Insurance: Part 1
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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.
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FROM THE EDITOR

Improving Oral Health One Practice at a Time

My father was a shepherd and livestock buyer. There are some valuable lessons for dentistry in the sheep industry. I will talk about the barn book, the Polypay, and making car payments.

My father raised a breed of sheep called Shropshires. This is an important American breed, raised primarily for meat rather than wool, that thrives on farms and in large flocks. My father kept two flocks. One was a commercial flock of sheep, cross bred to produce the best results appropriate for the Willamette Valley in Oregon. The other flock was the purebred Shropshires with their specialized characteristics such as size and meatiness. The purebreds were used to improve the market flock by introduction of unique characteristics and were sold as breeding stock. When my father began his breeding program, Shropshires were somewhat in decline because of the overemphasis on show ring characteristics rather than commercial attributes.

My father managed his flocks through something called the barn book. These were plain white, twenty- or thirty-page constructions, measuring about three by six inches. They were ruled for entries in such columns as tag number (each sheep has a tag in its ear with a unique identifying number), sire and dame (father and mother), date of birth, number of days to market weight, number of twins produced (if a breeding ewe), health and care problems such as wool blindness in the eye or hoof rot, etc. My father carried one or more barn books in his hip pocket at all times and constantly noted both casual observations and systematic data.

Dentistry is by definition custom work, delivered in small units called practices.

The use of the barn book as a management tool came at market time and breeding time. Questions such as when should various sheep be sold, which should be sold for market and which kept as breeding stock, and how much profit or loss had been made in the operation were more easily determine in light of the information in the books. How else, for example, could my father decide which male lambs to castrate and which to keep for breeding purposes? (That decision had to be made almost two years before one could look to see whether a ram was actually effective for flock improvement. The situation is something like dentists placing new composite products in their patients' mouths with no information about how the restorations will hold up two years after placement.)

The barn book was also used at breeding time to match rams to ewes in order to improve quality in the flock. In particular, my father bred for overall size, rapid weight gain, longer length and larger hind quarters (lamb chops and leg of lamb are the most valuable cuts), absence of wool on the face and long legs to prevent such problems as wool blindness and promote ease of maintenance in rough terrain. Sometimes, his barn book told him that the flock needed certain genetic features that none of his rams possessed, and he would purchase one from another flock that had these needed characteristics and then monitor its performance in the barn book. By repeated cycles of breeding and marketing, guided by the information in the barn book, my father was able to substantially improve the quality of the flock and make a reasonable living.

Roughly contemporaneous with my father's sheep work in Oregon was an experiment in Sonoma, California, where I now live. A breed of sheep known as the Polypay was developed by an internationally renowned turkey breeder name George Nicholas. The origin of the name Polypay is uncertain: the "pay" part meaning either "pay load" or the French word for "country" or "land." In any event, the intent was to breed a
universal sheep, one that would have all of the desirable characteristics of the species and could be raised in any climate or condition.

My father's notion was to start with what he had on his own land and improve it with each marketing and breeding cycle. George Nicholas' idea was to identify the optimal combination of characteristics among sheep generally and then breed to that type. For example, a balance was sought between meat and wool, twinning and triplets were desirable, as was the ability to breed and lamb at any time during the year. Optimal size, maturation rate, and other characteristics were identified. Research was done on breeds known to have the hoped-for characteristics and four breeds were identified and cross bred in predetermined proportion guided by extensive data collection and analysis.

Nicolas' experiment has largely ended (there is a small flock in Two Rock, California, and one in Idaho). It made sense to raise turkeys this way because of the huge numbers involved and the potential for factory-like standardization, but turkeys and sheep are as different from each other as are medicine and dentistry. Dentistry is by definition custom work, delivered in small units called practices. Creating the ideal practice is much like creating the ideal farm. Both depend heavily on the character of the land, local market conditions, and the temperament of the owner. As fine as it sounds in theory to combine the best characteristics of many individual examples, often this does not produce the best result in reality. The Polypay sheep was less ill suited on average to the geography and flock size requirements of any place it was raised than would be sheep of different breeds. But the Polypay could not better the Suffolks on maintained pasture land in moderate climates or the Columbia in the huge flocks on range lands in the Western inter-mountain states or the Cheviot in the scrubby hill country of south Missouri. It also sounds plausible that an optimal blend of characteristics such as meatiness and wool would make sense. But the ratio of meat prices to wool prices varies from year to year, and in some cases there are enormous fluctuations. The market can adjust more quickly by breeding commercial flocks from pools of purebred stock with known characteristics than it can by breeding one type that is supposed to be ideal for all times and circumstances.

I believe the analogies in dentistry are obvious. There is no standard dentist, only a vast range of types that are best for different circumstances. It is appropriate to resist the forces that would make dentistry uniform, whether these forces be third-party carriers, government or other regulatory groups, or well-meaning idealists. It is appropriate to resist the forces that would make dentistry uniform, whether these forces be third-party carriers, government or other regulatory groups, or well-meaning idealists. It is equally important to resist the notion that solo practice fee-for-service care is the only acceptable model because it happens to be the most appropriate model for many dentists. There are market fads in dentistry just as there are in any other industry. Orthognathic surgery peaked several years ago. There are signs that the market for bleaching is softening, and natural supplements may be the next big thing dentists need to be concerned about.

The third part of this story is about making payments on the car. My father also operated a stockyard—he pur-
chased cattle, sheep, and hogs from farmers and sold them to packing plants. As a professional is only reacting to external circumstances.

As fine as it sounds in theory to combine the best characteristics of many individual examples, often this does not produce the best result in reality.

Occasionally he would notice sellers who arrived in pickups or in cars with small trailers with a few animals and he would mutter to himself, "... making payments on the car." By this he meant that small farmers were selling their livestock to meet cash needs. This was a fact of life and my father provided a valuable market service. But it is certain that those who sold small lots based on personal needs neither improved their stock in any systematic fashion nor did they sell their stock at the optimal market time.

There are dental practices that follow the same model. The dentist is making payments on the car — usually a much fancier car then my father's farmer clients. But being in dental practice for motives other than improving the quality of oral health care provided by the practice can lead to exactly the same conditions that so troubled my father. The practices don't get better in any planned way, although there are occasional spurts of improvement. And if the driving forces behind dentist's behavior are not in the office itself, the dentist

I believe it is appropriate to have individual dental practices, and even better to have ones that are constantly improving. Such improvement is unlikely to come from grand theoretical schemes or Procrustean efforts to converge on the universal dentist. It is much more likely that they will be driven by individual dentists' innate desires to want to do better in the circumstances where they find them- selves practicing. There may not be universal best practices, but there are plenty of opportunities for best fits. The instinctive desire of a professional to do better today then yesterday can be helped along by gathering simple information from the practice and analyzing it for the obvious useful outcomes. Most know enough to stop doing those procedures that result in poor outcomes. It is natural to replace them with new procedures and new ones that are better. If dentists had the equivalent of my father's barn book, the natural improvement cycle would be accelerated.

My father used a philosophy of improving only his own flock on the particular farm land he owned. He used simple handwritten notes in the barn book to guide him in this process. But he achieved something pretty spectacular. The American Purebred Shropshire Registry Association defines the breed characteristics of what a true Shropshire sheep is. My father's flock demonstrated that the breed could be meatier, faster maturing, and healthier to maintain than had been the case before, and the result was a change in the national standard. In just the same way, the standard of dentistry may be summarized by commissions and agencies, but it is improved by dentists practicing better dentistry one patient at a time and one practice at a time.

There may not be universal best practices, but there are plenty of opportunities for best fits.

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

Insurance now pays for slightly less than 50% of America’s dental bill. The explosive growth in dental insurance in the 1970s and 1980s is traced to the tax effect (coverage paid for with pre-tax dollars offsets fees up to a point) and the insurance effect (costs for care can be projected, although improvements in oral health status are leading to lower projected costs). An equilibrium point appears to have been reached. Dentists must weigh the trade-offs between discounted fees and increased number of patients, and carriers must weigh the trade-offs between smaller discounts and wider participation by dentists. There are no market forces forecast that will substantially change this equilibrium in the near future.

During the 1970s and 1980s, dental prepayment coverage in the U.S. experienced its most substantial growth. The 1990s saw little or no growth in prepayment coverage, and there is little reason to expect significant growth to return.

As the market for dental prepayment expanded, methods of cost control among carriers evolved. From usual, customary, and reasonable (UCR) based indemnity plans to preferred provider networks, carriers sought to offer employee groups competitive premiums through efforts to manage care. The evolution of the market for dental prepayment follows a path that reflects the basic economic forces at work. An understanding of such economic forces offers a foundation from which to explain historical trends and develop expectations of the future.

Dental Prepayment Coverage: From Its Beginnings

Early estimates of dental prepayment coverage are not generally reliable, given the relatively small beginnings and the lack of a general understanding of its potential importance. Data from the Health Care Financing Administration (HCFA) indicate that it was not until 1966 that health insurance payments for dental care reached as much as $2% of total expenditures. Dental prepayment really began significant development in the 1970s.

There have been several attempts to measure dental prepayment coverage in the U.S. over its nearly forty-year history. However, the measurement of dental prepayment coverage is difficult in that all carriers do not regularly report the number of individuals covered. Surveys of households often discover individuals who are not sure if they have dental prepayment coverage.

Perhaps the best or most reliable measure of the extensiveness of dental prepayment coverage is the ratio of HCFA’s measure of health insurance dental payments to total dental care expenditures. This ratio is available annually from 1960 through 1999. Although this statistic fails to offer direct evidence of the percentage of the population with dental prepayment coverage, it does measure the importance of dental prepayment as a source of funds.

It was in the early 1970s that dental prepayment, as a source of funds, reached 5% of total dental expenditures. By 1980, dental prepayment had reached almost 30% of total expenditures. During the 1980s, dental prepayment continued its growth, reaching 47.85% in 1989. This growth in the 1970s and the 1980s was so rapid that some felt dental prepayment would mirror contemporary projections for medical insurance. At some point within the twentieth century, most individuals would have dental prepayment coverage, and more than 75% of all dental expenditures would be funded through carriers. These projections did not come true.

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In the 1990s, the growth in dental prepayment coverage reached its present plateau. HCFA figures through 1999 show that slightly less than 50% of all dental expenditures were paid by private carriers. It seems that during the 1990s, the magical 50% barrier was approached but never broken.

**Why the Plateau?**
There are perhaps differing opinions regarding the existence of the 1990s plateau, but the most convincing explanation relates to the economics of the enrollees' decisions. This entails an understanding of both the tax effect and the insurance effect. Both play a role in establishing the plateau.

Most understand the tax effect. Because dental prepayment is usually a component of employee compensation that escapes the federal income tax, employees benefit from transferring wages into dental prepayment coverage. If an individual faces a 30% marginal tax rate, he or she can elect to use wages to pay dental prepayment premiums and experience a personal net gain if there is an expectation of dental expenses. For instance, suppose an individual expects to pay $300 during the next twelve months for dental care. Suppose that a dental prepayment plan is available at an expense of $400 with no deductible and no co-payments. If the employee chose not to purchase the coverage, he or she would have an after-tax income of $280 but would face an expected $300 dental expense. If instead the individual chose the coverage, he or she would forego $280 in after-tax income but would have $300 in dental care fully paid by dental prepayment. There would be a $20 net gain from prepayment coverage and a $20 net loss from no coverage, or a swing of $40 in after-tax benefit. If dental prepayment coverage were cheaper than $400, the swing would be greater. For instance, if dental prepayment coverage were $350, the swing would be $110 in after-tax benefit. With the $400 premium and a 35% marginal tax rate, the swing would be $80 in after-tax benefit.

In short, the tax advantage of dental prepayment clearly fosters dental prepayment enrollments. The higher the tax bracket of individuals, the greater the benefit. The lower the premium, relative to one's expected expenditures, the greater the benefit.

The second major reason for dental prepayment coverage is the insurance effect. The individual does not know with certainty exactly what his or her annual dental expenses will be. Given a large enough group, one's individual experience will not significantly affect the pricing of the plan. The individual has a net gain from enrollment if his or her dental expenses are greater than the premiums paid, ignoring the tax effect and the possible re-pricing of the plan. Many will enroll if there is a reasonably large possibility that his or her future dental expenses will be greater than the premiums paid. Even if last year's dental expenses were significantly less than the premiums paid, there remains a potential benefit next year in that next year's dental expenses could be greater than the premiums paid.

