

CHAPTER 1

Why dental benefits?

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Introduction

This chapter delves into the history of dental benefits and lays the groundwork for the subsequent chapters. The story is one of the social transformations of health care in the USA and the expansion of access to care to wider segments of our society. Prepaid dental benefits available to a worker and their family did not exist, in the way we understand dental benefits, until the last half of the 20th century. From that point in the 1950s to the new millennium, dental benefits broadened in scope and depth as coverage grew to include new eligible members. Dental benefits that became available to a wide swath of consumers profoundly changed the dental profession and dental care delivery.

Dentists enjoy a great deal of professional autonomy and independence in their practice. These features attracted generations of students into the profession and shaped their dental personality to the point the dentistry is rated the number one best job in the USA. From the mid-20th century, the emergence of dental benefits fueled the demand for dental services that fostered dental practice growth and lifted the dentist into the club of well-paid professionals. This is the world into which all dentists who practiced at the turn of the 21st century were born.

But the health-care world continues to evolve into a new order from care delivered by guilds to fraternal group purchases, to industry and union-provided health care, to capitated care, to the emergence of dental benefit companies to the Affordable Care Act. Now, dentists must once again adapt to a profound change in the order of dental care delivery to continue to deliver quality care to a wider segment of the population.

This chapter sets the stage for the coming chapters. Perspective is important to understand that change in the way dental care is delivered and financed has changed over the past 150 years and will continue to change. The status quo isn't destiny.

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The coming of health insurance

We all practice and thrive in a world where dental benefits are a common benefit of employment. We have always practiced where patients we targeted for care had access to dental benefits. While we sometimes struggle with the administrative requirements to bill for our services and chafe at the paper work and the rules of the road, we understand that dental benefit coverage drives patients to our offices. Without dental benefits, many people would not seek dental care on a regular basis and dentists would struggle to fill chairs. For those dentists that started dental practice in the 1960s around new housing developments in the former fruit orchards of the Santa Clara Valley (CA) that became Silicon Valley, the convergence of employer-purchased dental benefits with families moving to new homes proved to be a true golden age to start from scratch a solo private practice and grow a patient base at a lightning-fast pace. So for many dentists, dental benefits proved to be godsend for their practice and their patients.

But dental benefits are a relatively new phenomenon and health insurance didn't always exist. Can you imagine a world where all of your medical, hospital, and prescription bills are paid out of pocket? Can you imagine a world where the middle class pays a large proportion of their income for a medical bill? Can you imagine a world where the working poor are consigned to welfare infirmaries?

The manner in which health care is paid evolved slowly in the USA over the past 150 years. Historically, medical care was available to and paid by principally the upper class with the hospital portion of care taking place in their home. Only the poor went to a hospital. The middle class and the working poor were left to seek episodic care at rates that comprised a significant portion of their income. The very poor sought care at charity infirmaries.

In the 19th century, on the East Coast, fraternal organizations and benevolent societies sprang up among the immigrant tenements to help pay for health care through the voluntary, mutual pooling of money. The fraternal organizations contracted with individual medical providers to deliver care on a prepaid per-capita basis. This medical financing arrangement was more prevalent on the East Coast than out West because of the high density of immigrant populations on the East Coast. Young physicians struggling to establish a private practice contracted on the prepaid basis with these groups for their services but hurriedly left the arrangement as fast as they could once their private practice grew. Organized medicine, in the form of the local medical society, frowned on prepaid contract medical care and ostracized these young and struggling physicians that participated in such arrangements and often refused their membership into the medical society. Out on the West Coast, a large French immigrant community in San Francisco established a French hospital, La Societe Francaise de Bienfaisance Mutuelle, during the gold to aid their French compatriots.

Early in the 20th century, industries like the railroad and mining established health centers for their employees. Industry medical care was limited to work-related injuries to get the workers back to the job. The railroads hired physicians

along their rail lines to care for their workers. In the mining industry, unions hired physicians to care for those with injuries from mining accidents. Throughout this period, tension existed among industries, unions, organized medicine, and the government on the proper role of health insurance in the American society and on the people who would control payments to hospitals and physicians. For physicians, it was about the autonomy of the medical profession from any outside influence over who and what controls the cost of care and where it is controlled. For industries, unions, and the government, it was also about the cost of care and gaining access to care for a wider swath of the population.

With the coming of the Depression, workers' wages plummeted or disappeared all together. Hospital and medical visits decreased and physician bills were left unpaid so that families could pay for their food and rent. During the Depression, medical care became recognized as an essential welfare need, and welfare agencies began to pay physicians for their medical services. While the government-sponsored medical relief fund was a benefit to the lower-paid physicians, organized medicine urged all of its members to hold the line against any form of medical insurance. Third-party payment for physician services was seen as the first step toward the socialized medicine and the loss of professional autonomy. The response of organized medicine, in the form of the American Medical Association and its constituent medical societies, to the financial crisis on young physician income, brought on by the Great Depression, was to limit the physician supply (limit medical student spaces in medical school) and increase the price of medical care (through physician autonomy) rather than stimulate the demand for physician services through health insurance. Autonomy and high fees trumped more patient access to medical care.

