Dental Care Benefits, 1995

Although declining since 1984, a majority of full-time employees had employer-provided dental care coverage in 1995. Over the years, the types of plans providing coverage and the methods of financing them have changed.

BY ANN C. FOSTER

During the early 1980s, dental care benefits became more prevalent among employees in medium and large private establishments (those with 100 or more workers). Data from the Employee Benefits Survey (EBS) showed that in 1980, 56 percent of all full-time employees in medium and large private establishments participated in an employer-provided dental care plan. Participation reached 77 percent in 1984, but declined to 57 percent in 1995.[1] (See chart 1.)

A possible factor affecting participation rates might be that employers, attempting to control health care costs, increased employee cost-sharing requirements.[2] In 1993, 54 percent of all dental care participants in medium and large private establishments contributed to the cost of individual coverage compared with 34 percent in 1988. In that same year, 66 percent contributed to the cost of family coverage compared with 50 percent in 1988.[3]

This article uses data from the 1995 Employee Benefits Survey of medium and large private establishments to examine dental care benefits provided to full-time employees. The initial sections describe types of dental plans, including fee arrangements and financial intermediaries. The article then examines covered services, reimbursement methods, maximum benefit provisions, and pretreatment authorization clauses.

Types of dental plans

In 1995, the majority of dental care participants (85 percent) were covered under a traditional fee-for-service (FFS) plan. With this type of plan, covered individuals receive dental care from the providers they choose. The plan reimburses either the provider or the individual for covered expenses.

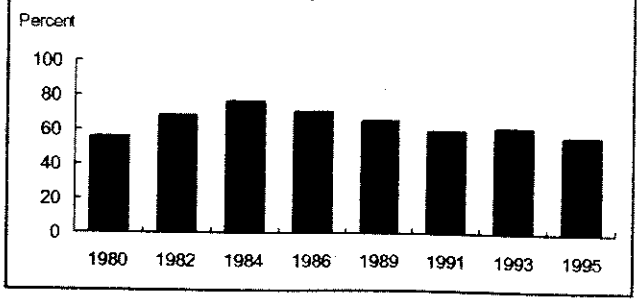
Employers have attempted to control dental care costs by adding to or replacing traditional FFS plans with dental health maintenance organizations (HMO's) and preferred provider organizations (PPO's). In 1995, 8 percent of dental care participants were in dental HMO's, and 6 percent were in dental PPO's.[4] In 1980, the combined enrollment in both plan types accounted for 2 percent of dental plan participants.[5]

Dental HMO's provide comprehensive dental benefits to a defined population of enrollees in exchange for a fixed fee per member (capitation), regardless of the work performed. This differs from FFS plans where dental care providers are reimbursed only when a service is performed.[6]

Dental PPO's contract with providers to furnish services at a discount in exchange for increased patient volume. PPO participants incur lower out-of-pocket expenses when they are treated by in-network providers.[7]

Coverage costs. The 1995 Employee Benefits Survey does not provide information about employee dental care costs.[8] Data from the National Association of Dental Care Plans, however, does show that premiums for dental FFS plans were higher than those for dental HMO's and PPO's. For example, in 1995, the median FFS premium for single coverage was $18 per month compared with $15.50 for PPO's and $10.95 for HMO's. For family coverage it was $48, $44.50, and $25.12, respectively.[9]

Chart 1. Percent of full-time employees with dental care benefits, medium and large private establishments, selected years, 1980-95



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Financing methods

The term "financial intermediary" refers to the organization responsible for paying dental care claims. Dental care financial arrangements have changed since 1980, when the majority of participants (77 percent) were in plans with a commercial insurance company as the financial intermediary.[10] In 1995, many participants were in plans with Blue Cross/Blue Shield, self-insurers, and other independent organizations as financial intermediaries. The following tabulation shows the percent of participants in each plan type by financial intermediary in 1995.

	FFS	HMO	PPO
Total participants	100	100	100
Blue Cross/Blue Shield	6	11	18
Commercial insurance company	17	25	15
Self-insured	61	5	38
Other	15	57	28

NOTE: Due to rounding, totals may not equal 100.