Since both the tax effect and the insurance effect promote enrollment, how is it that dental prepayment coverage has essentially stopped growing? With the growth of dental prepayment, those with the higher marginal tax rates would be among the first to secure coverage. After those have enrolled, the next best candidates for enrollment would be those with slightly lower marginal tax rates. As enrollments continue to expand, individuals with lower and lower marginal tax rates become the best candidates. With as much as 40% of the population enrolled, further growth must reach even lower tax brackets, and it is these individuals who should experience much smaller tax benefits from enrollment. At some point, one exhausts the pool of individuals with sufficiently high marginal tax rates to make dental prepayment plans attractive.

Secondly, there has been a considerable improvement in oral health between 1960 and 1990. This improvement in oral health changes the expectations of the individual. Expected future dental expenses are smaller than before, and the future expenses are less uncertain.

**At some point, one exhausts the pool of individuals with sufficiently high marginal tax rates to make dental prepayment plans attractive.**

With better oral health, there is less likelihood of the need for a relatively expensive set of dental procedures. With improving oral health, the insurance effect declines in importance as more and more individuals view future dental expenditures with much less uncertainty. Accordingly, fewer opt for dental prepayment coverage.

In short, as dental prepayment coverage expands there are fewer non-covered individuals for whom dental prepayment coverage is made more attractive due to the tax effect. Furthermore, improvements in oral health make dental prepayment coverage less attractive. At some point, one would expect to see a saturation point in coverage, and the U.S. may be approaching that point.
The Growth of Managed Care

Studies clearly show that dental prepayment increases the demand for dental care. Economics clearly tells us that if the covered individual faces a much lower out-of-pocket expense for care, more care will be demanded. Once the premium is paid, the individual has a greater incentive to seek care. This is hardly a debatable point.

The expanded quantity of dental care demanded, promoted by the reduced out-of-pocket expense to the patient, results in relatively high levels of claims. This forces the carrier to increase premiums in order to earn a reasonable return on investment. However, market shares are gained among carriers who are able to offer lower premiums for the same coverage. Competition provides carriers with incentives to offer lower premiums and thereby promotes efforts to better manage the levels of claims.

It has been said that managed care in dentistry has been around since the early growth in coverage. If one defines managed care as attempts by a carrier to manage claims, then managed care came with the earliest of policies. With time, the features of managed care have changed, but its intent is as old as the industry.

In the early years of dental prepayment, carriers sought to manage claims by setting limits on the fees used to reimburse dentists for the care rendered to covered patients. UCR was the common method by which rates were established at which dentists would be reimbursed. Carriers sought “participating” dentists who would agree to accept as the fee basis a certain percentile fee measured from the claims filed by dentists in the geographic area. The ninety-fifth percentile was a common ceiling for reimbursement. From claims filed among participating dentists, the carrier would construct the ninety-fifth percentile for a particular fee. Dentists filing claims with fees below the ninety-fifth percentile would be reimbursed at the fee levels recorded on the claim form. Dentists filing claims with fees above the ninety-fifth percentile would be reimbursed at the ninety-fifth percentile—not the fee recorded on the claim form.

There has always been a struggle among carriers to establish a sufficiently large network of participating dentists in key geographical areas. It was the participating dentist who would not charge the patient the difference between the allowable fee of the carrier and the current fee charged among patients without prepayment. The carrier with the larger network of participating dentists in a community offered assurances that the patient would be protected from “excessive” fee levels. However, carriers seeking to reimburse dentists at relatively low fee levels would have a greater difficulty establishing and maintaining a large network of participating dentists.

In the late 1970s and early 1980s, carriers were in effect a combination of indemnity -type coverage. Capitation in dentistry has remained a quite small segment of the prepayment market. Capitation forms of dental prepayment, in which a fee is paid to the dentist to provide whatever care a patient requires during a specified period, surfaced in the U.S., but virtually all of these forms were in effect a combination of capitation and fee-for-service. Some services were capitation based and some were fee-for-service based. Carriers could dramatically reduce the risks of capitation plans to dentists by covering some services through the traditional indemnity-type coverage. Capitation in dentistry has remained a quite small segment of the prepayment market.

The Trade-Off

Today, only about half of the total dental expenditures are paid through dental prepayment. Public funds supply a small fraction of the total expenditures, and the remaining dental expenditures come from out-of-pocket. Most patients are not covered by dental prepayment. This lack of coverage is the principal feature of the market place that constrains managed care.

Most dentists are confronted from time to time with participation agreements that seek fee discounts in return for membership in the carrier’s network of dentists. The dentist facing the trade-off of providing care and receiving a discounted fee must weigh the benefits of possible greater patient loads with the costs of lower reimbursements. This trade-off is the mechanism through which carriers seek larger fee discounts from dentists. In addition to the larger fee discounts, the carrier benefits from participating agreements. The carrier with the larger dental provider network has some competitive advantages in the sale of its policies.

The dentist facing the trade-off of more patients offered for reduced fees gains economic protection from the un-
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covered patient. As long as there are sufficient numbers of uncovered patients who are willing to pay the dentist's full fee, carriers will be unable to obtain the deep discounts. Why would a dentist accept a 30% fee discount when there are sufficient numbers of patients willing to pay a non-discounted fee? This availability of uncovered patients limits the ability of carriers to obtain participating agreements with heavily discounted fees.

The Future

The stagnation in the growth of prepayment coverage in recent years will most likely portray future trends. There do not seem to be any market forces at hand that would substantially promote the growth of prepayment coverage. An increase in marginal tax rates would have a promoting impact, but such an increase does not appear to be a political possibility. Improvements in oral health may be a discouragement for enrollment. Less uncertainty of future dental expenses for the individual reduces the advantage of dental prepayment. Improvements in oral health are expected to continue in the future.

Many observe the plight of physicians in their struggles with managed care. Some have sought collective bargaining as a means to limiting fee discounts imposed by carriers. Is such a situation in the cards for dentistry? No.

The dentist must weigh the benefits of possible greater patient loads with the costs of lower reimbursements.

The lack of prepayment coverage among significant numbers of patients constrains carriers in their quest for larger fee discounts. It is the marketplace that continues to offer the economic protection dentists seek from managed care.
Dental Insurance: Design, Need, and Public Policy

Richard J. Manski, DDS, MBA, PhD

Abstract
The demand for dental insurance is likely to increase as our nation ages. However, future dental benefit plans may need to differ considerably from their present day counterparts to be cost-effective. These plans will be designed to minimize adverse selection, limiting or excluding some components found in today’s dental insurance plans. Interest in improving access to care for the undeserved has gained significant support as of late. Dentistry should be prepared to provide the leadership necessary to help shape the design of future dental plans and to help improve the effectiveness of public coverage programs.

Health and health policy have been at the forefront of our nation’s political debate for several years. Health insurance has dominated much of this discussion. Recent estimates suggest that approximately 42.3 million Americans do not have health insurance (Rhoades, Brown, & Vistnes, 1998).

Nature of Insurance
Insurance is a mechanism conceived to help smooth some of life’s induced and inevitable bumps. Although for any one person the risk of facing one of these unexpected setbacks may be low or rare, if the unanticipated should happen the resulting consequence could be serious and potentially quite harmful. As a protective mechanism, insurance works well to divide the potentially devastating financial result of such an event into small and relatively inconsequential costs among many people. Life insurance, disability insurance, car insurance, homeowners insurance, and unemployment insurance have been designed to provide security against misfortune or difficulty or to protect against a significant, unpredictable financial loss associated with adversity.

Health insurance is somewhat more complicated because it, unlike other forms of insurance, is provided to not only protect against a significant financial loss associated with adversity but is also provided to protect against a financial loss, significant or not significant, for events that would normally be considered desirable. While major surgery may be unwanted, unpredictable, uncommon, and financially catastrophic, other covered services such as office visits and preventive care are favored, predictable, common, and not financially ruinous.

Dental insurance is even more atypical. While dental insurance like medical insurance differs from other forms of insurance, dental benefit plans also differ considerably from their medical plan counterparts. Unlike medical insurance plans, which may include a prevention component but have been primarily fashioned to protect against expensive adversity, dental benefit plans have been designed principally to encourage prevention. Dental benefit plans reimburse participants for dental care expenditures that are often expected, routine, and usually not too expensive (American Dental Association, 1990; Feldstein, 1988; Zatz, Landy, & LeDell, 1987). In fact, according to one estimate 90% of all families of four visiting a dentist have expenditures of less than $1,000 (Sunshine & Dicker, 1987).

With the exception of accidents and some dental infections, dental care needs are widespread and more or less predictable. In comparison with medical expenditures, Feldstein notes that dental expenditures are relatively small, expected, and not catastrophic (Feldstein, 1988). Zatz and colleagues (1987) sug-
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suggest that the term dental “insurance” is actually a misnomer and correctly submit that dental benefit programs are not truly insurance but are rather a form of prepayment for a universal need. In apparent agreement with Zatz, Feldstein adds that dental care programs are a “form of forced savings.” Accordingly, dental care coverage has often been referred to as “pre-paid” dental care rather than dental insurance. If car insurance were designed like a dental plan, an oil change and tune up would be covered at 100%; shocks, tires, and batteries would be reimbursed at 80%; and accidents would be reimbursed at 50% with an annual maximum limit of $1,000.

Uses of Insurance

Dental care coverage is popular and its effect on the use of dental services is noteworthy. According to the Department of Health and Human Services, dental care expenditures have increased by almost $54 billion ($2 billion in 1960 to $56 billion in 1999) during the past forty years (Health Care Financing Administration, 2000). A contributing factor in this growth has been the rapid proliferation of dental insurance (Health Insurance Association of America, 1988, 1990; National Association of Dental Plans, 2000). During the late 1960s, insurance companies began offering coverage for dental expenditures to large groups already underwritten for medical expense coverage. While in 1967 only 4.5 million persons were covered by dental programs, by 1985 approximately 100 million persons had some form of dental care coverage (Health Insurance Association of America, 1988, 1990; American Dental Association, 1984). Increasingly, dental care became a popular fringe benefit sought after by employees and their representatives during contract negotiations. Although the rate of growth had leveled somewhat by 1985, today approximately one hundred and fifty million Americans have some form of dental coverage (Health Insurance Association of America, 1990).

Historically, health insurance including dental insurance is secured through employment. For many who are employed, dental insurance may be acquired independently as a standalone insurance plan or as a component of a multi-part health insurance benefit plan. For some who are not employed, dental insurance can sometimes be secured through a benefit plan offered by a spouse’s employer or in limited cases through the private market. Others are less fortunate and may be unable to purchase any dental insurance at all. Having dental insurance can also be transitory. Persons with dental insurance may lose their coverage subsequent to leaving or losing a job. In addition, many older Americans presently employed and covered by a dental benefit program may face the loss of dental care coverage upon retirement.

While the loss of dental care coverage subsequent to unemployment may present an additional challenge, some individuals are offered the opportunity to maintain their coverage after employment as a Post-Retirement Health Benefit (PRHB) at a cost commensurate with active employee rates (DiCarlo, Gabel, Lissovoy, & Kasper, 1989). In addition, other displaced workers not eligible for PRHBs may be spared the loss of dental care coverage as a result of Federal legislation. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA I) and The Tax Reform Act of 1986 (COBRA II) included provisions that may extend dental care coverage for some retirees and for some persons recently out of work by as much as eighteen months (Jaffe, & Spacapan, 1988). While PRHB costs are often employer subsidized, continuation coverage as mandated by COBRA is often not subsidized. As a result, the cost for a recently retired or laid off worker for continuation coverage can be high (Huth, 1988; Jaffe, & Spacapan, 1988; Shalowitz, 1990).

Persons not eligible for PRHBs or qualified for COBRA continuation coverage may be eligible for govern-
ment assistance to help pay for dental costs. However, governmental support for dental care is limited (Kerschbaum, 1983). For instance, with rare exception, Medicare insurance generally does not pay for dental care (Health Care Financing Administration, 1990, 2000; Health Insurance Association of America, 1989).

Therefore, the absence of dental coverage through Medicare may present additional difficulties for recent retirees. The Health Insurance Association of America reported that almost 60% of elderly Americans reported that they were concerned about a dental care gap in Medicare. Medicare supplemental coverage, often referred to as Medigap, is a form of health care insurance that is offered to Medicare enrollees by private insurance firms as a supplement to Medicare. While Medigap policies are not sold or serviced by the Federal or State governments, state laws do exist that regulate and establish minimum standards for all Medicare supplemental policies (Health Care Financing Administration, 1990; 2000; Rice, Desmond, & Gabel, 1989).

