The Trade Looks at Dental Reimbursement
Mission

The journal of the American college of dentists shall identify and place before the Fellows, the profession, and other parties of interest those issues that affect dentistry and oral health. All readers should be challenged by the journal to remain informed, inquire actively, and participate in the formulation of public policy and personal leadership to advance the purposes and objectives of the College. The journal is not a political vehicle and does not intentionally promote specific views at the expense of others. The views and opinions expressed herein do not necessarily represent those of the American College of Dentists or its Fellows.

Objectives of the American College of Dentists

The American college of dentists, in order to promote the highest ideals in health care, advance the standards and efficiency of dentistry, develop good human relations and understanding, and extend the benefits of dental health to the greatest number, declares and adopts the following principles and ideals as ways and means for the attainment of these goals.

A. To urge the extension and improvement of measures for the control and prevention of oral disorders;

B. To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all and to urge broad preparation for such a career at all educational levels;

C. To encourage graduate studies and continuing educational efforts by dentists and auxiliaries;

D. To encourage, stimulate and promote research;

E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;

F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;

G. To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public;

H. To make visible to professional persons the extent of their responsibilities to the community as well as to the field of health service and to urge the acceptance of them;

I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the potentials for contributions to dental science, art, education, literature, human relations or other areas which contribute to human welfare—by conferring Fellowship in the College on those persons properly selected for such honor.
The Trade Looks at Dental Reimbursement

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Very broadly speaking, opportunities for innovation in dental practice come in the form of new products or new knowledge. Most new procedures are a combination of new things and their supporting know how, but there are important differences between the way we treat physical capital and intellectual capital in the dental profession.

Products that are sold over the counter must show evidence to the Food and Drug Administration that they are safe for their intended use. If the product makes a therapeutic claim, there must also be evidence of efficacy. The procedural protocols for this evidence are sophisticated and rigorous. They add to the cost, time, and risk in bringing new products to the market.

Knowledge, especially the know how kind, is another matter entirely. Where is the referee who has reviewed the rigorous evidence on safety and efficacy for the newest fad in practice management or biological indicators? Sometimes there is sound scientific evidence for the technique tips entrepreneur dentists develop and spin off in continuing education programs; sometimes the evidence is shaky, and sometimes is absent all together.

Let’s look at some of the differences between products used in dental offices and knowledge used there to see if we can explain this double standard. One conspicuous difference is the existence of a subsidized, trusted, third party that scrutinizes products but not knowledge. The American public generally has agreed to invest a tiny fraction of its taxed dollars in the Food and Drug Administration, and manufactures and consumers of specific products and devices have agreed to pay slightly higher prices in order to insure predictability and safety. Beyond the possible limited role of the Commission on Dental Accreditation, there is no counterpart agency for certifying dental knowledge that is universal, subsidized, and third party. We have been through a period where individuals or groups within the profession saw the certification or rating of knowledge as a potential source of income or influence for themselves. On balance, it is easier to see where this practice has hurt the profession more than it has helped.

There is another reason why products and knowledge differ and it has to do with wanting to control the profession. I have never been a fan of mandatory continuing education requirements—it strikes me as being too much like a placebo. Can anyone imagine requiring that dentists purchase so many pounds of impression material or so many counts of 2 x 2s every other year in order to retain their licenses? Perhaps a case could be made for requiring certain courses such as the state’s practice act or basic life support in the same way that local building codes often require the presence of a fire extinguisher. The fact remains that “registration” of continuing education courses is based on content area and qualifications of the speaker rather than value of the presentation. Anything approaching the standards of safety and efficacy for knowledge is still a long way from reality.

Those involved in producing and distributing dental products are relatively small in number compared to those who are promoting new knowledge. The sec-
The most commonly cited source for new dental knowledge, according to a survey published in the Journal of the California Dental Association, is one's professional peers. It would be impractical to regulate this source of knowledge. The primary source of new information is the dentist himself or herself—trial and error. It would be both impractical and unpopular to attempt any regulation here. A fairly large proportion of the "formal" CE courses and practice management consultants (the third and fourth most common sources of dental information) are often practitioners who have discovered better ways to practice, are supplementing their incomes through innovative practice, and are sharing their insights.

A fourth reason for the double standard is the difference in shelf life between dental products and dental knowledge. Once you use a carpel of anesthetic, you have to replace it with another. Some dental products are subject to spoilage. Dental knowledge on the other hand loses no value in storage and may actually improve through use. Only the threat of obsolescence is common between products and knowledge.

The greatest difference between products and dental knowledge is the most subtle. Products and devices have a life of their own essentially independent of the dentist. Although their value ultimately depends on the practitioner, they can be produced and warehoused in volume far exceeding their need. The same can be said for the artifacts of dental knowledge such as articles in research journals.) Dental knowledge, especially the knowledge upon which the profession is based, can never be separated from individual dentists. To find it, go look in dental offices—that's the only place it is alive. Dental products and devices are acquired throughout economic exchange. Dental knowledge is acquired through professional growth—not something a dentist has, but something a dentist becomes. On this view, the double standard between innovation in dental products and innovation in dental knowledge is quite natural.

There should be another double standard in the innovation of dental practice—the overlapping of individual and community responsibility. The watch word is not caveat emptor but caveat utens—user assumes responsibility. Dentistry is fundamentally a personal act of healing and each dentist individually assumes responsibility for the safety and efficacy of care given, including all of the products and know how used. Dentistry is also a profession where the actions of one effect the reputation of all. No dentist could possibly learn enough by working alone to ensure the proper care of his or her patients.

What is needed are individual standards for the safe and effective treatment of patients and collective standards for products and knowledge that will meet these objectives. Regulation is an incomplete answer, as is CE requirements or reliance on a completely well informed practicing community. There is, however, much we can do through organized dentistry, industry, the scientific and educational communities, and individuals to create ethics of better products and better knowledge—an ethic of continuously improved safety and efficacy in oral health care—something that has no shelf life but lives through common use.
Dear Dave:
Please accept my congratulations for your stewardship as Editor of our Journal of the American College of Dentists. The quality of the papers presented in the “theme” issues have been uniformly good and the topics chosen are timely. I particularly commend you for including a broad variety of viewpoints on each subject. We in dentistry often limit our exposure to ideas that are congruent with our own, and in so doing, limit our ability to expand our knowledge of the subject under consideration. There are always at least two sides to a story, and it behooves us to understand all viewpoints before charting a course of action.

As a presenter in the American Association of Orthodontics “Practice Alternatives” program, I plan to use the full issue of the Journal on “Financing Oral Health Care” as background reading for the orthodontic residents who will receive our program.

My best personal regards:

Georg S. Payne, DDS, FACD
Santa Rose, CA

Dear Dr. Chambers:

At the urging of some of my colleagues who are also Fellows in the American College, I just finished a second reading of the issue concerning the financing of oral health care (Fall, 1997). Based on the allocation of resources and content, I must question the appropriateness of the two articles by Dr. Van der Wal and Ms. Cathye Smithwick in our journal. It may be considered good journalism to present all sides of an issue, but allocating them sixteen pages in a fifty-two page journal to defend the position of insurance companies in the dental market is really disproportionate.

The content of the articles is inflammatory, offensive, and illogical. Remarks justifying the existence of third party carriers stating they are “performing an economically beneficial service” by “enforcing provider compliance” and “monitoring activities that place constraints on provider profit-maximizing behavior” are offensive. That language is an insult to our profession and the intelligence of both consumer and provider. It could easily be argued that some of the cost-saving charts and examples used to justify “bashing” of the ADA-endorsed direct reimbursement programs are unrealistic, distorted, and illogical. I think it would be fair to give proponents of direct reimbursement equal space to respond.

Issues like fairness, trust, freedom of choice, quality, and relationships are also factors that add value to our services and are as important as cost when making a decision concerning purchasing of health care services.

I do not know what it costs the American College of Dentists to produce sixteen pages, but we could have provided a better service to the overall health and quality of life of the public by dedicating the expense of publishing to support Rep. Charlie Norwood’s PARCA bill or any other freedom of choice or patient bill of rights legislation pending on the state or national level.

Sincerely,

Albert C. Coco, DDS, FACD
Omaha, NE

Dear Dr. Coco:

Thank you for your letter of 4 February. It is thoughtful, expressing a deep concern that I believe other Fellows share, and is clearly written. I would like to publish it exactly as you have written it in the next issue of the journal.

Without challenging any of your assertions or wishing to blunt their impact, I do want to provide some background.

The original submission from Van der Wal and Smithwick was over sixty pages in manuscript and highly technical. I believe it was an MBA dissertation or something of the sort. It was accepted for publication based on peer review, with many recommendations that it be severely edited. That was done, and it was reduced in length by more than 40%, mostly through eliminating technical, economic material.

I agree with your point that equal time must be given to direct reimbursement. A paper was requested from a former ADA council member based on a presentation he made on that topic. He prevaricated
Dear David W. Chambers,

I have read the Fall JACD at least twenty times. I am appalled at the lack of responsibility by you and the editorial review board. I understand a fair presentation of all viewpoints in a quality professional publication, but you have allowed a bias that is not representative of the membership of the College to become the focus of the Fall Journal.

One only has to look at who funded the articles to realize that this is not an unbiased factual representation with a intent to provide accurate information. It is rather an advertisement to inaccurately portray direct reimbursement. This can hardly be referred to as an abstract. The disturbing part is that the editorial board of the Journal and to a greater extent the entire Board of Directors of the ACD has allowed this travesty of "journalism" to occur.

I expect an equal amount of space to properly represent the alternative of direct reimbursement. If you truly are a referee publication then you will realize your responsibility to your profession. Incidentally, that is the profession of Dentistry not Tabloid Journalism. It makes me question if the ACD is representative of its membership. The last two issues of its journal (Fall and Winter, 1997) certainly are not representative of what I believe and support.

Sincerely,

Michael D. Vaclav, DDS, FACD
Amarillo, TX
people's lenses and questioning my own assumptions about things. Only when issues are presented differently or with a different set of assumptions do we have the potential for growth.

The recent theme issue on the financing of dental care was extremely interesting. While I have been reading voraciously all that I can lay my hands on about contemporary financing issues in dentistry, quite frankly, much of what is published in trade journals and even professional journals simply adopts too many preconceptions or fails to balance the biases. I believe that the biases in this issue in all of the articles were explicit enough that a mature reader could readily handle them. The end result was an important contribution to dental literature. As long as the quality of the Journal remains as high as it is now, I will remain an avid reader. Yes, even choosing it over the *Washington Post* or television sporting events.

Sincerely,

Stephen B. Corbin, DDS, MPH, FACD
Brookeville, MD

Re: Letter To The Editor

I wish to complement this journal on its effort to highlight the complex subject of financing oral health care in America today. Regarding the article “An economic analysis of managed fee-for-serve and direct reimbursement” I would like to bring forth a different perspective with different data. Since the article (as noted in the beginning introduction) was prepared outside the Woods Hole Group Study and was not funded by the independent Kellogg Foundation, but funded by Delta Dental Plans Association, it is fair to assume this could be more prejudiced commentary than accurate observation. To publish the conclusion “the expected result under a DR arrangement is additional financial burden to employees, and employers, greater utilization of high cost, marginally beneficial services, lower utilization of routine, preventive services, and higher dental care prices over time” is quite inaccurate, and is made without regard for the hundreds if not thousands of highly successful and well maintained DR plans across this country which have existed now for many years.