Since the turn of the 19th century, physician autonomy has been a recurring theme from the medical profession. The issues of the dentist supply (too many), dentist autonomy (organized dentistry over consumers), and the financing and delivery of health care (status quo) are as fresh today as they were 100 years ago. These issues are not a new, unique 21st-century phenomenon, and the response from the dental profession to the financing of and access to health care is the same. The difference that drives change that didn't exist 100 years ago is the Internet with disseminated health information, changing consumer purchasing behavior, and the advent of the Affordable Care Act (Chapter 6).

Private health insurance

In the 1930s, simultaneously, as Franklin Roosevelt's Social Security legislation to support the elderly was born, his national health insurance efforts died. The American Medical Association's campaign to paint national health insurance as socialized medicine was too powerful to overcome. But, following the Second World War, national health insurance was once again resurrected and hotly contested but three times defeated even though President Harry Truman was a strong

proponent of a single universal health insurance plan. The thrice-defeated effort to establish a national health insurance program meant that health insurance in America would remain a private enterprise rather than a government program. The question then became, “Who in the private would control health insurance? Would it be a commercial enterprise or the medical profession?” The form of private health insurance would take different changing forms in the next 60 years.

Dental insurance is designed to provide financial assistance for events that are relatively high frequency, low cost, and predictable. Many patients have a general sense of their oral health status that allows them to work with their dentist in regard to the course of their treatment.

In dentistry, there are a high number of alternative treatments and materials from which to choose, each with its own set of cost, benefit, and risk. The essence of solo private practice allows treatment decisions to be developed ad hoc, independent of the peer oversight as would occur in a hospital or physician group practice. Treatment decision is considered the prerogative of the dentist as determined by the rule of what-is-effective-in-my-hands standard of care that can be at odds with the dental professions body of knowledge and evidence-based care.

However, dental treatment can usually be postponed, sometimes for years, and that creates a high potential for adverse selection. Those without coverage may “store up” needed care until they are covered by dental insurance. As a result, a well-designed insurance plan creates incentives for subscribers to remain in the plan for a long time.

Moral hazard

Insurance requires the insurer to assume a financial risk. It derives a gain when it estimates utilization accurately and sustains a loss when it does not estimate utilization accurately. Too much gain and competitors enter the field that drives the price to the consumer down. Too much loss and the company is out of business.

A moral hazard is a lack of incentive to guard against risk knowing that one is protected from its financial consequence by insurance. The presence of insurance, itself, can lead to moral hazard and cause increased loss. Insurance requires that an insured risk and the loss that ensues is unambiguous when it occurs and beyond the control of the insured. Otherwise, the insurer cannot estimate their probable cost of care. Difficulty arises in underwriting dental plans because dental disease is not always a well-defined condition, the course of treatment is not codified, and many of the costs of treatment are within the control of the insured and the provider. So, dental benefit plans, like all insurance, must control for moral hazard.

An insurance company incurs moral hazard when the insured is insulated from financial risk of the care and the provider controls the cost of that care, the case where the provider says you need it, the patient says I want it, and both say someone else should pay for it. Moral hazard is exacerbated when the provider of the care works in isolation away from the scrutiny of other providers and there is

no clear, evidence-based solution for a particular diagnosis as in dentistry. Moral hazard exists when treatment selection ambiguity exists and both the insured and the provider are insulated from the consequences of the cost of care.

In group insurance, all subscribers have the opportunity to benefit from pooled community resources and utilization risk. Sometimes, an opportunity appears for an individual to benefit from temporary personal advantage to overuse resources. When an individual continually takes advantage of the common good, the system fails and shuts down. The fix to the problem of moral hazard is to spend resources to identify and control those that take more from the community good. The mechanisms to pay to enforce the rules are like taxes to pay the police and water meters to control water waste. Investing in the public good is good if moral hazard can be controlled. Transparency controls moral hazard.

Moral hazard gives the free rider an increased benefit at the expense of the other members of their risk group. The unrestrained opportunity for a free rider to disregard financial expense increases the cost for the entire risk group and the free rider needs to be restrained in order to keep costs down for the whole group. To do so, private insurance evolved into three types of plan designs defined by the benefit they delivered and the method to control moral hazard. The insurance plan design types are indemnity insurance, benefit service plan, and direct service. Each party benefits from certain elements of a plan design.