All Medigap policies must cover several gaps in Medicare coverage such as the Medicare Part A deductible for hospitalization and coverage for the coinsurance amount of Medicare eligible expenses under Medicare Part B. Some Medigap plans cover additional services including the cost of a private room, in-hospital private nurses, home health services, and prescription drugs. However, Medigap plans generally do not cover dental care expenses. On the other hand, some Medicare Supplemental Insurance Products available do offer dental care coverage as either a supplement or as a purchasing inducement (Maryland Office on Aging, 1991; Maryland Register, 1990).

Targeting to Avoid Adverse Selection
The demand for dental insurance is likely to increase as our nation ages. However, future dental benefit plans may need to differ considerably from their present day counterparts to be cost-effective. Since many of these plans will not be secured through employment and persons with poorer health will tend to seek coverage at a greater rate than will persons with fewer health needs, applicants will represent a level of risk greater than that of the general population. Feldstein (1988) describes "adverse selection" as a condition where "high-risk individuals are able to purchase insurance at a premium that is based on a lower-risk group."

Specifically, individuals with higher than average risk will have an increased incentive to purchase insurance, while individuals with lower than average risk will have a decreased incentive to purchase these insurance plans. As such, including the cost of a private room, in-hospital private nurses, home health services, and prescription drugs. However, Medigap plans generally do not cover dental care expenses. On the other hand, some Medicare Supplemental Insurance Products available do offer dental care these plans will be designed to minimize adverse selection by crafting plans that are based on true insurance models by limiting or excluding the pre-payment component found in today's dental insurance plans and by including other limiting restrictions. As such, waiting periods, limited open enrollment, exclusion of pre-existing conditions, deductibles, and copayments will be integrated into these plans.

Persons with limited income who are eligible for Medical Assistance (Medicaid) may also qualify for dental coverage. However, while Medicaid provides medical care coverage for all enrolled children, Medicaid dental coverage varies in scope and generosity among the different states consistent with the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), state regulations and state eligibility expansions. For instance, children up to age six in families with a poverty status at least up to 133% FPL, and children up to age nineteen (phased in until the year 2002) in families with a poverty status at least up to 100% FPL are eligible to have Medicaid dental coverage. Additionally, children residing in certain states that expanded Medicaid eligibility beyond these minimum income requirements provide Medicaid dental coverage to all who are otherwise Medicaid eligible (Blue Cross/Blue Shield of Maryland, 1990). Further expansions in coverage were introduced in 1997 to provide health insurance coverage to uninsured children up to 200% FPL. The State Children's Health Insurance Program (SCHIP) makes funds available to states to provide this extended coverage either by expanding Medicaid or by creating a State Children's Health Insurance Program (SCHIP).

Refocusing the Debate
During the last fifteen years the concern and debate encompassing health insurance has crystallized into several specific related topics including catastrophic care coverage, health care reform, patient protection, patient privacy, and prescription drug coverage. While today's de-
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bate may appear to be principally focused on patient protection and prescription drug coverage, increasingly at-

tention and interest has also been focused on dental insurance, dental use, and the difficulties that many poor and near poor have in getting access to the care they may need and want.


Interest in improving access to care for the underserved has gained significant momentum and support lately. For instance, the recently released report of the Surgeon General, Oral Health in America, has inspired new and added interest in the oral health care needs of poor Americans (Department of Health and Human Services, 2000). In addition, initiated by several members of congress, the GAO published two reports describing disparities in access to dental care that exist among poor children (Government Accounting Office, 2000a, 2000b). The Health Care Financing Administration (HCFA) has also become involved with an attempt to improve State's commitment and obligation to appropriately administer and fund dental care for poor children. The American Dental Association has devoted an entire chapter to dental care access in its soon to be released report on the future of dentistry. Although most of this attention has been concentrated on children, it may only be a matter of time until this interest expands to include adults and more specifically the elderly as well. In fact, this time may be near.

Perhaps, as soon as the prescription drug coverage debate ends, the debate to provide dental care coverage for the elderly may soon begin. The elderly constitute a vocal and powerful force capable of influencing Congress. The turmoil concerning catastrophic care during the late '80s and recent efforts to add prescription drug coverage to Medicare provides evidence of the relatively new capacity of the elderly to affect policy outcomes. In addition, the American Association of Retired Persons (AARP), a significant lobbying force on Capitol Hill, relentlessly attempts to initiate, block or change proposed legislation on behalf of its members.

Therefore, dentistry should be prepared to join this debate as well if and when it begins. However, in the near term our primary challenge will be to improve access for those covered by Medicaid or SCHIP. Causes for disparities in access among poor and near poor persons are multifaceted. While specific suggestions required to reduce disparities in access may be complex and beyond the scope and purpose of this paper, dentistry should be prepared to provide the leadership necessary to improve the effectiveness of these programs.

References


The Full Cost of Dental Insurance: Who's Really Minding the Store?

Frederick E. Aurbach, DDS, FACD

Abstract
A private practitioner describes the evolution of control of practice by insurance companies. The effects of assignment of benefits have been to limit patients' demand for care to what will be covered by insurance, postponement of needed care, damaging the relationship between patients and dentists, and erosion of patients' sense of responsibility for their own oral health. Current trends toward electronic filing of insurance claims are seen as an acceleration of these practices. Educating patients regarding their role in their own care is proposed as a needed response.

This system, which seemed so innocent, has spawned a monster.

So you're in the private practice of dentistry? You're the owner of the practice? That makes you "self-employed" doesn't it? Or so you think! If you are accepting assignment of benefits from insurance companies, you are working for the insurance companies. As one of my mentors has stated, "Most dental offices have at least one employee that works for the insurance companies, yet the 'employing' dentist pays the salary and provides any benefits for that 'employee.'"

With the advent of "third parties" in the form of dental insurance companies, there was a great controversy as to whether or not a dentist should accept "assignment" of the payment directly from the insurance company. Many dentists warned that by accepting assignment the profession was opening itself to the ultimate control by the insurance companies. Many scoffed at such a prophecy and proceeded to accept the assignment. The acceptance of the assignment was justified as "providing a service to the patient." Soon, the insurance companies were asking for radiographs to be sent to them to verify the validity of the claim. The prophets again said, "don't do it, the insurance companies will eventually control the profession." Due to many of the prophets being in leadership positions of organized dentistry, their warnings were not welcomed by the insurance industry. As a result, the federal government became involved through the Federal Trade Commission, (FTC). There were several state dental organizations that were sued by the FTC, eventually resulting in a settlement that has to this day muzzled the voice of organized dentistry.

In many ways the advent of dental insurance was beneficial to dentistry. For the first time there was a designated dental dollar in the hands of the general public. Many people sought needed dental treatment that had been postponed due to what they perceived to be financial reasons, and for the dentists, business was booming. Most insurance carriers offered a "benefit" with the patient paying a percentage of the fee with the insurance carrier's liability being a maximum of one thousand dollars per year. This system, which seemed so innocent, has spawned a monster. We have now raised a generation of people, including...
legislators, who feel that dental benefits are a right and a generation of dentists who have been trained to fill out claim forms and to treat only for what the insurance company will pay. Dentists have

into the relationship between the dentist and the patient. Dentistry has moved away from the original dental model to the model that we see in veterinary medicine. In the veterinarian's office, it is

readily agreed to become the insurance agent for the insurance companies, resulting in the patient expecting the dentist to be knowledgeable about every policy, provide claim services, and accept the assignment of the benefit which has eroded the personal responsibility of the patient. By being so eager to please, the profession of dentistry took the bait. The insurance companies have kept their fiscal liability at the same level over the course of the years; they pay a percentage of an average fee covering a postal zip-code area or range of zip codes whichever they find to their benefit. By this tactic, the insurance companies are the ones that establish the fees of most dental offices.

One of the most misunderstood terms in the business of dentistry is "fee-for-service." The confusion exists because it depends on the definition of the term. The American Dental Association defines fee-for-service as when the dentist establishes and expects to receive full fee for service rendered. Third parties define it as whenever the dentist establishes and expects to receive full fee for service rendered. Third parties define it as whenever the dentist establishes and expects to receive full fee for service rendered. Third parties define it as whenever the dentist establishes and expects to receive full fee for service rendered. Third parties define it as whenever the dentist establishes and expects to receive full fee for service rendered. Third parties define it as whenever the dentist establishes and expects to receive full fee for service rendered.

whether it is in the traditional insurance system or DR, we must re-educate the public to the individual responsibility for one's own health. Many dentists warned that by accepting assignment the profession was opening itself to the ultimate control by the insurance companies.

W

In the dental office we see many patients who now believe that if the insurance company doesn’t cover it, they must not need the diagnosed treatment, which supposedly instructed the patient as to what the insurance company’s limit of liability was in providing benefits under the contract. This procedure has evolved into an administrative game by which needed dental treatment is postponed by the insurance company using different techniques of procedural delay. Obviously, the longer the insurance company can cause the patient to postpone treatment, the fewer claims they will have to pay.

When the pre-determination is eventually returned to the patient in the form of an “Estimate of Benefits Statement, (EOB),” the patient is told that his or her dentist is charging fees that are beyond the policy limits. Sometimes the statement even uses the term usual, customary, and reasonable, (UCR). These statements, not so subtly, tell the patient that their dentist is too expensive (or dishonest). Most policies have what is known as the LEAT clause, meaning that the policy will pay for the Least Expensive Alternative Treatment. When this clause is applied, the subliminal message is that the patient’s dentist is over-treating. During this process of pre-determination the treatment is delayed and with each succeeding question put forth by the insurance company the knife of distrust is thrust into the dentist-patient relationship. Today, the EOB directs the patient to call a toll-free number to receive the name of a dentist who participates in the insurance company’s “plan.” This type of subversive tactic is a blatant attempt to get the patient to change dentists.

There is an axiom that needs to be stated at this point: The dentist does not need the insurance industry to provide dental services to patients. Sadly, even organized dentistry (the ADA) in response to the involvement of a vast ma-

Insurance
the process of returning the responsibility for the insurance claim back to the patient and to the employer can only begin by first giving it back to the patient.

Once the ADA accepts standardized electronic information systems, the insurance industry and government will have the means by which they can and will totally control the practice of dentistry.

Insurance programs that use a “preferred provider” list from which a patient must choose a dentist is not freedom of choice! In those situations, the patient is stripped of his or her freedom to choose and becomes nothing more than a pawn in the employer’s search for a low cost dental plan. Peter Block, in his book, Choosing Service Over Self-Interest, says, “If you have the right to dictate service to another, you cannot call them a customer (patient). Calling people you can demand a response from a customer (patient) is manipulation—using the language of consideration to soften the coercion in the relationship.” When the patient is subjected to the dictates of others outside the dentist-patient relationship, the patient is not being treated with dignity and mutual respect. Not until the dentist eliminates the insurance companies from the dental office will the dentist understand just how much the insurance company is in control of the practice of dentistry.

A word about direct reimbursement. DR is what is hoped to be the great emancipator—and it is better than the traditional dental insurance programs. However, DR still perpetuates the idea that someone else is responsible for the patient’s dental care. What can one do? Somehow, whether it is in the traditional insurance system or DR, we must re-educate the public to the individual responsibility for one’s own health. I have chosen to re-educate my patients by not accepting the assignment of their benefit. By doing so, and by encouraging the patients to complain to their Human Resource department about the administrative games played by the insurance companies in the delaying of claim payments, the patients are beginning to understand that the insurance companies are in the business of collecting premiums, not paying claims. When the insurance company balks at paying the claim, the patient’s anger is now directed toward

imbursement. The Parameters of Care, as developed by the American Dental Association, are the only parameters of care that have been developed without regard to costs or limitation of the professional judgment of the dentist. All other parameter documents have some element of control over the professional judgment of the dentist as it pertains to the techniques, materials, and costs of treatment rendered. Unfortunately, the insurance industry doesn’t care what the membership of the ADA thinks or wants — unless it is to the benefit of the insurance industry. The insurance industry accepted the standardized claim form developed by the ADA, and for the most part they have accepted the Current Dental Terminology (CDT-2) but they refuse to accept the non-insurance friendly Dental Practice Parameters.

Any suggestions or recommendations to the insurance industry from the ADA are ignored; giving a perfect example of the adage, “he who has the gold makes the rules.” The only way the ADA will be able to affect the insurance industry will be through legislative action. Unfortunately, unless the ADA is aggressive, it may be too late! We are fighting an uphill battle. To paraphrase another dentist, “To Arms! To Arms! The HIPAA is coming!” HIPAA (Health Insurance Portability and Accountability Act) regulations that are supposed to go into effect in October of 2002 will force all dental offices (and all medical providers of all types) to file insurance for the patients and will probably require that this be done electronically. If you liked OSHA, you’ll love HIPAA! The ADA is going to have to expend some legislative capital in order to preserve the private practice of dentistry.

