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CLERRI PLAYBOOK

How to reduce PPO dependence without losing patients or production

A six-step playbook for reviewing your payer mix, renegotiating or exiting plans that no longer work, and keeping patients with your practice through the change.

Dental membership plans are not insurance.

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This guide draws on the experience of practices that have made this transition and on published industry research. Every external figure is sourced in the footnote on the page where it appears.

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✦ THE CASE FOR A REVIEW

Why practices are rethinking payer mix

Dental insurance helps many patients get care. It was never built to carry a modern practice. Reimbursement has not kept pace with the cost of running an office, and the administrative load keeps growing. That pressure lands on teams who are already working hard to deliver good care.

55.3%
of dentists named insurance issues, including low reimbursement and denials, their single biggest challenge for 2026, ahead of staffing and overhead

22.2%
had already dropped out of some insurance networks by the first quarter of 2026

6%
rise in dental equipment and supply prices in the 12 months to February 2026, against 2% general inflation

The squeeze is measurable. Indexed to January 2016, dental provider reimbursement stood at 131 in February 2026 while general inflation reached 138. Reimbursement is not keeping pace with the cost of doing business, , and ADA Health Policy Institute data shows dental reimbursement trailing general inflation.

Most practices still participate in insurance because their patients rely on it, and that is a reasonable choice. The question is no longer whether to accept plans. It is which plans, on what terms, and what you offer patients who have no benefits at all.

That is why practices are taking a closer look at their payer mix. By optimizing participation and building an alternative for cash and uninsured patients, they protect access to care while strengthening the business behind it. You do not have to overhaul everything at once. You can take one strategic step toward a more sustainable model.

Payer mix is a decision you make, not a condition you inherit. Reviewing it once a year is ordinary business practice.

ADA Health Policy Institute, The State of the U.S. Dental Economy, 4th Quarter 2025 Update and 1st Quarter 2026 Update (Economic Outlook and Emerging Issues in Dentistry Poll, n=796; BLS PPI, CES and CPI data).

SECTION 01

When care is in your control, growth happens

When you control the terms of care, the day runs differently. Patients get a price before treatment instead of an estimate after it. Your team spends less time chasing claims and prior approvals. The schedule fills with work you chose to do.

Figures are illustrative and not a guarantee of results.

STEP 1

Face your fears

Many dental teams feel stuck. They know certain plans are no longer serving the practice, but they worry about what happens if they change anything. What if patients leave? What if production drops? What if the risk outweighs the reward?

Those concerns are common and completely valid. Often the fear of disruption is exactly what keeps things the same. Maybe most practices in your area accept the plan. Maybe a large local employer offers it. Maybe some of your most loyal patients are on it. Stepping back feels harder with every one of those facts.

But without understanding what each plan is worth to you, it is impossible to move with clarity. And the margin of error is usually wider than teams expect, because a discounted patient is not worth the same as a full-fee patient. Run the arithmetic on your own fee schedule. It looks something like this.

Illustrative comparison	In network	Out of network
Production at your full fee	$1,000	$1,000
Contracted write-off, shown here at 35%	$350	$0
Collected	$650	$1,000
Patients needed to collect $65,000	100	65

In this example you could lose roughly a third of that plan's patients and still collect the same money, while working fewer hours and handling fewer claims. The real number depends entirely on your contracted write-off, so pull your own fee schedule and replace 35% with your figure before you draw any conclusion.

> **Do this arithmetic before you make any decision. Most teams find the number of patients they can afford to lose is larger than they assumed.**

The table is illustrative arithmetic using a hypothetical write-off, not an industry average. Figures are illustrative and not a guarantee of results.

STEP 2

Implement a dental membership plan

Before you renegotiate or drop anything, put a membership plan in place. It gives patients a way to keep receiving care at your practice, it serves the cash and uninsured patients you already treat, and it generates recurring revenue that steadies the practice while your payer mix changes.