Indemnity insurance

Indemnity plan design is fee for service that reimburses the subscriber directly for costs incurred although the bill is not usually paid in full. The subscriber is free to choose any willing provider and the provider is free to charge their patient any fee. Indemnity plan design allows a provider to price discriminate among patients and charge more to some and less to others. The what-the-market-will-bear design allows the provider to apply the wallet x-ray. The patient pays the medical bill when the expense is incurred and then submits a claim that is paid directly to the subscriber.

The indemnity insurance plan design creates the least interaction between the practitioner and the payer. The payer assumes little or no responsibility to their subscriber for the cost or the quality or quantity of care. The insurance plan controls for moral hazard through the application of a deductible amount, cost share, and a benefit maximum that constrains the member's tendency to become a free rider and disregard the financial consequences of their choice.

Dentists prefer that dental insurance be indemnity insurance. Indemnity insurance does not require the dentist enter into any agreement with the insurer. Rather, the indemnity insurer has an agreement with the insured where payments are submitted and reimbursed by and to the insured. The dentist is not held to any specific fee and is free to choose the type, intensity, and frequency of treatment. Dentists collect for their services on a fee-for-service, per-piece basis and are free to price discriminate among patients. This relationship creates the ample opportunity for moral hazard. There are virtually no pure dental indemnity plans in existence today.

Benefit service plan

Benefit plans offer employers a dental product with certain guarantees for their employees. Plan design is fee for service that guarantees payment directly to the provider and sometimes covers the service in full for diagnostic and preventive services. This is where the similarity to dental indemnity insurance ends.

The participating panel of credentialed dentists is the defining element of a benefit plan design. To offer this feature, the benefit plan actively enrolls and credentials dentists into a panel of participating providers. Providers enter into a participating provider agreement with the benefit company that contractually defines their relationship to each other and the provider's obligation to the subscriber.

A benefit plan offers subscribers certain maximum fee guarantees when they seek care from a participating provider. This is a significant feature for the subscriber because the comparative cost of a health-care service, unlike other kinds of consumer services, is opaque to the consumer and the knowledge imbalance in favor of the provider can lead to provider-induced demand. Providers sometimes decry this maximum fee because every patient is reimbursed at same fee level that restricts the provider's ability to use a sliding fee scale among patients. Both indemnity and benefit plans attempt to control overutilization of services (the moral hazard) through a waiting period, deductible, frequency, limitation, and exclusion features of the plan design.

The dental benefit plan can be a risk plan where the benefit company assumes the financial risk for the utilization of services or an administrative service only plan where the employer retains the financial risk for the utilization of services and the benefit company provides the services to administer the plan. In both instances, the benefit plan offers the subscriber access to a panel of participating dentists.

The first dental benefit plans, like the Washington Dental Service, paid for dental services like an indemnity insurer but was actually a dental benefit service plan. It is more accurate to say that a dental benefit plan is more liberal in its fee, policy, and procedure than other benefit plans.

Direct service plan

Direct service plan designs combine both the benefit and the delivery of care. That is, a direct service plan collects prepayment from the payer (employer or individual) and also directly delivers the care through its own panel of dentists. The direct service plan is responsible for the cost, quantity, and quality of the service. Kaiser Permanente is an example of a direct service plan design. Kaiser Permanente arose from the work of Sidney Garfield's industrial programs in construction (Colorado River Aqueduct Project and The Grand Coulee Dam) and shipyards (Kaiser Shipyards). The projects paid Garfield a fixed payment for each worker in return for all medical services. Kaiser Permanente began to accept public enrolment in 1945 with the support of the International Longshoremen's and Warehousemen's Union and the Retail Clerks Union.

One early dental direct service plan was Max Schoen's Harbor Dental Group (Los Angeles County, California) in the 1950s. Like Kaiser Permanente, Schoen's dental group worked with the International Longshoremen's and Warehousemen's Union and the Pacific Maritime Association (ILWU-PMA) and the Retail Clerk's Union. Schoen initially treated the children of union members on a per-member per-month benefit plan. With its focus on prevention, the Harbor Dental Group realized higher utilization of preventive care and lower extraction rate than other dental plan designs as Schoen recounts in his 1969 UCLA doctoral dissertation. However, Schoen's practice model that was fixed fee and closed panel found little support among private practitioners and organized dentistry that favored fee-for-service payment with freedom to choose a dentist. As with similar plan designs in the past, Schoen's model was characterized as socialized health care that challenged the autonomy of dentists and was to be avoided at all costs. A successful direct service plan posed stiff competition to the solo fee-for-service model.

Despite opposition by and ostracism from the dental association, Schoen's Harbor Dental Group continues to thrive to this day and Max went on to an illustrious career in academia and health services research. The principles that Schoen championed 60 years ago are the same principles embedded within the current accountable care organization (ACO) models. ACOs supported by the Affordable Care Act foster a shift to Schoen's direct service plan model that is focused on disease prevention, patient focus, cost-effective care, disease management, and health outcome. The Harbor Dental Group enabled children to access care that improved dental health in a cost-efficient manner 50 years before the Berwick introduced the Triple Aim to health-care reform. It appears that what's old is new again.