Today, even though the policy of the ADA is to oppose mandatory electronic claim filing, the ADA is heavily involved in developing procedure codes and other areas of electronic standardization (SNODENT, HIPAA). Once the ADA accepts standardized electronic information systems, the insurance industry and government will have the means by which they can and will totally control the practice of dentistry. The sad part of this is that we are doing it to ourselves! Could it be that the Division of Dental Practice through the work of the Council on Dental Benefit Programs, Council on Dental Practice, and the Department of Informatics is an inadvertent “Trojan Horse?”

As insurance invaded the dental office, “dentists were taught to use the insurance game for profit. Insurance companies used the insurance game for profit. Patients used dental insurance as a claim filing, the ADA is heavily involved in developing procedure codes and
the insurance company, not the dentist. This is not to say that the dentist cannot be an advocate for the patient. It is possible to help the patients help themselves without assuming responsibility for the patients. If a narrative is needed, I send a “patient education” letter to the patient to accompany the patient’s own letter to the insurance company. The decision to totally disassociate the dental office from dental insurance is a major step and one that cannot be made flippantly. The process of weaning the office from insurance dependency begins in the mind of the dentist. This is such a departure from the norm that many dentists do not believe that it can be done. It would be much easier never to begin taking assignment than to retrain an established patient base. However, most dentists who began practicing in the early seventies have grown up with dental insurance and have readily accepted the assignment of benefits.

During this process of pre-determination the treatment is delayed and with each succeeding question put forth by the insurance company the knife of distrust is thrust into the dentist-patient relationship.

The process of returning the responsibility for the insurance claim back to the patient and to the employer can only begin by first giving it back to the patient. This is being done, one office at a time, one patient at a time. More and more offices are being successful in severing the insurance umbilical cord. This trend will further differentiate a private care practice from the insurance driven model.
Abstract
The Executive Director of the National Association of Dental Plans presents statistics describing recent trends in product mix, growth in voluntary benefits and referral plans, geographic concentration, and industry consolidation in the dental benefits industry. Current issues include dental workforce, the economy, human resources policies, and regulation. The issue of quality oral health care is identified as needing consensus definition by the entire dental industry.

The Forest
It is important to examine the broad impact of the dental benefits market before delving into the detail of the segments of the market from a descriptive or critical perspective. What impact have dental benefits of all types had on oral health in the United States?

In 2000, the Surgeon General’s Report on Oral Health, clearly established the link between oral health and general well being. That report also showed that one of the major barriers to oral health was lack of dental insurance. Dental insurance meets the consumer issue of inability to pay out of pocket. Data in the report illustrated that when insurance was present there was an increase of more than 20% in the use of dental services. More than 70% of Americans with private dental insurance have seen a dentist in the past year, while of those without insurance only about half see the dentist annually.

The report went on to estimate that while forty-four million Americans lack medical insurance, about one hundred and eight million lack dental insurance. It concluded that only 60% of baby boomers receive dental insurance through their employers, and most older workers lose their dental insurance at retirement. It also documented that uninsured children are two and a half times less likely to receive dental care than insured children, and as well that children from families without dental insurance are three times as likely to have dental needs as compared to their insured peers.

Clearly dental insurance promotes access to care and dental health. Expanding insurance and other forms of dental benefits therefore expands access with a positive impact on dental health. Contracting dental benefits has the opposite effect.

The Trees
The dental marketplace has changed significantly over the past decade. In the late 1980s when the federal government measured the dental insurance marketplace, there were approximately ninety-five million Americans with dental benefits. In 1999, NADP market data puts the number of Americans with dental benefits at 56% of the population (Table 1). Early reports of 2000 and 2001 enrollment place that figure at more than 60%.

Dental Benefits Product Mix/Cost
Since the late 1980s the mix of dental benefit products has changed as well. Until the mid-80s virtually the only dental benefit product was dental indemnity coverage, i.e., reimbursed fee for service (see sidebar of terms). In the mid-80s dental HMOs developed as a balance to relatively high dental benefit premiums in indemnity dental plans and as a reflection of the medical market’s move to this model to provide care focused on prevention. From that time through today, dental HMO monthly premium averaged 40% to 50% below dental indemnity premiums (see Table 2) offering a similar mix of benefits that focus on prevention though low out-of-pocket or no cost preventive services. Through the mid-90s dental HMOs grew at a rapid pace.
Table 1. Dental Benefits at a Glance

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental HMO SubTotal</td>
<td>24,668,084</td>
<td>27,205,413</td>
<td>27,927,504</td>
<td>27,400,350</td>
<td>17.9%</td>
</tr>
<tr>
<td>% Changes Year-to-Year</td>
<td>24.75%</td>
<td>10.29%</td>
<td>2.65%</td>
<td>-1.90%</td>
<td></td>
</tr>
<tr>
<td>Dental PPO SubTotal</td>
<td>21,479,793</td>
<td>29,115,333</td>
<td>39,462,795</td>
<td>47,722,518</td>
<td>31.2%</td>
</tr>
<tr>
<td>% Changes Year-to-Year</td>
<td>37.11%</td>
<td>35.55%</td>
<td>35.54%</td>
<td>20.93%</td>
<td></td>
</tr>
<tr>
<td>Dental Referral Networks Subtotal</td>
<td>8,640,888</td>
<td>9,443,651</td>
<td>10,549,735</td>
<td>11,984,170</td>
<td>7.9%</td>
</tr>
<tr>
<td>% Changes Year-to-Year</td>
<td>22.01%</td>
<td>9.29%</td>
<td>11.71%</td>
<td>13.60%</td>
<td></td>
</tr>
<tr>
<td>Dental Managed Care SubTotal</td>
<td>54,788,764</td>
<td>65,764,397</td>
<td>77,940,034</td>
<td>87,107,038</td>
<td>57.0%</td>
</tr>
<tr>
<td>% Changes Year-to-Year</td>
<td>-4.04%</td>
<td>-4.30%</td>
<td>-6.10%</td>
<td>-6.10%</td>
<td></td>
</tr>
<tr>
<td>Indemnity SubTotal</td>
<td>78,020,224</td>
<td>74,661,490</td>
<td>70,107,140</td>
<td>65,830,604</td>
<td>43.0%</td>
</tr>
<tr>
<td>% Changes Year-to-Year</td>
<td>-4.04%</td>
<td>-4.30%</td>
<td>-6.10%</td>
<td>-6.10%</td>
<td></td>
</tr>
<tr>
<td>EST: Total Dental Benefits Market</td>
<td>132,808,988</td>
<td>140,425,887</td>
<td>148,047,173</td>
<td>152,937,643</td>
<td>100.0%</td>
</tr>
<tr>
<td>% Changes Year-to-Year</td>
<td>7.25%</td>
<td>5.74%</td>
<td>5.43%</td>
<td>3.30%</td>
<td></td>
</tr>
<tr>
<td>% Population with Dental Benefits</td>
<td>52.44%</td>
<td>54.78%</td>
<td>56.08%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Increasing from 7.8 million Americans covered in 1990—the first year that NADP recorded the size of this market segment to almost 30 million in 1998. This was nearly a four-fold increase. Through the mid-90s, there were two types of dental insurers. The traditional health companies that offered dental indemnity benefits and newer—often entrepreneurial—dental HMOs. The latter were mostly free-standing companies or

Table 2. Group Dental Benefits Employee-Only Dental Benefits Premiums

<table>
<thead>
<tr>
<th>Year</th>
<th>HMO</th>
<th>PPO</th>
<th>Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>$10.95</td>
<td>$15.50</td>
<td>$21.25</td>
</tr>
<tr>
<td>1996</td>
<td>$11.25</td>
<td>$16.00</td>
<td>$21.16</td>
</tr>
<tr>
<td>1997</td>
<td>$11.96</td>
<td>$16.50</td>
<td>$21.45</td>
</tr>
<tr>
<td>1998</td>
<td>$12.00</td>
<td>$17.87</td>
<td>$24.65</td>
</tr>
<tr>
<td>1999*</td>
<td>$12.09</td>
<td>$18.28</td>
<td>$25.89</td>
</tr>
<tr>
<td>2000</td>
<td>$12.25</td>
<td>$19.41</td>
<td>$27.20</td>
</tr>
<tr>
<td>2001E</td>
<td>$12.36</td>
<td>$20.62</td>
<td>$27.20</td>
</tr>
<tr>
<td>2002P</td>
<td>$12.36</td>
<td>$20.62</td>
<td>$27.20</td>
</tr>
</tbody>
</table>

in some instances, subsidiaries of large life and health insurers.

**Dental PPO Market Emerges in the Mid-90s**

However, for every market change, there is a counter trend; for every action, a reaction. Not all of the increase in dental HMO enrollment came from overall market growth. Much of the increase in dental HMO enrollment was at the expense of traditional insurers dental indemnity block of business. This fact coupled with dental HMOs detractors spawned the development of dental PPO products in the mid-90s. In 1994 when NADP began representing and measuring the dental PPO market, enrollment was just under eleven million Americans; this is about where the dental HMO industry was in 1991. However, the dental PPO product has grown more swiftly since the mid-90s and today serves about sixty million Americans. By 1998, the growth of all network-based dental products, largely pushed by the introduction of dental PPOs, had pushed the majority of the market from traditional dental indemnity products to the three types of network-based products, i.e., dental HMOs, dental PPOs, and dental referral plans.

**Voluntary Benefits Grow**

As the types of benefit plans changed, who paid for them did as well. Many employers paid for all or part of dental indemnity benefits. With the birth of the dental HMO, low monthly premiums, allowed small and medium employers to offer benefits but not pay for the premiums. This type of product was called a "voluntary" benefit, as employees voluntarily signed up for the benefit. In the early 90s, this product was virtually only written by dental HMOs. However, its success in this sector, has expanded into all segments of the dental market today.

This left a market niche to be filled for both the self-employed, small groups, and the unemployed. Following the trend in prescription drug discount cards, several companies developed dental referral plans, i.e., products which provide the consumer a discount although he or she must pay the full cost of dental coverage out-of-pocket. In
1994 when NADP began tracking dental referral plans data, enrollment was about six million and is more than double that today. Dental referral plans are based on a network and so can be offered as a lower cost alternative product when employers cannot afford and insured product. Typically, dental referral plans average $3 to $6 for individuals and $6 to $9 for families per month.

Integration
As the market matured, dental insurers found that employers focused on different benefits to meet different needs. Dental benefits are a highly rated employee benefit—among the top three according to the U.S. Chamber of Commerce. Different employee populations had different needs that were met by different products. Employee populations that needed low cost and low, predictable out-of-pocket expense because the employee's were buying coverage themselves or had little disposable income fit the dental HMO profile. Employers who focused on cost but wanted broader networks to meet employee needs might ask for a dental PPO or POS (Point of Service) option on a dental HMO. Employers that were involved with collective bargaining or wanted no limits on choice of dentists, might opt only for a dental indemnity plan.

Companies with only one product could not meet the range of market demands. Thus, in the mid 90s, the market began to consolidate into companies with an integrated array of products. Dental HMOs, such as today's CompBenefits, bought or formed partnerships with dental indemnity insurers. Other dental HMOs, like CIGNA Dental, created dental PPO products. Dental indemnity insurers, like Ameritas and Protective Life, bought dental HMOs. Today, except in markets where there is relatively high dental benefit penetration (the Pacific Coast) or unique market environments (Minnesota), there are relatively few dental benefit companies that write only one type of dental benefit product.

Geography
Since most dental benefits are provided as an employee benefit, the concentration of benefits follows highly populated states. In 1999, ten states accounted for about 75% of dental HMO enrollment, 68% of dental PPO enrollment, 78% of dental referral enrollment, and 65% of dental indemnity enrollment. Table 4 shows the similarity between the top ten states by line of business. Just seventeen states account for more than two-thirds of all the dental benefits in the United States.

Issues Affecting the Future of the Dental Benefits Market
There are four broad trends that affect the dental benefits market in the short and long term: dental manpower, the economy, human resources trends, regulation (both federal and state), and technology.

Dental Workforce. NADP began studying the predicted downturn in the number of dentists in late 1999. Our Provider Practice Capacity Initiative outlined the impact of a decrease in the number of dentists to more than 2000 dental benefit executives at our Annual Conference last October. From a peak of 60 dentists per 100,000 population in 1990 to project 50 per 100,000 in 2015, absent offsetting trends like new therapies that change the mix of dental services, the number of dentists serving the American public will have an impact on dental health and access. This trend could slow the growth of dental insurance products that provide access as well.

