

Storm Watch

TRACKING THE CHALLENGES IN THE DENTAL INSURANCE SYSTEM

By Lisa Neuman

From "*Inside Dentistry*" January 2008

The statistics are stark: As the first decade of this new millennium begins to draw toward a close, nearly half of all Americans do not have health insurance, leaving them one medical emergency away from financial disaster. Stories abound in the national media: the elderly who must choose between paying for their medications or buying food, parents losing their homes because of a child's serious illness, the poor or poverty-stricken who die because they could not afford the diagnostic tests that could have detected the curable disease. No doubt about it, the health insurance crisis is commanding everyone's attention these days: employers, healthcare providers, public policymakers, and presidential candidates.

But there's another closer-to-home issue of the health insurance challenge that that receives a lot less time and attention although its effects can be, in some cases, just as grave: More than half of the US population lacks even basic dental insurance coverage. That 50%—more than 100 million people—includes not only average, middle-class citizens who by all other statistical measurements could be categorized as at least mildly privileged, but it also includes populations most at risk and most in need of a way to pay for basic preventive and prophylactic care: the poor, the very young, the very old, the disabled, and minorities, all groups who traditionally find it hard if not altogether impossible to access the US healthcare system, medically or dentally. Just this past year, the consequences of a faulty dental health-care insurance system proved fatal for two children—one in Mississippi and another in Maryland—when they died from infections stemming from decayed teeth.¹

Some might argue that comparing medical and dental healthcare services is like comparing apples to oranges, and comparing the issues surrounding their respective insurances is like comparing watermelons to grapes. While purely elective medical services—such as plastic or reconstructive surgery done for cosmetic reasons—are readily available to those who can afford them, the vast majority of medical services are performed only when patients are in dire need of treatment for the disorder or the disease that ails them because it threatens their quality of life, if not their life itself.

Dental healthcare, on the other hand, is not typically a business of life-or-death. Rising oral cancer rates and the burgeoning proof of the oral-systemic link could change that—and soon—but for now dentistry still seems to be regarded in the minds and hearts of many employers and their healthcare plan providers as an expensive "perk." Better patient education and marketing efforts on the profession's part have already done wonders to change the perception that dentistry is a poor cousin to medicine, and indeed those efforts are coming to fruition. In our March issue, we reported the results of the National Oral Health Survey, commissioned by Oral Health America, which measured public perception of the dentist's role in oral healthcare. Robert Klaus, president and CEO of OHA, said then that, "the overwhelming sentiment among respondents is that they think that oral healthcare is healthcare... One of the lessons is that the public is paying attention to all of the oral-systemic research that has filtered into the mainstream media. As a result, a growing number of consumers are asking for the dentists to participate in their overall healthcare by acting as the physician of the mouth."

Most likely, consumers will continue this trend by also asking dentists to participate in their insurance plans by acting as a participating provider. Just as most people with medical insurance have grown accustomed to paying only a relatively small co-payment for doctor's office visits, they're beginning to expect the same when they visit the dentist's office. While the OHA survey provides documentation of a perception shift, there are still indications that those with little to no dental insurance are delaying preventive or prophylactic treatment—or worse, not visiting a dentist at all—because of affordability issues.

Together, the insurance industry, academia, and organized dentistry are striving to change all of that. One way some major insurance companies are doing that is by creating their own dental advisory councils comprised of some of the best and brightest key opinion leaders that dentistry has to offer to study the correlations between receiving regular dental healthcare and lowering medical care costs. CIGNA Dental,

Aetna, Delta Dental, and MetLife are just several of the companies leading the way in this new front. As David Guarrera, DDS, national clinical director of MetLife's dental division, explains: "Our dental advisory council includes dentists from academia, dentists from our network, and employer groups' decision makers. By bringing them together, we're able to identify the benchmarks of the best dental practices and provide this information to all dentists. We're blending what employers are looking for from their dental plans with what research says are the benchmarks of quality dental plans and dental practices. I think in the past when people tried to get dentists to change, they came at it from the outside, changing their plan designs but not getting any insight from the dentists on the best way to make that happen. When you start communicating with all of those groups, you start to find out that you can actually make changes that bring value to all stakeholders."

Degrees of Separation

On one end of the affordability spectrum, there are the 100 million people who do not have even basic coverage to get their teeth cleaned and examined once a year, much less the strongly suggested 6-month prophylactic recall. They do not have the coverage they need to excavate and restore a decayed tooth, or to get a badly needed root canal. They do not have the coverage they need to treat or prevent periodontitis, now a recognized risk factor for cardiovascular disease, diabetes, and adverse pregnancy outcomes.

