

Dental Benefits Plan Evaluation Form for Employers provided by the Illinois State Dental Society



The Illinois State Dental Society has developed the Dental Benefits Plan Evaluation Form for Employers to assist companies and benefit managers in selecting a dental plan for their employees. Since every employer is attempting to control the costs of providing employee benefits, it becomes even more important that the benefit plans selected for your employees provide the highest possible level of care while still balancing costs.

The evaluation form provides questions that should be asked of each insurance company or managed care organization that is presenting a dental plan proposal for your consideration. Each question includes a background statement that explains the rationale on why the question is important and should be asked.

Since the passage of Public Act 91-0355, also known as The Dental Care Patient Protection Act, effective January 1, 2000 employers and employees who are covered or are considering joining a managed care dental plans, are now allowed to obtain additional information about the dental plan's benefits and the operations of the managed care company.

Many employers are utilizing managed care techniques to control the costs of medical care that is provided to their employees. In medicine, cost reductions are obtained by moving services from hospitals to less expensive outpatient facilities and by implementing gatekeeper physicians to oversee the care that is provided by medical specialists. In medicine, specialists account for about 80% of all physicians.

However in dentistry, 80% of dentists are general practitioners and almost all of the care that is provided to your employees is already being provided at the least expensive site, the private dental office. Therefore, it is important to keep in mind the differences between medicine and dentistry when considering health plan options.

We appreciate that many employers have recognized the importance of providing dental benefits to their employees. There are many topics to consider and the Dental Benefits Plan Evaluation Form for Employers can help guide the decision making process so that employers can succeed in providing quality dental plans at an affordable cost.

Check list items for employers:

Answers & Notes

1. How many individuals are currently insured or covered by the entity?

As a general guideline, your number of employees should not represent more than 15% of the entity's total number of covered individuals. This would give you a good idea as to the relative size of the entity and if the entity would have the ability to administer your program.

2. What percentage of premium is paid out for employees' dental care or what is the permitted loss ratio?

This will illustrate how efficient the entity is in providing services to your employees.

The range of the entity's costs, including marketing, taxes, administration and profits can range from 15% to 45% of the premium that you are charged. Anything over 30% should be carefully investigated.

3. How many group plans does the entity currently have in effect in Illinois?

If the entity has only a few plans in force, the entity may not be able to properly administer a new group with the number of employees that you cover.

Obtain reference information from the entity. This should include the names of three employers who have approximately the same number of employees and be in the same general area of the state. It is also important to obtain the names of two employers who terminated with the entity during the last year. Discussions with these employers may provide additional information that may be important in the decision making process.

4. What type of reimbursement is used by the dental plan? Is it on a capitated & copayment basis? Is it based on a table of allowance, or is it determined on a "usual and customary" basis that is defined and controlled by the entity?

If "usual and customary" is used, how often is it updated and what percentile is used? If it is not routinely updated, employees will be required to pay more out of their pocket for dental services. In Illinois, entities are required to disclose this information. If reimbursement levels are not periodically increased because the underlying data that is used is not properly updated, your employees will be required to pay more out of their pocket for covered services.

A capitated payment reimburses the dentist on a monthly per patient basis, whether the employee receives services or not. If a capitated payment is made to the dentist, the dentist retains more by performing fewer services. Does this affect the ability of employees to obtain appropriate dental care?

5. Are referrals to specialists made by the dentist and patient/employee or must they be approved by the entity?

If the entity has an excess amount of control over referrals, the entity may be more concerned about holding down costs than allowing your employees to obtain a proper referral to a dental specialist.

The remaining points apply to managed care dental plans such as PPOs and HMOs.

10a. How many general dentists participate in the plan's provider network?

Without a sufficient number of dentists, employees will not have proper or convenient access to the benefits provided by the dental plan and they will not utilize the benefits of the plan that you have purchased on their behalf for them.

10b. What is the ratio of total covered insureds to dentists that has been established by the entity?

A general rule is that the ratio should not be greater than 300 insureds to each dentist in the geographic area of where the insureds reside.

11. How many specialists participate and are all six specialties adequately accessible to your employees?

The six types of specialists that should be available in the network are endodontists, oral & maxillofacial surgeons, pediatric dentists, periodontists, prosthodontists and orthodontists.

Verify that specialists are actually available to perform specialty services and that the entity is not simply referring specialty services to a general dentist.

12. Have you determined that participating dentists are located where your employees and their dependents can actually utilize the plan and obtain dental care? In some cases, participating dentists no longer accept new patients.