Direct reimbursement

In the dental reimbursement market, a direct reimbursement plan is a permutation of an indemnity plan where the subscriber has a set benefit amount available to use for care and the provider decides the quantity and cost of that care. The presence of moral hazard exists for the member and especially for the provider when the entire fee is paid upon the asking with nothing to control the fee or the quantity of services. The direct reimbursement plan design is probably the most expensive plan for the employer, the payer, to maintain.

Health insurance: The Blues

In response to third-party arrangements for hospital payment by commercial private parties, physicians sought to control both the financing and the delivery of medical care.

For over a century, fraternal organizations, mutual benefit societies, industries, unions, and employers developed prepaid programs in order to mitigate the cost of medical care, hospitalization, disability, and death. Immigrant groups formed mutual benefit organizations to insure against loss of wages due to illness and death.

These initial efforts to control health-care costs to a group were local and limited in scope. On a larger scale, industries and unions developed medical service plans to protect their workers against compensable on the job injury. When mutual benefit groups, unions, or companies contracted or directly hired physicians on a capitated basis to deliver medical services to their group, organized medicine vehemently opposed the prepaid arrangement on the grounds that this third-party relationship infringed upon proper medical care. But as these types of prepayment arrangements continued to grow in number and scope, physicians sought to control the process.

The Blues are two physician-led health service companies with considerable influence on prepaid health care. Blue Cross is the older sibling that provided hospital benefits. The birth of Blue Cross took place in 1929 when Baylor University Hospital provided 1500 schoolteachers prepaid hospital care benefits. Baylor soon offered the same hospital coverage to thousands of other people as the hospital plan expanded to other hospitals in the area and to other states. Group hospitalization payment opened the floodgate to the acceptance of health insurance for medical care. Blue Shield, the physician's shield, provided medical benefits.

Physicians approved of the Baylor hospital plan because during the Depression, the plan paid the hospital bill and left cash for their patients to pay their medical bill. But physicians worried about applying the same principle of hospital insurance to medical services. The thought of third-party payment for medical services, even if it meant more income for young physicians, was anathema to the established physicians. The thought of the third-party payer, even a physician lead payer, was perceived as a threat to physician autonomy and hegemony over medical care.

Never the less, in 1939, a statewide medical benefit plan appeared in California sponsored by the California Medical Association and was called the California Physicians Service, the physician's shield. This medical benefit plan paid its physicians as if it were an indemnity plan with fee for service at the physician's retail fee. Similar medical benefit plans were established in Michigan, New York, and Pennsylvania. Blue Shield (medical service) and its older sibling Blue Cross (hospital service) cooperated to control the hospital and medical benefit market to dampen commercial insurer competition and to keep the commercial insurance companies incursion into health insurance at bay. The two Blues worked in different ways. Blue Cross was more of a prepayment model and offered service benefits. Blue Shield followed an insurance model and allowed physicians to apply a sliding scale to their fees to charge some patients more than others. Today, the Blues continue to provide both hospital and medical benefits.

Federal health benefits

When President Lyndon Johnson signed Medicare into law at the Harry S. Truman Library on July 30, 1965, he told the nation that it had all started with the man from Independence. Truman, Johnson said, had planted the seeds of compassion

and duty that led to the enactment of Medicare, a national health insurance for the aged through an expanded Social Security system.

Truman was the first president to publicly endorse a national health insurance program. As a senator, Truman became alarmed at the number of draftees who had failed their induction physicals during the Second World War. For Truman, these rejections meant that the average citizen could not afford to visit a physician to maintain their health. Truman said that is all wrong in his book and tried to fix it so the people in the middle-income bracket can live as long as the very rich and the very poor.

Truman's first proposal in 1945 provided for physician and hospital insurance for working aged workers and their families. A federal health board was to administer the program with the government retaining the right to fix the fees for service, and doctors could choose whether or not to participate. This proposal was defeated after, among many factors, the American Medical Association labeled the president's plan socialized medicine that took advantage of the public's concern over communism in Russia.

Truman was never able to create a national health-care program. He was able to draw attention to the country's health needs, legislated for funds to construct hospitals, expand medical aid to the very poor, and provide for the expansion medical research. In honor of his continued advocacy for national health insurance, Johnson presented Truman and his wife Bess with Medicare cards Number 1 and Number 2 in 1966.