On the opposite end of that same spectrum, there are many middle-class and wealthy Americans who will gladly pay out-of-pocket for "boutique" dental services, such as whitening, veneers, and even adult orthodontics, just to get one step closer to the elusive fountain of youth personified by the "Hollywood smile." Baby boomers who have plenty of discretionary income—at the moment, at least—to spend on their looks keep many an esthetic dentist not only happily employed but happily profitable.

But for many people living in the infancy of 21st century America, it's finding a way to pay for basic healthcare services—both oral and systemic—that takes a toll on the entire healthcare system, insurance companies included. As talk of some kind of universal health program shares center stage with the economy, global warming, and the war in Iraq, coverage programs for dental healthcare remain a very distant second in the national psyche. While some progress has been made, much more forward action is needed to make a truly significant difference. If accessibility for all is to become a reality, public policy and private funding need to build on their previous successes to compel the entire profession to move forward in achieving the combined goals of providing comprehensive oral health-care at prices patients—and dental practices—can afford.

Just What Exactly Does Dental Insurance Do?

The short answer is: It helps your patients pay for the services you provide. The hard reality is that many of your patients cannot afford your care. What's more, there are many patients in great need of your care whom you've never met because either they don't have insurance through their employers (the most common way for people to carry dental insurance) or your practice doesn't accept the insurance they do have. Without that all-important ability to pay, many people will forego not just elective treatment, but treatment that is necessary to maintaining the most basic of oral health—treatment that in a great majority of cases can be covered by some type of dental insurance plan.

Understandably, many dentists may be hesitant to participate in dental insurance plans because of the reduction in the usual and customary fees dictated by many of the insurance companies. But that difficult practice-management decision may leave their patients in a difficult predicament that should not be ignored. There is a proliferation of articles both in the professional literature and the main-stream media extolling the woes of the typical dental consumer. Already struggling to make ends meet, paying for basic dental healthcare may be for many a very secondary priority to paying for other necessities, and without some kind of financial assistance, oftentimes becomes a non-priority entirely.

That is not to say that the predicament that accepting dental insurance sometimes leaves dentists in should not be ignored, either. For many dentists, especially solo practitioners or new dentists just getting their practices off the ground, accepting the reduced fee structures mandated by many insurance plans can be a make-a-profit or break-the-bank decision. Because of the many expenses dentists face in running a practice and supporting a staff, as well as making a living for their own families—and, in many cases, paying off hundreds of thousands of dollars worth of dental school loans—they are often forced into making difficult financial management decisions at a cost, to them as well as their patients.

How does one profession come together to navigate a realm so widely varied that it can find itself catering to the haves on the one hand, and serving the have-nots on the other hand? The growing trends in high-end, elective dentistry aside, the fact remains that the rising costs of dental care and the widespread lack of dental insurance coverage and acceptance are the main reasons why Americans either don't have access to basic preventive dental care, or choose not to access that care.

Just how effective have the dental profession and the insurance industry been in providing quality dental healthcare at rates that everyone—insurers, practitioners, and patients—can be happy with? What do dentists really need to know and understand about the machinations of dental insurance so that they can provide the best, most appropriate treatment to their patients while building their practices into profitable businesses? Can dental insurance, high-quality treatment, and practitioner profit make good bedfellows?

Dental Healthcare as Part of Whole Healthcare

Proving the association between oral and systemic health has been steadily gaining momentum since the early 1990s. While many researchers have published their study findings in the most prestigious dental journals, and more and more academicians and clinicians have widely embraced the merit of those studies, it was the study by Dr. Maurizio Tonetti and his team, published in the March 2007 issue of the *New England Journal of Medicine*,² which catapulted the role that oral health plays in systemic health to the forefront of both professions. That study was remarkable in that it showed a definite, positive association between the treatment of severe periodontitis and improvements in endothelial function, but what made it a landmark study was its publication in the medical profession's most prestigious journal. For perhaps the first time, the oral-systemic link was presented in a forum that no healthcare provider on either side of the aisle could ignore.

In an interview with *Inside Dentistry* in May 2007, Dr. Tonetti articulated what he hoped the larger result of his study would be when he said, "I think my biggest hope for this study is that dentists understand that oral infections like periodontitis may have consequences beyond the mouth and need to be treated—not totally for the oral health benefits such as maintaining the dentition, but perhaps in a way that contributes to the patient's general well-being. It is also my hope that physicians and cardiologists will see dentists and periodontists more and more as partners with whom they can better treat their patients."

It seems that it may be more than doctors and dentists working together that will result from the progressive work of researchers like Tonetti. Insurance companies are beginning to come around as well; carriers such as CIGNA, Aetna, Met Life, and Delta Dental are taking the point on changing the dental insurance industry to reflect the changing dental profession to one that is, first and foremost, a health profession esteemed in the same light as medicine.