The Economy. In a near full-employment economy where liberal employee benefits are one key to obtaining and retaining the best employees, the most open dental benefit products have an edge in the market. Despite this situation in the recent, past, dental PPO benefits grew while dental indemnity products lost market share. As employers are faced again with double-digit medical cost increases and less unemployment, surveys like Mercer/Foster & Higgins indicate that more costs will be shifted to employees. This means that lower cost dental benefit products may see some resurgence in the near term.

Human Resources Trends. Employee Benefit News and other human resources publications herald a trend to cafeteria plans of benefits, i.e., create a mix of benefits, then let the employee choose what is appropriate for their circumstances. With dental benefits being highly rated, there is little likelihood that they will be dropped by employees, but again with higher medical costs, lower cost benefits with predictable out-of-pocket costs will prevail. This trend to consumer choice may also dictate a resurgence in comparable information on plans, like the trend to medical report cards in the late 80s and early 90s. NADP is exploring the creation of a common dental benefit satisfaction index to meet this need.

Regulation. Dental benefit plans are licensed exclusively at that state level. The description of the state scheme of regulation can best be described as varied. Some states, like California and Texas have relatively strict dental HMO regulation, but little on other types of dental benefits. Texas does not even permit the traditional dental PPOs. Other states regulate dental benefits under the Limited Health Service Organizations Acts or a variety of other statutory schemes.

The most significant upcoming regulation of dental benefits and indeed of dentists themselves is not at the state level, it is federal implementation of Title II of the Health Insurance Portability and Accountability Act or HIPAA. Title II relates to administrative simplification and addresses electronic transactions, privacy, and security. The first compliance date under this title is October of 2002 for electronic transactions, the next is for privacy in April the following year. The compliance efforts with the relevant regulations for most companies are taking two to three years and will cost between $750,000 and $3.5 million per company.

Dentists may rely on their practice management software for electronic
transaction compliance and the industry is working on solutions that will make that part of HIPAA transparent to a dental office. However, that does not relieve the dentist’s obligation for compliance. Compliance with the Privacy and Security Standards under HIPAA will not be as simple for the dental office as patient information and records are the focus of this effort and penalties are steep.

HIPAA should occupy center stage on the regulatory front for the next several years as well as engage significant capital. While NADP data that is about to be released shows that recent savings in administrative costs have gone to higher payments to dentists as well as to three key arenas in which to focus to fulfill this mission.

**Dental Workforce.** What are the ways that the dental benefits industry can work with other segments of the dental benefits marketplace to expand current capacity and create additional capacity. The issues are myriad. From unfilled faculty positions at dental schools to unfilled student slots there and at schools of dental hygiene, there are opportunities for the entire industry to work together to expand access to care.

### Table 4. Top Ten States by Line of Dental Benefit Product
*(Listed in Decreasing Significance of Size Unless Noted)*

<table>
<thead>
<tr>
<th>Rank</th>
<th>Dental HMO</th>
<th>Dental PPO</th>
<th>Dental Referral</th>
<th>Dental Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>California</td>
<td>California</td>
<td>California</td>
<td>California</td>
</tr>
<tr>
<td>2.</td>
<td>Florida</td>
<td>Florida (8)</td>
<td>Florida (7)</td>
<td>California</td>
</tr>
<tr>
<td>4.</td>
<td>Texas</td>
<td>Texas (7)</td>
<td>Texas (4)</td>
<td>Texas (5)</td>
</tr>
<tr>
<td>5.</td>
<td>Pennsylvania</td>
<td>Pennsylvania (2)</td>
<td>Pennsylvania (10)</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Maryland</td>
<td></td>
<td>Maryland (5)</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Tennessee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>New Jersey</td>
<td>New Jersey (9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Illinois</td>
<td>Illinois (3)</td>
<td>Illinois (2)</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Arizona</td>
<td></td>
<td>Arizona (8)</td>
<td></td>
</tr>
</tbody>
</table>

- Michigan (4)
- Massachusetts (6)
- Massachusetts (6)
- Ohio (10)
- Virginia (9)
- North Carolina (7)
- Wisconsin (9)
- Minnesota (10)

**Facing the Future Together to Expand Consumer Access**

NADP’s mission is to “promote and advance the dental benefits industry to provide consumer access to affordable, quality dental care.” There are at least
As Executive Director of NADP, I have participated in the American College of Dentists Ethics Summits and ADTA's Dental Summits to build bridges to other organizations and create networks as one method of assuring adequate access. To expand networks, a variety of experiments are beginning with other methods of payment for dental HMO networks. Some of these are prevalent in the Medicaid market, other are being tried in the largest dental market, California. Long-term stability in the dental HMO market may be meet by developing new forms of payment for dentists in the networks or making the old forms more understandable.

**Benefit Structures.** The 2000 Mercer/Foster & Higgens’ National Survey of Employer-Sponsored Health Plans found that the median deductible of $50 and maximum annual benefit of $1000 for dental plans overall remained unchanged. New therapies such as remineralization, the impact of sealants on the reduction of caries, and other changes in the practice of dentistry raise questions for the structure of the dental benefit package. A panel at this year’s NADP Annual Conference, October 10-12 in Toronto, Canada, will begin to explore potential changes in the structure of dental benefits.

**Capitation.** This for of financing oral health care has been a difficult concept for dentists to reconcile with the historical fee-for-service method of reimbursement. While capitation offered an immediate, stable patient base and monthly income, it was hard for dentists to grasp the reduction in overhead for marketing and the incremental addition of income to a practice for dental HMO patients. As well, dental HMO networks remained relatively narrow of necessity to assure that dentists in the networks had enough patients to met costs. Employers consistently demanded expanded networks. Many state regulators also measured depth of dental HMO

Dental insurance meets the consumer issue of inability to pay out of pocket.

Dialogue that is necessary to work together. NADP profiles individual company efforts at funding faculty positions and working with schools of dental hygiene to create more capacity. But, more must be done.

**Quality.** Today, there is no system for measurement of dental quality.

Many publications and television programs have amply demonstrated that a single patient will get differing recommendations for treatment from a cross-section of dentists. Until there are diagnostic codes and outcomes research on appropriate treatment for specific diseases, quality is basically a defense for the way a particular dentist prefers to practice. While state regulatory authorities may require dental benefit plans to have quality programs, they are largely done by chart audits where one dentist judges the work of another based on experience with limited calibration.

The only quality measurement programs that exist today in dentistry have been created by dental benefit plans.

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The only quality measurement programs that exist today in dentistry have been created by dental benefit plans, i.e., HealthPartners of Minnesota and their dental groups developed a system of prescribed treatments for specific dental problems. Delta Dental Plan of Massachusetts and Kaiser Dental Plan have worked on similar programs. The California Association of Dental Plans has undertaken a calibration of the dental auditors program to establish common review standards of charts in required audits. MetLife recently announced funding of a study to explore whether dental risk assessment has an impact on the amounts and types of treatment provided. These are but a handful of ongoing industry initiatives.

Dental benefits in general do not measure quality or interfere with the individual dentist’s preferred practice patterns. Claims review focus largely on whether a benefit exists for the treatment provided. Until the industry and/or the dental profession develop a system of measurable quality, quality will be little more than a political debate. NADP asked the ADA to join in a discussion of the development of a system of quality in the mid-90s. After initially accepting our invitation to a panel discussion at our Annual Conference, the ADA canceled its appearance just a few weeks before the conference. Quality remains a topic that demands the attention of the entire industry.

**Summary**

The dental benefits system is working to expand access to dental care and improve dental health. All industries have their issues, NADP stands ready to work with dentists, the dental manufacturing and supply industry, labs, pharmaceutical, dental schools, schools of dental hygiene, auxiliary programs, and other to improve consumer access to affordable, quality dental care.
Dental Benefits Terminology

Capitation is a provider reimbursement method where general dentists are paid a fixed fee per month based on number of individuals enrolled under a dental HMO benefit plan select or are assigned to a dental office. This method of reimbursement pays the dentists regardless of the care accessed by the enrolled population assigned to the dental office. There are no pre-authorizations for care or claims to file although some dental HMOs require authorization for referral to a specialist. The enrollee often also pays a fixed fee per office visit for the type of procedure performed in that visit.

Dental HMO refers to a company that provides comprehensive dental benefits to a defined population of enrollees in exchange for a fixed monthly premium and pays for general dentistry services primarily under capitation arrangements with a contracted network of dentists. Specialists are generally paid on a discounted fee-for-service basis. This term includes point-of-service dental HMOs that provide an enrollee option to opt out of the HMO provider network at the point-of-service and obtain dental services on a fee-for-service basis.

Fee-for-Service refers to a method of payment where beneficiaries are covered under a benefit plan allowing access to any dental care provider. Providers or the beneficiaries are reimbursed on a per procedure basis based upon fees charged.

Dental Indemnity refers to benefit plans where the providers are reimbursed on a fee-for-service basis and there are no discounted provider contract arrangements whereby the provider agrees to accept a fee below their customary fee. This type of coverage is usually fully insured, i.e. the risk for claims incurred is transferred from employer to a third party insurer for a specified premium. However, many large employers self-insure this and other products by retaining the risk for claims and paying a contractor service fees to manage claims processing and other administrative functions.

Dental PPO refers to a dental plan that provides dental benefit products with two key characteristics. Dental plans enter into contracts with providers for the express purpose of obtaining a discount from overall fees. Discounts may be negotiated on a provider practice basis or through use of a schedule of fees. Enrollees receive value from these discounts when using contracted providers. Again this type of dental benefits plan may be fully insured where the risk for claims incurred is transferred from employer to a third party insurer for a specified premium or self funded where the risk for claims is retained by the employer or its employees and service fees for processing claims are paid to a third party. (NOTE: Generally Dental PPO products do not include participating provider agreements based on fee-for-service where the provider and plan do not intend to reduce fees, such as Delta Premier plans or most Blue Cross/Blue Shield dental products.)

Dental Referral Plans are non-insured programs in which a panel of dentists agrees to perform services for enrollees at a specified discounted price, or discount off their usual charge. No payment is made by the referral plan to the dentists; dentists are paid the negotiated fee directly by the enrollee. Some industry members refer to this product as provider access organizations; others refer to them as discount card plans.

Voluntary refers to a group product offered through the employer where the employee pays 100% of the premium.
The Case for Dental Preferred Provider Organizations

Thomas D. Gotowka, DDS, MS, MPA

Abstract

The dental PPO market is the fastest growing segment of the dental benefits business. As with traditional indemnity plans, dentists are reimbursed on a fee-for-service basis. Members can refer themselves to dentists of choice, including specialists, inside and outside the network. Employers' interest in DPPOs is expected to continue as they seek to control or reduce expenses associated with dental benefits plans. Dentist participation in managed care programs significantly lags medical, and fewer than half of practicing dentists participate in DPPOs. Negotiated discounts vary across carriers and geographic regions, generally ranging 15% to 30% off average fees. The American Dental Association predicts that dentists’ participation in DPPOs will continue to increase, indicating further growth for these dental plans. There are financial incentives for members to stay in network.

In contrast, DHMO membership, which grew rapidly through the mid-1990s, has flattened over the past few years and has now begun to decline (i.e., 8.3% decline in 2000). The exception is the Medicaid sector, which still exhibits significant growth. Indemnity plan membership has also declined, with employers frequently replacing these traditional plans with DPPOs. (Note: Growth rates exclude referral plans, which provide access to a network of dentists who agree to provide a defined set of services at scheduled, discounted fees. Unlike indemnity, DPPO, or DHMO plans, referral plan members pay all charges out-of-pocket.)

The past few years have been witness to incredible consolidation of dental insurance carriers, and the composition of the industry has changed remarkably. For example, Aetna Inc. acquired U.S. Healthcare, NYLCare, and Prudential HealthCare. WellPoint purchased the dental businesses of John Hancock, Mass Mutual, and Cerulean. United Concordia

Current Dental Marketplace

The National Association of Dental Plans (2000, 2001) estimates the total population covered by dental benefits plans at year-end 1999 to be nearly one hundred fifty-three million, or about 56% of the U.S. population. The dental PPO market is the fastest growing segment of the dental benefits market, increasing 21% in 2000 alone.

Dental preferred provider organization benefit plans (DPPOs) began to develop in earnest in the early- to mid-1980s as alternatives to dental HMOs (DHMOs). DPPOs offer greater freedom of choice than DHMOs, while still controlling benefit costs over traditional indemnity plans. Alternatively, DHMOs generally provide greater cost savings than DPPOs, but with more limited provider access.

The DPPO segment of the dental benefits market covered less than ten million Americans in 1993, but is now approaching 40% of the population covered by dental benefit plans. (National Association of Dental Plans, 2001) As the cost of providing employee benefits continues to grow, employers will likely seek additional opportunities to manage dental expense; so, the interest in managed care programs like DPPOs is expected to continue.