Self-insured. In a self-insured plan, the sponsor, usually the employer, is the financial intermediary and bears the financial risk of paying for covered services. Employers who self-insure benefits may enter into an "administrative services only" (ASO) contract with a third party to disperse the employer's funds to pay claims and handle other administrative details.[11]

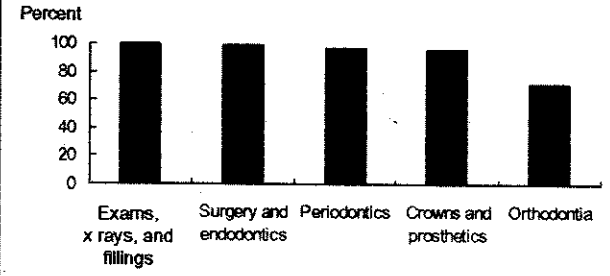
Another option for self-insuring employers is a minimum premium plan (MPP). In an MPP arrangement, employers purchase insurance to cover claim costs above a designated amount. The employer is responsible for costs below the designated limit, and the insurance carrier is responsible for the rest.[12]

In 1995, few dental HMO participants (5 percent) were in self-insured plans. However, 38 percent of dental PPO and 61 percent of dental FFS participants were in self-insured plans.

Commercial insurance companies. Instead of being self-insured, employers may contract with a commercial (for-profit) insurance company to pay claims. The employer pays the insurance company a premium to cover all claim costs and administrative expenses. In 1995, insurance companies were the financial intermediaries for 25 percent of HMO, 17 percent of FFS, and 15 percent of PPO participants.

Blue Cross/Blue Shield. Blue Cross/Blue Shield is a network of nonprofit insurers. Although many plans use the Blue Cross/Blue Shield name, each network member usually operates independently in a specific geographic area. In 1995, Blue Cross/Blue Shield was the financial intermediary for 18 percent of PPO, 11 percent of HMO, and 6 percent of FFS dental plan participants.

Chart 2. Percent of full-time employees with dental care benefits by type of procedures covered, medium and large private establishments, 1995



Other. Independent organizations other than Blue Cross/Blue Shield and commercial insurance companies also serve as financial intermediaries. As the tabulation shows, other independent organizations were the financial intermediaries for 57 percent of dental HMO, 28 percent of PPO, and 15 percent of FFS participants.

Covered services

Most dental plans cover preventive and restorative services. Preventive services include routine exams and x rays. Restorative services include fillings, dental surgery, endodontics (root canal therapy), periodontics (treatment of gum disease), crowns, and prosthetics (replacement of missing teeth with bridgework or dentures).

Chart 2 shows that in 1995 all full-time employees participating in a dental care plan had coverage for exams, x rays, and fillings. Virtually all had coverage for surgery and endodontics (99 percent), periodontics (97 percent), and crowns and prosthetics (96 percent). Orthodontia (correction of malpositioned teeth) coverage was available to fewer participants (71 percent).[13]

Reimbursement

Plan reimbursement for dental expenses is most often based on a proportion of the usual, reasonable, and customary charge for a procedure. Participants who were subject to this reimbursement method ranged from 77 percent of those with coverage for exams to 85 percent of those with orthodontia coverage. (See table 1.) The proportion of charges paid varied by type of procedure. Less costly procedures such as exams and x rays were more likely to be reimbursed at 100 percent.[14] Fillings, surgery, endodontics, and periodontics were more apt to be covered at 80 percent. The most expensive procedures—crowns, prosthetics, and orthodontia—were more often covered at 50 percent. (See table 2.)