Numerous testimonials with complete unbiased DR data were presented at the 1997 “ADA DR Days” in Chicago to validate these statements...and enough I believe to support its continued place in the dental market for a long time to come. According to studies by *Dental Economics Magazine* and Dr. Kelly Carr, the “Founder of Dental Direct Reimbursement,” the average American spends approximately $100 per year on dentistry. Slightly over half (about 55%) regularly go to the dentist. Forty to 45% of those have dental coverage do not file a claim with 90% of all claims less than five hundred dollars and 75% under two hundred dollars. These are important key figures to properly understand an industry which has maintained the highest possible standards for ethics, and which in a 1994 Gallup poll ranked third in consumer confidence for integrity and honesty behind clergy by putting the consumer first.

Dentistry is different! The hypothetical case models used and so deftly referred to by these authors are medical model prototypes wrongly associated with the dental profession. These models are based upon catastrophic health care models with economic needs for coverage and the associated communication constraints which are not applicable to dental health reality. The dental profession has worked for years to build public image and to raise ethical standards through cost containment emphasis outside of these medically induced parameters. Contrary to what pundits may spin in the dental market arena, dental benefit plans are simply the means of cost-shifting dental care to employers as an employee benefit, making dental benefits tax deductible...nothing more and nothing less.

Dentistry is “non-catastrophic” care... so the true definition of “insurance” has never applied, i.e., there has never been anything to insure. But certain companies have sold dental consumers “dental insurance” over the past two decades to become part of the medical-dental piggy backed health care plan that is bracing for future congressional mandating on national health care, i.e., there are certain companies which have a vested interest in seeing that DR is not successful. Even Dr. Carr in his 1979 publication “Direct reimbursement: The sensible cost effective approach to dental benefits” pointed this out almost twenty years ago with vivid clarity. Putting dentistry in these medical models with patient-agent references only reinforces the national health care scenario. So specious is this result, as your journal reports, that expenditures on oral health care over the last five years have climbed 37% while the economy has only grown at half that rate...And who has collected the most profit? The insurance industry, of course.

Direct reimbursement is the best dental plan ever developed in America. By correctly removing the middleman, it allows up to 98% of all dollars an employer chooses to spend on dental health care to actually be spent on employees’ dental health care, not management services or unnecessary administration. Also, DR plans give consumer patient bases (large and small) total freedom in choice and care without restriction, monitoring, delays or regulations; no other plans can compare. These issues are the crux of our free market capitalism. I believe there is no other type of dental plan yet devised nor will ever be devised which can match the benefits of the dental direct reimbursement plan system.

Sincerely,

E. Brian Smith, DDS
Austin, TX
The American Dental Trade Association Looks at Dental Reimbursement: Responsible Consumption of Appropriate Dental Services

Managed Care Task Force of the American Dental Trade Association

Abstract
The American Dental Trade Association Managed Care Task Force has provided an extensive study of the effects of reimbursement on the dental profession and the dental trade industry. There is great variety among the needs of patients and in the reimbursement plans available. ADTA is urged to take a leadership position to ensure that programs do not restrict access, value, or quality. The key to this strategy will be communicating a consistent message to dentists, patients, benefit managers, and the research community. The message is: “Responsible consumption of appropriate dental services.”

The original intent of this analysis was to address the key issues in dental service reimbursement as they may impact American Dental Trade Association members. The prospects for dental care demand under different managed care scenarios are a subject of concern and ongoing study. This report summarizes the research on this subject.

Task Force Background
The mission of this task force has been to inform members of the conditions, implications, and direction of dental reimbursement. Some of the conditions in managed care have served to expand the availability of dental services. Some of the conditions may, on the other hand, effectively constrain patient and provider choice and adversely affect demand. One of the key concerns of dentists and the dental industry is the potential impact of reimbursement on clinical choice, therapy mix, and value in context. Under some reimbursement schemes, patient access to appropriate services and quality may be constrained. The ethical and economic problems associated with these constraints have implications for the dental industry—distributors, laboratories, and manufacturers.

The leadership of the task force considered two objectives that are addressed in this research. First, they asked that we develop a body of information on dental reimbursement that is practical and meaningful for ADTA member firms. Second, they asked that we construct a set of response and communication strategy concepts for further consideration by the membership.

Approach to Analysis
This exploratory analysis involved gathering data from many sources in an attempt to build a balanced and complete picture of dental reimbursement. In this process, we generated information that reflects the perspectives of the major stakeholders of the dental economy: consumers, providers, employers, third parties, and suppliers. Each of these groups has unique motives but, in the end, serving patients is the essential common denominator and a key ADTA priority.

Assessment of Problems and Implications: There are a number of general challenges that make reimbursement one of the more complex and dynamic issues in the dental economy. This analysis defined a series of problems that can complicate patient choice, quality factors, and service access.
The Trade Looks at Dental Reimbursement

**Table 1. What is the Scope of Dental Benefit Coverage?**

<table>
<thead>
<tr>
<th>Service Lives</th>
<th>Service Cost</th>
<th>Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indemnity</td>
<td>92 million</td>
<td>$18 billion</td>
</tr>
<tr>
<td>Managed Care</td>
<td>38</td>
<td>$6</td>
</tr>
<tr>
<td>Direct Pay</td>
<td>80</td>
<td>$22</td>
</tr>
</tbody>
</table>

Source: Dewar Sloan/DeCEM analysis of actual dental care utilization ratios and consumption vs-coverage levels, based on an estimated 210 million consumers, a $46 billion service market, and premium ratio/cost level assumptions. Not fully adjusted for co-pays, non-paid electives, deductibles et cetera. Estimates: 08/20/97.

These same challenges have significant economic implications for all the stakeholders in the dental economy. The big issues include: (a) Disparate information, incentives, and standards—there are many ways to interpret standards of care, patient needs, case conditions, treatment options, and expanding clinical electives. Reimbursement systems are a control force for indemnity coverage while an estimated 38 million have some form of managed care. The practical distinctions of conventional indemnity coverage and managed care can become quite blurred, however, and this complicates the discussion. At some level, most dental care is managed. The issues are the source, goals, and power of “management” and how the decision process impacts the parties involved relative to access, cost-containment, and quality.

Generally speaking, managed care coverage is less expensive than conventional indemnity coverage. Cost-containment strategies may limit the rates of coverage for specific services or may include treatment incentives that discourage access to certain clinical alternatives. Some emerging reimbursement systems, including direct reimbursement, may reflect a combination of dental care financing and risk management themes in the facilitation of dental care.

**Important Facts and Figures.** From a combination of data sources and studies, the analysis provides information for a better understanding of the nature and extent of reimbursement. Some of the highlights from the task force analysis include the following facts and figures:

- Twenty-eight percent of full-time employees of small businesses have dental benefits, compared to 57% of full-time employees of large businesses and 62% of state and local government employees.
- Dental HMO membership varies dramatically by region, from an 8% national average to 3% of the population in the Northeast and East South Central regions and 17% in the Pacific Coast region. Even within regions, coverage varies greatly; local markets are diverse.
- The dollar value of dental reimbursement is about 55% of all dental spending, roughly $25 billion. Plan payments to providers range from roughly 65% to 85% of premium revenues.

One of the major concerns of the profession as well as the trade is that some reimbursement programs may restrict service demand. Reducing dental service access is not consistent with the goal of improving dental care. Responses to this reduction in dental service access could include more work on patient education, defined quality standards, and alternative practice models.

For better or for worse, reimbursement impacts service demand with controls on standards and patient information.

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**Table 2. What is the Covered Population for Dental Care?**

The different sources of reference data suggest that roughly 48% of the population is covered by some kind of dental care reimbursement scheme.

<table>
<thead>
<tr>
<th>Benefit Plans by Company Size</th>
<th>Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-9</td>
</tr>
<tr>
<td>With Plan</td>
<td>30%</td>
</tr>
</tbody>
</table>

Source: General studies by Delta Dental, Tower Group, and actuarial groups including Wyatt, Tillinghast.
Building a Response Strategy. There are two general alternatives for the ADTA. One option is to allow market forces to work through the major issues in service access, cost-containment, and quality. This is a relatively passive response approach. Another option is to participate in a response strategy that is geared to an active message that promotes patient interests and responsible consumption of appropriate dental services. The latter would be supported by communication efforts that focus on dental practices, benefit managers, and thought-leaders throughout the dental care system. This response strategy would address the objective of expanded access to dental care and increased service value in dental care, while also referencing practice model issues concerning costs, productivity, and choice.

Potential Avenues and Business Impact
Focusing on dental practices, benefit managers, and key thought-leaders in dental care, there is a core message that forms the basis for expanded access and service value. The message is a fairly simple but pointed assessment—one that focuses on responsible consumption of appropriate dental services. The message is prefaced by three simple but substantial facts:

- About half the population has some form of dental care reimbursement plan. Many of these plans involve patient cost-sharing and treatment choice restrictions.
- There are many reimbursement plan types and while most promote access, responsible consumption, and quality, some may act to constrain these goals.
- Every patient has unique needs and wants in the management of oral health. Responsible choices in treatment plans should be defined fully and fairly.

The general recommendation to the ADTA membership involves the education of each stakeholder group—consumers, providers, employers, third parties, and suppliers—regarding the issues and implications of dental finance and the reimbursement programs. This effort in stake-

The Perspectives of Stakeholders in Oral Health

Consumer Perspectives
In our review of dental consumers—patients and the families of patients—we found a number of conditions that shape the dental reimbursement and consumption equation:

1. General lack of awareness about clinical options
2. General lack of understanding about insurance
3. General lack of communication with the dentist
4. General lack of appreciation for cost-vs-value
5. Growing general interest in elective procedures
6. Growing diversity of patient needs and interests

Provider Perspectives
In our assessment of the market environment for dental benefits and service reimbursement, we uncovered the following concerns and perspectives of dentists:

1. General lack of understanding about insurance
2. General lack of awareness about patient behavior
3. General lack of comfort in presenting case options
4. General lack of flexibility in explaining options
5. Growing economic pressure from reimbursement
6. Growing administration complexity of practice

Employer Perspectives
Employers are actually a form of “customer” in the dental economy, performing a gatekeeper function that make key economic choices and set parameters for services. We discovered:

1. General lack of understanding about dentistry
2. General lack of understanding about reimbursement
3. General lack of understanding about case options
4. Growing pressure to contain all benefit costs
5. Growing pressure to keep the employees satisfied
6. Growing complexity of employee benefits in general

Third Party Perspectives
There are several hundred third party intermediaries who are involved directly and indirectly in the dental benefit and reimbursement arena. Some of the key issues in this zone include:

1. Changing demands of employers and employees
2. Growing need to provide competitive plan options
3. Growing pressure on cost and margin elements
4. General "countervailing" position with providers
5. General "gatekeeper" position with employers
6. Growing challenges with regard to elective costs

Supplier Perspectives
Naturally, the dental trade has a vested interest in stable and growing demand for dental care. Dental service utilization conditions serve to derive the demand for distributors, laboratories, and manufacturers in this environment. This raises several issues and concerns:

1. Reimbursement impacts the demand for services
2. Service demand "drives" industry considerations
3. Providers are caught in the middle
4. Patients are caught in the middle
5. Some reimbursement plans are not appropriate
6. The profession has difficulties in responding

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Table 3 Dental HMO Coverage by Region.

