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Dental Benefit Plan Handbook

Chapter 1 - Understanding Dental Benefit Plan Coverage

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In order to help a patient maximize dental plan benefits, both the staff within the dental practice and the patient should understand the type of services covered by the patient's plan, specifically, the plan's limitations and exclusions. This section is intended to educate you on the many types of dental coverage and the differences between dental and medical coverage, in order to aid you in explaining dental coverage to patients.

Dental is Different: Dental vs. Medical Coverage

To educate patients on their dental benefit plan coverage, it is helpful to know the differences between dental care and medical care. Being able to understand and explain these differences to patients not only benefits the patient, but the practice providing care.

Dental benefit plan coverage is generally designed with the following assumptions:

- There is near-universal incidence of dental disease – everyone has it, and hence, everyone needs and will utilize dental care.
- Apart from trauma and pain, the patient has complete control over when, or even if, treatment will be given.
- Unlike general medical diseases, dental disease is generally not acute or life threatening; hence, the financial implications of dental treatment may not be catastrophic.
- Much of dental disease is preventable, with minimal cost and effort. Hence, traditionally dental benefit coverage has a preventive orientation.
- The onset of dental disease generally occurs early in childhood; therefore, coverage extended to children is important in terms of establishing a lifetime of satisfactory oral health.

Furthermore, the dental profession is organized differently than the medical profession:

- 80 percent of dentists are general practitioners and primary dental care providers.
- The greatest percentage of dental care is rendered by one practitioner at a single site.
- Almost all dental care is done on an out-patient basis.

In summary, dental benefit plan coverage is designed based on the significant differences between dentistry and medicine.

Types of Dental Benefit Plans

The following provides a summary of the different types of dental plans:

Fully insured plans

Fully insured plans are qualified plans whereby contributions are made to an insurer and benefits and plan administration are provided by the insurance company on behalf of plan participants.

Fully insured plans are regulated by California's department of managed health care or department of insurance, depending on the plan type. These plans are more expensive to purchase since the purchaser is paying for the plan to assume the financial responsibility of ensuring care to the plan enrollees.

Self-funded plans

Approximately half of Californians are covered by self-funded health benefit plans operated by their employer or a third party administrator. Since such a large number of patients within your practice are likely covered by self-funded plans, here is what you should know:

Self-funded plans can take the form of a PPO or indemnity plan. Self-funded plans are designed by the employer based on the dental benefit plan the employer wants to offer their employees. One of the major differences between self-funded and fully insured plans is that the employer or union, or whomever is providing the benefits, assumes the financial risk associated with offering a self-funded plan, thus making it less expensive than paying for a fully-insured plan. The employer pays for care as needed and utilized by the employee members of the group.

The employer, or a designated third party, administers the benefits and pays the dental provider for treatment rendered to a covered employee and eligible family members.

Self-funded plans are regulated by federal law through the Employee Retirement Income Security Act of 1974 (known as ERISA), under the Department of Labor. ERISA sets the standards for administering these plans, including disclosures to plan participants, and sets minimum requirements for claims processing. State regulations for PPO and HMO plans do not apply to ERISA.

Self-Funded Benefits and Limitations	
Benefits	**Limitations**
• Employee may see any dentist. • Fee-for-service. • Less expensive than a fully insured indemnity plan. • Assignment of benefits is plan-/group-specific so check with the plan to see if the group has AOB for out-of-network providers. • Self-funded, employer-sponsored plans are regulated under ERISA and not covered by state law.	• Employer bears sole financial responsibility; premiums are paid to a trust fund or administrator. • Employer costs are not fixed, cost varies depending on utilization. • Employer responsible for selecting and paying for third party administrator (TPA). • Check references of TPA.

ERISA

Determining if a Patient Is Covered by an ERISA Plan

Administration of self-funded health benefit plans, including claims processing and the issuing of reimbursement checks, is typically provided by an independent administrative service organization. It could also be provided by an existing dental benefit plan. If administered under contract by a dental plan, confusion may arise when the dentist isn't paid what they believe they were entitled to. The explanation of benefits (EOB) form received by a dental office may have the name of the administrator printed at the top (i.e., the EOB may indicate "Delta Dental" or "Aetna" or "United Concordia") but the employer or union the patient receives coverage through is the entity that has paid for the care. The dental plan in this case is only the administrator; none of the money has been spent on reimbursing treatment. So while an EOB may make it look like the patient's plan is a fully funded standard commercial benefit plan, it may actually be a self-funded plan where the patient's employer or union is making payment on claims.