This paper reflects on the growth of DPPOs, and reviews the current dental marketplace, briefly examines evidence regarding changes in employer support for dental plans, discusses the characteristics of DPPOs, and considers the provider market environment.
acquired MIDA, a DHMO company, and Guardian bought First Commonwealth. In addition, United Health Care acquired controlling interest in Dental Benefits Providers and, most recently, California Delta consummated its deal with Pennsylvania Delta, creating Dentegra Group, a holding company managing Delta operations in sixteen states and the District of Columbia. Companies have also begun to develop strategic partnerships to gain national network presence. These include Pacificare and Guardian; and Ameritas and Principal.

A few potentially dominant national and regional players have emerged and, within the next few years, three-quarters of the covered dental population, excluding Medicaid and referral plans, may well be managed by six to eight large carriers.

Why such consolidation? The cost of developing and maintaining national dental networks is high, and managing networks requires development of complex analytic and reporting systems. Further, insurance carriers are making significant investments in replacing or updating old administrative and claim systems, moving toward fully automated (i.e., no human intervention) claim adjudication and electronic payment.

Also, significant investments are being made in Internet-based services, which include claim and radiograph submission, eligibility and coverage inquiries, claim payment status, and member "self-service" features. These initiatives result in quicker and more accurate claim payments and fewer problems for members and providers. Companies like Aetna Inc. are also making large investments in Internet technology to deliver dental clinical information to members and dentists (see www.dental.intelihealth.com). Partnering with the University of Pennsylvania School of Dental Medicine, the InteliHealth Dental site provides easy access to extensive information that will help patients and parents better understand their own or their children's dental conditions, allowing them to participate in decisions regarding treatment options.

Finally, the cost associated with complying with state and federal regulatory requirements is increasing. While managed care laws have historically focused primarily on medical plans, legislators and regulators are expanding the scope of governmental authority over dental plans, often applying medical standards to the dental industry. Administrative costs are certain to be impacted as these legal trends continue.

For example, states are increasingly requiring separate HMO licensure for capitated plans, and expanded licensure requirements for DPPOs have also been imposed or are being considered. Because comprehensive regulatory oversight for dental plans is relatively new in some states, dental versus medical standards may not be clearly delineated by regulation. As a result, regulatory structures that try to "fit" medical quality management standards or clinical protocols to dental programs may not be workable without unnecessarily high administrative costs for dental carriers. In some states, efforts have been made to impose laws that would shift the liability for malpractice and other treatment decisions from the providers of care to insurers.

Recent regulations proposed or already finalized under The Health Insurance Portability and Accountability Act (HIPAA) and relating to the privacy of health care information are expected to substantially increase administrative costs for dental plans. In addition, reducing or eliminating the scope of pre-emption by the Employee Retirement Income Security Act of 1974 (ERISA) of health care and bad faith claims under state law, could expose dental plans to increased liability for punitive and other extra-contractual damages.

Massive costs are associated with these initiatives, and some carriers have difficulty in making or justifying large capital investments to support relatively small membership bases.

**Employer Support for Dental Plans**

Employer interest in managed care programs like DPPOs is certain to continue. As noted earlier, as overall costs of providing employee benefits continue to grow, employers are seeking opportunities to manage the expense associated with dental benefits plans.

The Health Insurance Association of America (1998) reports that more than 97% of the covered population received its coverage through employee group plans. Most employees with dental benefits (83%) are employed in groups of fifty or more, and two-thirds of covered employees receive benefits through self-insured administrative services arrangements.

Growing evidence indicates that employers are increasingly calling upon employees to share in the burden of dental benefit costs. Given the perceived "discretionary" nature of dental coverage, employee participation rates are likely to
decline. Mercer/Foster Higgins’ *National Survey of Employer-Sponsored Health Plans* (2000) suggests that almost half of surveyed employers will be raising employee contribution levels this year, and a large number are considering raising plan deductibles. This is the same group of employers who, in past surveys, chose not to pass cost increases on to employees because of concerns regarding attracting and retaining employees in tight labor markets. The Life Insurance Marketing and Research Association (2000), reporting on a study conducted by Hewitt Associates, projected average health premium increases of 10% to 13% for 2001; some companies will absorb the majority of next year’s rate hikes, but many will pass at least 25% of the increase to employees.

LIMRA (1998) reported that 37% of employees currently pay the full cost of at least one benefit received through their employers, and 81% pay some of the cost of at least one benefit. The most frequently purchased voluntary benefit is dental coverage. According to the Bureau of Labor Statistics, only 34% of employees were required to share a portion of the cost of the dental benefits plan with their employer in 1988 (for individual employee coverage); but by 1993, over 54% of employees had cost sharing arrangements. The corresponding statistics for family coverage are 50% and 66% respectively (Blostin & Pfunyner, 1998).

**Characteristics of DPPO Plans**

DPPO plans enable covered members to receive dental care from a network of contracted dental providers. Dentists who participate in DPPO networks agree to provide services for negotiated (e.g., discounted) fees to the covered population. Dentists are reimbursed on a fee-for-service basis without DHMO-type capitation arrangements. By choosing to receive care from in-network dentists, cost savings are achieved by the member whose out-of-pocket costs are reduced over reasonable and customary levels. DPPO plans may also offer benefit differential incentives when care is received from a participating provider, generating further cost savings for members. In addition, because premiums for DPPO plans are lower than those for comparable indemnity plans, employers also save. As with member out of pocket costs, employers who “self-fund” their dental plans receive the benefit of the negotiated fees.

DPPO plans closely resemble traditional indemnity plans. Plan features include individual or family deductibles and, like indemnity plans, co-insurance rates that vary by type of procedure. For example, coverage for preventive and diagnostic services may be 100% of negotiated fees, while coverage for routine restorative procedures may be 80%.

In some states, efforts have been or are being made to impose laws that would shift the liability for malpractice and other treatment decisions from the providers of care to insurers.

Provider participation criteria should be spelled out very clearly and must include policies and standards for areas like appointment availability, emergency coverage, record keeping, sterilization, and billing practices. Dentists should be recredentialed on a regular basis, and offices may be evaluated onsite by a peer reviewer when quality of patient care issues arise. Member satisfaction should be monitored through regular surveys.
be measured and monitored on an ongoing basis.

Another characteristic of DPPOs is the ability to "self-refer." Plan members can refer themselves to dentists of their choice, including specialists, inside and outside the network. DPPO members have the choice, then, of going out of network to use the services of non-participating dentists. Unlike DHMOs, the member's primary care dentist in a PPO is not required to serve as a "gatekeeper" to specialists.

Clearly, however, there are financial incentives for members to stay in network. In "steerage" DPPOs, members who choose to seek care outside the network of participating dentists are required to pay a greater share of the costs of care. "Steerage" plans may increase member out-of-pocket costs through lower out-of-network plan co-insurance levels. For example, members receiving care in network receive coverage of 80% of negotiated fees for routine restorative treatment. Out-of-network coverage levels, however, may be limited to 60% of reasonable and customary charges. Thus, members who seek services from participating providers save twice; i.e., the plan pays a higher percentage of the cost, and the member's share of the cost is based on negotiated fees rather than reasonable and customary charges.

Other design features of "steerage" plans include lower annual maximums and lower lifetime maximums for members getting care from non-participating dentists. So, the annual maximum for members receiving care in network may be set at $2000 per person per year in total benefits paid, versus $1200 per person per year out-of-network. By the same token, in-network orthodontic benefits may be set at $1500 per person when treatment is provided by a participating orthodontist, versus $1000 for members receiving care from a non-participating specialist.

These incentives may be limited by state regulation for insured DPPO plans in certain states. For example, benefit levels for in-network versus out-of-network care in-network receive coverage of 80% of negotiated fees for routine restorative treatment. Out-of-network coverage levels, however, may be limited to 60% of reasonable and customary charges. Thus, members who seek services from participating providers save twice; i.e., the plan pays a higher percentage of the cost, and the member's share of the cost is based on negotiated fees rather than reasonable and customary charges.

Over 97% of the covered population received its coverage through employee group policies.

levels are impacted by other factors. For example, in areas where a single dominant employer converts its plan from indemnity to DPPO, local practitioners may be willing to negotiate "deeper" discounts to maintain their patient bases. None of these observations are hard and fast rules.

The Dental Provider Environment

Dentist participation in managed care programs significantly lags medicine, and a little less than half of practicing dentists participate in DPPOs, and only about 15% participate in DHMOs. An estimated 88% percent of physicians participate in at least one managed care arrangement.

Myriad factors contribute to this phenomenon. The "look" of independent dental practice has not changed much over the past twenty-five years. Dentists are still predominantly general practitioners and practice largely as "solo" providers (Brown & Lazar, 1998a). The dental delivery system has limited capacity. In contrast to physicians, the dental provider pool is shrinking. There are 40% fewer dental school graduates and one-third fewer dental school slots today than in the mid-1980s. Substantial num-

bers of male dentists are approaching retirement age, and dentist/population ratios will continue to tighten through 2020 (Brown & Lazar, 1998b).

Dental practitioners are prospering. Dental prices have recently been increasing at a greater rate than the CPI and other health sectors (U.S. Department of Labor, Bureau of Statistics). The income of dental general practitioners exceeds that of their medical counterparts, and dental specialist incomes have increased significantly relative to medical specialties (Brown & Lazar, 1998c).

Dental disease is increasingly a disease of American adults. The incidence of dental disease (and treatment need)
has decreased substantially in children and young adults, but has risen substantially in the older population, which is demanding more cosmetic services and more complicated/expensive procedures (Burt, 1992; Brown, Wall, & Lazar, 1999; Brown, Wall, & Lazar, 2000a; Brown, Wall, & Lazar, 2000b). However, low income individuals and the uninsured have a disproportionately high incidence of dental disease (USPHS, 2000). Sutro & Company (1999) estimate that demand for dental services will increase in the 10-15% range through 2007.

Dental practice management firms have grown significantly over the past five years, and these companies are undergoing consolidation. While it is unclear if these organizations will be successful in the long term, their negotiating leverage currently impacts dental networks. Further, in contrast to medical, dental IPAs have not been a major presence in managed dental care programs. While they appear to be growing in number, there are currently only about twenty-five dental IPAs operating in the United States.

Despite these factors, national DPPO networks, as currently reported by the top six DPPO carriers, range in size from about 35,000 to nearly 55,000 provider locations, and are growing. In contrast, the industry’s largest DHMO network, managed by Aetna Inc, reports fewer than 7,500 participating general dentists. (Note that the DPPO numbers include both general dentists and specialists.) Perhaps the biggest factor contributing to dentists’ willingness to participate in DPPOs is their similarity to traditional indemnity plans. Dental offices do not need to implement unique administrative processes to handle DPPO members.

The American Dental Association predicts that dentists’ participation in DPPOs will continue to expand, indicating further growth for these dental plans. However, participation in capitated plans may decline. The ADA’s survey found that the majority of DPPO participating dentists reported an overall “positive” experience, while more than half of dentists in DHMOs reported some dissatisfaction with the plans. DPPO providers also reported growth in practice revenues through an increased patient base. Further, the majority of dentists participating in DPPOs expected to renew participation when their contract expired; a much smaller percentage (though still a majority) of responding DHMO participants indicated the same. DPPO plans, then, seem more likely to be the type of plan that dentists will choose in the future. (Brown & Ruesch, 2000a; Brown & Ruesch, 2000b).

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**References**


A Position Paper: Six Lessons About Managed Care in Dentistry

David T. Ozar, PhD, FACD

Abstract
The limitation of resources available for oral health care makes it inevitable that groups (such as third parties) would arise with a view toward conservation of these resources. Although the concept of adequate care has been generally operationally defined in dentistry, a confusion remains between adequate and best. Dentists may be under an ethical obligation to inform patients of all available treatment options (ranging from the adequate to the best) and to perform the selected treatment to the best of their ability, but they are not under an obligation to offer only the best alternative or to expect that society will make the resources available for that level of care.

Important changes have taken place in the economics of health care in the United States in the last decade or so, and the issues they raise for professional ethics are among the dominant topics of discussion in this nation's health care circles. More and more health care, and thus more and more dental care, have fallen under the influence of the organizations that are collectively called "the managed care industry." This industry is made up of third-party payer organizations of many different kinds, some for-profit, some not-for-profit, some government organizations. But whatever their other organizational goals—and some of them have as their first goal providing access to needed health care to persons who otherwise might not have it—all of them have an interest in limiting expenditures for health care, including dental care.