"I think where CIGNA has really distinguished itself is that we were the first to think about changing our benefits based upon the relationship between good oral health and overall health," says Miles Hall, DDS, chief clinical director for CIGNA Dental. "Our added benefit is what we call the Oral Health Integration Program, which allows reimbursement for co-pays and co-insurance for members who are pregnant or have various conditions, such as diabetes, cardiovascular disease, or have had or are at risk of having a stroke. The program educates the member on how good oral care can have a positive impact on his or her overall health and it takes away the financial barrier for those individuals. It works very well for clients who have both dental and medical coverage with CIGNA because it leverages the clinical information from our medical

claims systems and for those who are in our disease-management program for cardiovascular and diabetes disease."

Sheila Riggs, DDS, DMSc, president and CEO of Delta Dental Minnesota, agrees. "Our dental benefits really do focus on prevention and early diagnosis very heavily and very strongly. That's probably the strongest message, how consistently diagnosis and prevention is covered."

Her organization also takes an approach not seen in many medical plans. Delta Dental doesn't dictate the terms of care. Dentists do. "We really don't get in the middle of what the dentist suggests to the patient, what should be done to meet their oral health needs. The employers have defined what the benefit is going to be, the dentist makes recommendations to the patients, and the patients are the ones who really decide. The patient balances those two things," she says.

MetLife's national dental director, Alan Vogel, DMD, concurs that the changes dental insurance is undergoing are the result of more and better research. "To look at dental plans for the last 50 years, you will see that not much has changed. The dental plans that were written in 1954 haven't changed dramatically from the plans written in 2000. What we're doing now is looking at the new research and building that research into the plans. We're looking at the allocation of services. What we are looking to do is base our plan designs on current research and the concepts of consumerism. We are designing plans and supporting services that will help people get healthy."

Dr. Guarrera adds, "An example of that would be adding coverage for dental implants, which is an appropriate standard for replacing missing teeth. Within the past 3 years, many plans that hadn't previously covered implants are now doing so. This would be an example of adding or modifying a plan to include a benefit that is more current. Another example would be covering things like brush biopsies, which is a tool a dentist uses to help make a diagnosis for oral cancer. Now the results of research are adding procedures to dental plans."

While our experts agree that ongoing scientific research is needed to substantially and sufficiently prove the etiology of oral diseases and their links to systemic diseases in the quest to improve the standard of care for both the medical and dental disciplines, they also agree that another positive offshoot will be the efficacy and cost-effectiveness of rendering that care as a result of better prophylactic and prevention efforts. That in turn would, in theory, lead to lower dollar amounts on medical insurance claims. In these terms, increasing dental insurance eligibility to cover more patients and more procedures makes good fiscal and Hippocratic sense.

Alien Nation

Currently, the state of dental insurance can be summed up, in Tom Limoli, Jr's view, as one of alienation. Limoli, the president of Limoli & Associates, explains: "When you talk about what's changed in insurance, it's a product that is sold to the plan purchaser, which is the employer, and it really doesn't care about the patient. It's like General Motors designing a Geo Metro. They're not designing that for the Cadillac purchaser; they're designing that for the person who's got \$6,000 in their pocket and they've got to buy a car. That's really the way dental plans are put together. They're designed for the plan purchaser, not for the patient. The plan purchaser's got x amount of dollars that they've got to invest on behalf of a dental plan and that amount of money determines what's payable and what's not. Unfortunately, it's got nothing to do with the wants and needs of the patient, either clinical, or financial, or treatment-wise. That's the nature of the beast."

Dental insurance really does not work in the same way or for the same purposes as health insurance.³ Health insurance provides coverage for both preventive and acute care which, with the skyrocketing costs of even basic medical procedures, is absolutely necessary to prevent a financial catastrophe in the event of a serious health crisis. There is usually a deductible, and once that deductible is met the covered party may be covered up to a lifetime maximum of a very large amount. Doctors' visits are covered with a small co-pay and, in many plans, are unlimited in number. So if a patient has a chronic health problem and needs to see a

general practitioner or a specialist repeatedly, while there is paperwork involved with referrals and preauthorization, those visits are generally covered with just the co-pay coming out of the patient's pocket. Dental insurance policies, on the other hand, generally cover routine procedures, such as prophylaxes, examinations, and fillings. More complex procedures, such as periodontal or endodontic treatment, may be covered but with a much higher co-pay than a visit to a general medical doctor. The biggest difference is in the yearly maximums: Dental maximums are very low compared to medical maximums, with most plans capping yearly expenditures between \$1,000 to \$1,500.³ In an article published in 2001 in the Journal of the American College of Dentists, Richard J. Manski, DDS, MBA, PhD, a professor and director of the Division of Health Sciences Research in the Department of Health Promotion and Policy at the Dental School of the University of Maryland, wrote this analogy: "If car insurance were designed like a dental plan, an oil change and tune up would be covered at 100%; shocks, tires, and batteries would be reimbursed at 80%; and accidents would be reimbursed at 50%, with an annual maximum limit of \$1,000."⁴ Manski categorizes dental insurance as "part insurance, part prepayment, and part large volume discount."^{3,4}