<table>
<thead>
<tr>
<th>Region</th>
<th>Covered Lives</th>
<th>Total Population</th>
<th>Share of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>400,000</td>
<td>13.3 million</td>
<td>3%</td>
</tr>
<tr>
<td>Mid Atlantic</td>
<td>2,600,000</td>
<td>37.1</td>
<td>7</td>
</tr>
<tr>
<td>S. Atlantic</td>
<td>3,800,000</td>
<td>47.5</td>
<td>8</td>
</tr>
<tr>
<td>E. South Central</td>
<td>450,000</td>
<td>15.0</td>
<td>3</td>
</tr>
<tr>
<td>W. South Central</td>
<td>2,000,000</td>
<td>28.6</td>
<td>7</td>
</tr>
<tr>
<td>E. North Central</td>
<td>2,700,000</td>
<td>45.0</td>
<td>6</td>
</tr>
<tr>
<td>W. South Central</td>
<td>675,000</td>
<td>22.5</td>
<td>3</td>
</tr>
<tr>
<td>Mountain</td>
<td>1,200,000</td>
<td>15.0</td>
<td>8</td>
</tr>
<tr>
<td>Pacific Coast</td>
<td>7,500,000</td>
<td>46.9</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: NADP and Interstudy.

One of the major concerns of the profession as well as the trade is that some reimbursement programs may restrict service demand.
ported that patients in managed care programs are satisfied with “ease of use/management,” “choice and flexibility,” “quality considerations,” “access considerations,” and “level of dental benefits;” with the overall relatively satisfied rating being 56%.

What Does This Mean for the Trade?
The distributors, laboratories, and manufacturers that serve the dental economy have a clear stake in the evolution of demand for goods and services. As a sensitive and ethical institution of commerce, the ADTA membership is concerned about payment systems and their policy implications on:

- The amount and nature of dental care demand
- The relationship between doctors and patients
- The evolution of better standards of care

These and other business, social, and ethical considerations are the backdrop for this analysis of managed care and reimbursement.

As with any matter as complex and dynamic as healthcare finance, there are many ways to examine the issues. The following outline is intended as an overview of the key points that provide a working definition of problems and opportunities. Again, the orientation here is about a balanced point of view for all the parties involved in the improvement of dental care access, value, and quality.

Disparate Information. Patients, providers, employers, and third parties have different kinds of information and knowledge about dental care choices and consumption. This confuses the decision process regarding case diagnosis and treatment plan alternatives.

Treatment Plan Alternatives. There are natural alternatives in diagnostics and treatment. There are various incentives at work for providers, patients, employers, and third parties that impact the choice process. Some of these incentives are economic, while others reflect personal concerns.

Transaction Elements. As the so-called information age moves forward, new methods for managing administrative data have become available. These help track information about dental care standards, utilization, costs, and delivery conditions. They also serve to control them.

Financial Reality. While the majority of existing dental plans have balance and “reasonableness” in their structure, some plans place economic constraints on patients and providers that have consequences for the access, value, and quality goals of dental care.

Marketplace Diversity. Today, researchers recognize that many consumer segments exist in the dental healthcare marketplace. Patients vary greatly in terms of the socioeconomic and behavioral foundations that drive dental service consumption.

Their knowledge and motives are diverse, and their clinical needs can vary as well.

Provider Differences. Similarly, not all practices operate with the same set of business and clinical norms. These differences impact the ability of the practice to provide service quality, practice, sustenance, and patient access. Some also regard the profession as a very independent group of providers.

Employer Differences. Benefit plans and policies vary greatly from one firm to another. There are many issues that shape and influence employee benefit manager decisions on dental plans. Fundamental access, value, and quality issues apply, but the information is complex.

| Table 4. What is the Employee Benefit Management Picture? |
|---|---|---|
| Employees with Medical and Dental Benefits |
| Medical Plan | Dental Plan | Employment |
| Small Business Full Time | 66% | 28% | 36 million |
| Small Business Part Time | 7 | 3 | 14 |
| Large Business Full Time | 77 | 57 | 35 |
| Large Business Part Time | 19 | 13 | 8 |
| Government Full Time | 93 | 62 | 20 |
| Government Part Time | 87 | 62 | 14 |

The Trade Looks at Dental Reimbursement

Table 5. What are the Key Trends in Benefit Coverage?
Over the last thirty to forty years, dental benefit programs became popular with employees and employers. The level of aggregate benefit coverage continues to expand, while the different types of programs proliferate.

<table>
<thead>
<tr>
<th>Market Share</th>
<th>Service Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental HMO</td>
<td>17.7% 23 million</td>
</tr>
<tr>
<td>Dental PPO</td>
<td>11.5 15</td>
</tr>
<tr>
<td>Indemnity</td>
<td>70.8 92</td>
</tr>
<tr>
<td>Total</td>
<td>130</td>
</tr>
</tbody>
</table>

Sources: Actuarial studies, Employer Benefit Plan Review, Delta Dental, National Center for Health Statistics, Dewar Sloan estimates.

Healthcare Reform. American society continues to wrestle with the issues in healthcare delivery rights, purpose, cost, and quality. On one hand, we believe in the need for broad patient access to care. On the other hand, we believe in some limits to service and costs. The social and philosophical issues are a cause of conflict.

Expanding Electivity. As the science, art, and methods of dental care have evolved, the relative level of diagnosis and treatment electivity has greatly expanded. This compounds the challenges of making the best clinical choices while keeping costs in control for the system.

Each of these problems and opportunities deserves a discussion all its own—one that covers the details and nuances of each issue and consequence. In the end, however, what we have is a marketplace that is complex and tough to organize. There are conflicting motives in some areas, and there is imperfect information. These make for a general “marketplace mechanism” that will probably never be in full balance and harmony for the stakeholders. No single solution exists.

Practical Consequences. Based on the problems and opportunities defined in the previous pages, we can assume a series of consequences for patients, providers, third parties, employers, and suppliers.

1. The demand for dental care will be impacted: To some extent, the demand for professional care is encouraged or restricted by price and by the conditions placed on utilization. Managed care shapes both of these variables.

2. The overall cost of dental care will be impacted: The pressures of broader healthcare reforms are geared to the total costs of benefit programs, reflecting employment conditions, and talk” about quality in context, value, and standards, but relatively little real substance in terms of National Center for Quality Assurance measures for clinical or service quality by procedure type.

3. The spread of economic tension: As practice economics show the stresses of price pressure from managed care, there is a tendency to target dental distributors, laboratories, and manufacturers for the “sharing” of this tension, increasing the economic concerns.

4. Potential reductions and constraints in patient care: As technical, practice, and economic pressures converge, the stakeholder that is most likely to be ignored in the fray is clearly the consumer patient. Diminished dental care access, eroded value, and mixed quality are possibilities. These consequences range from positive to negative, depending upon points of view. From a trade and economic and social perspective, the interests of this as-

<table>
<thead>
<tr>
<th>Table 6. What About Employee Contributions to Costs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plans Requiring Some Benefit Contributions</td>
</tr>
<tr>
<td>Typical % Contribution</td>
</tr>
</tbody>
</table>

Relative to Total Cost

Source: Wyatt Group COMPARE database and Dewar Sloan studies.
The Trade Looks at Dental Reimbursement

Table 7. Typical Employee Contributions to Benefits.

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>No contribution</td>
<td>45%</td>
<td>35%</td>
</tr>
<tr>
<td>Less than $120 per year</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>More than $120 per year</td>
<td>16</td>
<td>53</td>
</tr>
</tbody>
</table>


ADTA Response

Ultimately, the strategic intent of this task force plan is to improve access, value, and quality in the dental care system. This is a fairly complicated frontier, for all the reasons explored. The task force agreed that there were two major response strategy options: to let the marketplace sort things out over time or to make plans for a series of strategic and tactical interventions that would provide leadership. The latter response was chosen. The foundations for these recommendations involve two themes.

1. A simple message on dental economics: Reimbursement is a complex issue with lots of room for confusion, conflict, and concern. If we can promote a universal message on the quality in context of dental services, all stakeholders can use this language to deal with different needs, issues, and constraints in the dental care system.

2. A simple market communication platform: Taking the message to the streets is a challenge at every level. Fortunately, this task force is linked with a group of key dental healthcare principals and thought-leaders who can help trigger a broader movement in the promotion of dental access, value, and quality, along with a good set of solutions.

The desired impact of this strategy is to bring some order to the problems of access, value, and quality in dental care. The practical goals behind the recommended strategy include promoting and supporting:

- Patient access to services
- Patient choices in services
- Responsible consumption
- Practice sustainability
- Quality of dental service

These goals recognize the existence of differences in practice models, patient profiles, employer needs, third-party concerns, and supplier norms. They also set the stage for communicating at all levels of the profession. The common theme we recommend is: "Responsible consumption of appropriate dental services."

This addresses the essential concerns of dental reimbursement plan. Most plans involve some out-of-pocket costs or cost sharing. There are many different approaches to providing dental benefits. Most plans limit the amount and type of dental care services that are reimbursed. Some plans are very strict in scope, others are relatively flexible.

- Dental services are widely available to most of the population. About half the U.S. population has some form of dental reimbursement plan. Most plans involve some out-of-pocket costs or sharing. There are many different approaches to providing dental benefits. Most plans limit the amount and type of dental care services that are reimbursed. Some plans are very strict in scope, others are relatively flexible.
- There are many clinical procedures that are not covered by typical dental benefits. These procedures may be in the best interest of the patient, but

Stakeholder Definitions

There are many perspectives that need to be addressed in any discussion about healthcare reimbursement. As the history of healthcare reform movement has unfolded in the last fifty years, many forces have been at work. To some extent, these have impacted the definition, development, and delivery of dental care.

1. Consumers have been treated for basic dental disease; they have been exposed to an increasing array of treatment options, and in the last twenty years they have been served with new elective options.

2. Providers have delivered an evolving mix of care, with an evolving set of standards and a growing base of technology under a shifting set of economic and operational circumstances.

3. Employers have introduced, funded and managed a growing range of employee benefit programs that often include dental care services.

4. Third Parties have developed and managed a range of finance and reimbursement options that facilitate payment for dental services and support the delivery of care in different environments.

5. Suppliers of dental materials, equipment systems, and services have developed and delivered products and laboratory services that facilitate patient care and support the dental practice environment profession.

Each of these stakeholder groups is impacted by the mechanisms of reimbursement, directly and indirectly. Each has unique motives and concerns that are personal and economic. Each has broader motives and concerns that relate to the goals of dental care in modern society.
The Trade Looks at Dental Reimbursement

Table 8. Typical Benefit Coverage.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Preventive</th>
<th>Routine Operative</th>
<th>Prosthodontics</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% coverage</td>
<td>79%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>80% to 100%</td>
<td>3</td>
<td>7</td>
<td>More than 60%</td>
</tr>
<tr>
<td>80%</td>
<td>13</td>
<td>63</td>
<td>50% to 60%</td>
</tr>
<tr>
<td>Under 80% coverage</td>
<td>4</td>
<td>21</td>
<td>Under 50%</td>
</tr>
</tbody>
</table>

Seventy-seven percent of orthodontic treatments covered: With maximum lifetime benefits of 11% less than $1,000, 74% between $1,000 and $1,500, and 15% above $1,500.


the benefit plan may restrict the delivery of those services.
• Everyone is interested in appropriate access to dental care, responsible cost-containment, and quality in the context of standards of care—for basic dental services as well as advanced procedures and elective treatment.
• The dental profession, benefit managers, third party reimbursement entities, suppliers, and patients must work together to consider appropriate standards of dental care and good economic value for patients and families.