Look for key words on the patient's health plan ID card, such as "ERISA plan, Managed by…," or "Administered by…" When in doubt, your billing manager should ask the patient if they know if their dental plan is "self-funded." They may not know, but they can be encouraged to ask this of the benefit manager in their company's human resources department. Additionally, self-funded ERISA-regulated plans are required to file a Form 5500 with the U.S. Department of Labor. Search the Form 5500 database on the website freeerisa.benefitspro.com to determine if a group is self-insured.

The Importance of Understanding ERISA Plans
Self-funded plans are exempt from state consumer protection laws, meaning that the rights enjoyed by both patients and providers in California law will likely not apply. This means, for instance, that California's prompt-payment requirements on claims do not apply to ERISA plans. Nor does California's law defining the payment responsibility of secondary dental plans in a coordination of benefits situation.

Federal laws apply, and this means that the path of appeal on a payment dispute with a self-funded plan will be different with an ERISA-regulated plan.

More on payment disputes with ERISA plans is provided in the section discussing appeal of payment disputes with plans.

At the end of this chapter you will find a sample letter Sample Letter Informing a Patient About an ERISA Plan that may be used to inform patients about their ERISA plans. This resource provides a checklist of steps necessary to determine whether an adverse payment decision is appealable.

"Timeliness" Requirements on Self-Funded ERISA Plans When Paying Claims
Most states, including California, have a "prompt-payment" requirement that establishes parameters for when complete claims for care provided must be paid. Typically, such "prompt-payment" laws require health plans to issue payment within 30 working days of receiving a claim. This is where there is a distinction between state-regulated health benefit plans and ERISA-regulated plans.

A self-funded benefits plan has 30 days from the date of a claim to issue a benefit decision; the plan may seek a 15-day extension on making a decision for "reasons beyond its control" if it notifies the claimant of the need for the extension before the end of 15 days. However, 30 days to make a payment decision is not the same as actually making a payment. ERISA requires plans to pay in a "reasonable amount of time" and what is reasonable is not defined. Should a claim not be paid within 30 or so days, the dental office should make an inquiry about the status of the claim through the patient to the patient's self-funded plan. In addition, a call to the regional U.S. Department of Labor's Office of Participant Assistance should be made to inquire as to whether the plan is in violation of ERISA for its delay in payment. (See below for contact information to the regional offices of participant assistance.)

Commercial Plans: Managed Care

Preferred provider organization (PPO), also known as dental preferred provider organization (DPO), programs are plans under which patients can select a dentist from a network or list of providers who have agreed, by contract, to discount their fees. PPOs allow patients to receive treatment from a dentist who is not a participant in the plan's network (out-of-network), but patients are sometimes penalized with higher deductibles and co-payments. PPOs can be fully insured or self-insured. They are usually less expensive than comparable indemnity plans and are regulated under the appropriate insurance statutes in the company's home state of operation.

PPO/DPO Plan Benefits and Limitiations	
Benefits	**Limitations**
• PPO plans are less expensive than indemnity plans. • Employer may be able to customize plan's benefit levels and covered services. • PPO plans are similar to an indemnity plan; however, the plan contracts with a dentist to provide services for reduced rates. • PPO plans can limit the co-payment the dentist is allowed to charge, thus reducing the patient's out-of-pocket expenses. • PPO plans are regulated by state or federal law depending on if they are self-funded or not.	• To maximize benefits, the employees may be required to change from their current dentist to an in-network provider. This could discourage patients from seeking care outside of the network. • Patient may expereince reduced benefits if they are seen by a non-participating dentist. • Exclusive provider organization (EPO) does not cover any expenses when a patient is seen by a non-participating dentist. • Benefits are commonly limited to yearly dollar maximum.

Dental health maintenance organizations (DHMO), or capitation plans, pay contracted dentists a fixed amount (usually on a monthly basis) per enrolled family or individual regardless of utilization. In return, participating dentists agree to provide specific types of treatment to the patient at no charge (for some treatments a co-payment may be required). Theoretically, the DHMO rewards dentists who keep patients in good health, thereby keeping costs low.

