurer will incur the deductible.

These plans have a maximum annual benefit for each covered individual that sets a limit as to the insurer’s payout liability for the year. Once that limit has been reached there will be no more payment by the insurer on dental services for that person. Maximum benefit amounts vary greatly and are usually determined by how high a premium the insured is willing to pay. Higher premiums mean higher maximums and overall better coverage. When the new policy year begins the annual maximum renews itself.

As mentioned earlier, a dental plan will be defined by the services it covers and how they are covered. Do not expect any dental policy to provide coverage for all the various treatments that are available in dentistry today. Within its framework, the policy will define the services it covers under the category of “preventive”, “basic”, or “major”. These designations are not in any way related to how a dentist assesses your health needs, and I feel

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that the use of these three words serves only to confuse the patient. As such, their inappropriate use can interfere with the elemental trust in the working relationship of the doctor and the patient. So please do not think that the use of these terms by your insurer is for any legitimate purpose other than to define the services which the policy covers and how they are paid. Whatever insurance designation is applied to the treatment you receive has a direct effect on the amount of payment the insurer will provide for that service.

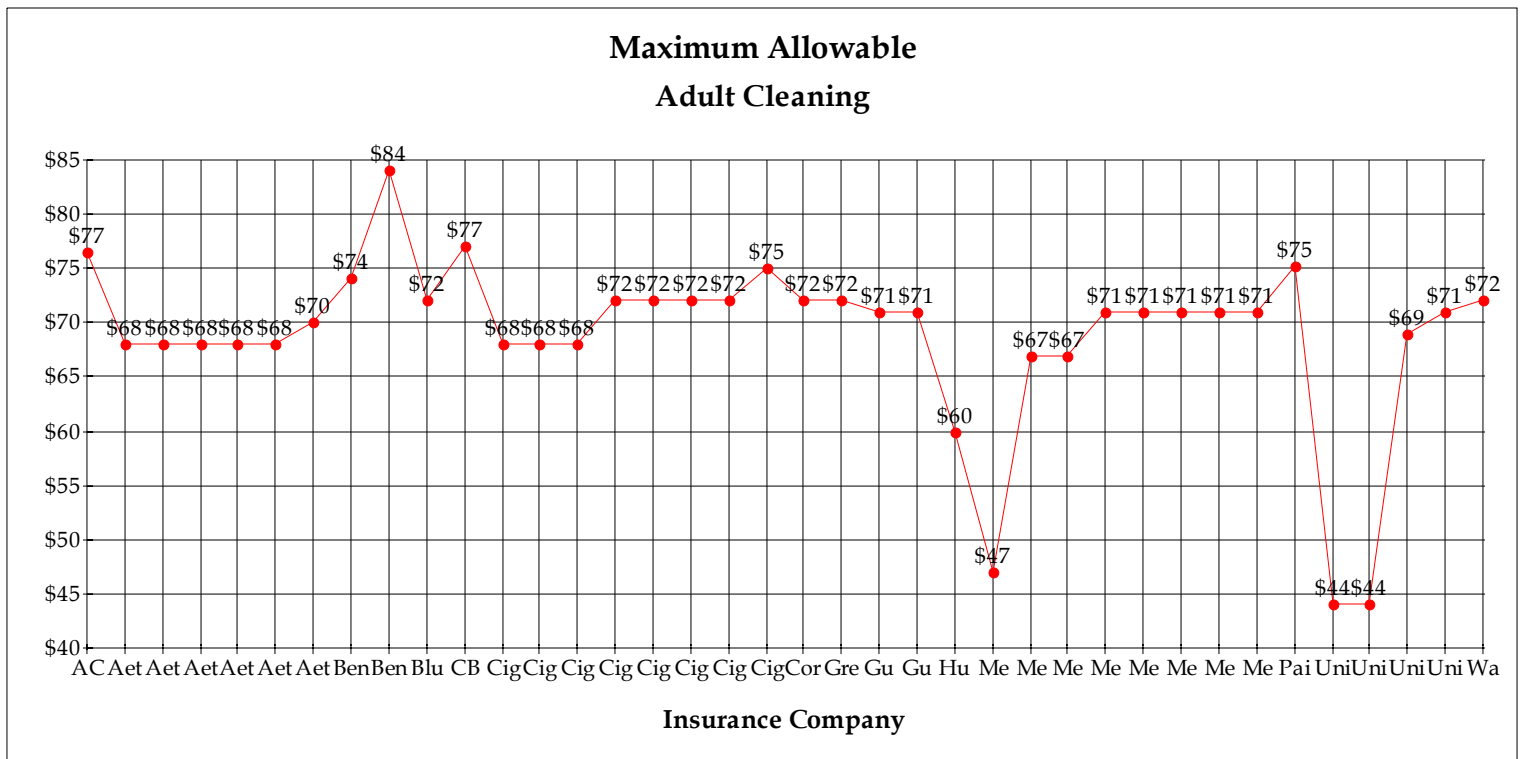
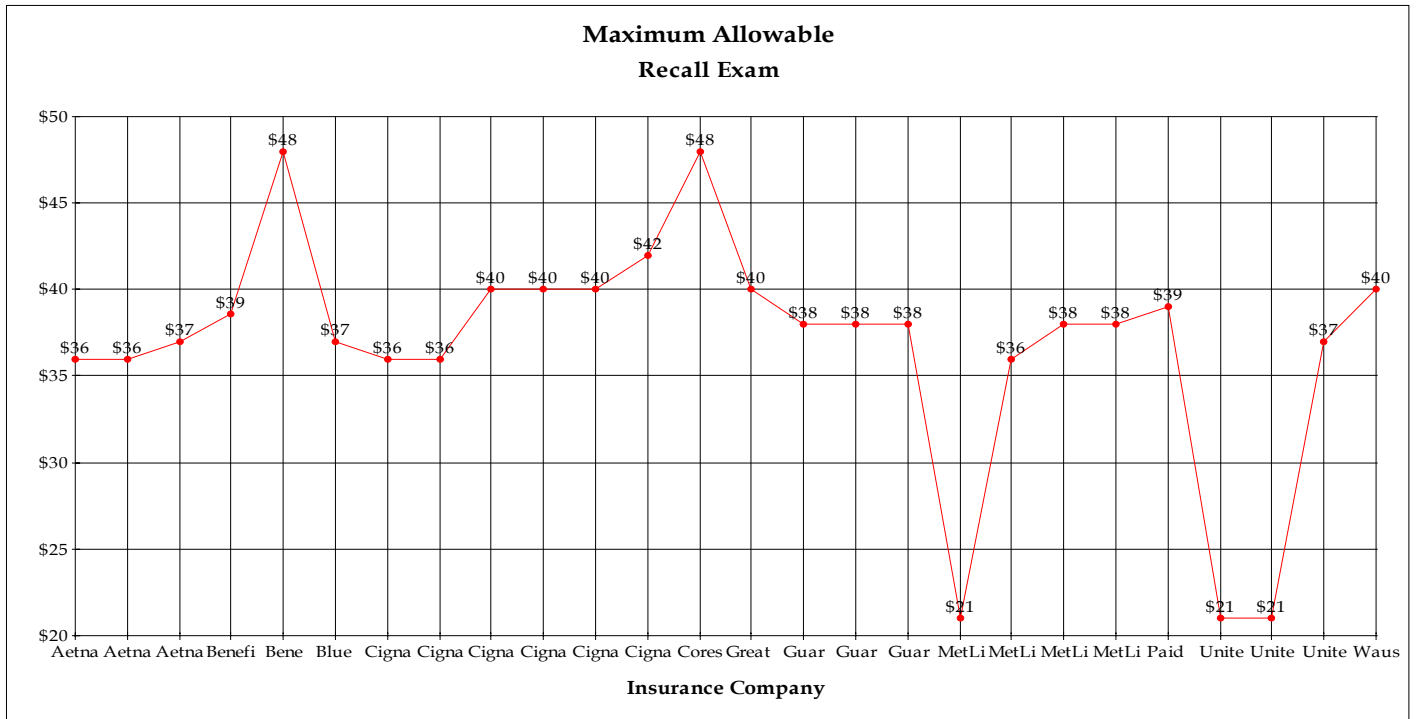
There is an inverse relationship between the designation applied to a dental service and the percentage amount that the insurer will pay. The more expensive dental treatments are usually paid at a lower percentage. More expensive services often are designated as “major”, with less costly ones categorized as “preventive” or “basic”. This is done by design.

As an example, most policies consider fillings in teeth to be covered as “basic” services, so the insurer will calculate the co-payment for a filling based upon the percentage it is obligated to pay under the “basic” designation. Full coverage crowns are typically considered “major”, and as such carry a higher co-payment cost to the policyholder because they are more difficult and expensive to do.

Unfortunately it is not as simple as that. Do not expect the policy to calculate that percentage based upon the dentist’s actual fee for the service. Instead, it will impose its own “fee” amount for that service and then apply the percentage payment factor to that. So, in essence, unless the dentist charges the same amount or less than the amount that the insurer imposes for that service as defined by your plan, the patient will end up with a larger dollar co-payment for the treatment.