The federal government did become a major health insurer when the Great Society of President Lyndon Johnson established two groundbreaking programs: Medicare for older adults and Medicaid for the poor and disabled. Up to this point in time, the federal government played little role in health-care insurance. The 1965 Medicare legislation established the precedent for government to participate in the health-care financing for its citizens. In 1967, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program was established and marked the first mandate for pediatric Medicaid benefits. The purpose of EPSDT was to provide comprehensive and preventive health care for children under 21 years old by eliminating economic barriers to health care. The 1989 Omnibus Budget Reconciliation Act required that dentists rather than physicians perform EPSDT dental screenings with the effect that children were funneled into the dental care system.

Later, in 1997, the State Children's Health Insurance Program (SCHIP) extended coverage to the children of working poor families who did not qualify for Medicaid benefits. When SCHIP expired in 2007, the program was reincarnated as the Children's Health Insurance Program Reauthorization Act (CHIPRA) when President Barack Obama signed it into law in 2009.

CHIPRA underlies many of the precepts of the Patient Protection and Affordable Care Act (ACA) in that it mandates dental benefits for children and adolescents, establishes a new definition of dental care, and addresses the issues of prevention, workforce, quality, reporting, and the dental safety net. The ACA exemplifies a deep commitment of President Obama and his legislative supporters

to make health care available to vulnerable populations defined by age, socioeconomic status, or health condition. This commitment is demonstrated by mandated dental care for children, dental education programs for underserved populations, and promotion of new classes of dental care providers to serve those with limited access to dental care.

The Patient Protection and Affordable Care Act, Medicaid, and CHIPRA represent major and lasting efforts of the federal government to influence and extend health-care benefits to the entire population.

Dental benefits

As late as 1960, the percentage of personal dental care expenditures in the USA covered by health insurance or some form of third-party payment was so small as to be reported as zero. Families accessed dental care as needed. During this period, full dentures were common even among the middle class and dentists were adept at fabricating removable appliances to replace extracted teeth. The loss of adult teeth at an early age was accepted as the natural progression of age. During this period, dentist income was modest, more Buick than Cadillac.

However, a profound change in dental care utilization was on the horizon. On the West Coast, a major stimulant to dental benefits occurred in 1954 when the ILWU-PMA established a children's dental program. Two group practices contracted with the ILWU-PMA to provide dental services on a capitated basis in port cities of San Francisco and Los Angeles. After the successful introduction of the ILWU-PMA pilot program, there was a steady growth of third-party payment plans. Throughout the 1960s, access to dental insurance offered families a new employment benefit that increased the number of members who sought dental care. A dental benefit is nonwage compensation for the employee and a tax deduction for the employer. With the growth of dental benefit membership and the increased ability to access dental care, dentist's financial stature grew beyond that of their predecessors as liberal dental benefits drove families to seek dental care and dentist incomes grew year upon year. This firmly boosted the dentist into the upper middle class to where Mercedes-Benz is now organized dentistry's endorsed automobile.

The function, design, and implementation of dental care benefits continue to evolve as dentists, dental organizations, government payers, commercial insurers and the public struggle to balance the cost, quality, access, and equity of health care across a wide and deep spectrum of need.

Dental service company

In the 1950s, to thwart commercial insurance incursion into dental benefits, the state dental associations in Washington, Oregon, and California established dental service corporations like the physician-sponsored health benefit companies,

the Blues. The new dental service corporations in these three states provided dental care benefits to the ILWU-PMA pilot program with a design of open panels and fee-for-service reimbursement. Dentists sensed the opportunity to gain access to a new patient base, be paid fee for service at their retail fee, control the dental benefit market, and keep commercial dental plans at bay. With agreement from the Washington State Dental Association, the Washington State Dental Service Corporation (WSDSC) was created in 1954. In the ensuing 20 years, WSDSC pioneered the dental benefit industry and subsequently broadened and grew the dental benefit industry segment into emergency coverage for children, adult dental coverage, and added dental benefit contracts with the Boeing Company and the Washington Education Association. The Federal Trade Commission soon had concern over dentists controlling both the benefit payment and delivery of care to the detriment of the consumer. Dentists were enjoined to divest themselves from dental plans from which they directly benefited. The renamed Washington Dental Service was separated from the Washington State Dental Association in 1980. A similar progression occurred when the Oregon Dental Service and the California Dental Service were established in the same period. Employer-based dental benefits were now firmly entrenched within the commercial sector and opened access to dental care to a wider community for which dentists continued to thrive.

What is dental insurance?

One important way to improve America's oral health is to increase the number of individuals who have dental insurance because to have dental insurance drives individuals to seek dental care. Individuals with dental insurance are more than twice as likely to visit the dentist as those without insurance. Dental practices flourished when employer-based group dental plans became available during the 1960s.

There are a number of dental payment terms that are sometimes used interchangeably. Some of these terms are indemnity insurance, dental benefit plan, preferred provider organization (PPO), health maintenance organizations (HMO), direct service plan, direct reimbursement plan, discount plan, and administrative services only (ASO). Newer terms are ACO applied to Medicaid plans and CCO applied to commercial plans.