At the same time that this cost-limiting initiative is underway, three or four generations of U.S. health care professionals, including dental professionals, have been trained to the view that their professional obligation to each patient is to provide that patient with the best possible health care, which ordinarily means treatments that take advantage of the most recent advances in biomedical
It is not a proper statement of the ethics of American health professions to say that dentists are committed to always providing the best available care.
Health care resources are limited and oral health care competes, in many respects not very successfully, for a share of them.

and whom it will thus affect. The managed care organizations, along with the benefits managers of employers, and key governmental policy-makers and legislators, are the ones doing that in the United States today.

So the first lesson is simply that the resources our society has available for health care, including dental care, are both finite and insufficient to provide quality health care for all the needs of everyone in the society. This may not look like a positive lesson, since has to do with scarcity. But it is arguably a positive lesson insofar as it states an important truth about human life and encourages human beings to therefore learn to live together ethically in a world in which there is not enough for all of our dreams and wishes to be realized.

Lesson 2
A second lesson that is relevant to the environment of managed care is one that dental professionals have long understood. It is a rather abstract lesson because it is about the meaning and the meaningfulness of an important concept, namely the concept of adequacy in relation to health care. There are many presenting conditions in oral health care for which the dental professional may rightly offer a variety of treatment interventions.

A dentist may recommend treatment for a molar with multiple deteriorating restorations that could range from an amalgam build-up to a crown that could be constructed of several different materials or even an implant. An endodontically affected tooth may receive root canal therapy or be extracted, and if extracted it may be replaced with a fixed prosthesis or a removable prosthesis or not replaced at all. Of course, the particular presenting conditions will determine the clinically acceptable treatments that may be ethically offered to the patient. But the point is that, in many situations of oral health care, there is a range of treatments that can be ethically offered to the patient, including those that are not the best available, but still are clinically adequate.

In many other areas of health care, there is no room, neither room in the habits of health care professionals nor in the realm of ethics, for care that is “only” adequate. Here the concept of adequacy has been emptied of its meaning. In these settings, the common-sense distinction between adequate actions and the best actions for the situation has lost its meaning. For many health professionals, the only treatment that is ethical is the best treatment available. It is not a large step from this view to one that completely empties the concept of adequate health care of all its meaning, namely the claim that is not uncommon in the health professions today that the only adequate treatment is the best treatment.

Thus it appears that those who provide oral health care have learned and retained a lesson that many others in American health care would benefit from learning. Dental practitioners know that the notion of adequate health care is not meaningless because in both the habits of practice and the ethics of good dental care there is conceptual room for the concept of adequate care along with better and the best care. It is a concept that has as appropriate a place in health care as it does in the rest of our ordinary conversation, where many sorts of things are accepted, even accepted gratefully, because they are adequate and will meet the relevant needs.

Lesson 3
The third lesson is also one well known to dental professionals. It builds on the second lesson by taking it from the abstract into the concrete. It is that oral health care has operationalized the notion of adequate care in a number of ways. Because there are so many presenting conditions in which the patient is rightly offered a range of treatments from the adequate to the best, the concept of adequate health care is not merely an abstraction. In fact, dental professionals are probably far more familiar with concrete examples of adequate care, in contrast with better care and the best care, than they are with the abstraction, adequacy in health care, identified and stressed in the second lesson.

Those health professionals for whom the abstraction of adequate health care has no meaning may also have a problem in its operationalization. It is not uncommon today for a third party payer's case manager to propose that a treatment desired by a health professional is not truly needed and that an alternative treatment will adequately meet the need. But for many health professionals, this cannot be understood as a proposed operationalization of adequate care, because that concept has been emptied of any acceptable meaning. The proposal must therefore be interpreted as a refusal to provide care at all.

Because dental practitioners have been operationalizing the concept of adequate oral health care in concrete terms for years, they are in a much better position to understand what managed care orga-
Many patients are perfectly capable of understanding and applying the notion of adequacy to their personal health care decisions.

Lesson 4
A fourth lesson, which is also known to dental professionals from long experience, is that most patients can understand the difference between what is adequate and what is better or best in available treatments if they are educated to do so.

Because the concept of adequacy is in such common use in ordinary life, there is no need for the dental professional to explain the concept in order to explain the range of clinically acceptable treatments available. All that is needed is for the dental professional to explain the particular deficiencies and benefits of the several treatments and offer his or her judgment that one or more of these treatments is adequate, but that others are better and best for specific reasons. This is especially a lesson that health professionals need to learn for whom with the concept of adequate health care has been emptied of its meaning. Contrary to their assumptions, many patients are perfectly capable of understanding and applying the notion of adequacy to their personal health care decisions.

Lesson 5
The fifth lesson concerns a pattern already noted that affects almost all health care professionals in the United States today, dental professionals included. Three or four generations of U.S. health care professionals have been trained to the view that their professional obligation to each patient is to provide that patient with the best possible health care. This is as common for dental professionals as for professionals in other health care fields.

This means that, even though dental professionals have been trained to understand and routinely operationalize the distinction between adequate care in relation to the patient’s needs and the best case, many of them also believe that they are acting less professionally when adequate care is all that they provide. The powerful emphasis on the value of patient autonomy in contemporary American health care is often used in dental schools to explain why the patient’s choice can ethically trump the proposed professional commitment to always providing the best care. However, even though patient autonomy is a high professional value in American health care, it cannot justify a dentist providing a treatment outside the range of what is clinically acceptable. That is, patient autonomy cannot trump the dentist’s professional commitment to the values of the patient’s oral and general health.

What then is amiss when the patient’s choice of an adequate treatment appears to conflict with the professional commitment of the dental professional to provide the best? I submit that the error lies in the professional’s claiming that he or she is ethically committed to always providing the patient with the best treatment available. To be sure, dental professionals are ethically committed to always providing whatever treatment they offer to the best of their ability and are obligated to make sure that they are fully competent to provide that treatment.

There are at least these two “best’s” that are part of dental professionals’ commitment to patients. These two “best’s” represent as an ethics of “best practice” as contrasted with an ethics of “the best treatment available.” They apply equally to adequate treatments and to the best treatment. The treatments that every dental professional is ethically committed to explain to the patient is precisely all clinically acceptable treatments, along with his or her professional judgment and recommendation about which are adequate, which are better and best, and the reasons why. The dental professional’s recommendation is a crucial component of the dentist-patient relationship, educating the patient about the benefits and deficiencies of the clinically acceptable treatments and about the professional’s ranking of them in a certain way.

The fifth lesson bearing on the environment of managed care, then, is that it is not a proper statement of the ethics of American health professions to say that dentists are committed to always providing the best.
providing the best available care. In fact, I submit, those who educate health professionals to believe that this is their professional commitment mislead their students and set them up for ethical distress and confusion. Professional students are rightly educated to inculcate the two "best's" mentioned above, i.e., the ethics of best practice, and probably to certain other perfectionist traits as well.

Health professions, are often burdened by a sense of acting unprofessionally because they have been trained to believe they have an obligation to always provide the best treatment, when that is not their true ethical commitment. 

Lesson 6
The sixth lesson is related to the fifth, but concerns the public. There are no doubt many reasons why so many contemporary Americans, especially those of middle class means and up, are so prone to believe that they ought to receive the best care available. Surely, one is their correct belief that health care professionals are committed to the two "best's" mentioned above, and possibly to other perfectionist ethical traits. That is, it is at least somewhat understandable that laypersons might not notice the importance of a shift from expecting a commitment to best practice to expecting a commitment to the best treatment available. A second reason is our culture's unstated but often obvious assumption in practice that the resources available for human endeavors are unlimited. A third is our culture's (equally implausible) conviction that the technologies that we humans invent are perfect and flawless, so that anything that goes amiss must be due to human error and negligence. A fourth would be the prevalence of the conviction of so many health care professionals themselves that the best care should always be provided, as emphasized in the previous section, since the lay community's views about health care are powerfully formed by the convictions of health care professionals. Sociologists and social psychologists might well explain this pattern in far more complex ways.

But it is there. That is, there are many people among our patients who, even though they understand the commonsense meaning of the notion of adequacy in other areas of their lives, are nevertheless convinced they and their family members ought to receive the best treatments available when it comes to health care. Some of them are even able to understand without difficulty the explanations of dental professionals about adequate compared with better and best treatments for their dentition, but cannot take the same concepts into other aspects of health care.

It is far beyond the scope of this essay to propose any remedy for this broad social trait. But it is an important lesson about our managed care situation that those who believe health resources are finite and need to be managed by someone are not necessarily the ones who perceive the situation wrongly. The fact that large numbers of people in our

It is the larger social system in the United States that has not yet dealt ethically or even in practically effective ways with the challenges of distributing health care resources.

But on the matter of what kind of health care to provide, I submit, it is mis- education to claim that health professionals are committed to providing only the best. There is no ethical reason that adequate care will not do and should not be provided if chosen. Furthermore, students trained to misunderstand this will learn it later under difficult circumstances at best, and some unfortunately not at all.

Thus it is that many of today's health professionals, including many dental professionals, feel as if they are acting unprofessionally when, by reason of limitations by third party payers or by reason of patients' own choices, they provide "only" adequate treatment rather than the best treatment. Or they feel they have failed in patient education if the patient chooses "only" the adequate treatment. Or they feel inappropriately burdened by patient autonomy as a goal of professional practice when patient's autonomy means they may choose "only" adequate treatment. Dental practitioners can at least remember in such circumstances that what patients receive is at least adequate care. But many dental professionals, and certainly many more members of the other professional commitment mislead their students and set them up for ethical distress and confusion. Professional students are rightly educated to inculcate the two "best's" mentioned above, i.e., the ethics of best practice, and probably to certain other perfectionist traits as well.

The powerful emphasis on the value of patient autonomy in contemporary American health care is often used in dental schools to explain why the patient's choice can ethically trump the proposed professional commitment to always providing the best care.

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Lesson 6
The sixth lesson is related to the fifth, but concerns the public. There are no doubt many reasons why so many contemporary Americans, especially those of middle class means and up, are so prone to believe that they ought to receive the best care available. Surely, one is their correct belief that health care professionals are committed to the two "best's" mentioned above, and possibly to other perfectionist ethical traits. That is, it is at least somewhat understandable that laypersons might not notice the importance of a shift from expecting a commitment to best practice to expecting a commitment to the best treatment available. A second reason is our culture's unstated but often obvious assumption in practice that the resources available for human endeavors are unlimited. A third is our culture's (equally implausible) conviction that the technologies that we humans invent are perfect and flawless, so that anything that goes amiss must be due to human error and negligence. A fourth would be the prevalence of the conviction of so many health care professionals themselves that the best care should always be provided, as emphasized in the previous section, since the lay community's views about health care are powerfully formed by the convictions of health care professionals. Sociologists and social psychologists might well explain this pattern in far more complex ways.

But it is there. That is, there are many people among our patients who, even though they understand the common-sense meaning of the notion of adequacy in other areas of their lives, are nevertheless convinced they and their family members ought to receive the best treatments available when it comes to health care. Some of them are even able to understand without difficulty the explanations of dental professionals about adequate compared with better and best treatments for their dentition, but cannot take the same concepts into other aspects of health care.

It is far beyond the scope of this essay to propose any remedy for this broad social trait. But it is an important lesson about our managed care situation that those who believe health resources are finite and need to be managed by someone are not necessarily the ones who perceive the situation wrongly. The fact that large numbers of people in our

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care resources within the society as a whole.

The substance of the sixth lesson is caution about drawing conclusions on the basis of this broad pattern of conviction, obvious and vocal though it so often is.

It is the larger social system in the United States that has not yet dealt ethically or even in practically effective ways with the challenges of distributing the health care resources of our technologically advanced health care system. The health professionals who practice under these circumstances are unavoidably faced with complex moral feelings and difficult ethical decisions as a result. But there are some lessons here. Some of them are very positive. Others can at least help us understand what is going on. It is hoped that this account of six such lessons will be found useful.
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Benchmarking

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

The German Kaiser Otto Bismarck is supposed to have said something like this, “Of course you have to learn from your own mistakes, but I prefer to learn from other people's mistakes.” When I was growing up, I spent a lot of time at the YMCA playing pickup games of basketball. My father had the following advice, “Don't play with people of your own ability level; always try to get in games with people who are better than you are.” Both Bismarck and my father were talking about benchmarking—systematically learning by imitating the best.