Because dental plans are designed this way, many patients may not be seeking the care they need. Dr. Vogel admits that part of the problem is that in the past plans were not based on research, and many plans did not cover the services needed to get a person healthy. "If a patient is going to get services based upon periodontal disease, they need to get services that make them healthy," he says. "There are professional guidelines for periodontal treatment. If a plan tries to reduce costs by minimizing these services, will the patient fund the costs themselves? You can see why some people can't get healthy. Some people with severe periodontal disease need treatment at a more intensive level than the plan will cover. If the plan doesn't cover it, will the person spend the money on their own? The answer may be no. When you start to say 'We're going to get you healthy,' your plan has to be supported by research. And if you talk to dentist they'll say, 'Well, your plan covered implants, but what about the diagnostic tests that help to place the implants? If not, do you again compromise the ability of an individual to get the appropriate service?'"

Regardless of the discrepancies between the structures and machinations of health and dental insurance, numerous studies have borne out two important facts: first, there is a strong correlation between the number of people who have dental insurance and the number of people who use that insurance.³ Those who do have dental insurance are more likely to seek out dental care, even if it's on a purely preventive basis. They are also more likely to seek out more complex or emergency dental care; those without dental insurance have been shown to either delay complex treatment if not avoid it altogether, and to seek out emergency dental care in a hospital setting rather than a dentist's office, because their health insurance will pay for the emergency room visit.

The second fact that has come to light is the correlation between dental insurance use and the lowering of overall costs for both medical and dental treatment. For example, the National Institute of Dental and Craniofacial Research estimates that for every dollar spent on dental disease prevention, \$4 is saved in subsequent treatment costs.⁵ As Dr. Lamster, DDS, MMSc, dean of Columbia University School of Dentistry, points out, "If insurance companies provide additional dental benefits to a patient who has cardiovascular disease or diabetes, that may not save the insurance company money in the short term, but may save the company money in the long run. In addition, a person receiving such benefits will have a healthier mouth, which may be a part of a healthier lifestyle."

While insurance companies are coming on board, it seems that the government may be the last one to get on the train. The Medicare/Medicaid system is hard to navigate, for both patients and practitioners. Many dentists do not accept Medicare/ Medicaid patients because they know that they will never recoup many of their costs of providing treatment to patients under these programs. The reimbursement rates are so low that for many dentists, regardless of their desire to help patients caught in the quagmire, it is simply impossible to provide quality care and pay their own costs in staff salaries, materials, and over-head to render that care. Hopefully that will change in the future. One person who looks optimistically at Medicare's future is Robert Laurenzano, DMD, president of the American Academy of Dental Consultants, who says, "We can't leave out another type of plan, and that's the government programs, Medicare and Medicaid, and CHIP [Children's Health Insurance Plans]. These are not really insurance, but it's a benefit that's available to people at certain economic levels. The government is in control here and you can see what's going on at the federal government. There's a tremendous need, therefore, for these plans. How's that going to play out? What kind

of coverage and how broad is that cover-age and what are the economic levels to qualify for that coverage? For the oral and overall health of our citizens, those are very, very important considerations.”

He goes on to issue his own call to action: “Medicare as an insurance-type plan has historically been focused on medical. Finally the light bulb went on and they figured out that the mouth is connected to the rest of the body. Shouldn’t older people have Medicare dental coverage? Does the mouth stop being important just because people are 65 or older? Oral health is equally or even more important to these folks. The care that’s necessary is more difficult when somebody is ill or chronically ill. This is a whole segment of the population that’s being dentally ignored. They’re retired. They’ve lost their medical and dental benefits as a result of retirement. They’re dependent on Medicare, and there are all these benefits to taking care of the mouth. Oral health impacts many other conditions. I think that the Medicare program has to wake up. The politicians don’t want to hear it because it’s another expense, but dental has to be—should be—included under Medicare coverage.”

