

# Clearing Up The Confusion About Dental Networks



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In today's world, where employers are facing constant economic challenges and looking in every direction to save healthcare benefit dollars, Participating Provider Organization (PPO) dental plans continue to gain in popularity.

To make the right choices, it is important to understand the subtle but important nuances between dental PPOs. Many employers and producers believe PPO dental plans are basically all the same, and after an exhausting sale or difficult renewal of the medical benefits, they may spend much less time looking at the details of the dental plan. Frequently people make decisions based solely on price without fully understanding each carrier's differences, including the process for calculating payments and reimbursing claims.

## Dental Network Design

When setting up a PPO network, dental insurance carriers contract with dental offices in each market, negotiating discounts from the dentists' "usual and customary fees." These discounts can be as little as 10 percent or as much as 40 percent, depending on the dental offices in that market, and the number willing to agree to the fees being offered by the carrier.

In many markets, the greater the requested PPO discount, the smaller the number of dentists willing to contract with the PPO. It is an important balance that each PPO dental carrier has to manage, so they can provide a large number of available dentists, yet have a strong enough discount to provide competitive premiums to their employer groups.

Generally plan members using dentists in the network will only incur out-of-pocket costs for coinsurance or noncovered procedures as stipulated by their plan design. Much of the confusion about payments for services relates to visits to out-of-network dental offices. While employees with a PPO dental plan may visit any dentist, they could experience higher out-of-pocket costs with dentists who are out of the network.

## Percentile or Percentage?

Insurance carriers usually determine the out-of-network payment based on the usual and customary fees charged by dentists in a particular three-digit ZIP code. To obtain this information, many insurers purchase data from a third-party company that gathers dentists' actual charges from insurers, who have collected the information from dental offices in that three-ZIP market. This company tabulates the fees for each procedure to arrive at the usual and customary charges for that area. The amount paid by the carrier for out-of-network services is based on the payment percentile specified by the producer for the group plan.

Consider this example: In a specific three-ZIP area, dentists may charge anywhere between \$40 and \$80 for a preventive checkup, which is their usual and customary fee. If a plan pays up to the 90th percentile for usual and customary, what does that really mean? It means nine out of 10 dentists in that area charge an amount that is equal to or less than the amount the dental carrier will reimburse for that procedure. In this example, the 90th percentile signifies that nine of our 10 dentists in that area charge \$65 or less for a checkup.

## **Avoid Potential Problems**

Insurance carriers typically pay out-of-network dental procedures somewhere between the 50th to 90th percentile. However, producers should understand that there are variations in these calculations:

- ***Independent calculations.*** While many dental carriers use claim data from a third-party service, others may rely solely on their own internal data sources to determine the percentile amounts. If their information is not accurate for each three-ZIP market, they may misrepresent the usual and customary fees for procedures, and the payment amount may be more or less than what other carriers provide.
- ***Payments at the 99th percentile.*** Recently some carriers have communicated that they pay at the 99th percentile in specific markets. Third-party companies only calculate payments up to the 95th percentile, so these carriers are probably using only their own internal data to determine payments at the 99th percentile. Essentially this means that employees who go out of the network for dental care should incur minimal out-of-pocket costs. While employees would be thrilled to have nearly all of their out-of-network dental costs paid by the carrier, there are several potential problems with this practice:

*Limited cost controls.* Under a 99th percentile plan, the dental carrier is committed to paying almost whatever out-of-network dentists charge. There are no cost controls to keep dental charges in line with the market.

*Reduced incentives for in-network participation.* If some dentists in the market receive payment from carriers for whatever they charge, dentists participating in an insurance network may decide to withdraw. If there is no cost incentive for employees to use in-network dentists, why should the dentists agree to accept a lower payment for a procedure when out-of-network dentists receive a higher payment amount?

*Dental plan premiums may increase in cost.* Dental insurance carriers offering the 99th percentile may need to increase premium costs for dental benefits in order to cover higher procedure costs. Employers may pass along this higher cost to employees, which may cause many to drop their dental plans due to the higher premiums. The low participation rate may then result in employer dissatisfaction with the insurance carrier and producer.

## **New Opportunities for PPO Plans**

The continuing financial hardships that businesses and employees are experiencing provide opportunities for producers to strengthen and renew employers' interest in dental insurance, helping them to increase the value of their benefit packages without incurring significant costs. Provide information to employers to help them educate employees about their dental benefits and the money they can save using in-network dentists versus those outside the network.