The following is an example of benchmarking in dentistry. The dentist has used various composites for several years but is unsatisfied. The acceptance rate among patients is not what he had expected. There have been a number of failures of various sorts. Both he and his staff find the materials somewhat awkward to use. And this has not been the big practice builder promised in the CE course. The dentist begins the benchmarking process by making a list of the problems and problem situations he is encountering. He and his staff collect information such as the proportion of procedures where unexpected results occur. There have been a number of failures of various sorts. Both he and his staff find the materials somewhat awkward to use. And this has not been the big practice builder promised in the CE course. The dentist begins the benchmarking process by making a list of the problems and problem situations he is encountering. He and his staff collect information such as the proportion of procedures where unexpected results occur. There have been a number of failures of various sorts. Both he and his staff find the materials somewhat awkward to use.

After several more months of gathering data, the benchmarking dentist has his questions well focused. He sends the summary information he has gathered to his colleague and they arrange for a visit. The hosting office seems to welcome the visitors so there is a lot of questioning.

Back at the office of the dentist who first became concerned about benchmarking, the data from both offices are laid out side by side. Notes are made about the differences observed in the data and on the site visit. It turns out for example, that variation in patient acceptance rate of aesthetic treatment plans is almost entirely a function of age, life style, and other characteristics of the patient population base. Handling properties, time, and inconvenience might be a large difference between the two offices and might be due to procedural differences. It could even happen that the technical failure rate is comparable between the offices. The dentist and his particular product they had been unsuccessful with seemed to work in the benchmarker's office and he would like to arrange a reciprocal visit to see how that was accomplished.

The three most common ways for dentists to learn while practicing are trial and error, discussions with colleagues or sales representatives, and formal instruction as in CE courses. Benchmarking is different from all three. Benchmarking is more than learning from your own successes and failures; it adds learning from others, particularly the best. Benchmarking is more than comparing notes, finding what is popular, or taking people's word for their successes. Finally, benchmarking differs from continuing education presentations because it is driven by the learner not the teacher and is based on what the high performing office does rather than...
what the persuasive speaker says is being done. There is some pretty good research in the business field showing that executives in successful companies are not particularly accurate in describing the reasons for their successes.

The initial internal audit is guided by the question, Where are the greatest opportunities for increasing value added in the practice.

The accompanying figure describes the basic characteristics of successful benchmarking. Benchmarking is continuous, or at least extended over a period of months or years. It is also systematic. This means there is a comprehensive plan for collecting information, performing analysis, and implementing changes. It also means that the focus of performance is constant, not changing from cost one month to quality the next month and then to convince, for example. Although benchmarking is driven by outcomes such as reducing errors or cost or increasing patient satisfaction, the focus is on improving processes in order to achieve these results in a consistent fashion. Benchmarking is evaluative and not just descriptive. Differences matter; the desire for high performance leads to action. Benchmarking is sensitive to contexts. It is difficult and often meaningless to investigate isolated technical procedures or business functions without looking at how they fit with the practice as a whole and even with a practice in a community where it is located. This is especially important in choosing benchmark partners, the desire being to make realistic comparisons. Finally, benchmarking is comparative, but it would be unusual to benchmark against a group average. Instead, benchmarking is performed against best-in-industry (for example, the best dental practice in the area) or against best-in-class (the best performing function in any comparable organization). For example, best-in-class accounts receivable management might be in a chiropractor's office or a car repair service.

There are a number of books available describing how to benchmark. The exact sequence of activities varies from one authority to another, but the following six steps seemed to be common across approaches.

Benchmarking starts with a look inward. More is needed then a vague sense that things can be better. The initial internal audit is guided by the question, "Where are the greatest opportunities for increasing value added in the practice?" It would be nice to think in terms of adding value to patients, such as reducing the number of redos, lowering the cost of procedures, or providing a greater range of alternatives for various dental problems. Some dentists think in terms of adding value for themselves or for their staff. Without a clear focus, however, on increase in the value of dental practice, benchmarking or any other approach to practice improvement is likely to be without direction, sporadic, and short-lived.

Once the targets for maximum potential improvement in value added have been identified, the next step is a systematic process of measuring current processes and outcomes in one's own practice. There are two reasons for going back to have a fresh look at your own practice in light of the greatest opportunities for improvement. In the first place, you will need an accurate baseline so you know where you are starting from and don't fool yourself about what really matters. More important, you have to develop reasonably objective ways of describing your processes and results because you are going to make comparisons with other organizations. A practical suggestion: keep the measurements simple. Use a small number of categories such as "success" and "failure." Strive for percentages. This means you will incorporate some comparative standard into the numbers. For example, four rejected insurance claims in an office that submits a dozen or so in a month means something very different from four rejected claims in an office that does hundreds. Group data by potentially actionable categories. Type of material makes sense, but cost does not. Finally, do not attempt to measure the frequency of very infrequently occurring events. Describe them in great detail when they occur. List everything about the patient and the situation, describe the procedure in detail, particularly any variations that might have occurred—what else was going on at the same time?

The third step is to identify benchmark partners. The term partner is used to emphasize the fact that benchmarking is not an arms-length comparison against passive standards. It involves active participation on the part of the partner. Potential benchmark partners have the following four characteristics. They are better than you, hopefully much better, in some important outcomes. Secondly, they should be similar to you in many ways. They should serve comparable patients, be of roughly the same size, have similar staff and personal values, etc. Thirdly, your benchmark partner should make it reasonably convenient and inexpensive to gather data. A practice that is many miles away or one that has restrictions on sharing of opera-
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Nitional information, such as military facilities, would be an impractical match. Finally, the benchmark partner must be willing to share. One way to enhance the likelihood of sharing is to partner with offices that are not in direct competition. This might include offices in nearby towns or an orthodontic practice benchmarking with an endodontic one.

Don’t assume that a potential partner is automatically closed to sharing. Most best-in-class operations are built on a pattern of practices developed over time and not on little gimmicks that can be easily extracted. The best organizations are quite aware of this. The dental school where I work is frequently benchmarked and we welcome visitors. Our humanistic philosophy and competency-based approach to education have been developed over a twenty-year time frame. There’s also a touch of pride in being asked, and we are ruthless in learning as much as we can from those who visit us. Whenever a visitor expresses surprise at one of our procedures or one of our results, we instinctively ask them to explain their procedures and their results. Since we are better then they are at the procedures that are being benchmarked, we are in a position to learn more effectively. Besides, Otto Bismarck was onto something.

Select the partner or partners that provide the best match and negotiate an agreement that is comprehensive and candid. Discuss what information might be shared, the cost of getting the information, and especially who else might have access to the information. As a general rule, personnel and other cost information such as dentists’ take-home pay is not to be benchmarked. When data are sensitive, such as fees for a specific procedure or the salary of a specific employee, meaningful information might still be collected in the aggregate such as the average fee across several procedures or the average salary across several employees. It is normally an implicit agreement, but one that should be formally recognized and strictly adhere to, that information gathered from benchmarking should never be made available to outside parties or for other purposes.

The fourth step is actually gathering benchmark data at your partner’s facility. Rarely in dentistry would a complete benchmarking project be possible without a visit. It is wise to prepare for the visit by having your benchmark partner make certain data available to you in advance that corresponds to the data you have collected in your own practice. The likelihood of this happening increases if you are willing to first share your own data. This sharing has the advantage of clearly communicating the kind of information and level of detail you are seeking. This is why it is so important to perform your own benchmark process as a preliminary step.

When visiting, make sure that you disrupt the normal flow of operations in the office as little as possible. This way you will see how the practice functions in reality and will be much more welcome visitors. It is also useful to focus your attention, questions, and comments on the most positive aspects of the practice. You are there precisely because of your partner’s excellence. Most people appreciate positive comments and typically follow them with more detailed explanations of their practices. Say “Thank you,” with emphasis on specific details. This is absolutely obligatory.

The next step is analysis. Careful notes should be made immediately following the visit and it is recommended that more than one individual from your office go on the visit. In that way you can see more, from different perspective, and discuss your findings.

There are many ways of performing analysis of benchmarked data, some of them quite sophisticated. The real work can be done quite simply. The essential first step is to list on a sheet of paper the value added targets you identified in the first phase of your benchmark process. If there are multiple value added targets, there should be multiple pieces of paper. Under the value added target draw a line and write the heading: “Key Out-

The Six Steps to Successful Benchmarking

1. Determine where value can be added in your practice
2. Measure your current processes and outcomes
3. Find partners
4. Exchange data and visit your partner
5. Analyze
   a. Compare outcomes in areas that matter most to you (Key Outcomes)
   b. Identify critical differences (Performance Gaps)
   c. Compare factors not open to imitation (Environmental Considerations)
   d. Compare factors to be imitated (Live Levers)
6. Plan strategy

comes.” Here is where you list on the page all of the evidence from your own practice characterizing your shortcomings or opportunities in the area related to your target value added. This should be a column down the left-hand side of the page enumerating the actual numbers you recorded in your internal benchmarking. On the right-hand side of the page make a corresponding column for the outcomes you observed in the practice you benchmarked. This listing is a scorecard defining the ways in which your benchmark partner is better than you are in things that matter to you. It is sometimes useful to underline or otherwise highlight the outcomes that matter most. Some of the information gathered is nice to know but not directly related to your value-added opportunity. You should know which are your leading indicators for success.
Information gathered from benchmarking should never be made available to outside parties or for other purposes.

The next step in the procedure is to compare the two columns—yours and your benchmark partner’s. Use a bright magic marker to indicate those outcomes where your benchmark partner significantly exceeds your performance in areas you have said matter most to you. These are called “Performance Gaps,” and they are your keys to practice improvement.

Draw a line or start a new piece of paper and label it “Environmental Considerations.” These are fancy words and maybe there is some other way for you to list all of the differences between your practice and your benchmarked partner’s practice that cannot be imitated. If the other office has a very up-scale patient base and you do not, indicate that this is an environmental difference and something that is not under your control. Another difference might be the size of the comparison practice, both the physical facility and the number of employees. Keep adding to the list those factors that you cannot change or choose not to change but that are different between your practice and the practice or practices you benchmarked.

Draw a line one more time or start a new page and label it “Live Levers.” As before, you will make two columns: one for your practice and one for the benchmark practice. But this time you are going to list differences you are prepared to do something about. The benchmarked practice might invest more heavily in employee training or salaries than you do. Your benchmark partner might use different materials or the same materials in different ways. A difference might be as concrete as office policies for payments or as vague as the office “culture.” What you are looking for are processes that explain the performance gaps in outcomes that you can do something about. The environmental factors enumerated in the environmental section are “dead levers” in the sense that you cannot or will not pull them to make your practice work better. Only live levers matter.

What you are looking for are processes that explain the performance gaps in outcomes that you can do something about.

The final stage of benchmarking is to use the levers for process improvement to reduce the gap between one’s benchmark partners and oneself. This is a matter of planning to implement changes in an incremental fashion while carefully monitoring the effects in terms of key outcomes that add value to the practice. A prescription for tragedy is to assume that the gap between the best of comparative organizations and yours can be closed by simply identifying the factors that make a difference and announcing your intention to “make it so.” One of the lessons of successful benchmarking is to spread the business of closing the gap over several years, depending on the size of the gaps and the difficulty of implementing process changes. Milestones—projected smaller gaps at six-monthly intervals—are useful.

Benchmarking is not a common practice in dentistry—but it could be. Benchmarking is the business of finding out what is possible and finding out how to accomplish it. That sure beats sitting at home wringing your hands or paying someone else to tell you what they think will work based on their experience.
American Dental Association, Various practice management and marketing resources. (800) 621-8099. Among the greatest under used resources available to dentists are the publications and reports of the ADA. This is an excellent way to begin benchmarking, by reading some of the reports of the association to establish comparisons with other dentists of similar practice characteristics.


Benchmarking is simply the systematic process of searching for best practices, innovative ideas, and highly efficient operation procedures that lead to superior performance. This is a practical manual for accomplishing it.


Another book filled with examples of how organizations have achieved marked improvements in performance as a result of benchmarking.


The model suggested involves deciding where value can be added to an organization, gathering data from comparable organizations, evaluating it, and taking action to close the identified gaps. There are suggestions for finding partners, writing questionnaires, and preparing reports, but few concrete illustrations. "The critical issue that must drive benchmarking is the opportunity to add value."


Introduction to the Malcolm Baldrige National Quality Award criteria. These were commissioned by an act of Congress and have been refined over the past twelve years to promote competitiveness in American business. These are standards for health care.


Addresses issue of “knowledge management,” capturing and making available what various members of an organization know so that it can be used for the benefit of the whole organization.

Editor’s Note

Summaries are available for the three recommended readings preceded by an asterisk. Each is about four 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 Executive Office in Gaithersburg. A donation to the ACD Foundation of $15 is suggested for the set of summaries on having your say; a donation of $50 would bring you summaries of all the 2001 leadership topics.