Indemnity insurance

Indemnity insurance can be thought of as pure insurance that reimburses for a loss. Members select any dentist for their care and the member is reimbursed on a fee-for-service basis up to a fixed amount. There is no relationship between the dentist and the insurer. Members are responsible for any differences between the insurance payment and the dentist's charge. In this arrangement, the dentist charges their retail fee, the usual, customary, and reasonable fee (UCR), which is based on what other providers in their geographic area charge for the same service.

The arrangement is between the insured and the insurer; think of automobile collision insurance. In this arrangement, the dentist charges their retail fee, the usual, customary, and reasonable fee (UCR), that is based on what providers in their geographic usually charge for the same service. The UCR in private practice is elastic where some patients are charged more and some charged less. The UCR in private practice is not derived from cost-based accounting but rather a what-the-market-will-bear strategy. The incentive for the provider's income control focuses on fee increases rather than expense decreases. Pure dental care indemnity insurance plans are rare. Those that seem to be dental insurance plans are merely dental benefit plans with liberal fee and utilization policy like the first dental benefit companies in the 1950s.

Dental benefit plan

Most group dental purchases are designed around dental benefit service plans. Dental benefit service plans are those in which the dentist and plan enter into a participating dentist agreement where certain activities between the dentist and the plan are codified. Dentists agree to be credentialed to become part of a panel of providers with access to a subscriber base. Fee allowances are negotiated in advance. The dental benefit plan can be designed as a fee-for-service plan or a capitation plan. Dental benefit service plans offer the purchasers of the dental benefits, usually employer groups or unions, a panel of dentists, quality oversight, utilization review, and financial risk mitigation.

The participating provider agreement is a binding contract between the dentist and the benefit company that delineates each party's responsibility to the member. There is no obligation for a dentist to participate and no obligation for a benefit plan to accept a dentist. One contractual issue is the most-favored-nation clause where the participating dentist agrees not to charge the subscriber any fee higher than a fee from another dental benefit plan, that is, the most favorable terms. The most-favored-nation clause is rarely invoked. Another issue is the noncovered service clause where the dentist agrees to limit their charge for a service to a predetermined amount for a service that is not covered by the dental plan. Thirty-three states have legislation that disallows noncovered service limitation (Table 1.1).

PPO

The PPO allows subscribers to receive dental care from a panel of participating dentists. The participating dentist agrees to abide by the provisions of the participating dentist agreement, submits claims on behalf of the plan member, and is directly reimbursed fee for service on predefined terms with a limitation on the maximum fee allowed. This type of benefit plan provides discounted fees and substantial savings to the subscriber, as long as the subscriber selects a dentist within the plan's network of participating providers. A nonparticipating dentist is usually reimbursed at a lower fee and the member is responsible to pay any balance the nonparticipating dentist chooses. In PPO plan subset design, the

Table 1.1 States with noncovered service legislation. <https://wf.employeebenefitsservice.com/wps/wcm/connect/Storefronts/obc/1398878240638>

State	Year	State	Year	State	Year
Alaska	2010	Kentucky	2012	Oklahoma	2010
Arkansas	2011	Louisiana	2011	Oregon	2010
Arizona	2011	Maryland	2011	Pennsylvania	2012
California	2011	Minnesota	2011	Rhode Island	2009
Connecticut	2012	Mississippi	2010	South Dakota	2010
Florida	2014	Missouri	2013	Tennessee	2011
Georgia	2011	Montana	2013	Texas	2011
Idaho	2010	Nebraska	2012	Virginia	2010
Illinois	2013	New Mexico	2011	Washington	2010
Iowa	2010	North Carolina	2010	Wisconsin	2014
Kansas	2010	North Dakota	2011	Wyoming	2011

Data from Ameritas 2010. © 2010, Wiley.

exclusive provider organization (EPO), all the PPO provisions apply except the member must select a PPO panel dentist to receive any dental benefit with a non-participating dentist not eligible for any reimbursement from the EPO plan.

HMO

A less common dental benefit plan design is the HMO that is sometimes called capitation or capitated plans. In this instance, the dentist or dental group is reimbursed for dental services on a per-member per-month basis rather than a fee-for-service rate. The capitated rate is a single fee paid per member per month to deliver all the dental care required of the member. For certain procedures, a copayment is allowed to be collected from the member. This plan design works when the member base is stable without adverse selection. A dentist participating in a HMO plan assumes financial risk for the set of patients.

In the best case where there is a sufficient patient base, all eligible HMO members are assigned to the dentists on the first day regardless of dental need, there is no adverse selection, and members remain with the dentist for the long term. These prerequisites for a successful HMO arrangement are rarely met in full. So to accept an HMO plan is risky for the dentist especially the solo dentist. HMO plans are more appropriate for dental groups. Most dental insurance companies offer an HMO product although a small part of their portfolio.

