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Some Thoughts on Dropping PPO Plans: No one knows or cares more about your practice than you. We recommend that you take the time to analyze each plan and its reimbursement levels. A key point to remember is that the reduction in the reimbursement level has a disproportionately large impact on the bottom line. In an extreme, but simple to understand example, a practice with 60% overhead that is forced to write off 20% of its fees will see a 50% drop in profitability. If the reimbursement falls to 40%, then profit disappears altogether. The goal, of course, is to generate enough new patients by going in-network, that it will overwhelm the severe hit to practice profits.

Dropping a Plan: The ideal plan to drop is the one with the lowest reimbursement level (e.g., MetLife or Anthem). If you have few patients that participate then it will be easier to muster the courage to drop the plan. Follow the contract provisions when it comes to cancelling the agreement. You will likely have to give 90 days advanced written notice. Follow this up with phone calls to be sure they get the message. Expect phone calls back from the insurance company asking you to reconsider and possibly even an offer to raise the reimbursements. Hold firm with your decision to cancel. The cancellation notice will also take care of terminating the subsidiary agreements with all the other insurers with whom the primary company negotiated side arrangements. Then prepare to have the insurer mess up the termination by continuing to list your practice as a network provider, for some temporary period. Also, expect to have problems with claims in process for a few weeks after the termination.

Communicating with Patients: We hear mixed opinions on how and when to tell patients that you are dropping out of their network. We like the idea of not drawing undue attention to the change and informing the patients when they come in for their next recall appointment. You can offer them a reduced co-pay as if they were still in network as a show of good faith.

One dentist friend, however, took a different approach. He went out of network with multiple carriers, including Anthem, which alone affected 1,200 patients. He and his wife (the business manager) determined that in their community dental insurance is ubiquitous. Patients tend to go to dentists who are in-network. They anticipated a big loss of patients if they were to drop out-of-network and not

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offer an attractive alternative.

They sent a letter to each Anthem patient explaining that the practice was going out of network, but that they remained valued patients. The letter blamed the insurance company for continuing to charge big premiums but also continuing to lower reimbursements. They then offered the patients two alternatives to traditional dental insurance - (1) an **in-house dental benefit plan** (sometimes called a membership plan) for patients who likewise drop their Anthem insurance, and (2) a **"hybrid" dental plan** which offers a modest discount to patients who decide to keep their dental insurance.

In-House Dental Membership Plans: With a membership plan, the patient pays an up-front annual fee and then qualifies for discounts on hygiene and dental services. This is offered to all practice patients who don't have dental insurance. Some of these patients won't join the membership plan and will remain fee for service. Others, who have had dental insurance at some point but dropped it, may find the membership plan to be a nice replacement. This is not traditional insurance, in that there are no insurance forms to file, and patients pay in full at the time of service. It offers patients a compelling alternative when the practice decides to drop a PPO and go out of network.

A typical plan might cost $300 per patient each year (more for additional family members) offer two free hygiene appointments each year and 10%-20% discounts on restorative and cosmetic treatment. If the patients are paying their annual membership payments up-front there is also a greater likelihood that they will come in on a more routine basis.

Another benefit the membership plan can offer patients is fee discounts with specialists to whom the practice refers. Consider entering into "affiliate agreements" with specialists in town. Patients enrolled in the membership gain access to the specialists and get the benefit of the reduced fees. A specialist may be tickled pink to accept a 15% fee reduction, not have to file insurance forms and be paid up front. The alternative would be seeing the patient in network and taking a 30% fee reduction -- or not getting the referral at all. We do not believe that such an affiliation constitutes an illegal fee splitting arrangement.

If you are interested in looking into adopting an in-house dental benefit plan, you can contact our office and we can provide you with a sample template. This can be a starting point for creating a plan that might work well in your practice.

Is membership plan insurance that is regulated by your home state? This is a gray area. If you decide to come up with a membership plan, contact your state dental association and/or a health care attorney in your home state. They should be familiar with your state's requirements.

"Hybrid" Dental Plan for Patients Who Keep Their PPO Insurance: If you notify patients that you are dropping their plan but will see them out of network, consider this as an alternative. If the patient keeps the dental insurance, he or she cannot participate in the in-house plan. However, the practice will give these patients a discount **only on the portion of the out-of-network fee that the insurance won't cover**, for example 25% off of the patient's residual co-pay.

If, for instance, a procedure's fee is $100, and if the practice is in-network, the discount may be 40%. The practice will collect only $60, and this might be allocated equally between the insurance company and the patient, with each one paying $30. Under the "hybrid" scenario, the practice is out-of-network and will charge $100. In this case, the out-of-network payment may be $40, leaving a $60 co-pay for the patient. If the co-pay is reduced by 25% to $45, the patient is paying only slightly more, and the practice still collects 85% of its fee, not 60%. The goal is to give the patient comfort that their out-of-pocket expense will be close to what it was before, but the practice will still be able to collect most of its full fee.

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Some Concluding Thoughts: If you offer one or both of these alternatives, your patient discounts (which should always be called "courtesy fee reductions") will be based on your current fee schedule. Keep up to date with the fees being charged in your community. Your equipment vendor can give you a questionnaire and can tell you where your fees rate within your community. If they are low, then raise them up to be in line with the quality of care you provide within the community. If your quality is in the top 80%-90%, then your fees should be there too. Patients do not leave the practice in this situation, and if you are offering courtesy fee reductions, then your starting point should be appropriately high.