The Baby Boom Busts

With much fanfare, the nation’s first Baby Boomers began turning 60 last year. Long heralded as the generation that shook the country to its core, first with their antiwar protests in the 1960s and their dominance of the corporate world in the 1990s, the influence of the Boomers is far reaching. Experts in every field from marketing to medicine to money have been studying the ramifications of their retirement for the last two decades. The way many experts see the aging effect of the Boomers, the dental profession is in for a two-part crisis: many dentists are beginning to retire, with far fewer dentists to replace them, just as the influx of retirees who’ve newly lost their employee-sponsored insurance plans begin to hit practices nationwide. According to the most recent American Dental Association data, less than 15% of the entire group of the over-65 population is insured. Twenty years ago, 66% of large employers provided medical and dental health benefits to their workers; today, that number has dropped to only 38%.³ Meanwhile, premiums for both medical and dental care continue to rise across all age groups. According to Rubenstein’s article,³ Towers Perrin’s 2003 Health Care Cost Survey found that while the increases in dental premiums were not as dramatic as the increases in medical premiums, they still outpaced the rate of inflation⁶

The declining group market has forced the insurance industry to develop models for the growing retail market of retirees, with the result being the rollout by the dental industry of a number of individual-type consumer programs. AARP, in conjunction with Delta Dental of California, has instituted a program for retired enrollees to receive dental benefits through monthly premiums. Other companies are developing voluntary programs for the senior population with limited success because they are generally classified into a category called adverse selection—the bane of insurance companies, because a disproportionate number of insured use the benefits and cause escalating premiums. Insurance companies prefer the group model because it more effectively spreads the overall risk among the healthy majority of enrollees not using the benefits, which in turn underwrites those who do use them.

And when it comes to groups, perhaps no group in history will have served to highlight the inadequacies and inequalities of the healthcare system more than the Baby Boomers. In the next 5 years, Boomers—65-million strong—will comprise a full 20% of the population. Many of them will retire into the lifestyle they worked hard for as corporate movers and shakers, and many of them will retire into a lifestyle filled with uncertainty about how they will support themselves into their old age. It is not only prudent but imperative that dentists and dental insurers be prepared for this new reality of the make-up of the dental population.

Where is Dental Insurance Going Now?

If the dental industry had been largely static since its beginnings a half century ago, it is now picking up speed as it moves forward at a more accelerated pace, stimulated in large part by the oral–systemic association and the needs of the retiring Baby Boomer population. To address these needs, and at the same time remain profitable as well as be good corporate citizens, insurance companies are taking their cue from

the old adage that “an ounce of prevention is worth of pound of cure” and are marshalling their resources toward prevention and treatment. Many companies are mediating among members, providers, academia, and both public and private entities to plan new strategies and programs that revolve around research, education, and delivery systems.

Our interviews with several of the leading dental insurers, such as CIGNA, Aetna, Delta Dental, and MetLife, revealed an increasingly cooperative partnership between industry and academia as the former provides the funding and the data bank to the researchers, who in return provide the analysis and findings necessary for structuring insurance plans for dental coverage and treatment. For example, according to Dr. Lamster, under the Aetna/Columbia University model, Aetna contracts with Columbia University faculty to provide the following services: information for its consumer Web site; evidenced-based reports for the professionals within the network; and scientific research based on the enormous data bank available to Aetna that allows examination of the relationship between dental treatment and certain systemic disease outcomes.

Dr. Riggs has already seen positive proof of this type of collaboration at Delta Dental Minnesota. Combining its data sets on pregnant women with those of Blue Cross/ Blue Shield of Minnesota, Delta is adding to the evidence on the oral-systemic link. “For a pregnant woman, we know if the delivery was a normal delivery or an early preterm delivery. We can go back and look, not only at the 9 months she was pregnant but even the year prior to conception and see what kind of treatment she was receiving and then stratify it by birth out-come. One of the interesting things we found is that if a mother had a tooth pulled prenatally or before conception, she had a stronger risk for having a preterm or low-birthweight child. That could be an early warning signal to the whole delivery system that she could be at higher risk for having an adverse birth outcome.” Not content to leave these academic studies “academic,” the dental industry uses them to formulate new strategies for education, prevention, and treatment. From advisory panels to continuing education programs for dentists to various modes of electronic and print communication, members receive the latest information pertaining to treatment and coverage. But education does not stop at the professional portal. Aetna, having access to both the dental and medical records of its members, is among the industry leaders in providing a particularly effective outreach program in con-tacting patients directly to enhance their awareness of oral-systemic connections and to emphasize the need for preventive care. In addition, the company offers its Dental Plan Selection and Cost Estimator Tool to assist employees in choosing their dental plan during open enrollment by allowing them to compare Aetna and non-Aetna dental plans. MetLife offers an online risk-assessment tool that allows its members to interactively answer a series about their health history and lifestyle habits to assess their relative risk of developing certain health conditions. CIGNA also has an online tool, the Dental Treatment Cost Estimator, to inform the prospective patient about the cost of specific treatments both in- and out-of-network.