No single solution exists.

care choice and value. It is a civilized and responsible message that is truthful and flexible and targeted at essential information objectives.

There are many ideas for the conveyance of the message to the various stakeholders. Professional associations have invested a lot of effort and money to influence the general public as well as their constituents, reimbursement parties, and policy principals. These investments have fared poorly in a marketplace cluttered with complicated service conditions, motives, and messages.

Based on a series of summit meetings and this task force research on the appropriate response strategy, we recommend the following channels for the response strategy message:
• Direct message to mainstream dental practice: Equip the dentist and staff with a clear, credible, and purposeful platform for reimbursement review.
• Direct message to mainstream benefit managers: Equip managers and analysts with a credible and reflective platform for plan assessment.
• Direct message to practice and quality research: The profession needs assistance in dealing with the "commodity challenges" inherent in dental care.
• Direct message for distribution to the patient: Equip various parties with useful material for the education of patients on choices and value.

These are four primary channel ideas for the response strategy as proposed. These channel ideas are developed further in this section.

Implementation Program. We have considered a number of implementation avenues for this response strategy recommendation. The list below is the original catalog of implementation options.
• Thought-leader proclamations and features
• Template for practice communication
• Template for study groups and societies
• Template for benefit manager groups
• Template for practice model dialogue
• Template for quality research dialogue
• Standard response to critical programs
• General Q & A response encyclopedia

These were reviewed by the task force with regard to advantages and possible drawbacks. The recommendation of the research team and task force is to concentrate on a single platform that works for practice audiences, benefit managers, thought-leaders, and perhaps consumers in the patient care environment. The basic platform is further detailed in the balance of this section, and a basic template is suggested.

Dental care issues and options is the general headline for the response strategy, and everything is directed toward: “Responsible Consumption of Appropriate Dental Services.” From the start, we envision the template as a package of very basic print and presentation materials, based on the message defined previously. It would

Table 9. Typical Benefit Plan Deductibles.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>No deductible</td>
<td>22%</td>
<td>50%</td>
</tr>
<tr>
<td>Less than $50 per year</td>
<td>72%</td>
<td>5%</td>
</tr>
<tr>
<td>More than $50 per year</td>
<td>7%</td>
<td>45%</td>
</tr>
</tbody>
</table>

involve a communication plan that delivers the message to and through four key audiences:

- Mainstream dental practices
- Mainstream benefit managers
- Practice and quality research audiences
- Dental patients and families

The presentation material evolves from a standard slide presentation that provides an overview of the background, issues, implications, and solutions as defined. The print materials can be developed from this same basic template and used in the form of newsletters, brochures, publicity materials, patient education resources, and so on.

Standard Presentation Outline. We have an option that requires the development of a generic slide presentation that can be duplicated and distributed for use at the practice level, conference study groups, society meetings, dental schools, and other audiences. Perhaps more importantly, as we have seen in Wisconsin, Pennsylvania, and other states, there is an opportunity to use this presentation as the vehicle for education and discussion with business groups, employers, benefit managers, benefit plan representatives, and other payers.

This presentation is currently in the prototype stage with slides and a text outline. This was originally requested by Dr. Gordon Christensen. The task force is indebted to both for their leadership in pulling this important vehicle together. Additional packages can be duplicated and prepared on a modest cost basis, with the possible "cross-label" of either business sponsors, local/state dental society sponsors, or perhaps the ADTA.

Other Print/Media Materials. While mass media campaigns to influence patients, providers, and employers are sometimes interesting, they are relatively weak as investments in market influence. The task force has taken a tack that provides a simple, basic message that can be replayed at the point of service—locally. This approach provides the essential content as expressed in this section of the report, in the simplest form, for inclusion in print materials, conferences, meetings, or education sessions with key stakeholders. The basic messages and themes from this research can be transferred to:

- Dental society or study club materials
- Individual dental practice newsletters
- Patient education materials for practice
- Employer and benefit manager education
- National and state level dental media
- Staff training and educational programs
- Dental schools and continuing education
- General population and public education materials

Our intent is to capture a few basic pages or paragraphs of balanced, thoughtful, persuasive content that can be applied in the most productive and relevant media. This allows the motivated leaders of the dental care system to show the way and realize patient care and related business gains along the way.

Responsible Consumption of Appropriate Dental Services

The leadership of the ADTA and key leaders in the profession have worked to address the challenges and opportunities of dental reimbursement. This task force study has isolated the facts, issues, and the implications of "managed care" and other

Table 10. Mix of Financial Options for Dental Benefit Coverage.

<table>
<thead>
<tr>
<th>Plans</th>
<th>Companies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional plan only</td>
<td>61%</td>
</tr>
<tr>
<td>PPO plan only</td>
<td>5</td>
</tr>
<tr>
<td>HMO plan only</td>
<td>4</td>
</tr>
<tr>
<td>Traditional + PPO</td>
<td>4</td>
</tr>
<tr>
<td>Traditional + HMO</td>
<td>21</td>
</tr>
<tr>
<td>PPO + HMO</td>
<td>3</td>
</tr>
<tr>
<td>All three types</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: 1995 William M. Mercer Survey of Employers with Dental Benefit Programs—Manufacturing and Service Firms.

Table 11. Service Payment Categories.

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
<th>PPO Plan</th>
<th>HMO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and Preventive Care mean</td>
<td>96%</td>
<td>98%</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td>median</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Basic Services and Operative mean</td>
<td>78</td>
<td>82</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>median</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>Major Services and Restorative mean</td>
<td>55</td>
<td>61</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td>median</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

Source: 1995 William M. Mercer Survey of Employers with Dental Benefit Programs—Manufacturing and Service Firms. Read the above data as amount paid by plan, with the premise that negotiated fees and pricing norms are a key variable in the payment scheme.
forms of dental care finance and reimbursement. Some forms of reimbursement may not serve patients well. Some forms of reimbursement may not be economical for those who hold stakes in the dental healthcare system. Through it all, however, dental reimbursement has provided access for many patients in the last forty years. Now, as we approach a market in which half the population has some level of dental benefit coverage, the complex needs and concerns of the marketplace and the era of healthcare reform force us to focus on a new and important agenda. The intent of this study was to put all the issues in a more relevant and balanced context, and then to determine if a response strategy of some form is necessary. We have produced and reviewed the facts, and we have made a modest response strategy recommendation. Beyond this conclusion, we strongly suggest that a broader demand strategy be considered by the ADTA leadership and individual members.

Acknowledgement

This report was produced for distribution to ADTA members and stakeholders. It covers the overall scope and purpose of the Managed Care Task Force study, along with informal recommendations for action. The study, conducted by Dewar Sloan Research and Planning Group of Traverse City, Michigan, was commissioned to address the condition, risks, and problems of dental reimbursement relative to the goals of providers, employers, third parties suppliers, and consumers of dental services.

Reynolds R. Challoner
Chairman, ADTA Task Force

Daniel T. Wolf
Managing Director, Dewar Sloan

Nikolaj M. Petrovic, CAE
ADTA President/CEO
4222 King Street West
Alexandria, VA 22302
phone (703) 379-7755
fax (703) 931-9429
e-mail npetrovic@adta.com

4222 King Street West
Alexandria, VA 22302
phone (703) 379-7755
fax (703) 931-9429
e-mail npetrovic@adta.com
Direct Reimbursement—
Its Role in Financing
Dental Benefits

Dale F. Redig, DDS, FACD

Abstract
Direct reimbursement is defended against its critics. It is a benefit plan, not insurance, has not raised costs, is inexpensive to administer, and is popular with patients. The concerns of the managed care industry over dentists being opportunistic are unfounded in view of dentistry’s outstanding ethical reputation. Such concerns should be more appropriately directed toward managed care itself.

Before describing what direct reimbursement is, it is of value to reference it from the perspective of what it is not. I believe this provides a solid base for better understanding what it is. Direct reimbursement is not a system:

- To restrict access to dental care.
- That restricts freedom of choice for the patient to choose his or her provider of care.
- Designed to insert provision of care exclusions or limitations, directed by a third-party, non-professional who is not involved with the dentist-patient relationship.
- Designed to limit preventive services or diagnostic measures.

- Designed to ratchet downward provider remuneration and place dentists in the exact same professional practice nightmare as has occurred in the medical managed care industry.
- Promoting the lessening of the standard of care through unrealistic, economically disastrous remuneration levels. It does not force the dentist, in order to avoid economic failure, to consciously reduce quality of care in order to remain in “business.” Nor does it entice a provider of care to adopt arguably unethical business strategies of cost-shifting to those who can afford inflated costs or services or “bait and switch” techniques to deliver even basic dental care.
- With commission and administrative fees in amounts upwards from 15% to well over 40% of premium paid by employers for provision of dental benefits.

What direct reimbursement is is the most effective and efficient way for employers to provide appropriate dental benefits to employees. It uses the simplest economic model available. It establishes, or re-establishes, direct connection between provider and patient. The patient and dentist decide on services to be rendered and how much those services will cost. The employer, through clearly outlined levels of benefit structure, reimburses the employee or patient upon receipt of paid claims for services. Records are kept of service provided, total fees paid, and amounts reimbursed by the employer. Administration is generally handled by a third-party administrator (TPA).

The first response by the managed care industry to this premise is that it is basically unworkable and unfair to employees and employers. In response to that argument one must say: Nonsense. Real results in the real marketplace show that it is eminently workable, fair, and reasonable. It provides for delivery of dental health care benefits using the same economic standard used for a number of other employee benefits—direct reimbursement: for travel, vision care, miscellaneous business expenses, retirement contributions, and in a growing number of instances, cafeteria health plans.

In understanding and discussing dental benefits, it is important to correctly reference what we are talking about. We should not talk about dental “insurance.” What was started in California, by California dentists and the California Dental Association, which was the advent of employer involvement in dental care for employees, was not and has not been “in-
The Trade Looks at Dental Reimbursement

surance.” What is often promoted and discussed as dental insurance is actually a dental benefit system of one sort or another, for employees by employers. The concept of spreading risk among a large group of persons by charging a standardized premium, thereby accruing a pool of funds to allow payment for major, potentially ruinous costs of providing care which only a limited number of persons will require, is what insurance is about. Dental benefits are not predicated on this model and have not been. It is widely agreed that 95 to 98% of the population has need for dental care. Dental benefit plans do not cover the majority of dental care costs in this country. Annual reports from sources public and private indicate that over 50% of all dental care provided in the U.S. is paid for out-of-pocket by the patient. Indeed, for most plans, the annual levels of employer contributions to employees reached plateaus of $1,000 to $1,500 years ago and in many instances, levels have gone down from there, rather than up. While for years dentistry seemed intent to mimic the medical model of indemnity insurance coverage, it has for the most part been only a figure of speech; it is correctly defined as a limited benefit in the vast majority of applications and everyone in the benefits industry knows this to be true. We all should try whenever possible to correct the record, with dentists, employers, and the public at large.