Only small proportions of workers were in plans that covered a procedure in full without requiring a deductible or specifying a limitation on the maximum dollar amounts to be paid. As table 1 shows, coverage in full was more common for less costly exams and x rays and almost non-

Table 1. Reimbursement method by type of dental procedure, full-time employees, medium and large private establishments, 1995

Reimbursement method[1]	Dental procedure								
	Exams	X-rays	Fillings	Surgery	Endodontics	Periodontics	Crowns	Prosthetics	Orthodontia
Total participants	100	100	100	100	100	100	100	100	100
Percent of usual, customary, and reasonable charge	77	79	80	81	81	81	83	83	85
Covered in full[2]	14	14	8	5	4	4	3	3	2
Scheduled cash allowance	6	6	8	8	7	7	8	8	6
Copayment	5	1	3	5	6	5	6	6	12
Other[3]	2	3	3	3	3	3	2	2	2
Not determinable	-	-	([4])	([4])	([4])	2	([4])	1	3

[1] Sum of individual items is greater than total because some participants were in plans with more than one reimbursement method.
[2] Includes plans paying the full cost with no deductible or dollar maximum.
[3] Includes plans providing benefits on an incentive schedule and plans providing discounted benefits.
[4] Less than 0.5 percent.
NOTE: Because of rounding, sums of individual items may not equal total. Dash indicates no employees in this category.

Table 2. Percent of usual, customary, and reasonable charge paid for selected dental procedures, full-time employees, medium and large private establishments, 1995

Percent of usual, customary, and reasonable charge	Dental procedure								
	Exams	X-rays	Fillings	Surgery	Endodontics	Periodontics	Crowns	Prosthetics	Orthodontia
Total participants	100	100	100	100	100	100	100	100	100
Less than 50	-	([1])	([1])	([1])	([1])	([1])	1	1	([1])
50	([1])	1	7	6	8	11	69	75	80
51-59	-	-	-	-	-	-	-	([1])	-
60	1	1	2	3	2	3	10	10	6
61-74	([1])	([1])	3	3	3	3	2	2	1
75	1	1	6	6	6	6	3	3	1
80	21	23	67	65	67	65	9	6	8
85	([1])	1	3	3	3	3	([1])	([1])	-
90	5	7	6	7	6	6	4	1	([1])
91-99	-	-	([1])	([1])	([1])	([1])	-	-	([1])
100[2]	71	64	8	8	6	4	2	1	3
Not determinable	([1])	([1])	([1])	([1])	([1])	([1])	([1])	([1])	([1])

[1] Less than 0.5 percent.
[2] Includes plans that paid 100 percent of charges, but imposed a deductible and limited payment to a maximum dollar amount.

NOTE: Because of rounding, sums of individual items may not equal total. Dash indicates no employees in this category.

existent for more expensive crowns, prosthetics, and orthodontia.

Some participants were in plans with reimbursement based on a schedule of cash allowances. In this type of arrangement, there is a specific maximum dollar amount the plan will pay for each covered procedure. For example, a plan might pay no more than $390 for a complete upper denture even if the usual, customary, and reasonable charge is substantially higher.

Other participants were in plans requiring a copayment, after which benefits would be paid in full. Copayments of $5 to $10 often apply to preventive care, with higher copayments for more costly procedures.

Few participants (2-3 percent, depending on the procedure) were in plans with "other" forms of reimbursement. This "other" category includes plans with discounted benefits available from approved providers and incentive plans which encourage participants to visit the dentist regularly for preventive and maintenance (minor restorative) care in order to reduce the incidence of more serious and costly dental problems. For example, an incentive plan might have an initial coinsurance rate of 60 percent for preventive and maintenance procedures. If the participant obtains the required level of care during the year, the coinsur-

Chart 3. Percent of dental plan participants with annual nonorthodontia benefit maximums, full-time employees, medium and large private establishments, 1995