HMO/DHMO Plan Benefits and Limitiations	
Benefits	**Limitations**
• Economically-minded dental coverage. Predictable co-payments or no co-payments. Preventive care generally provided at no cost to patient. • Incentives for preventive treatment. • Early diagnosis and preventive treatment helps control costs. • HMO plans are regulated by the California Department of Managed Health Care. • Plans are mandated by law to establish internal quality assurance programs, which may include on-site facility and chart reviews or assessments (audits).	• Employee must select primary care provider (PCP) from a list of participating dentists. • No benefit paid for services if the patient seeks treatment from a non-participating dentist. • Non-routine or major services may require patient co-payments or may not be covered by plan. • The dentist assumes some financial risk for the care rendered. Dentist receives a monthly compensation "capitation" fee for each patient assigned to practice regardless of actual service performed. Patient may be removed from actual cost of dental care; may not understand the value of the service provided, as generally there is no claim or EOB for services rendered.

Commercial Plans: Fee-For-Service/Indemnity

An indemnity plan is a fully insured or self-insured plan where a specified payment is provided to dentists for specific services, regardless of the actual charges made by the provider. Payment may be made to enrollees in the form of reimbursement payments or directly to dentists.

Fully Insured Indemnity Plan Benefits and Limitiations	
Benefits	**Limitations**
• Employee may see any dentist. • Various designs, some have fixed premium for 6-12 months. • Fee-for-service; benefits paid off of a usual and customary rate schedule (UCR). • Basic orthodontic coverage may be included. • Plans regulated by state laws.	• This type of dental coverage generally has high premiums. • May have maximums per calendar year for dental expenses. • May have excluded coverage for esthetic dentistry, implants or treatment for TMJ. • Patient is financially responsible for the balance remaining from the UCR fee to the actual fee charged. • Waiting periods may apply.

Self-Funded Indemnity Plan Benefits and Limitiations	
Benefits	**Limitations**
• Employee may see any dentist. Fee-for-service; benefits paid on a UCR schedule. • Less expensive than a fully insured indemnity plan. • Self-funded, employer-sponsored plans are regulated under ERISA and not covered by state law.	• Employer bears sole financial responsibility; premiums are paid to a trust fund or administrator. • Employer costs are not fixed; cost varies depending upon utilization. • Employer responsible for selecting and paying for third party administrator (TPA).

Affordable Care Act

The federal Affordable Care Act created a marketplace of lower-cost health care coverage for individuals and small businesses. Costs are controlled through the establishment of a minimum scope of essential benefits that plans operating within the marketplace are required to establish and the offering of these plans through health care exchanges. In California, the exchange is called “Covered California.” Stand-alone dental coverage is offered to both adults and children through family coverage as PPO and as DHMO products.

While these exchange plans function like other commercial insurance products, these are policies intended for sale to new patients who may have previously lacked coverage. A provision of the ACA requires every person to purchase health insurance coverage. Pediatric dental coverage is one of the essential benefits established in the ACA. Federal rules permit health plans to not offer pediatric dental coverage if the exchange marketplace has established stand-alone dental coverage that complies with the ACA’s requirements. However, California requires all exchange health plans to include dental coverage for children. For more information on the pediatric dental coverage offered by the plans through Covered California, go to coveredca.com.

Additionally, Covered California offers adult dental benefits through separate dental plans. Those policies are sold by stand-alone dental plans and are paired with the pediatric dental benefit as part of a family plan. All stand-alone dental plans are required to provide to policy holders a consumer-friendly statement of benefits and coverage (SBC), which clearly outlines the details of the plan: what is covered, what are the limitations and exclusions, what the out-of-pocket costs are, and how to find a network provider. A standard SBC was required for all medical plans in 2014, but dental plans were originally exempt. In 2015, that consumer protection was finally applied to dental plans offering coverage in the exchange.

While established through state implementation of federal law, the exchange marketplace plans function like commercial plans: they are administered by commercial dental benefit companies; those companies are required to maintain networks of dentists to provide care to enrollees of the plans; in the PPO exchange products, the enrollees are allowed to see an out-of-network dentist; administration of benefits is the same as with any other commercial plan; the plans in the exchange must meet the same requirements of state law that other commercial plans must meet.