Direct service plan

The HMO resembles but is quite different from a direct service plan. The HMO finances dental care on a capitated basis and the dental services are delivered by other entities. Direct service plans both finances and delivers the dental care as a single entity. Western Dental (California) is both a dental direct service plan and a corporate dental entity. Western holds a California Knox-Keene license that

allows it to sell HMO dental benefits, and Western also delivers dental care for its HMO products in its own offices in California and Arizona. Western Dental is a straightforward corporate entity enabled by its Knox-Keene license to operate its facilities and dental group without the convolutions required of other corporate entities. In some respects, it resembles a Kaiser Permanente model except it accepts patients other than its HMO policyholders.

While the direct service model showed promise to deliver health care to a wide range of people with a cost within a family's budget, the thought of a physician being employed by this system was anathema to organized medicine and the model was strongly resisted. Ross-Loos medical group in Los Angeles, California, and Sydney Garfield with Kaiser Permanente were the early adopters of this model. In dentistry, the model is less widely represented and usually relegated to specific population segment.

Direct reimbursement plan

A direct reimbursement plan is neither a dental insurance plan nor a dental benefit plan. It is a self-funded employer dental plan in which the employer reimburses the employee directly for all or part of their dental expenditures. Like an ASO plan, direct reimbursement plans are usually administered by a dental benefit company. In direct reimbursement, the employee chooses their dentist, pays the charge directly to the dentist, submits the receipt, and receives reimbursement. The reimbursement is usually based on a percent of the dollars expended for dental care and not for a specific procedure. There is an annual maximum.

A direct reimbursement plan does not moderate fees a dentist charges to the employee. There is no ceiling except what the traffic bears. The fee charged for a procedure can vary between dentists and can vary within the dental practice. Direct reimbursement is the design favored by dentists because of the freedom to charge the retail fee without oversight for the quality or quantity of services.

There are a number of reasons why direct reimbursement plans are an insignificant part of the dental benefit market in comparison to other benefit plan designs. The primary reason for microscopic market share and no growth, even with the support of organized dentistry, is that direct reimbursement plans are designed to benefit the dentist and not the subscriber or the payer. Carte blanche and rubber stamp plan designs overrely on the lack of moral hazard among providers and are inherently not consumer friendly.

Discount plan

Discount plans are neither insurance nor dental benefit. Rather, the discount plan is a fee list of discounted dental fees available to discount plan members. There may be a membership fee but there is no premium, waiting period, or exclusions. A dentist agrees to accept the discounted fee from plan members in exchange for the plans access to its members. Some dentists offer their own private label discount plan. To combine a discount plan in conjunction with a member's dental benefit plan may cause conflict with the dental plan's participating agreement.

For a discount plan to add certain prepaid benefit features like free diagnostic and preventive services may be in conflict with the state insurance law. The worst permutation of a discount plan is a percent discount on dental fees because the provider can change fees on a whim and the consumer rarely has access to fees in the community.

ASO

ASO can be thought of as a third-party administrator (TPA) that handles the administration of an employer self-funded dental plan. The administrative services offered include any or all of the benefit plan's services including actuarial analysis, plan design, claims processing, and the dental provider network.

The ASO plan and a dental benefit plan offered by the same benefit company will look the same to both the subscriber and the dentist. The eligibility, deductible, fee schedule, and Evidence of Coverage are identical.

The difference between ASO and a dental benefit plan is the employer (payer) in an ASO assumes all of the financial risk of utilization while the dental benefit company assumes the financial risk in a dental benefit plan.

For an ASO plan, the dental benefit company has little latitude to authorize payments outside of the plan design (it's not their money). In a dental benefit plan, the dental benefit company has wide latitude to authorize payments outside of the plan design (it's all their loss). For instance, when a subscriber is not reimbursed for services because a nonparticipating dentist treated them, there is no opportunity for a pay-and-teach in an ASO plan but pay-and-teach is frequently done in a dental benefit plan.

Bundled payment

In 2013, the Centers for Medicare & Medicaid Services introduced Bundled Payments for Care Improvement where organizations entered into payment arrangements that include financial and performance accountability for episodes of care. The episode of care methodology is an innovative initiative to replace the traditional fee-for-service payment for individual procedures or course of treatment that results in fragmented care with minimal coordination across providers and health-care settings. Fee-for-service rewards the quantity of services delivered rather than the quality or coordination of care. Episodes of dental care are currently bundled with medical care in the community health clinic setting.

Bundled payment and the episodes of care concept can be effectively introduced into the dental care setting with the adoption of dental diagnosis codes. For instance, bundled payment for a periodontal disease episode of care would be identified with a diagnostic code and ultimately reward the nonrecurrence of periodontal disease. The bundled payment system is the interim step away from fee-for-service payment for the quantity of service and toward an integrated system like the accountable care or coordinated care system that rewards health outcome and disease management.