If education and research are the necessary first steps in the advancement of dental care, the logical next step is implementation. And here the major insurance carriers have not been asleep at the switch. Aetna launched its dental/ medical integration program in the beginning of the year and has expanded benefits to provide—for the first time— full coverage for certain periodontal services to be paid at 100% for pregnant women and at-risk patients with cardiovascular disease or diabetes. Likewise, CIGNA provides oral health integration programs, combining dental and medical coverage so that any treatment of periodontal or systemic disease is reimbursed through co-insurance at 100%. Other major carriers, such as MetLife and some Delta Dental plans, also provide a host of expanded benefits, including more frequent dental visits, additional cleanings, white fillings, implants, oral exams, and brush biopsies for cancer diagnosis.

Technology Plays a Part

For their part in facilitating the work and compensation of the dental practitioners who are ultimately responsible for implementing these new techniques and procedures, the dental insurance industry is making great advances in streamlining the approval process—to the delight and satisfaction of patients as well. According to Aetna’s national director of clinical operations, Mary Lee Conicella, DMD, auto-adjudication of dental claims has doubled since 2002 so that about 80% of claims are automated, leaving only a small number requiring clinical approval, which streamlines and speeds up the reimburse-ment process for practitioners. (The clinical policies are on Aetna’s Web site for dentists’ access.) Likewise, Dr. Hall reports

increasing use of electronic claims submission, or EDI (electronic data interchange) at CIGNA Dental, as well as the use of a provider Web site. MetLife also has invested heavily in technology that stream-lines the transmissions of diagnostic information and claims to the point that these can be transmitted in real time as the patient is sitting in the chair. With 55% of claims submitted electronically and up to 69% processed in a single day, MetLife is also pushing electronic payment (EFT) on the back end in which payment is made directly into the dentist's account, according to Drs. Vogel and Guarrera.

Do Raindrops Keep Falling On Your Overhead?

With all of the sundry expenses challenging dentists to keep their practices afloat and, hopefully, profitable, how can participating in one or more of the many insurance plans out there benefit today's practitioner? One of the main incentives should be the expanded patient base that becoming a participating provider would offer. While accepting reduced rates on the fee structure may be a possibility, with good practice management and practice marketing plans, these reductions could and should be compensated for by the increased numbers of new patients coming into the practice as well as by the retention of your already-existing patient base. As we have seen, many surveys have pointed out that patients are more likely to seek dental treatment if they have dental insurance and can find a dentist who accepts that insurance, as the cost of dental treatment often dips into patients' own rainy-day funds. It is those patients coming into your practice who are going to help you finance your overhead expenses.

But it is equally as important for you as the practitioner to find the insurance plan or plans that best fit your needs as well as the needs of your patients and your practice. By enlisting the help of a qualified practice management consultant to help you with completing the research and due diligence on all of the various companies and their myriad plans, you can make good decisions that will create a win-win for everyone involved in your practice. The dental insurance benefits industry is making its own improvements to give you the incentive you need to consider forging such a relationship.

Patients, dentists, and dental insurance plan sponsors are in a much better situation today than in past years because the dental industry's heavy investment in research and technology is providing much better access to critical information about health issues and plan structures, and the dental benefits industry is working hard to improve and to expand coverage as well as to streamline the approval and payment processes for their participating dentists. The remaining challenge is to make these excellent advancements that the dental profession as a whole has achieved more accessible to those left aside or behind, in ways that benefit patients, dentists and their practices, and the insurance carriers. Working together, dentists can provide the treatment their patients need at costs that everyone can live with...even on rainy days.

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DHMOs, PPOs, and DRs, Oh My! Navigating Your Patient's Insurance Plan

When you come right down to it, most dental insurance plans are really just another business arrangement between an insurance company and an employer, and most plans are set up to pay just a portion of an employee's (i.e., your patient's) dental expenses. But it's a business arrangement that makes sense for employers; dental disease and oral pain or discomfort are as valid reasons for employees to miss work as

any kind of medical malfunction. Many employers are seeing the advantages in offering a dental plan not just to keep their existing workers happy and pain-free, but also to use as a recruiting tool to attract new workers.

Unlike medical expenses, which tend to be unexpected, unpredictable, and, unfortunately, catastrophic, dental expenses (not including traumatic accidents or injury) tend to be the polar opposite. Dental diseases are not only in many cases preventable, they are relatively easily treatable once they are detected. Diagnostically, dental maladies are much easier and much less expensive to detect than many medical disorders, and once they are detected,, the decay, disease, or other disorder is, generally speaking, less expensive to treat than a highly complex medical problem.