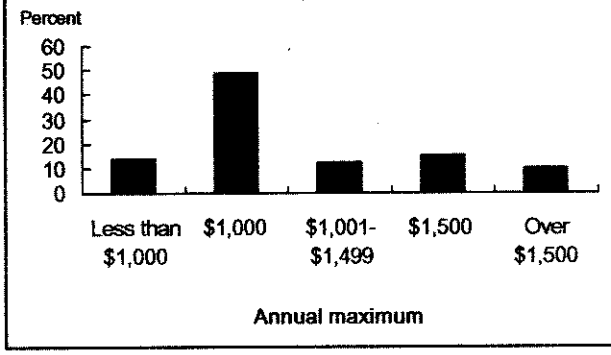
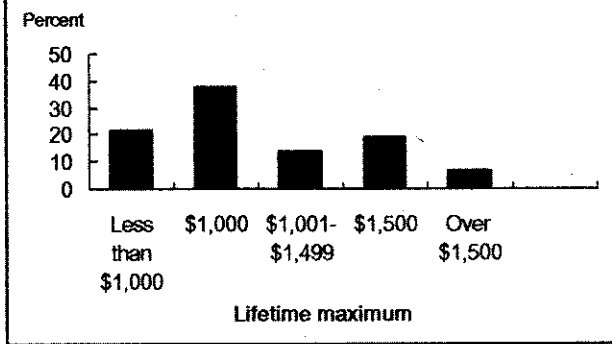


Chart 4. Percent of dental plan participants with life-time orthodontia benefit maximums, full-time employees, medium and large private establishments, 1995



ance increases to 70 percent the following year, 80 percent the next year, and 90 percent the year after. If the participant fails to obtain the required level of care, the coinsurance rate would revert back to the original 60 percent.[15]

Deductibles. FFS and PPO plans often require participants to meet a specified deductible before benefits will be paid. A majority of participants (61 percent) were in plans that required a yearly deductible, averaging $46. Among participants with annual deductibles, 65 percent were subject to a $50 deductible, 24 percent to a $25 deductible, and 8 percent to deductibles over $50. Few dental care participants (1 percent) were in plans with a lifetime deductible or both a yearly and a lifetime deductible (3 percent).[16]

Procedures subject to a deductible differed among plans. Of the participants with a deductible, 20 percent were in plans that required a deductible for all covered procedures. The greatest proportion (46 percent) were in plans that required a deductible for all procedures except exams and x rays, and 24 percent were in plans requiring a deductible for all procedures except exams, x rays, and orthodontia.[17]

Maximum benefit provisions

Most dental plans included a calendar year plan maximum applicable to nonorthodontic expenses. Orthodontic expenses were usually subject to a separate lifetime maximum.

Dental plans with an annual benefit limit for nonorthodontic care covered 82 percent of plan participants. Among participants with limits, the average limit was $1,166. Almost half (49 percent) of these participants had a benefit maximum of $1,000, 15 percent had a maximum of $1,500, 14 percent had maximums less than $1,000, and 10 percent had maximums over $1,500. (See chart 3.)

Most participants with orthodontia benefits (83 percent) had lifetime benefit maximums. Among participants with limits, the average was $1,138. The greatest proportion (38 percent) had a $1,000 limit, 19 percent had a $1,500 limit, 22 percent had limits of less than $1,000, and 7 percent had limits over $1,500. (See chart 4.)

Pretreatment authorization

Almost half (49 percent) of employees with dental coverage were in plans requiring pretreatment authorization. This means that if a procedure is expected to exceed a certain cost, it must be approved by the dental claims administrator before reimbursement will be made. For participants in plans with this feature, the average minimum expense requiring preauthorization was $225. Thirty-eight percent had preauthorization levels of more than $200, 26 percent had a level of $200, and 16 percent had levels of $100.[18]

Voluntary coverage

Data from the Employee Benefits Survey show that participation in employer-provided dental plans has declined in recent years. From the information collected, however, it cannot be determined if the decline occurred because employers stopped offering dental care coverage, employees chose to be covered under another family member's plan, or employees dropped coverage because of increases in cost-sharing requirements.

A study by the Life Insurance Marketing Research Association found that 56 percent of employees without dental insurance rank it, after medical care coverage, as the most desired benefit. Some employers have sought to balance their need to control health care spending with employees' demand for dental coverage by providing voluntary dental coverage. Under a voluntary plan, employers offer dental coverage at less costly group rates, but employees pay the entire cost of the coverage. Offering voluntary dental plans may increase employee satisfaction with benefits coverage and allow employers to maintain or enhance benefit offerings without incurring additional costs.[19]

—ENDNOTES—

[1] It should be noted that a small part of the apparent decline in dental care coverage stems from the 1988 Employee Benefits Survey expansion to include all service industries. Dental care coverage has traditionally been more prevalent in goods-producing rather than service-producing industries. For more information, see *Employee Benefits in Medium and Large Firms, 1988*, Bulletin 2326, Bureau of Labor Statistics, 1989.