You are in control of the plan. You set the pricing, the benefits, and the structure. Payments go directly into your own merchant account. Patients typically pay around $30 a month, or $360 a year, for their preventive care, and save between 10% and 25% on other treatment, with a 5% to 10% family discount. There are no deductibles, no waiting periods, and no annual maximums, and benefits start the day a patient joins.

48%
of Americans say they are interested in subscription-based health care

27%
of US adults, about 72 million people, have no dental insurance at all

18%
of adults went without dental care in 2025 because they could not afford it, making dental the most skipped form of care

That is the market sitting in your own patient database. People want predictable monthly pricing and they want to know the number before they sit in the chair. A membership plan gives them exactly that, and it gives your team something concrete to offer instead of an apology.

Build the alternative first. Every later step in this playbook is easier when patients have somewhere to go.

Subscription interest: Tebra, survey of 1,000 US adults fielded February 5, 2025. Uninsured adults: CareQuest Institute for Oral Health, State of Oral Health Equity in America survey, fielded March to May 2024, released May 2025. Skipped care: Federal Reserve Board, Report on the Economic Well-Being of U.S. Households in 2025, May 2026. Dental membership plans are not insurance.

✦ STEP 2 CONTINUED

What a membership plan does to your numbers

By making it easier for patients to commit to the care they need, practices create a membership effect. Loyalty rises, visits rise, treatment acceptance rises, and production follows.

76%
more visits after patients join a plan

146%
more procedures

172%
more cash production

That works out to roughly $807 more production per member per year. Clerri customer data also shows membership patients making two to three times more hygiene re-appointments and generating twice the production of cash-pay patients. And unlike claims revenue, subscription payments arrive on a schedule you can plan around.

Practice	Members	Year-over-year result
Peter K. Cocolis DDS	1,818	+119% cash collections
7 to 7 Dental	1,275	+85% production
Covington Family Dental	167	+84% procedures
Arbor Dental Group	471	+78% cash collections

Clerri first-party and customer data. Named practice results are year-over-year change, 2023 to 2024, provided by the practices and illustrative of individual results. Figures are illustrative and not a guarantee of results.

✦ STEP 2 CONTINUED

Set your plan up for success

A membership plan succeeds on design and follow-through, not on enthusiasm. These are the practices that separate plans that grow from plans that stall.

- Provide comprehensive care. Include preventive treatment, usually two cleanings, two exams, and routine X-rays each year, plus discounts on additional treatment.
- Price it right and publish the price. Transparent pricing builds trust. Balance patient value against practice results.
- Stay compliant. Plans must follow state and federal rules, including HIPAA, state licensure where it is required, consumer protection law, and payment processing standards.
- Make it simple to join. Patients should be able to sign up from any device in a couple of minutes.
- Make it easy to pay. Offer monthly, annual, or both. Most patients want the monthly option.
- Make it immediate. Benefits begin the moment a patient signs up.
- Make it hassle free. No sign-up fees, no deductibles, no waiting periods, no annual maximums, no pre-approvals.
- Assign a plan champion. One person owns enrollment and tracking.
- Get the whole team on board, doctors included. Everyone should be able to explain the plan in one sentence.
- Offer it to everyone. Do not pick and choose who hears about it.
- Set goals and track them. Pick a weekly enrollment target from the cash-pay patients you already see, and review it every month.
- Promote it. In the office, on your website, in email, and on social.

What to look for in a platform: enrollment in about 30 seconds from the schedule view, membership activity, payments and balances written back to your practice management system automatically, and state licensure handled for you. Clerri Bridge connects to the practice management system itself, so your PMS stays the source of truth.

Clerri holds DMPO licensure in all 36 states that require it, builds plans to applicable law in all 50 states, and is Knox-Keene compliant in California.

✦ STEP 3

Analyze your PPOs

Now understand what each plan is actually worth and what dropping it would do to your results. This step is an inventory and some math. Document the following for every plan you participate in.