Direct Reimbursement Plans (DR)

A self-funded dental benefit plan that reimburses patients according to dollars spent on dental care, not the type of treatment received. It allows the patient to choose any dentist. Instead of paying monthly insurance premiums, employers pay a percentage of actual treatment provided, or a fixed amount into the fund. Direct reimbursement is not considered "insurance." Employers are removed from influencing treatment decisions due to plan selection or sponsorship. Direct reimbursement is considered a form of self-funded care. For more information on Direct Reimbursement refer to the American Dental Association.

Direct Reimbursement Plans (DR) Benefits and Limitiations	
Benefits	**Limitations**
• Employees have freedom of choice to see their own dentist. • Employer determines benefit level. • Employees have control of how they use their benefit dollars. • Employees are directly involved in the payment process. • Low administrative cost. • Some employers may choose to self-administer or select a TPA. • Almost all monies go directly to dental benefits. Self-funded, employer-sponsored plans are regulated by ERISA and not by state law.	• Less predictable than a premium plan; costs can vary depending upon utilization. • Plan is not regulated by state law. Employees may be required to pay dentist directly for services and are later reimbursed by the employer. • Employer can establish plan to directly pay dentists.

Alternative Forms of Dental Benefit Coverage

Discount Dental Plans

Technically not insurance plans, discount dental plans offer a panel of dental providers that have agreed to offer services at a reduced rate. The patient pays for all dental expenses out-of-pocket, although discounted below the dentist's usual, customary and reasonable fees rather than a third-party insurer paying for the major portion of treatment costs.

Discount dental plans *are required to obtain a license from the California Department of Managed Health Care to ensure that discounts for services are authentic and that the statements made in their marketing materials are truthful.*
DMHC licensing verification: 1.888.466.2219

Discount Dental Plans Benefits and Limitiations	
Benefits	**Limitations**
• Provides employees/patients discounted dental services, similar to "discount membership clubs." • Membership fees are predictable. • Employees/patient has control of which benefits or treatments to purchase. • Administrative costs are minimal or nonexistent for employers.	• Discounts are available only through dentists in the plan's network. The amount of discount varies from plan to plan. • While treatment fees are discounted, the cost of care is paid by the patient

Government Programs

Aside from commercial benefit plans, there is a principal publicly funded dental program in California: the Medi-Cal Dental Program (Denti-Cal). Additionally, information regarding Medicare is provided.

Denti-Cal

Denti-Cal is California's Medicaid dental program. The program has been administered by Delta Dental of California since 1974. Eligibility for this program is determined by the patient's county department of social services.

Details of services that Denti-Cal provides are found in the program's *Medi-Cal Dental Program Manual of Criteria*, which is available on the Denti-Cal website, denti-cal.ca.gov/Dental_Providers/Denti-Cal.

Medicare

While Medicare does not generally cover dental care, when treating or providing supplies to beneficiaries of the Medicare program dentists may come under some of the registration requirements of Medicare.

For more information on Medicare Dental Coverage refer to CMS, cms.gov/Medicare/Coverage/MedicareDentalCoverage/index.html

Traditional Medicare and Medicare Advantage Plans

While routine dental services are not covered under the traditional Medicare program, Medicare will pay for dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury) or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Some dental services are covered by certain Medicare Advantage plans and administered by private commercial health plans. Dental coverage through Medicare Advantage is optional and outside the scope of Medicare regulations and is not paid for by the Medicare program. Dental benefits offered by Advantage plans vary.

Becoming a participating provider with Medicare

Dentists who want to enroll as Medicare providers must accept assignment on all Medicare claims and accept Medicare-approved payment in full. A dentist choosing to be a participating provider with Medicare must enroll through the completion and submission of the CMS-855I.

Becoming a non-participating provider with Medicare

Dentists may elect to opt-out of the Medicare program by privately contracting with Medicare-eligible patients utilizing a sample private contract form. When a dentist opts out of Medicare, the dentist cannot receive Medicare payments for a two-year period. Opt-out affidavits and the private contract form can be found at the Noridian Health Care Services website, med.noridianmedicare.com/web/jeb/enrollment/opt-out. Dentists choosing to opt-out of Medicare and to bill patients privately must complete the Medicare Opt-Out Affidavit and send it to Noridian at the applicable address.