[2] For example, multivariate analysis of Current Population Survey data found that growth in the employee share of coverage costs was responsible for 76.4 percent of the decline in participation in employer-sponsored health care coverage between 1989 and 1996. For more information, see AFL-CIO, *Paying More and Losing Ground: How Employer Cost-shifting is Eroding Health Coverage of Working Families*, Washington, DC, AFL-CIO, 1998.

[3] Data on employee contributions for dental care were first available in the 1988 survey. For more information, see *Employee Benefits in Medium and Large Private Establishments, 1993*, Bulletin 2456, Bureau of Labor Statistics, 1994; and *Employee Benefits in Medium and Large Firms, 1988*.

[4] The remaining 1 percent was in other types of plans such as exclusive provider organizations. Like PPO's, these organizations contract with providers to furnish services at a discount in exchange for increased patient volume. Unlike PPO's, however, participants receive no reimbursement if they are treated by a non-network provider.

[5] For more information, see *Employee Benefits in Medium and Large Private Establishments, 1995*, Bulletin 2496, Bureau of Labor Statistics, 1998; and Rita S. Jain, "Employer-sponsored Dental Insurance Eases the Pain," *Monthly Labor Review*, October 1988, pp. 18-23.

[6] For more information on dental HMO's, see Christopher Brown, "Dental Benefits: Setting Objectives, Picking A Plan," *Employee Benefit Plan Review*, March 1995, pp. 30, 32-33.

[7] A PPO is a type of fee-for-service plan in that the provider does not get reimbursed until a service is performed.

[8] The Bureau of Labor Statistics discontinued publication of information on employee dental care costs and extent of cost sharing after the 1994 surveys of small private establishments and State and local governments.

[9] These figures are based on all benefit structures—employer paid (wholly or in part), entirely employee paid (voluntary coverage), individual direct paid, etc. For more information, see National Association of Dental Plans, *1996 Census and Directory*, Dallas, TX: National Association of Dental Plans, 1997.

[10] For more information on changes in funding arrangements during the 1980-86 period, see Jain, "Employer-sponsored Dental Insurance," pp. 18-23.

[11] For more information, see *Employee Benefits in Medium and Large Private Establishments, 1995*.

[12] *Ibid.*

[13] When orthodontia coverage is available, it is usually limited to dependent children.

[14] Some plans paying 100 percent of charges may impose a deductible and limit payment to a maximum dollar amount.

[15] For more information on incentive plans, see Ronald L. Huling, "Dental Plan Design," in Jerry S. Rosenbloom, ed., *The Handbook of Employee Benefits—Design, Funding, and Administration (Fourth Edition)* New York: McGraw-Hill, 1996, pp. 199-215.

[16] For more information, see *Employee Benefits in Medium and Large Private Establishments, 1995*.

[17] The remaining participants were in plans applying the deductible to all categories except orthodontia (3 percent), all categories except exams and orthodontia (1 percent), and other category combinations (6 percent). For more information, see *Employee Benefits in Medium and Large Private Establishments, 1995*.

[18] Ten percent had levels between $101 and $199. For the remaining participants subject to pretreatment authorization, the dollar amount could not be determined. For more information, see *Employee Benefits in Medium and Large Private Establishments, 1995*.

[19] The Employee Benefits Survey only collects dental benefits information on plans that are either fully or partially paid for by the employer. For this reason, it cannot be determined how much of the decline in participation is due to employee coverage under voluntary dental plans. For more information on voluntary plans, see Alain Sherter, "Voluntary Dental Plans Offer Employers Affordable Solution to Employee's Dental Care Needs," *Employee Benefit Plan Review*, January 1997, pp. 27-29.