The insurer’s “fee schedule” for the policy is almost always *lower* than what dental offices charge for health care treatment today, sometimes being devalued by as much as forty percent. It has always been so and is unlikely to change in the future. The “fee schedule” of your policy is determined by how much premium the policyholder is willing to pay. *You get what you pay for.*

Not all Dental Plans are created equal.
The charts on the following page show
what insurance companies “allow” for
Recall Exams and Adult Cleanings.
Where does your plan fall?



Source: Explanation of Benefits from 2004/2005 Insurance Claims

Other provisions that are frequently seen in dental policies include what are known as *“limitations” and “exclusions”*. “Limitations” refer to services which can only be considered as covered treatment if they fall within certain restrictions imposed by the plan. An example would be a sealant, which is placed on the biting surface of a back tooth as a preventive treatment to reduce the potential for bacteria to cause cavities in the grooves and pits of the tooth surface. Most policies limit who can have sealants and on which back teeth they can be placed. Adults often are not covered, and while children below a certain age may be, they are limited as to which teeth are covered. It has no bearing from a health standpoint as to who and which teeth would benefit from this treatment.

“Exclusions” are just that, treatment options for which the policyholder is not eligible to be covered under the provisions of the policy. If you elect to have these treatments then you will absorb the entire cost for them out-of-pocket. Which services are excluded varies from plan to plan and follows no discernible rhyme or reason, other than, again, the more premium one is willing to pay the likelihood that there will be fewer limitations and exclusions in the policy.

Hopefully by now you are getting a real sense of the quicksand that exists in deciphering dental insurance policies and their provisions. It is an ever-changing landscape often filled with futility and frustration when trying to analyze the variety of plans that exist in the marketplace. And it is becoming more so. The financial squeeze of ever-increasing premiums impacts each employer’s ability to provide quality insurance. Underwriters have responded to this situation by placing new and more creative restrictions on their policies, with the trend in recent years to reduce the amount of plan benefits.

An alarming example is the explosion of PPO (“preferred provider organization”) and DMO (“dental maintenance organization”) plans being promoted. These plans were



practically non-existent five years ago. Their common bond is that they take away your freedom of choice to pick your own dentist without interference. The insurance underwriter recruits individual dentists to provide treatment under these plans at a substantial discount below their usual fees by imposing a “fee schedule” on them through contract. These contracted dentists often are young and inexperienced, not realizing that in order to provide services for these fees one is under pressure to compromise the quality of care given. When they do finally understand the circumstances of their situation, they either cancel the contract or continue in what can best be described as a professionally-conflicted environment.

You may ask, what is the benefit to the dentist of contracting with these organizations? Good question, and one I ask myself. Perhaps it is the prospect of gaining an influx of new patients for a dentist who is trying to build his practice. Often, because these plans offer such poor

compensation to the participating dentists, the insurer has difficulty recruiting dentists to be providers. The result is few, if any, contracted dentists being available in your neighborhood. This is a real inconvenience for most people. In my opinion, DMO's and most PPO's are a lose (the patient) - lose (the dentist) - win (the underwriter) proposition, with only the insurer benefiting.

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So what is a person to do? I can assure you that the majority of dentists are true professionals who take seriously their responsibility to care for their patients' health as best they can. They want their patients to make good decisions about treatment needs and not be overly influenced by insurance considerations. They will, however, help you to research your policy and make every effort to aid you in receiving the benefit you are entitled to under the provisions of your plan. Become knowledgeable about your coverage before you need to use your dental policy.

Also, you can help yourself by taking a preventive approach to your health and maintaining regular recare visits to the dentist. *Letting too much time pass between check-ups almost always leads to more and worse health problems, necessitating greater cost to remedy the damage.* When additional treatment is needed, ask your dentist what payment options are available. These options are meant to assist you in managing the cost of treatment.

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The future of dental insurance as we know it is not bright. With the rise in insurance premiums and reduction in coverage relative to the actual cost of dental care, *it will eventually make no sense to purchase policies that cost essentially what they pay out* on an annual basis. In addition, insurance companies will continue to narrow the scope of services that they cover, and many of the ones covered will fall under increasing restrictions. Thankfully, good dental care is not so expensive as to cause severe financial hardship for most families. And there are alternatives to the traditional model of dental insurance. Read on to learn more about dental plans that can be a win-win-win for the employer, the patient/policyholder, and the dentist.