Enroll as a Medicare Ordering and Referring Provider

Regardless of whether a dentist has opted-in or out as a Medicare provider, the dentist may enroll as a Medicare ordering and referring provider. As an ordering and referring provider, dentists do not send claims to Medicare for payment. By registering as an ordering and referring provider, dentists will be placed on the Medicare Ordering and Referring Registry and will be able to order and refer patients to Medicare-enrolled providers and suppliers.

CMS (Centers for Medicare and Medicaid Services) provides an overview of Medicare dental covered items, exclusions and exceptions: cms.gov/Medicare/Coverage/MedicareDentalCoverage/index.html

Also see the CDA resource on government programs cda.org/public-resources/community-resources/california-government-benefits-programs

Reference Guide for the Types of Dental Benefit Coverage

When a new patient calls your office, are you prepared to answer the question of whether the provider accepts the patient's insurance plan or not? Are you familiar with the variety of plans that are offered and the contract status the dentist has with the plan? This chart will assist you with answers to these questions.

Plan	Design	Network	Limitations	Fully Insured or Self-Insured	Regulated By	How to file a Compliant with the regulator
PPO (also known as DPO) Dental Preferred Provider Organization	Provider agrees to contract to discount fees.	Patients select a dentist from a network list of providers, but may seek treatment out of network.	Patients may have a higher deductible and co-payment if seen by a non-contracted provider.	Can be fully insured or self-insured. Employers may be able to customize plan benefit levels and covered services.	Fully insured Plans are regulated by state laws, state department of insurance. Self-funded, employer-sponsored plans are regulated under federal ERISA.	*The Department of Insurance*, Provider Complaints Consumer Complaint, *1.800.927.HELP (4357)*
DHMO Dental Health Maintenance Organizations	Capitation plans pay contracted dentists a fixed amount (usually on a monthly basis) per enrolled family or individual regardless of utilization.	Patient must select a primary care provider (PCP) from a list of participating dentists. Patients may be required to change dentists to utilize their plan benefits. No benefits paid if the patient does not seek treatment from PCP.	Predictable co-payments. Preventive care generally provided at no cost to patient. Incentives for preventive treatment.	Employers may be able to customize plan benefit levels and covered services.	DHMOs are regulated by the California Department of Managed Health Care, a state agency.	*The Department of Managed Health Care*, Provider Complaints Consumer Complaints, *1.888.466.2219*

Plan	Design	Network	Limitations	Fully Insured or Self-Insured	Regulated By	How to file a Compliant with the regulator
Commercial Fee-For-Service: Fully-Insured Indemnity Plan	Fee-for-service; benefits paid off of a plans UCR schedule.	Patient may see any dentist. No contracted network of providers.	Patient is financially responsible for the balance remaining from the plans UCR fee to the actual fee charged. Waiting periods may apply.	Fully insured	Plans are regulated by state laws by the department of insurance.	
Commercial Fee-For-Service: Self-Funded Indemnity Plan	Fee-for-service; benefits paid off of a plans UCR schedule.	Patient may see any dentist. No contracted network of providers.	Employers may be able to customize plan benefit levels and covered services.	Employer bears sole financial responsibility; premiums are paid to a trust fund. Employer costs are not fixed; cost varies depending upon utilization. Employer responsible for selecting and paying for third party administrator.	Plans are not regulated by state laws. Self-Funded, employer-sponsored plans are regulated under federal ERISA, not by state law.	U.S. Department of Labor, Office of Participant Assistance at the appropriate regional office: in Southern California at 626.229.1000; and in Northern California at 415.625.2481. freeerisa. benefitspro.com

Plan	Design	Network	Limitations	Fully Insured or Self-Insured	Regulated By	How to file a Compliant with the regulator
Direct Reimbursement	A self-funded dental benefits plan that reimburses patients according to dollars spent not on type of treatment received.	Patients may see any dentist.	Employer determines benefit levels. Employees have control of how they use their benefit dollars.	Self-funded	Self-funded, employer-sponsored plans are regulated by ERISA, not by state law.	U.S. Department of Labor, Office of Participant Assistance at the appropriate regional office: in Southern California at 626.229.1000; and in Northern California at 415.625.2481. freeerisa.benefitspro.com
Discount Dental Plan	Provides employee/patient discounted dental services, similar to discount membership clubs.	Discounts available only through dentists in the plan's network.	The amounts of the discounts vary from plan to plan.	Not applicable as patient bears the financial risk.	Discount dental plans are regulated by the California Department of Managed Health Care.	The Department of Managed Health Care, Provider and Consumer Complaints, 1.888.466.2219.

