6 STEPS TO SUCCESSFULLY DROPPING YOUR FAVORITE PPO

MEMBER ARTICLE |
BY NICOLE HARTSHORN, FAADOM

MEMBER FEATURE
PEER-TO-PEER ARTICLE

You have been on hold with Insurance Company X for 56 minutes and counting. You've used their portal to get basic benefit information; you still have questions that their "Convenient Self-Serve Options" didn't answer. After over an hour on hold, you finally got the information you needed.

We have all seen how this story plays out; hours of staff time invested, combined with low reimbursements, makes you question your profitability and network status. Could it be time to pull the trigger and go out of network? Can this be done successfully? I work in a large group practice, and we wondered the same thing. Here are our top six tips to successfully drop your PPOs.

#1: RESEARCH! RESEARCH! RESEARCH!

I encourage you to do lots of research. One huge deciding factor for us was that Insurance Company X would pay out of network benefits to THEIR patients. With this knowledge we were able to formulate a plan on how we would move forward financially without being the middleman for this insurance. For us, this meant collecting up front and supplying the patient documentation to file their own claims. In our abundance of research, we also found out that Insurance Company X makes it quite easy for their members to file claims on their own portal! At least they're making it easy for someone!

We spent a great deal of time pulling reports and figuring out who our target audience was, since we wanted to notify anyone who currently or even recently had this insurance. Our team also spot-checked these policies to see if they were calendar year plans or fiscal year plans (more on why this is important later). We researched what the average premiums were for Insurance Company X and had a dedicated team member (myself) available to discuss if our in-house plans were more financially feasible for our families than paying insurance premiums with a company who has become increasingly difficult to work with.

#2 COMMUNICATION!

Get a letter or communication out to your patients before Insurance Company X does. I've read several articles and various social media posts about whether or not to send correspondence to patients. I don't have the big-ticket answer for you other than, "No one knows what's best for your patients better than you!" We felt that we needed to reach out to our patients in a variety of ways via mail, email, and phone calls.

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We wrote an amazing letter that went through about seven different drafts before we felt it was as perfect as it was ever going to be. We chose to snail mail it to all the patients who were on the list mentioned above. Knowing that the insurance company was going to send a letter to our patients telling them to seek an in-network provider was the biggest reason we wanted to get out ahead of their letter. It was important to us to tell our patients in plain language that they did NOT need to find another provider. We did not want Insurance Company X to bully our patients into transferring to another provider.

Two weeks after that mailing, we reached out via phone to every family on that list. Yes, this was time-consuming, but 100% worth the effort! When speaking with our families, we were pleasantly surprised to find out they knew that their insurance company had been exceedingly difficult to deal with, and supported this change! During that two-week gap between mailing letters and calling patients, we prepped our phone teams with various trainings and resources they might need when making these calls. More on that later.

#3 TIMING IS EVERYTHING!

Isn't this the case with everything in our lives? Remember above when I mentioned researching if these plans renew on calendar year versus fiscal year? This was key in deciding when to pull the trigger. We found most of our patients were on a calendar year plan. This led us to want to get as much exposure to this change BEFORE OPEN ENROLLMENT, which we know takes place late fall. We know that most of our employer groups of Insurance Company X offered other options to their employees (back to that research thing again). We wanted to get our letter out and allow time for families to schedule their second recall date of the year before our contract termination date. We wanted our termination date to fall close to open enrollment time so that it would be fresh in our patient's mind.

#4 TRAINING!

We provided our team with lots of script and scenario training. They received a flowchart with the best ways to respond to an assortment of questions. We had multiple Q & A sessions with our team members to give them all the resources they would need to answer our patients' questions confidently, effectively and honestly. We knew that we needed our team's buy-in and comfort for this to be successful. These are difficult conversations, and making sure our team was comfortable telling a patient why they do not have to leave our practice was key!

#5 NOW WHAT?

Our contract termination date has arrived; we have patients with Insurance Company X on the schedule, so it's time to see if our prep work was successful. We preloaded the original letter into our practice management system in order to email it out to our families as a friendly reminder of what to expect when they come into our office. We sent this out a day or two ahead of their appointment.

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MEET THE MEMBER

Nicole Hartshorn, FAADOM, has served in the dental field since 2002. She has experience in orthodontic, periodontic and pedodontic practices. She is currently a regional manager with a large group pedo practice in the Denver Metro area. Nicole started her career as a dental assistant and has worked in most areas of the practice including her current role as office manager. She enjoys facilitating the orthodontic side of the practice. As a Colorado native she enjoys the beauty that the Denver area offers her family throughout the year.

Nicole has been an AADOM member since 2016 and is the president of AADOM's Denver Colorado Chapter. She earned her AADOM Fellowship designation in 2018, and is on track to be inducted as an AADOM Master (MAADOM) at AADOM's conference this September.

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As we moved forward full speed ahead, OUT OF NETWORK, we found patients were compassionate, accepting, and ready to pay OUR FEES at time of service! As open enrollment season came and went, most of our patients returned with new and improved insurance, or better yet, are now cash-paying patients of our in-house system.

Why did we not do this sooner?!?!

#6 WOULD WE HAVE DONE ANYTHING DIFFERENTLY?

Yes! Something small. One afternoon a patient who had been with our practice for a long time called our office with their new insurance for the year. They had always had Dental Insurance D2 before, in all the years they had been with us. Now their employer had switched to Insurance Company X. UGH! This was one scenario I had not thought of ahead of time. Looking back, I wish I had put a little blurb in our quarterly newsletter for one or two cycles notifying ALL PATIENTS of this change.

Overall, of the 20% of our patient base who carried Insurance Company X, we did lose approximately 2%. Losing 2% to get our full-service fees back on the other 18% = success in my book! We have even had patients who left, found the grass wasn't greener elsewhere and returned to our office! WIN!

Hopefully these tips have been helpful. If you would like more information on flowcharts, letter templates, or have any other questions, comments or feedback, please reach out to me at aadomdenver@gmail.com. ■