- Insist on obtaining a list of dentists that participate in the plan and still are accepting new patients.
- Obtain list of dentists that participate.
- Have entity determine how many general dentists that participate in plan are within 25 miles or 30 minutes travel time of the majority of your employees' residences.
- At a minimum, a zip code analysis should be obtained.
- Ask selected employees to review the list of participating dentists to see if their dentist is on the list. If a high number of employees will be required to change dentists to obtain dental services, will the dental plan be viewed by the employees as a real benefit?

13. What is the turnover rate of dentists who participate in the dental network?

A high turnover rate may mean that dentists find the entity difficult to deal with or the entity is not dedicated to providing proper dental care. This could cause problems and disruptions for employees in obtaining dental services.

14. How often are dental offices reviewed or credentialed?

Randomly select the names of five dentists that participate in the provider network and request from the entity a copy of the dental office review report that took place in the last 12 months. This will verify that a thorough review of the participating dentists is being conducted by the entity so as to assure proper care is being provided to your employees.

15. What criteria is used to review or credential dentists that wish to join the dental network?

Verify that the criteria is based on both patient satisfaction surveys and a valid clinical competency review.

16. Does the dental plan require employees to select a dentist exclusively during an open enrollment period?

How long is the open enrollment period and is it held on an annual basis?

If an employee is unhappy with the dentist they selected, can they change dentists at times other than during open enrollment?

17. Does the plan offer a point-of-service option?

A point-of-service option provides employees with the ability to obtain services outside of the network, although the level of benefits is at a lower reimbursement rate than if the services are obtained from a participating dentist. This option allows for the employees to have some choice in where they obtain care, but it still holds the line on the expenses that are incurred by the dental plan.

Managed care dental plans are now required by Public Act 91-0355 to offer employees a point-of-service option if the employer has 25 or more employees and the employer contributes 25% or more to the cost of a dental HMO. The employer is not required to incur any additional costs associated with offering the point-of-service option as the cost, at the employer's option, may be passed to employees who have selected the point-of-service option.

18. Will the entity provide you with annual utilization reports, including a report showing how many different employees have utilized the plan during the year?

A report that only surveys or reports the services for those who utilized the plan is insufficient. Such a report must also analyze how many unique employees annually use the plan. If less than 50% of employees use the plan, either the plan is presenting barriers to care or employees do not understand how to utilize the plan.

19. If a new managed care dental plan is being offered as an option to an existing plan, will your employees have to "opt in" to the managed care plan?

An "opt in" basis allows employees to maintain a doctor/patient relationship with their current dentist if they so choose. It can be very confusing for employees if they must do something to keep an existing benefit. Employees should be asked to take some type of action to access a new benefit. The entity is the only one that will benefit by requiring employees to "opt out," as utilization of the managed care plan will be artificially low since some employees may not know they are in the new plan.

20. Does the entity maintain an 800 telephone number that participating dentists can use to verify employee eligibility?

Without access to current employee eligibility information, dentists may not be willing to provide care to your new employees or to employees who have made recent changes in coverages. If the entity only provides quarterly or monthly lists to participating dentists, weeks may pass where employees cannot access your dental plan.

21. Does the entity require participating dentists to sign a contract which prohibits the dentists from discussing the financial incentives of the plan or other clinical options that may be better for the patient but are not covered by the dental plan?

Some provider contracts contain “gag clauses” which restrict what the dentists can say about the services that are covered by the plan and how the dentists are reimbursed under the plan. Such clauses are contrary to a proper doctor/patient relationship and could restrict your employee from obtaining important facts about the care they need.

22. What is the entity’s disenrollment rate (the number of employees who choose to switch to another option)?

If other employers who use this plan have a high number of employees choosing to leave the plan during subsequent open enrollment periods, this could be a sign that the entity is not providing the care that it is promoting.

23. What is the entity’s reassignment rate? — How many employees ask to be reassigned to a different dentist in the network?

If covered employees are asking to be reassigned to other dentists in the network, employees may be having difficulty obtaining the care they need or are unhappy with the quality of the care provided. The reason employees are requesting reassignment needs to be determined.

24. Is the plan certified by the National Committee for Quality Assurance (NCQA)? Have they ever applied?

While the current NCQA standards are drafted for monitoring dentists who provide care under a medical plan, many employers are requiring that the same standard be applied to all dental plans. You may obtain information about NCQA by calling 202-955-3500 or on the internet at www.ncqa.org.

25. Is the plan accredited by the American Accreditation Healthcare Commission/URAC and its Network Based Dental Plan Accreditation Program?

American Accreditation Healthcare Commission/URAC may be contact by calling 202-216-9010 or on the internet at www.urac.org.



Illinois State Dental Society
P.O. Box 376
Springfield, Illinois 62705
telephone: 217.525.1406 • fax: 217.525.8872