ACO

An ACO is a group of hospitals, physicians, and affiliated health-care providers who gather under an umbrella organization to deliver coordinated care to a population. Payment is through some form of bundled payment. The goal is to give the right care, at the right time, in the right amount and avoid duplication of services. The ACO shares in the savings it achieves through cost-efficient care.

The Centers for Medicare & Medicaid Services introduced the ACO model for its Medicare members. Oregon developed its CCO model built around the Triple Aim. Oregon implemented its Medicaid program by dividing the state into regions with one CCO designated to care for Medicare members in each region. Oregon's CCOs will next extend their services to state employees and other health-care payers through strategies that emphasize alternative payment models, patient-centered primary care, and robust quality measures for accountability. Oregon's vision is to create a health system in which oral health is integrated and coordinated.

It's reported that one Silicon Valley technology company moved from its health insurer and their provider network to a physician-controlled ACO to provide health care for its employees. The ACO concept is moving from serving federal programs to the private sector. Dentists and dental practice will be impacted when ACOs in the private sector integrate dental care as an important component of overall health care.

Antitrust

Dentists feel that there is unfair weight of the law when they deal with the third-party payers of dental benefits. Insurance companies enjoy financial heft and reach that surpass any individual dentist. It seems only fair that individual small practice owners in a community can band together in a show of force to present a countervailing force to insurance companies and negotiate favorable terms with the third-party payers. But as you know, this is per se illegal and a violation of the Sherman Antitrust Act. A per se violation is inherently illegal and requires no further inquiry into the actual effect on the market or the intentions of the individuals. For individual dentists to conspire to lower fees is equally per se illegal and a prohibited action. To individual dentists, there appears to be a disparity in the bargaining power between providers and payers, but the government does not believe that monopsony power exists in most health-care markets.

Even if it were assumed that providers confront monopsony health plans, the government believes that to allow providers to exercise countervailing power doesn't serve the consumers' interests. This is not a trivial issue for individual dentists. In *United States v. A. Lanoy Alston et al.*, the defendants were convicted in a criminal case for a concerted action to conspire to fix and raise their copayment fee (Box 1.1).

Box 1.1 Antitrust**United States v. A. Lanoy Alston et al.**

The case was the first criminal case the Antitrust Division brought against medical practitioners in over 50 years. The Justice Department charged three dentists with conspiracy to fix and raise the copayment fees paid to the dentists from four prepaid dental plans in the Tucson area. In Tucson, some dentists failed to break even on some common services like porcelain crowns. Several Tucson dentists individually requested fee increases but were rejected. Subsequently, 50 local dentists met to discuss the copayment fees from prepaid dental health plans, which had not risen for 10 years and were lower than fees in Phoenix. The government contended that the defendants agreed to persuade the health plans to raise their copayments and then mailed identical letters demanding a higher fee schedule. The Justice Department contended the dentists met with the intention to exert pressure on the plans to raise fees. The dentists claimed they met, *at the behest of president of one of the plans*, to justify, in a show of show-of-force, a new copayment schedule that would rationalize fees between Tucson and Phoenix. The Justice Department alleged that the conspiracy caused the dental plans to pay higher copayment fees than they might otherwise had to pay. The case was tried in December 1990, and the jury found all the three defendants guilty. In January 1993, the Government reached a settlement with all parties.

Conclusion

Dentists practicing today have always worked in a world of dental benefits. It is a way of life that has remained essentially unchanged since the inception of the dental benefit service company in the 1950s. Dental insurance is a benefit of employment with the employee having very little input to a plan design. Dental care is delivered through small private practice and the dentist is paid fee for service. The dentist considers the provider–patient relationship sacrosanct with third-party scrutiny detrimental to quality of care. The dentist is accountable to only their patient.

Given a shifting payment environment, it is incumbent upon each dentist to understand how dental benefits work and how they can efficiently manage the current and emerging systems of dental care payment. The rising cost of health-care services as percent of GDP is rising and is not sustainable. The emerging models of payment for services and dental care delivery attempt to control the cost of care while extending access to care to more individuals. Patient-centered care and a streamlined office process are key elements to the emerging models.

As dental benefits become uncoupled from employment, the fee-for-service method of payment is being evaluated for sustainability, procedures are being linked to diagnosis, more individuals have access dental care, and payers look to cost-effective care with positive health outcomes.

So, to understand the history of the prepayment of health-care services and the future vision of dental care delivery is the essential first step for a dentist to design a sustainable and competitive model of care for the future. This chapter describes the past and present states of dental care payment and the tentative

forays into the future state of dental care payment through ACO and bundled payment. Dentists just entering into dental practice can look back at what was successful for their colleagues but shouldn't rely on past successes to model their future behavior and strategy for success.

Further reading

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