What to document	Where it comes from
Participating doctors	Your signed agreement
Current fee schedule	Payer portal or your carrier representative
Plan patients seen in the last 12 months	Practice management report
Net production from those patients	Practice management report
Net production per patient	Net production divided by plan patients
Treatment frequency by procedure code	Practice management report
Termination terms and notice period	Your signed agreement

Read the numbers

Calculate the weighted average discount for each plan, then set it against the patient count and the net production tied to it. A plan with a deep write-off and few patients is a very different decision from a plan with a moderate write-off and 900 patients. Rank them, and you will see which to keep, which to renegotiate, and which no longer fit.

Check the termination language while you are in the agreement. Many contracts require written notice, often 90 days, but terms vary by carrier, so read your own before you plan any exit date.

Most practices want a second set of eyes here. Clerri customers get a dedicated success manager and growth-specialist plan reviews to work through the numbers with them.

Verify all contract terms in your own signed agreement. This guide is informational and does not constitute legal advice.

STEP 4

Renegotiate or drop PPOs

Now renegotiate the plans that can work for your practice and set exit dates for the ones that cannot. A few ways to build a strong case.

- Focus on high-impact codes. Identify 10 to 15 of your most valuable procedure codes, either the ones you perform most or the ones with the highest fees, and make those the basis of your proposal.
- Build a fair and competitive fee schedule. Propose rates that reflect both your production and the realities of your market.
- Highlight what makes your practice stand out. Strong retention? A large share of that payer's local members? Show them where you deliver value.
- Know your leverage. Only mention termination if you are prepared to follow through. Being genuinely ready to walk away is what makes the conversation different.

Send the proposal to the plan administrator to open negotiations. For the plans you intend to drop, set an exit date and give written notice inside the window your agreement specifies.

Do not rush. Negotiate and drop one plan at a time, starting with the ones that have the fewest patients or the lowest reimbursement. You will learn from the first attempts, and your team will build the confidence to take on the plans with more patients and larger financial stakes.

35.0%

of dentists planned to drop out of some insurance networks in 2026, so this is a conversation carriers are already having

ADA Health Policy Institute, Economic Outlook and Emerging Issues in Dentistry Poll, Q4 2025 and Q1 2026 (n=796).

STEP 5

Support patients through the transition

How you handle the change with patients matters as much as the change itself. Clear, early communication builds trust and keeps people connected to your care. Three things need to happen: identify who is affected, tell them well, and help them with reimbursement afterward.

Identify the patients affected

Run a report from your practice management system listing every patient covered by each plan you are leaving. Include name, plan, last visit, next scheduled visit, email, and phone. That list is your working document for the entire transition.

Communicate with care

Avoid impersonal letters where you can. A phone call, or a conversation at the chair during a visit, is far more effective. It lets your team answer questions, offer reassurance, and introduce your membership plan as a way for the patient to stay with you.

01 **Start about six months before your exit date.**

02 **Send a reminder email around 90 days out, and again at 30 days.**

03 **Follow up with calls or in-person conversations wherever possible.**

04 **Track every conversation on your affected-patient list so nobody is missed.**

Patients rarely leave over the change itself. They leave when they hear about it late, or from a form letter.

Dental membership plans are not insurance.

What to say when you tell patients

- Lead with your why. This change is about delivering better care with fewer restrictions: more time with patients, fewer administrative delays, less interference in clinical decisions.
- Reassure them they can still see you. Going out of network does not mean turning anyone away. Your team still provides the same care. What changes is how payment is handled.
- Explain how payment will work. Payment is due in full at the time of the visit. You accept cash, check, credit card, and HSA.
- Offer help with claims. Tell patients you will submit claim paperwork on their behalf so they can be reimbursed directly, and explain in one sentence how that works.
- Share financing options. For larger treatment plans, remind patients that financing partners like Cherry can spread the cost over time.
- Introduce your membership plan. This is the moment it earns its keep. Give them the monthly price and what it includes, in plain numbers.

Assist patients with reimbursements

Build a process for it before the first exit date. Most practices that successfully move out of network keep submitting claim paperwork for their patients. The process is the same one you use today, submitted on behalf of the patient rather than the practice.