Managed care proponents state that direct reimbursement will lead to increases in dental benefit costs and major increase in incidents of fraud. In response to that, one must say: Show me the money! Direct reimbursement has been around for many years. In virtually all instances, its use has resulted in stable or reduced dental benefit costs to employers. Further, surveys indicate that employees prefer direct reimbursement because they can make their own decision about what care will be provided by whom and the reimbursement they will receive as a benefit is not in question. Employers have learned that commission rates and administrative costs are sharply reduced, from levels of 15% to 40+, to levels of 2% to 7%, which translates into more plan contribution dollars available for provision of dental care. This pleases employers and employees.

As to allegations of fraud, it seems clear in reading about any and all managed care plans that fear of fraud and measures to prevent it is of central importance in administration of all those plans. Why? The implication to be drawn is that dentists are inherently dishonest. One does not often enough hear another point of view. There is another; it needs discussion.

I have been closely involved with the dental community, in practice, education, administration, and politics for over forty years. I have had the good fortune and bad fortune to see our profession at its best and sometimes at its worst. In my experience, its worst was rarely related to the trait of dishonesty or lack of ethics. We may sometimes lack professional judgment, we may sometimes be too gullible, thus “sitting ducks” for business entrepreneurs who care nothing about standards of care while professing to be friends of the people, but as a profession and individually, except for a distinct minority occupying the very far negative end of a bell-curve, I believe it is fair and correct to state that dentists are fairly described and judged to be high on the list of respected, ethical professionals. Our profession, perhaps more than any other in this country at this time, insists on retaining its standards for code of conduct and ethical behavior, often to the amazement of other related disciplines. The naysayers’ opinion to the contrary needs to be weighed against this perspective.

Could managed care’s fear of fraud and the subsequent expensive, cumbersome, frustrating-in-the-extreme measures to control and burden it with who knows what kind of sanctions, directly correlate to a feeling by the industry based on the principle that, because of increasing efforts by managed care entities to ratchet down provision of care through limitations, exclusions, denial of benefits, reduced fees, etc., some practitioners are or may be drawn to consider bending rules, upgrading procedure codes if possible, treating as few patients as possible with the least possible level of treatment and numbers of procedures, etc.? And doing so in order to make money to pay the costs of doing business, raise a family, and stay in business? Since it can be strongly argued that managed care carriers and representatives, who arguably know better than most practicing dentists the down and gritty intricacies of running a business based on profit-first, service-maybe, it also may follow that they would be the first to understand that placing practitioners at economic peril increases the risks of cutting corners and entering into risky ethical behaviors.

Isn’t it understandable that the managed care industry might consider all possible steps to posture an accusatory climate, with subsequent provision of dra-
conian steps to best assure that their bottom line will not be affected? Does anybody in that industry ever venture the aphorism stated so well by Walt Kelly's friend Pogo: "We have met the enemy and he is us."? Surely these are reasonable questions to ask.

Contrast this climate with what one finds in questioning employers and employees about direct reimbursement. Costs, compared to traditional "insurance get-rich-quick advantages to selling out; most of the time it doesn't work that way at all.

2. Individually managed dental practices, as currently structured in the marketplace, provide the strongest economic model for competitive provision of service. Monopolistic control by very large entities is effectively negated. This is to the ultimate advantage of the public and the profession.

Fee-for-service is the absolute standard for excellence in provision of services, now as always

plans" tend to go down for the employer, employees as patients are very satisfied with the right to select their dentist of choice, arrangements for care, and the care provided. They rarely, if ever, complain that they were treated as someone to be avoided or barely tolerated in the dentist's practice. Dentists do not complain about harassment by carriers, reimbursement delays, or the anguish of both patients and dentists in loss of patients to "preferred" providers.

With better understanding of the economic model driving managed care, now best exemplified by the extreme problems occurring in the medical care arena, dentists can learn much about what to do and not to do. Some points stand out:

1. The dental profession is largely a stand-alone model. Attempts by managed care entities to consolidate practices, which affords a ready-made base for takeover by managed care HMO type entities, have not been particularly successful. The dental industry, often referenced as a cottage industry, largely unknowingly insulated itself against corporate raiding. Dentists would do well to carefully consider any move away from solo independent practice if they wish to avoid maximum penetration by managed care interests. They will do equally well to view with jaundiced eye any

3. Fee-for-service is the absolute standard for excellence in provision of services, now as always. Most employers, and certainly most employees, want high quality service. Remember that quality is an ambiguous term; it can mean poor quality as well as high quality. Fee-for-service can stand the competitive rigors of capitated care as long as providers offering it are aware of the positive power of it.

4. Beware offers by Delta Dental Plans or other groups to market and administer direct reimbursement plans. Look carefully at what they are apt not to do in promoting direct reimbursement when agreeing to take it over.

5. Direct reimbursement must be making a significant impact. Why else

Our profession insists on retaining its standards for code of conduct and ethical behavior, often to the amazement of other related disciplines.

Author's Note: The Fall 1997 issue of the Journal of the American College of Dentists was devoted to the broad subject of financing oral health care. A number of papers were presented, for the most part painting a positive picture of managed care and its future, with the exception of the one paper on fee-for-service dentistry, a perspective that I believe is the one most often voiced by a very large majority of practicing dentists in this country. Direct reimbursement, a long-time part of dental benefit funding, which is now causing apparent serious consternation among dental "insurers" was referenced, but a paper outlining its perspective and role in the marketplace was not included, despite repeated efforts to obtain one from responsible spokespersons. This article is submitted in response to a request from the Editor following the publication of the Fall 1997 issue. It is an opinion piece—in the author's opinion it contains no more, hopefully far less, rarefied air than one finds in the series of "we have it figured out" presentations found in the Fall issue, excepting the opinion piece by Dr. Richard Wilson.

hit-piece of "research" against direct reimbursement found in the February 1997 issue of Reader's Digest? Why else the "they're hurting us" letter of

would billion dollar companies such as Delta Dental Plans of California pay an insurance brokerage firm a lot of money to do a hit-piece on direct reimbursement? Why else the complaint against direct reimbursement filed with the Federal Trade Commission by the Executive Director of the National Association of Dental Plans?
Direct reimbursement may not become a giant in the dental benefits marketplace. Then again, as more and more employers and employees learn the benefits of true freedom of choice regarding provider, treatment, outcome, and cost of providing dental benefits by using self-funded direct reimbursement, who knows? A lot of nervousness in the dental marketplace might not be a bad thing in ultimate effect for the most important group in this situational drama: the patients to whom we owe our right to practice and to whom we are obligated by professional standards to be as good as we can possibly be.

Further information can be obtained from J. Philip Pfeifer, Associate Director, Marketing and Programs, Post Office Box 4976, Cary, North Carolina 27519, (919) 467-3423, Fax: (919) 467-3083.
Abstract
A taskforce of dental professionals and industry leaders looked at the impact of dental benefit programs on America’s oral health. When properly done, such benefits programs are positive; but precautions must be taken to ensure that underfunded programs and those which restrict choice are not allowed to erode dental health. Six possible courses of action are developed, centered around education, communication, and collaboration.

Managed care in various forms has evolved as a general concern for the dental profession and the dental industry. On August 22, 1996, a group of leaders from the dental industry and profession met to consider the issues and implications of dental managed care. The objectives of this meeting are summarized as follows:
• To consider the nature of the dental economic system and the connections between quality dental care, access to services, and the financing of dental care.
• To better understand the positive and negative trends in dental care that are shaped by reimbursement methods, dental care financing, and managed care as commonly defined.

Conditions and Concerns
Based on extensive discussions and formal presentations at the August 22 meetings, the following points were developed by the group: Managed care is a term that has a wide scope and definition. It can be defined as any intervention between patient and dentist on treatment options and payments for dental services.

There seems to be some controversy and concern when the discipline of managed care is associated with specific therapy restrictions, significant discounting, patient choice restrictions, communication restrictions, or utilization disincentives.

For a variety of reasons, professional dentistry has not been completely successful in establishing the importance of clinical choice and quality in context for the patient. Clinical choice refers to dentist and patient options for restorative therapy approaches. Quality in context refers to appropriate technical quality at every level or every standard of care, whether that standard involves an amalgam restoration case or the alternative endosseous implant with a ceramic and metal crown. As a result of this condition, the following issues exist: patient relationships are centered around financing, benefit managers may undervalue dental services, and powerful third-party payers control the system.

Significant underfunding and restrictions in managed care programs appear regionally. There is more pressure and eco-
nomic tension in some areas, and virtually no impact in other areas. The conditions and problems evolve reflecting this variation.

Under some conditions, the structure of individual managed care programs can contribute to service quality degradation, access limitation, and extreme economic constriiction. These circumstances are not consistent with the goals of patient satisfaction, comparative quality, practice profitability, and professional ethics and progressive clinical norms. They are not consistent with socially accepted healthcare objectives.

An economic prospective about resources that go into managed care is important:

- The value of total U.S. dental services delivered is roughly $47.5 billion.
- The value of conventional dental materials, equipment, and laboratory services approximates $6 billion.
- Reimbursement programs cover roughly $25 billion of these services on premium costs that are estimated at $32 billion—leaving roughly $7 billion in facilitation costs. Market development costs for reimbursement could approach $3 billion.

The respective players must consider these facts when determining available prorata resources that could be used to deal with the issue.

Response Strategy
The problems with some forms and structures of dental managed care were defined by the group in terms of the following six points. These are described in a very preliminary manner, the response strategy priorities are yet to be determined. These problem definitions are a starting point for focus, sequence, and action:

1. Patients, benefit managers, and providers have difficulty understanding and communicating about basic differences in treatment quality and alternatives.
2. For professional, technical, social, and economic reasons, practices have a difficult time managing patient treatment options with case plans that reflect certain standards of care. This issue is a significant challenge for practices.
3. Underfunded and restrictive managed care plans impact some market areas and are virtually absent elsewhere. This makes impact of these extreme plans geographically uneven.
4. Underfunded and restrictive managed care plans create clinical, economic, and ethical tensions in dental practice as the autonomy and viability of practice are damaged.
5. Benefit managers are largely uninform about the nature and characteristics of dental managed care. They have limited knowledge about the impact of underfunding and restrictions.
6. While many organizations have made statements about the virtues and vices of "managed care," there appears to be no common voice that is dealing with the real issues of extreme plans and their impact on quality, access, and value.

These problems have led to populist stress and turmoil that do not help sort out the real issues for patient, practices, benefits managers, third parties, and ultimately the profession and industry. The basic definitions also confuse the clinical and business issues of dental care. In some instances, managed care provides essential access to dental services. In others, it restricts treatment options, the dentist-patient relationship, and choice. In general, managed care tends to redistribute the economic formula of the dental care system and the value-chain of each stakeholder in the dental economic system. We need to understand the differences.

To deal with these issues, the group proposed a set of six preliminary themes that could contribute to practical and purposeful solutions. These are subject to further discussion, and again these elements and potential priorities represent the starting points for focus, sequence, and action.