Sample Letter Informing a Patient About an ERISA Plan

This sample letter may be used by the practice to inform patients about ERISA plans. This provides a checklist of steps necessary to determine whether an adverse payment decision is appealable.

[Date]

Dear [Name of Patient]:

We are writing this letter to you to assist you in understanding your employer-provided dental benefit plan and to help you maximize your dental benefit plan coverage for treatment in our practice.

Unfortunately, your dental benefit plan has denied payment of a claim for your treatment, and we want to explain your options toward appealing the decision should you wish to do so.

Your employer-provided dental benefit plan is defined as a ***self-funded plan***. Within California, some dental benefit plans are self-funded plans, which are regulated by the U.S. Department of Labor under the provisions of the Employee Retirement Income Security Act (ERISA).

Self-funded health plans are typically established by large employers, multi-state employers, cities, counties, school districts and labor unions, to mention the usual examples. ERISA contains a provision that preempts self-funded health plans from state laws, which means that many of the advances in state laws typically do not apply to self-funded health plans.

ERISA recognizes the right of enrollees (patients) of self-funded plans to file complaints or appeals regarding plan payment decisions. Further, ERISA permits patients to authorize another party to act as their representative in such disputes. Such an authorized representative of the patient is logically the patient's health care provider (our practice). There is no formal means to be designated a patient's authorized representative but getting a designation in writing from the patient helps our practice if the question arises.

If you wish to appeal the recent payment denial of your claim, you should do the following:

- Determine what the plan's coverage contract requires. As an enrollee in a self-funded plan, you should provide a copy of your our coverage contract to our practice. It will describe the plan's scope of benefits, limitations, exclusions and other policies that determine what it will and will not cover. If an adverse payment decision is challengeable, it will need to be challenged based on your coverage contract, not based on ERISA law or regulations.
- Request a second review of the claim with the plan's administrator. Most groups that self-fund health benefits for their members contract with a third-party administrator to run the benefit plan. These contractors are often commercial dental benefit plans such as Delta Dental, Aetna, Cigna, MetLife and the like. As contractors, they are responsible to administer payment for covered benefits consistent with the coverage contract and can assist by reviewing whether the payment was made in a way consistent with the plan established by the group.
- Thirdly, contact the employer or whoever is the sponsor of the self-funded plan. As an enrollee with the plan, you can take the payment dispute directly to the human resources department of the group that is providing the self-funded coverage and discuss it with the benefit manager. This is key, because while the plan's administrator may have paid a claim correctly, payment policies are ultimately determined by the employer or group. If a good case can be made for paying the claim, the employer may decide to override the administrator in this particular case or perhaps even change its coverage/payment policy to cover the care you've received.
- The final level of appeal is the courts. However, again, if your coverage contract specifies that a particular service is not covered or is covered but with certain limitations, a court is not likely to overturn the contract.

Some issues regarding a payment dispute are relevant to ERISA requirements. To determine whether a self-funded plan's payment decision (or lack of a decision) is a possible violation of ERISA, either you as the patient or our practice as your "authorized representative" may contact the U.S. Department of Labor Office of Participant Assistance at the appropriate regional office: **in Southern California at 626.229.1000 and in Northern California at 415.625.2481.** The Office of Participant Assistance can tell a patient or provider what the ERISA law requires, but it does not enforce the law. If the OPA hears a situation that indicates that a self-funded health plan is violating the law, it will likely refer the case to the Office of Enforcement for investigation.

Please contact our practice to discuss options to appeal your ERISA plan's adverse payment decision and whether you wish to designate our practice as your authorized representative in following up with either the group or the U.S. Department of Labor.

Sincerely,

[Enter Provider's Name]