Political Action Against Managed Care: We are delighted to see that dentists, if not organized dentistry, are mobilizing to thwart the dental insurance companies. In particular, U.S. Congressman Paul Gosar (a dentist) has introduced legislation ("H.R. 494, The Competitive Health Insurance Reform Act of 2015") which would amend the McCarran-Ferguson Act of 1945 and make health and dental insurance companies (including Delta) subject to federal anti-trust laws. This will create a more competitive marketplace, prevent collusion, lower insurance premiums and increase dental benefits. The bill still sits in committee and needs support to get it to a vote in the House and Senate as a stand-alone bill.

You can go to www.supporthr494.org to watch a short video on the bill and sign the petition, electronically, to move the bill towards a vote. Share the link with your staff and colleagues and encourage them to sign it as well.

Encourage Your State's Dental Association to Get Your State to Enact a "De Minimis" Law: Most every state has by now passed legislation prohibiting insurance companies from mandating reduced fees on procedures that they were not covering. The insurance industry is starting to get around these laws by covering these procedures only minimally, say 5% or 10%, so that they can once again force the write-offs. The "de minimis" law will require the insurance company to cover a substantial portion of the procedure before they can claim it's a covered service and force a write-off. This is an important amendment to the non-covered services legislation that has already been enacted.

Purchase Supplies Only from a Reputable Dealer: At our seminars we will occasionally hear dentists brag that they are able to buy clinical supplies at deep discounts by purchasing from lesser-known dealers. We caution against this. It is natural for the doctor or the staff who is responsible for ordering supplies to seek out discounts. However, there is a growing incidence of "gray market" sales of dental supplies, and the quality of these materials is suspect.

The term gray market means the sale of goods outside of the normal distribution chain and at lower costs. In the case of dental supplies, the original manufacturer sells its products to dealers who then sell to the dentist. The manufacturer earns more money on the sale to U.S. distributors and earns less on the sale to foreign dealers, and much less when the products go to poor countries. The foreign dealers buy at deep discounts and if they order too much, they will sell the over-supply to lesser known gray market dealers in the U.S. They turn around and sell to U.S. dentists at much lower prices than what the dentist would pay to the legitimate dealers like Henry Schein, Patterson or Benco.

The gray market products are not counterfeit. The problem is that when they are sold outside of the normal distribution chain, you won't know if they have expired (the expiration dates can be changed) or whether they have been stored correctly and not exposed to excessive heat or humidity. Do not buy from these dealers. You won't know that you used a defective product until after the patient complains. If the prices look to good to be true, that should be a dead giveaway. Only buy from reputable dealers. In the grand scheme of things, the savings are minor compared to the importance of preserving your good reputation.

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The Next Time You Go to the Hospital for a Procedure, Ask How Much it Will Cost if You Pay in Cash and Don't Use Your Insurance: The February 15th issue of the Wall Street Journal contained an interesting story titled, "How to Cut Your Health Care Bill - Pay Cash." Since the passage of Obamacare, tax-exempt hospitals can no longer price gouge uninsured patients. They must charge prices that roughly track the Medicare rates. This concept has spread to other hospitals, imaging centers, outpatient surgery centers and pharmacies, which now offer rates to uninsured patients that are far lower than what the insurance companies have negotiated for their policy holders. For example, the article stated that a Colorado patient was charged $600 for a knee X-ray if she paid under her high deductible insurance policy or $70 if she paid cash and didn't submit it under the insurance.

This is a bizarre turn of events, but it's worth inquiring about. If you have traditional non-high deductible insurance and only have a modest co-pay, then that will likely be your best option. But, if you have a high deductible policy and would be paying a large amount out-of-pocket in any case, then you may be better off paying cash and not putting it on your insurance. That would be a mistake, however, if you know you will be spending a lot of money in a given year (e.g., X-rays, MRIs and surgery) and want to meet your deductible so the insurance starts paying.

Robo Advisors Charging 0.3% to Manage a Portfolio Offer a Relative Bargain Compared to the Human Advisor Who Charges 1%: Robo-advisors are SEC regulated financial advisors that dispense with the human intervention. You will complete a survey and the robo-advisor will construct a portfolio based on your financial situation and tolerance for volatility. The investments are typically made in low-cost stock and bond index funds. Thus, the overall fees will be modest. The investment returns will likely beat the advisor charging roughly 1% of the portfolio and will do even better compared to such an advisor who puts the client's money in actively managed funds which themselves have high annual expenses.

The robo-advisors are limited to portfolio selection and management. They do not offer the other services of a good financial consultant like planning for retirement and cash flow management. But, as the investing public comes to better understand the financial impact of advisory fees that are based on a percentage of a client's portfolio, companies like Betterment, Wealthfront and Schwab Intelligent Portfolios will see much greater demand for their services.

Allocating Ownership Profits in an Orthodontic Practice: The orthodontic specialty is unique in dentistry in that a partner's "production" is difficult to measure where the doctors are all treating the same patients. If the partners can agree that a day worked by one partner is as valuable as a day worked by the others, then the partnership documents will often define production based on relative days worked. If one partner works 200 days and the other works 180, then the profit (salaries plus fringe benefits) will be allocated 52.6% to 47.4%.

However, if a day worked by one partner is significantly more valuable to the practice than a day worked by another partner, then a different formula could be used. For example, the formula might allocate profit as follows: 50% based on the number of patient appointments during the year, 30% based on the number of new patient starts for which a partner is responsible, and 20% based on relative practice ownership.

This is an over-simplification of the issue as it ignores potentially other mitigating factors. For example, the less productive partner might be more involved in business management for which he or she is not being compensated, or is stuck with a less productive treatment coordinator. However, the fundamental point here is that if the over-producing partner feels that he or she is being underpaid, then that, by definition, means there is a problem that must be addressed for the long-term health of the partnership.

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