1. Possible Action—Assist in the education of providers and practice staffs: From dental school through continuing education programs, the subject of business structure, impact, and behavior relative to the natural goals of dentistry need to be addressed.
2. Possible Action—Assist in the education of employee benefit managers: Employee benefit managers and staff have many other issues to contend with, and there is a need for legitimate reference information on dental services, benefits, and major options.
3. Possible Action—Communicate with managed care principals and representatives: The connection between the dental profession, managed care, and the industry can be improved by sharing important standards, principles, and objectives for dental health care.
4. Possible Action—Contribute to better practice and economic models: Standard practice models are being challenged by alternative models which affect the patient, the dentist and staff, third parties, and company dental benefits. Better practice models may yield better service levels, economics, and "products" for the different patient populations and company benefit programs.
5. Possible Action—Assist in the development of practice-public communication: The public has very little information about standards of care in dentistry, value in context, or benefit management. Improved communication at the public level is essential.

For a variety of reasons, professional dentistry has not been completely successful in establishing the importance of clinical choice and quality in context for the patient.
6. Possible Action—Provide inter-organizational leadership on finding solutions: Several professional and industrial organizations have a vested interest in finding practice management, dental education, and benefit management solutions. These organizations are connectable.

These themes are intended as positive, productive means for improving the overall dental economy, as well as the ideals of quality dental service and the nation's oral health. This intent is consistent with quality standards, economic reality, technical reality, and other conditions that shape the system of dental care delivery and finance.

Leadership Prerogative

Members of the dental trade and leaders from the dental profession have a practical and ethical commitment to appropriate dental service finance structures. Benefit programs that support patient access, quality, and value in context, and finally responsible cost management are appropriate in the view of this leadership group. Programs that restrict patient and provider choice, the alternatives, and the dentist-patient relationship produce conditions that have troublesome consequences. They jeopardize the quality of dental care delivery, which in turn erodes the nation's oral health care. The development of more appropriate dental care financing and reimbursement programs and assisting stakeholders in responding positively to the fundamental of healthcare reform are the key challenges.
The Trade Looks at Dental Reimbursement

A Strategy for the Profession and Trade to Deal with the Changing Dental Environment

Reynolds R. Challoner

Abstract
A former plan purchaser who is now the owner of a dental laboratory explains how dental benefits have been frequently introduced as supplements to medical benefits programs by large carriers. This has created a "knowledge gap" regarding the effects of underfunding and restriction of choice on the oral health of Americans. The dental profession and the dental industry should embark on a program to supply the information upon which patients and employers can make sound decisions.

Dentistry has been the last healthcare field to be affected by the changing and evolving benefits and managed care industry due to it being less than 5% of the healthcare dollar and thus relatively insignificant by comparison to the size of medicine. With the exception of some very large companies such as Boeing, General Motors, Texas Instruments, etc., who have very formalized and active dental benefits management, by far the majority of U.S. industry has not had significant knowledge of or interest in dentistry or dental benefits. Since the inception of dental benefits over forty years ago, the actual cost to the companies has increased minimally, with reimbursement maximums remaining at $1,000 annually. But the benefit plan industry, having developed its medical managed care products (HMO, PPO, etc.) is now looking for "a product" on the dental side which they can sell to their corporate customers. Hence the increased focus on dentistry, whose inflation rate is now above medicine where historically the reverse has been true.

Three or four years ago, there was significant activity and high growth rates of dental managed care, with numerous benefit companies developing dental HMO and PPO programs to offer to their corporate customers. In many regions of the country where there is a balanced supply and demand of dentists to dental services (or even where there is a shortage of dentists), DHMOs and DPPOs have had limited impact. In fact, with the supply and demand going from an excess supply position five years ago to a balanced or slight shortage today, it will be even more difficult for benefit plans to develop a significant number of providers when providers are asked to discount their services by 30% (particularly when the average dental practice margin is 35%). The initial incremental income model developed by PPOs in the past, which could economically justify a practitioner taking on incremental business in the form of new patients in underutilized practices is no longer valid in many areas of the country. That is why many benefit providers are now starting their own practice management groups or contracting with larger dental group practices to provide those products to their corporate customers.

Lost in all of this has been the fact that the dental economic system is made up of segments, including the patient, the dentist, and the supplier and laboratory—in addition to payers and third parties. The current dental benefit system's plans look at a homogeneous patient population which obviously does not correspond with reality. This, combined with the fact of changing demographics of the patient population (which is increasingly interested in higher esthetics and more friendly personal services) are making the naturally restrictive current benefit plans less attractive to the patient. This will eventually be fed back to benefits purchasers as a negative by employees.

New technologies and improved practice models which focus on patient communication and involvement in the decisions will continue to grow, further differentiating conventional indemnity and the newer managed care plans from the needs and wants of patients. This will put pressure on current benefit plan designers to...
provide more choices. It is reasonable to assume that any economic free-market system will balance itself over time as long as knowledge and information are in the hands of the decision makers. The challenge facing dentistry today is centered around making this information available.

Through my experience as vice president and general manager of a large Wisconsin paper mill which put in a low-cost dental benefit to obtain a co-pay and deductible in our medical benefit, I had very little knowledge about dentistry, or in fact oral health, nor did I really care. I did not know any better, I just wanted to have a competitive benefit to attract and keep quality employees. Now that I own a laboratory and look back through the system at the oral health needs and wants of the patient, my opinion has changed dramatically. I now know what dentistry can provide, and I see this current system of benefits programs becoming less practical.

Much of what the benefit industry hears from corporations is cost maintenance or containment because of the lack of information at the corporate decision-maker’s level about what dentistry can provide. The benefit providers, therefore, rightly develop cost-containment schemes to restrict choice and keep managed costs down for their corporate customers. This is in the face of that portion of the patient-employee population wanting to have more esthetic and personal high-quality services. For example, a CEO or vice-president of a corporation has significantly different needs for himself or herself and family than the average production worker in U.S. industry. Managed care programs will meet the basic needs for the oral health of a segment of the patient population willing to give up choice for a low cost, but there may be very little application to the higher-income patient segments that want and demand better service and treatment.

Management focusing on patient communication is up significantly as dentists prepare to differentiate their practices from managed care and sell “value.” Also, we cannot forget that consumer confidence is at record levels the past two years, which has driven up discretionary purchases, thus a significant portion of dentistry.

With this as background, in Wisconsin we have undertaken programs to pull together dentistry leaders and CEOs and benefit managers from moderate-sized to larger corporations who make decisions on benefit plans to hear each other’s perspectives and needs for maintaining the oral health of employees and the perceived value of their companies’ benefit plans. The hope is that the corporations will become more informed about dentistry and how benefit plans from their inception restrict the type and mix of dental services which are able to be provided to the differing needs of the different patient-employee populations within their companies. These meetings have been very well received by the employers, but now dentistry must provide the educational materials and support for not only the employees but also the benefit managers and decision makers themselves. Informed decisions are the key to the eventual rationalization of the dental benefits industry.

There are several different ways to educate the patient population in the U.S., including consumer advertising, articles and information through channels including magazines, newspapers, and television. Also, a little-developed method is through companies to their employees. Since companies have dental benefit plans that pay for roughly 45% of all dentistry provided in the U.S., it would seem that focusing on this channel of education should have a higher priority within organized dentistry. The question is, can organized dentistry on a national basis, or even on a regional or local basis, have the level of commitment needed to carry on an ongoing dialogue with and support of the companies who pay for roughly half of the services dentistry provides?

It is my feeling that if benefit managers are educated about what dentistry can provide, they will look toward less restrictive, greater choice plans that put the responsibility with the employee to make appropriate “value” choices about the

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of the state. The ideas from these forums were taken initially to a summit group of independent dental profession leaders and dental industry leaders in April 1996. From there, the American Dental Trade Association formed a taskforce on dental reimbursement and managed care which began its activities to determine the facts and principles involved in the changing dental reimbursement and managed care industry and how it impacts oral health, costs, the profession, and the industry. The October 31, 1997 report of that taskforce is the result and it lays out some strategies that the profession and industry might partner in to deal with the managed care issue in a less emotional and more strategic manner.

The net of all this is that employee satisfaction will eventually affect the design of dental benefits and the impact that managed care might have. “Choice” is the main determinant in employee satisfaction. The fact is that there are different corporations that view benefits in different ways; there are different employees who have varying needs in dental benefits; there are different practitioners who provide different types and levels of services and practice “personalities;” and there are different benefit plans and practice models that provide different costs and “value.” As long as the different segments are knowledgeable of the different aspects of the system, a rationalized economic system will result. Our job is to provide unbiased information to each segment of the dental economic system in hopes of reducing stress.

Another key factor in determining the market penetration of managed care long term will be supply and demand of dental services. Based on the decreasing number of dentists and increasing demand, dentistry is in an ideal position—particularly in this current strong economy. But, in a recessionary economy, its dental services being discretionary, supply could exceed demand and the picture might be substantially different.

The changing demographics of the patient population will continue to produce a significant increase in esthetic dentistry which is outside of most benefit plans. Therefore, those benefit companies that can design plans of “choice” covering not only the needs in dentistry but the wants as well, will be more attractive to employers who are trying to attract employees in this tight marketplace. Direct reimbursement is one of those wide-choice plans that may be attractive to a certain segment of the business population. If it is looked at in the light of offering “choice” and being a benefit of “value,” it may find its niche. The key is how to communicate and educate benefit managers and employees about what dentistry can offer in service so benefit plans are evaluated in that light. Therefore, dentistry must to a greater degree focus its efforts on educating the benefit manager and employee. It would be dollars well spent by the profession and industry and an obvious area for both to partner.

“Informed decisions are the key to the eventual rationalization of the dental benefits industry.”

“Responsible consumption of appropriate dental services” must always be the goal of everyone in the dental economic system. This will assure the viability of high choice, non-managed care benefit products which are provided in primarily a fee-for-service environment.
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Managing Today's Changing Dental Environment: A Manufacturer's Perspective

Thomas Figurelli

Abstract
The dental trade industry is not growing at the same rate as the profession or as managed care. Concerned over this trend, the American Dental Trade Association is looking at the changing marketplace in dentistry. It is apparent that managed care is having some impact, but its exact nature is difficult to define since plans are evolving. Another emerging pattern that the industry is watching is the growth of larger practices. These have different purchasing and marketing characteristics than the traditional solo practice.

As a member of the American Dental Trade Association and a member of what started out to be The Managed Care Task Force of that association, the objective seemed to have been pretty clear to me at the time...Managed care was an emerging phenomenon that was not understood to any degree by anyone. What we knew of it from our partners in medicine was not especially good. It seemed to be destroying what once was a very profitable pharmaceutical industry by forcing physicians to make treatment decisions on the basis of third-party reimbursement payments and to prescribe generic drugs based on pharmacy prescription plans. The only companies that appeared to be benefiting from managed care were the insurance companies that ran the managed care programs.

Now, low and behold, managed care was rearing its ugly head in the dental industry. So our job was to learn more about managed care and to help educate the ADTA on the three and four monogrammed terminology that was the managed care lingo!

As we set out to do this—and as we began to sort out the facts—some things were becoming more clear to us. First, managed care as an entity of dental reimbursement is on a fast track! While DHMOs represent about 20% of the market, it is growing at a rate of 10% to 15% annually. And, as DHMOs are growing, so are PPOs. PPOs seem to be a vehicle for easing employees into managed care plans.