Be that as it may, for many patients, having dental insurance is the deciding factor in whether or not to seek dental treatment, even if that treatment is simply preventive, such as getting an annual prophylaxis and examination. If and when they do decide to seek treatment, many times the dentist they see has the luck of the draw—if the dentist takes the patient's dental insurance, that dentist gets the patient. But once in your chair, how do you treat patients who are more worried about what their insurance is going to cover than what's going on in their mouth? How do you navigate the long, winding road of dental insurance benefits? Here, we give you a snapshot of the main dental plan structures to help you decide what's best for you, your practice, and your patient base.

The Plans at a Glance*

According to the American Dental Association (ADA), the numerous models of dental plans can be divided into two categories: managed care and fee-for-service. Managed care plans strive to contain treatment costs by restricting the type, level, and frequency of treatment; limiting access to care; and controlling the amount of reimbursement for services rendered. The two primary forms of managed care plans are the Preferred Provider Organization (PPO) and the Dental Health Maintenance Organization (DHMO). Fee-for-service plans offer much more freedom because the dentist is paid for services rendered according to his or her established fee structure. The concept of Direct Reimbursement (DR), is the primary form of fee-for-service plans, and is the ADA's preferred method of financing dental treatment. Here's a look at each type of plan in more detail:

PPO

With PPOs, patients have to select a dentist from a network or a list of accepted providers who have agreed to discount their established fees for services rendered. Some PPOs do allow their members to be treated by a non-participating provider, but there are penalties involved, such as higher deductibles and co-payments for the patient. PPOs are generally less expensive than comparable traditional indemnity plans. One of the questions for patients and dentists that are raised by PPOs is whether the amount of the discount the patient receives through the plan will be enough to influence him or her to change dentists. For instance, if your patient recently changed jobs, and therefore insurance plans, but you don't participate in the patient's new plan, how much incentive does the patient have to search for a new dentist who does participate in the new plan? Conversely, how many new patients are you missing out on by not participating in a specific PPO? The larger the PPO, the more potential patients will be in that PPO.

Another question, one with potentially far-reaching implications, is whether the treatment options will be limited for patients with PPOs because of the discounts the dentist is required to offer to remain within the usual and customary fee structure of the PPO. While treatment decisions always remain with the dentist and the patient, keep in mind that the patient with a PPO may be restricted in their treatment alternatives based on their ability to pay. If they can't afford the difference between what the PPO will pay for and what you need to charge for the treatment, they may be less likely to accept that treatment, or worse, think about looking for a different provider with lower fees.

The last few questions that are important for dentists to consider when deciding to participate in a PPO are the criteria for selection as a provider in a particular PPO plan. First, does the PPO you are considering participating in have enough dentists under contract to adequately serve the number of potential patients in your geographic area? If you are among a small number of dentists in an area with a lot of patients in a particular plan, you could get inundated with those patients, not leaving a lot of time or room in your practice for fee-for-service patients or specialty dentistry. The second question you might want to ask is whether the PPO provides for specialist referrals—are you limited to referring patients to contracted specialists, or can you refer patients to specialists with whom you've built professional trust and relationships, even if they don't participate in your PPO? This could be very important when making treatment decisions, not to mention maintaining your professional ethics and credibility.

DHMO

DHMOs pay the contracted dentist a fixed amount per enrolled family or individual, regardless of how much the DHMO is used. The dentist agrees to provide specific types of treatment to the DHMO's patients at no charge, and can provide other types of treatment with a co-payment on the patient's part. DHMOs are designed to reward dentists for keeping their members in good oral health, so that costs are kept low. DHMOs are typically among the least expensive dental insurance plans.

The questions for the dentist to ask when considering participating in a DHMO are generally the same as for PPOs, but one additional question that would be important to ask is what provisions are made for dentists with unexpected usage rates or difficult-to-treat cases? With a DHMO's fixed rates, a dentist could potentially run into trouble if he or she encounters an influx of patients carrying this type of plan.

DR

A DR plan is one in which patients are reimbursed according to the amount spent on dental care and not the type of treatment received. It allows patients the freedom to choose their own dentist. Rather than a monthly premium, the employer offering this type of plan pays a predetermined percentage of the actual treatments received by their employees. Perhaps the biggest advantage to this type of plan is that there is no outside influence on treatment decisions because of plan restrictions. The dentist is free to charge his or her usual fee structure, which the patient pays the dentist directly, and then, with the receipt of services rendered in hand, goes back to his or her employer for reimbursement.

The main drawback to this type of plan is that participating employers are very limited. According to the National Association of Dental Plans (NADP), in 2005, only 1% of the benefits market was occupied by DR plans.¹ Also according to the NADP, PPOs dominated the market in 2005 with an estimated 50% market share, with that trend continuing upward, while traditional fee-for-service plans were trending down-ward, from 35% in 2002 to 27% in 2005.¹ DHMOs seemed to be holding steady at approximately 14% to 15%.¹

DENTAL DISEASE AND ORAL PAIN OR DISCOMFORT ARE AS VALID REASONS FOR EMPLOYEES TO MISS WORK AS ANY KIND OF MEDICAL MALFUNCTION.