Even done well, you will lose some patients. That is expected, and it is why the last step exists.

Dental membership plans are not insurance. Confirm claim-submission practices against your own agreements and state requirements.

STEP 6

Market to new patients

As plans move out of your practice, some patients will follow their benefits rather than their dentist. Decide how many of them you want to replace, then build a plan to attract them.

- Create a marketing voice that differentiates your practice from every other office in the area.
- Set a target for how many new patients you want, and by when.
- Build a budget against that target.
- Define the audience you actually want, not everyone within five miles.
- Develop the message and the campaigns to carry it.
- Deliver a genuinely superior patient experience, which is still the best marketing there is.

Do not overlook the patients already in your database. Cash and uninsured patients who have been putting off treatment are the fastest source of new production, and you already have their contact details.

Most teams do not have time to build a marketing program from scratch, so Clerri includes the essentials at no extra cost: a plan landing page, brochures and social tools, automated campaigns to reach patients in your database, real-time reporting on how enrollment is trending, and a growth specialist who reviews the plan with you. Every morning, Clerri Bridge also matches diagnosed but unscheduled treatment against the day's schedule, so the opportunity is on the screen before the patient walks in.

> **Backfilling patients is a marketing problem, not an insurance problem. Treat it like one and budget for it before your first exit date.**

Figures are illustrative and not a guarantee of results.

NEXT STEP

Make the transition work for your practice

As you change how your practice participates with insurance, keeping patients connected to your care is the whole game. A membership plan gives them a simple reason to stay, and it re-engages the cash patients you are already treating.

Clerri supports 25,000+ dentists and 200+ dental groups across all 50 states. Bridge connects to your practice management system, works with over 90% of systems in the market, and most practices are live in about two weeks. You keep your existing contracts for as long as you want them.

Clerri LLC, a discount medical plan operator. P.O. Box 163990, Austin, TX 78716-3990. (877) 545-4188. hello@clerri.com. California-consumer plans administered by The CDI Group, Inc.

Book a walkthrough at clerri.com/get-started

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IMPORTANT INFORMATION

Disclosures and sources

Sources

Insurance as top practice challenge (55.3%): ADA Health Policy Institute, "The State of the U.S. Dental Economy, 4th Quarter 2025 Update," Economic Outlook and Emerging Issues in Dentistry Poll.

Network dropout (22.2% already dropped, 35.0% planned): ADA Health Policy Institute, Economic Outlook and Emerging Issues in Dentistry Poll, Q4 2025 and Q1 2026 (n=796), reported in "The State of the U.S. Dental Economy, 1st Quarter 2026 Update."

Supply and wage inflation (6% supplies, 2% wages, 2% general inflation, 12 months to February 2026): ADA Health Policy Institute, "The State of the U.S. Dental Economy, 1st Quarter 2026 Update" (BLS PPI, CES and CPI data).

Reimbursement index (131 vs 138, January 2016 = 100, February 2026): ADA Health Policy Institute, "The State of the U.S. Dental Economy, 1st Quarter 2026 Update" (BLS Producer Price Index, Dental Care).

Subscription-care interest (48%): Tebra, commissioned survey of 1,000 US adults fielded February 5, 2025, reported in The Intake.

Adults without dental insurance (27%, about 72 million): CareQuest Institute for Oral Health, "State of Oral Health Equity in America" survey, fielded March to May 2024 by NORC at the University of Chicago, press release May 21, 2025.

Skipped dental care due to cost (18% in 2025): Board of Governors of the Federal Reserve System, "Report on the Economic Well-Being of U.S. Households in 2025," published May 2026.

Membership outcomes (76% more visits, 146% more procedures, 172% more cash production, $807 more production per member per year, 2-3X hygiene re-appointments, 2X production of cash-pay patients): Clerri first-party and customer data. Figures are illustrative and not a guarantee of results.

Named practice results: year-over-year change, 2023 to 2024, figures provided by the practices and illustrative of individual results.