Secondly, managed care is evolving. In other words, it is not clearly defined or established and is changing on a day-to-day basis. The major concerns were real enough: that many managed care programs are undercapitalized and are, in fact, forcing the dentist to make treatment decisions on reimbursement schedules as opposed to treatment of choice; that the reduced fee schedules offered on PPO plans were having a negative effect on dental practice revenues; and that in some cases, corporate benefit managers were not making informed decisions on the dental plans they were buying for their corporations but were very happy at the savings in health benefits they seemed to be getting health benefits by adding dental managed care programs onto their medical benefit programs. While there are disagreements among the experts as to how deeply managed care will penetrate dental reimbursement programs, it is indisputable that it will have a major impact on the dental industry. There are several factors that suggest this to be true:

• Corporate America likes managed care because they see a real savings in benefit costs.
• Patients like the savings they get from managed care programs. While they may not be enamored with the quality of care or the restrictions of choice that go with managed care, low co-pays and no paperwork are still very attractive benefits.
• Managed care is evolving in both medicine and dentistry. Most complaints about managed care usually revolve around quality of care, convenience of access, restrictions in treatment options, and physician and dentist preferences. As managed care organizations become more competitive these issues may be resolved.

Mr. Figurelli is at Block Drug Company, 105 Academy Street, Jersey City, NJ 07302-9988. He is Chair of the ADTA Strategic and Long Range Planning Committee.

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- Dental student career goals are changing. Few graduating dentists expect to enter private practice within the first two or three years. The incredible debt spent on their dental education, compounded by the cost of setting up a practice, makes working for a managed care group very attractive.

The jury is still out as to whether managed care will have a negative or positive impact on the dental industry. If it attracts new patients into the dental chair, it will have accomplished what the profession has not been able to accomplish in decades.

Another key lesson that surfaced as a result of several market research reports that were commissioned by the American Dental Trade Association and the Dental Manufacturers of America is the fact that the dental market is not growing. Recent research studies show that the dental market—the amount of money spent each year on dental supplies and equipment—is only growing at a rate of 3% annually...barely keeping up with the rate of inflation. This says to those of us who are in the manufacturing and supply end of the business that we must focus our efforts on expanding the size of the industry as opposed to fighting each other for market share, if we are to grow sales and profits.

The result of all this insight was for the Task Force to report its findings and to accomplish its original goal of educating our members on the dynamics of managed care. Moreover, to recommend that the Managed Care Task Force be reorganized into a new ADTA Committee with a broader mission of business development.

Marketing Strategies

Two marketing strategies upon which I will focus are new product development and changes in selling tactics, both of which may be impacted by the changes that are affecting the dental industry.

New Product Development. As the structure of dentistry changes, the needs of dentistry will change as well. Managed care, especially, will have its own set of requirements that will be different from the solo practice environment in which we have become accustomed. Generally speaking, when we market dental products to the solo practitioner, we try to provide products and services that appeal to the individualistic nature of the private practicing dentist. We recognize—and capitalize—on the fact that individual dentist preferences usually outweigh cost. We can sell products that "work" in the dentist's hands that provide treatment value to him or her. Marketing to managed care—and to the large corporate managed practices—has a different appeal, usually associated with pharmacoeconomics, definitive clinical outcomes, and quickness/ease of delivery. The following are some specific examples of new product strategies that may be considered:

- Products that make treatment delivery quicker and easier. Managed care, in particular, is focused on chair-time...
The focus shifts from satisfying the dentist's individual needs and preferences to satisfying the goals of the dental organization.

Clinical outcome studies and pharmoeconomical models will replace sales aids and promotional pieces as the media for selling.
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care and other forms of dental reimbursement.
3. Information and response plans are needed.
4. The broader issue is dental care demand.

This last point speaks to one of the facts raised earlier in this paper—our industry, vis-a-vis the busy-ness of the dentist, is not growing. The issue is how to increase the demand for dental services, either through more procedures provided to the existing base of patients, or bringing new patients into the dental chair. Clearly, the solution to this problem is in the hands of both the profession and the industry, because neither one alone has the ability or the resources to affect the changes that are required, especially bringing new patients into the dental chair. Both must work hand-in-hand to educate corporate benefit managers on the value of the dental plans they are purchasing for their corporations and providing to their employees; that cost is not the sole criteria for selection; to communicate more effectively to patients on treatment choices and alternatives; to accept the realities of the insurance market place—that no one form of reimbursement plan is either the panacea nor the villain; that informed decisions should be made by the dental practitioner in determining what course of action is best for that practice; that as manufacturers and suppliers of dental materials and equipment we support the dental profession’s efforts to provide quality care to the dental patient population.
Meetings

David W. Chambers, EdM, MBA, PhD, FACD

Abstract
Meetings are useful when managed so that those present can accomplish more working together than they can individually. Setting the agenda, picking the attendees, using subcommittees, ensuring full participation, allowing group space, and making certain participants know what it means to vote are all skills successful meeting managers must master.

Meetings should be used to articulate the will of the group, solve problems, create solutions, and bring everyone to a common level of understanding. They are only appropriate when these same purposes cannot be accomplished or cannot be done as well by the same individuals working independently. What gives groups their power is the capacity to focus multiple perspectives on a single topic, the results of that effort becoming the common property of all group members. Meetings are damaged when the common purpose is compromised by one or more dominant individuals, hidden agendas, members who are not paying attention or who withhold their participation, agendas that lack focus, and protocol that is so heavy it pushes content aside or so weak that group members withdraw in confusion.

Groups work best when the members agree on their purpose and their method of achieving it. These are called the “task function” and the “maintenance function” of the group. Research has shown consistently that the most effective groups are those lead by individuals with sensitivity to and skill in the maintenance function. This is why important meetings require facilitators, even paid, professional ones. (Even before the research showing the primacy of the maintenance function, this insight was codified in parliamentary procedure, where the chair is expected to surrender the gavel in order to speak to an issue.)

Let’s look at some of the important maintenance functions in managing a meeting such as setting the agenda, use of subcommittees, ensuring full participation, developing group space, and voting.

Agenda
The agenda is a plan for what the meeting intends to accomplish. Meetings with no agenda are wasteful. If you find yourself in such a meeting, it is appropriate to say “In order to use our time efficiently, I suggest that we agree on the business we have to accomplish this morning.” Another alternative is to speak privately with the chair to the effect that you are able to contribute more effectively if you know in advance what topics will be covered in a meeting.

Unfortunately, the typical meeting agenda may be only a small improvement or none at all. A list of topics to be discussed creates the impression that the purpose of a meeting is to discuss topics. The true purpose of an agenda is to itemize the accomplishments the meeting intends to achieve. Consider these model agenda items: “Receive the treasurer’s report.” “Approve the Spring schedule.” “Accept the recommendation of the nominations committee for national officers.” “Change the organization’s policy on new members.” In all cases what is needed is a verb describing the action the committee intends to take. The fact that the verb is expressed in a positive sense (approve, accept, endorse) is only a linguistic convention and does not prevent the committee from taking alternative actions such as disapproval, amendment, referral for clarification, or postponement.

Typically, the agenda is arranged in order from the most structured to the least structured actions the meeting might take.

Meetings run most efficiently when members speak from the perspective of the group as a whole, expressing and voting their wisdom rather than their interests.

Consent items include the minutes of previous meetings, reports of standing committees which require no actions, certain communications, and other topics that can be handled without discussion. These are prepared in writing and circulated in advance to all members and adopted by consent at the beginning of the meeting. This means that the chair asks whether any
member objects to any of the consent items. Disputed items are pulled out as separate agenda issues to be debated and voted on and the remaining items are approved by consent, without comment. Sub-committee reports containing recommendations for action are usually considered next. The recommendations of the subcommittees are motions to the main committee calling for specific action and requiring no second. Next in order are the planned agenda items of general concern, usually placed on the agenda by officers. These are the most difficult items to handle because they have not had the benefit of focused discussion in a subcommittee. They take the most time, cause the most confusion, are often amended and re-amended, and in many cases the wisdom is to refer them to ad hoc committees for appropriate detailed analysis. The least structured agenda items and always the last are additional items or "new business." Of course there are differences in style and circumstances, but my own policy is to allow the discussion of new business only to the point where members have basic familiarity with the sharing of information. Subcommittees often dispense with formality and adopt other structures which promote collaborative problem solving around specific issues they have been assigned. Formal meetings such as hearings, or houses of delegates honor ritual and make it difficult to introduce new topics.

The agenda is one of the most precious prerogatives and responsibilities of a chair. Through the agenda, the success or frustration of many meetings is determined before the meeting is called. Good chairs review the agenda at the beginning of each meeting and at every point where the meeting is struggling. The agenda is the action plan. Appropriate reference to it adds focus and cohesiveness to meetings.

The old joke is that committee members are people who don't move quickly enough to get out of the way, and the penalty for missing a meeting is to be named chair of something. In reality, who is present at meetings is second only to the agenda in determining their effectiveness.

Most organizations have rules about the election or appointment of members to committees. This includes ex officio members who are appointed by virtue of their office—national officers in the American College of Dentists are often ex officio members of their Section's executive committees. Ex-officio members may be with or without.

Appointed membership should be carefully considered. This includes subcommittees, task forces, representatives, or delegations, and other groups charged with a special responsibility. Individuals should be chosen for their expertise, interest, and the range of opinions they reflect. There is no advantage in stacking a task force which produces a report no parent committee could support, or worse, a supported report that is not in the best interests of the organization as a whole. There is substantial research demonstrating that committees with diverse opinion and committees with a single maverick member are most effective than homogeneous ones.

There is a subtle but important distinction between representation (speaking on behalf of the interests of part of an organization), membership (speaking on behalf of the interests of the organization as a whole, as one understands them), and expertise (speaking from a position of special knowledge). Individuals will usually want to make it clear whether they are speaking as a representative or as a committee member or for themselves in order to avoid confusion. (In hearings, it is essential that speakers clearly identify whether they speak on behalf of organizations or for themselves.) It is generally the case that meetings run most efficiently when members speak from the perspective of the group as a whole, expressing and voting their wisdom rather than their interests. Experts, such as legal council or individuals with deep, specialized knowledge in certain disciplines, are seldom voting members on committees.

Working Groups
Working groups include task forces, standing and ad hoc subcommittees, and others who do the focused problem solving work for committees. When such groups are created by the whole committee with the intent of delegating specific tasks, it is es-
sentential to identify group membership on the committee, a committee charge, and a date by which the report is expected.

Working groups enjoy a number of advantages in their efforts to address difficult problems. First, committee membership can be chosen to reflect keen interest and expertise in the area under consideration; even to the extent of augmenting the working group by members not on the parent committee. Second, working groups tend to relax the formality of larger groups, often dispensing entirely with parliamentary procedure or only adding it as window dressing after the problems have been solved. Third, working groups have flexibility of time and location. Regularly scheduled committee meetings are constantly up against the adjournment time and are limited to the knowledge contained within the room. Working groups can meet as often as necessary to achieve a solution by the required reporting date. They can also gather documents, verify facts, do some informal opinion sampling, and even broker political deals which would be embarrassing if conducted under the public scrutiny of a formal meeting.

Working groups can submit informational reports (which are accepted by the parent committee) or can recommend action. Recommended action is the best analysis of the working group, submitted in writing with brief supporting reasons. A committee recommendation is always a motion which the main committee must consider.

Wise committee chairs are sensitive to the point where a large committee begins to struggle and is either incapable of focusing an issue clearly or lacks the background to form an intelligent decision. Under these circumstances, or where these problems can be reasonably anticipated, the course of action recommended by a working group to which such problems are referred is almost always superior to the course of action thrashed out by a committee as a whole.