Conclusion

Tom Limoli of Limoli & Associates sums up the broader picture of dental healthcare plans: "The dental benefits industry is charged with designing a product to best meet the needs of that employee group for those dollars that the employer has to offer," he says. "It is charged with being the policeman of the employer's money. If it's not reimbursable under the dental plan, that means the patient has to reach in their pocket and pay it."

Resources

All of the information under "THE PLANS AT A GLANCE*" was obtained and is attributed to the ADA's article, "The Advantages of Offering a Dental Benefits Plan." Available at: www.ada.org/public/manage/insurance/index.asp. Accessed November 19, 2007.

¹.Furlong A. ADA and payers convey concerns, ideas. Posted March 8, 2006. Available at www.ada.org/prof/resources/pubs/adanews. Accessed November 19, 2007.

Coding Dos and Don'ts

Once you've managed to navigate the various plans attached to the insurance cards that your patient's bring into your practice you need to be vigilant that the codes you send back to the insurance companies are accurate. Improper coding, even if it's an inadvertent error on the part of you or one of your staff members, carries serious consequences. Two of our expert panelists offer some sound advice to prevent this from happening to you.

"There are several ways to improperly code," says Bruce Seidberg, DDS, MScD, JD, president of the American College of Legal Medicine. "There's upcoding, downcoding, or unbundling. If you do any of that, it's fraud.

According to Seidburg, upcoding means trying to obtain more money for a particular procedure than allowed by law. For example, in a root canal procedure, the code includes x-rays in that treatment. To bill separately for x-rays is unbundling the root canal procedure by upcoding for those x-rays. Similarly, "If you have a patient in for a consultation and you do some other treatment on that patient included in the consultation, just by unbundling what the code calls for is a matter of principle of increased charging, and again, you're seeking money for things that aren't allowed by law." Downcoding is often used when the insurance companies take the claim and "downcode" it into a least expensive alternative treatment, implying that a lower level of care should have been provided. "That creates a conflict with the provider and the patient because the provider is recording a submitted procedure to a less complex or lower cost procedure, which may not be appropriate," Seidburg says.

In addition, some dentists make the mistake of trying to bill a patient's health insurance plan for camouflaged dental procedures. Bad idea, says Tom Limoli. "Dentists need to quit looking for a Pandora's Box that will solve their problems. And they need to quit looking at the patient's medical insurance or health insurance to cover up the inadequacies of what is not adequately reimbursable under the dental plan," he cautions. This is becoming more common, Limoli says, because benefit plans are becoming more restrictive, but will ultimately come back to haunt a practitioner and his or her practice. "They [the practitioner] submit claims to these health plans that look like medical procedures, but they're not. Many times an office will get paid by a health plan but once the health plan finds out it was a service performed by a dentist and it was a dental procedure that either was or was not addressed by the dental plan, that health plan wants their money back. And they will get it back. If the office doesn't pay it back, that office is going to have a serious problem. And that serious problem is called mail fraud," Limoli warns.

Seidberg agrees that the consequences are extremely serious for the dentist, and can include the loss of licensure. "It is a felonious type of activity. You can be brought for charges through your professional licensing offices of whatever state you are licensed in, and it could lead to a suspension of licensure; could lead to a fine; could lead to a loss of license; or any penalty designed into that particular state's codes. It violates not only the code of ethics of the ADA [American Dental Association] but it also violates codes of ethics of the state in which one is licensed and if they were a specialist, they would also violate a code of ethics of that particular specialty," he says.

In Limoli's view, coding can go astray when the wrong member of the office staff is the one doing the billing. "I would say that 99 times out of 100, the problem is [when] the office manager or another member of the [administrative] team is dealing with the insurance and doing the coding. All too often they code based upon

plan specifics rather than the actual completed clinical procedure. The coding should be done by someone who witnessed the procedure, knows what the procedure was, and how it should be billed. Administrative staff should not be doing the coding. Procedure codes need to be done by the person who witnessed the procedure," he reiterates.

He also encourages dentists to embrace a different type of relationship with the dental benefits industry "They are blaming the insurance [companies] because they feel they can't do what is in the best interest of the patient. If only the dentists would realize that the insurance is only there to help the patient offset the cost of care, not to dictate treatment. The patient's insurance is no more than a term of payment. That's all it is. And offices are alienating themselves from the world around them when they feel the insurance is dictating what the treatment (should) will be. Those dentists have to wake up, and retrain themselves and retrain their teams."