**Full Participation**

A meeting is the collective interaction of its members; there must be some synergy present or the time would be better spent with each person working alone. This is where a good chair shines, creating the environment and the opportunity for each member to contribute. The chair has primary responsibility for the maintenance function.

In addition to the formal offices (vice-president, treasurer, etc.) recognized in committee bylaws, all committees have other roles which members play. Usually there is someone who prides himself or herself on knowing how meetings are supposed to run. There are those who specialize in “closing.” These are individuals who listen attentively to the discussion in an effort to anticipate the direction it is going. As soon as they can see the ultimate flow, they attempt to frame a group conscience and are often successful because they have not tipped their hand up to this point. Most groups have a “loyaler-than-thou” member, and sometimes several who are in a contest for “best values.” Groups often make use of an individual who inserts humor at awkward places—the master of the one-liner is usually the most appreciated of this class. Groups also have “hatchet men” who articulate the group’s displeasure with members who seem to have violated group norms. (This can be a high risk position since the hatchet man must read subtle clues from the chair or members; otherwise they are merely guilty of a personal attack.) Another risky role is to introduce a new topic.

Groups develop roles to serve maintenance functions, and, although there are personal proclivities towards various of these opportunities, the roles belong to the group and individuals can play different roles in different groups. The next time your meeting becomes tedious, write down the roles you believe individuals are playing each time they speak. You’ll be surprised how often individuals play the same function throughout the meeting that those who are wasting the group’s time by being repetitious or attempting to stifle alternative views should be limited. This requires a chair who is knowledgeable about the issues and the group, who has some personal courage and interpersonal skills, and who is above all an outstanding listener. Sometimes an individual will be asked to speak even though he or she has made no formal attempt to gain recognition. This can be because of that individual’s known position or expertise in an area or because of non-verbal behavior. Individuals who are seeking the floor for their own interests rather than the group’s can be put on hold (“Although you were at the microphone first, I would like to hear from several other speakers who have not already had an opportunity to express their views, I will return to you directly.”). Or they can be questioned (“Did you wish to respond directly to the point made be the last speaker or do you wish to introduce a new idea?”).

The most powerful tool a chair has for controlling the discussion is the agenda. Once the agenda has been agreed by the committee, it sets the purpose and the
frame work for discussion. Effective chairs frequently summarize the discussion (a factual summary of the main points that have been) and tie these summaries to the agenda. A chair can bring a group back to focus by saying, “As I understand the discussion to this point, we have three alternatives for handling the matter of a proposed dues increase: x, y, and z. How would you like to proceed from this point?” Summary and redirection from the chair are especially effective when some members of the group have lost their way and have too much to say about too little that matters.

Another effective technique to limit unnecessary discussion is to agree on a general formula for members to use when speaking to an issue. The formula is “I urge the group to take a particular action because...” It is an egregious time waster in meetings when no one can figure out what the committee is supposed to do based on the speaker’s comments. This is most likely to happen when the speaker is taking a personal or partisan perspective, has not thought the issue through well, or is just “making a point.” All “devil’s advocate” commentary should be strictly prohibited. In my experience, the devil has never needed an advocate, and most of us are not up to that responsibility anyway. An equally wasteful speech in a meeting suggests that the group take a course of action, but does not explain why, or offers a reason which is a misrepresentation. Reasonable groups need to consider alternative reasons. It can be an enormous challenge to an honest speaker to reveal the true reasons for the positions they are advocating. It is always appropriate for the chair to ask for clarification when it is unclear what a speaker wishes the group to do or why the speaker wishes the group to take that action.

**Group Space**

Group space is a subtle concept, but one that is critical to the success of meetings. It is the place where members put their ideas so that they can become public property for the collective and constructive use of the group. The agenda, the summarizing which good chairs do to retain focus, and the reading of a motion before voting or for the secretary’s record are all examples of group space.

Most committees rely on improvised group space such as individual member’s recollections of what has been said or written abstracts in the form of minutes which no one has access to until well after the meeting is finished. The worst example of group space is the *Congressional Record*. It is highly individualistic, partisan, reflects material that representatives or senators ask to be placed in the record whether they took place or not and is subject to editing by our representatives themselves. It is what each legislator wished he or she had said.

A conspicuous example of effective group space is the sheets of butcher paper taped to the walls of brain storming sessions. (There are now giant “post-it” notes that are more efficient.) These scribblings are public, are constantly available for all to see, and have become dissociated from their original proposer. One of the rules of brainstorming is that an individual who suggests an idea need not defend it or even claim ownership of it. The advantage of this type of group space is obvious for generating creative ideas and for problem solving. With everyone working on the same page and with personalities reduced to a minimum, pursuit of the common good is enhanced.

There are now computer systems which enhance group space through individual monitors connected through a network or by projecting a common minute on a screen large enough for all members to observe. Sensitive problem solving meetings such as strategic planning are usually enhanced by employing a professional facilitator. These are individuals skilled in the maintenance function of meetings and in preserving neutrality while enhancing the group space. When groups do their own facilitating, it is customary for the chair to appoint a separate recorder who manages the group space rather than trying to manage both functions simultaneously.

Large and formal meetings also use group space. Printed resolutions, the formality of reference hearings, rigid parliamentary control of a house of delegates, are all group space designed to ensure individual members’ focus on the group mission.

**Voting**

One of the features that truly characterizes a meeting is voting. This is true, but probably not in the way most people think. Seconds, points of privilege, hostile amendments, and reconsideration are the accouterments to effective meetings but not their substance. The sidebar shows some of the common rules that prevent procedural confusion from standing in the way of group effectiveness.

The more important considerations are why a person votes and what that vote means. I have had success with the “jury” system of voting. This approach calls for counting the number of eligible voters at the time the question is posed. Those in favor of the motion raise their hands and are counted. Those who did not raise their hands are presumed to have voted against the motion, so the decision of the group can be announced without calling for negative votes or for abstentions. The principle upon which this procedure rests is that members of a committee represent jurors, exercising their wisdom in the best interests of the organization based on the evidence that has been present in the discussion. Every member is presumed to have
wisdom, and is therefore qualified and responsible for rendering an opinion. Abstentions are allowed only in the case of conflicts and this must be announced prior to the discussion of the item. Where conflicts are minor, affected individuals will announce the conflict and agree to remain silent and not vote. Where conflicts are substantial, the individual will excuse himself or herself from the room during the discussion and vote and will only be informed of the outcome of the vote and not of the positions taken by individuals who participated. Chairs always have the opportunity to vote and it need not be limited to breaking ties. The method is efficient, but more importantly it reminds members that their job on a committee is to seek the best interests of the group as a whole.

Voting is the way groups create policy. Group membership means agreeing in advance to be bound by the policy created through group vote in exchange for the privilege of attempting to influence that vote. Meetings are one way that groups define themselves and commit to the actions they value. As cumbersome as meetings might get, most of us have an abiding belief that democracy—the principal on which meetings are based, is the natural and preferred way for organizations to promote their collective interests.

The connection between democracy and meetings is eloquently expressed in Alice Sturgis' *Standard Code of Parliamentary Procedure*. "The ultimate authority of an organization is vested in a majority of its members. This is a fundamental concept of democracy. A primary purpose of parliamentary procedure is to determine the will of the majority and see that it is carried out. By the act of joining a group, a member agrees to be governed by the vote of the majority. Until the vote on a question is announced, every member has an equal right to voice opposition or approval and to seek to persuade others. After the vote is announced, the decision of the majority becomes the decision of every member of the organization. It is the duty of every member to accept and to abide by this decision."

### Major Steps in Finding the Will of the Majority

#### Main Motion
Move that the group adopt an action or a position (or change its structure)

#### Amendments

**Editorial**
"You mean all ‘Fellows’ not all ‘Members.’"—adopted by agreement of maker and seconder of original motion.

**Friendly**
"I think you meant this to apply only to new application."—adopted by agreement of maker and seconder of original motion.

**Amendment**
"I move that the motion be amended to add a 20% fee to reinstate delinquent memberships."—modifies intent of original motion; must be seconded, discussed, and voted on.

**Substitute**
"The committee offers the following written alternative membership structure ..."—intended to replace entire motion; must be seconded, discussed, voted on.

#### Procedural Motions

**Table**
"In view of the fact that our visitors have arrived, I move that we table discussion of the dues structure until after the visit."—normally handled informally.

**Postpone**

- **Definitely**
  "I move that we suspend consideration of the dues matter until after the treasurer’s report."—seconded, discussed, voted on.

- **Indefinitely**
  Does not exist in Sturgis and frowned upon by experts in Roberts; intended either as a means for “killing” a motion without voting on it (if voting to kill it is really different from voting against it) or a means of prolonging debate.

**Refer to Committee**
"I move that the question of dues be referred to the Membership Committee."—must be seconded, discussed, voted on.

**Close or Limit Debate**
"I move that each person be limited to one more comment of no more than three minutes."—must be seconded, and voted on, but debate is limited by discretion of chair.

#### Directing Traffic

Only one motion is open for discussion and vote at a time. Generally, the motions that appear lower on the list above can be appended to any motion currently on the floor. For example, the main motion can be amended, then it can be moved that debate be limited. At that point the motion before the committee is to limit debate. Once that is solved by vote, the active motion is the amendment. Again, once it is resolved by vote, the main motion is considered and voted on.

**Hint:** When the parliamentary procedure is too confusing to follow, the meeting has lost focus. Smart chairs know the value of entertaining a motion to a brief recess. There is much that can be accomplished on the walk to the restrooms than Roberts and Sturgis ever imagined.
Leadership

Recommended Reading


Now almost twenty-five years in print, one of the first books to stress the maintenance function in meetings; filled with practical suggestions for using facilitators, recorders, group space, and “win-win” collaborative attitudes.


Group formation, purposes, and dynamics are presented, along with a thorough treatment of how groups make decisions, where they surpass individual decision makers, and how to make them more effective.


The thesis of this journalist's work is that teams promote conformity at a time in American organizations when creativity is needed. A blend of polemic, rich illustrations of collaborative teams, and an analysis of the requirements for making groups creative.


A philosopher takes a look at meetings. The issue is protecting democracy from the abuses of expertise (the professionals) and from majority vote (politics). The middle course, Habermas' discursive ethical community, makes each committee member a representative of the interests of the group as a whole.


Revised by the American Institute of Parliamentarians, this is “the other Roberts Rules of Order.” It has a modern and user-friendly approach and clear grounding in the principles of democracy that give it an edge, in many people's minds, over Roberts. The book also has useful information on nominations and elections, responsibilities of officers, legal obligations of boards, conventions, charters and bylaws, minutes, and finances.


Complete and comprehensive guide to planning and running a meeting. Special emphasis on creative and problem-solving meetings, with nice descriptions of techniques for building consensus: brainstorming, nominal group, multiattribute decision analysis, Hall's rule, and Delphi technique. Not bad for a book written by a committee!


Very clear, very general, very short.

Editor's Note

Summaries are available for the three recommended readings preceded by an asterisk (*). Each is about five pages long and conveys both the tone and content of the book through extensive quotations. These summaries are designed for busy readers who want the essence of these references in fifteen minutes rather than five hours. Summaries are available from the ACD Office in Gaithersburg. A donation to the ACD Foundation of $15 is suggested for the set of summaries on meetings; a donation of $50 would bring you summaries of all the 1998 leadership topics.