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DR plans boost access, ease administration, proponents say

Direct Reimbursement Poses Growing Threat to DHMOs, PPOs

Direct reimbursement -- perhaps the arch enemy of managed dental care -- continues to grow, although it's facing the same economic hindrances as other types of benefits as medical care eats up an increasingly huge share of many companies' benefits budgets. But while DR may not be expanding as fast as it has in the past, proponents note that it's not losing ground, like some reports say the dental HMO sector has lately. Indeed, fans of DR say they can imagine few scenarios that would lead them to abandon direct reimbursement and return to a more structured form of dental benefits.

The American Dental Association, not surprisingly, supports DR 100% "as the preferred mechanism of financing dental benefits," notes **Dennis McHugh**, the Chicago-based organization's manager of Dental Benefit Information Service and Third-Party Issues, within its Council on Dental Benefit Programs. "DR is a simple, self-funded method of providing a dental benefit for employees."

Under a DR plan, he explains, employees and covered dependents visit the dentist of their choice, receive treatment, make payment and later present proof of treatment for reimbursement. Employers then reimburse them for all or part of the expense, according to the plan design. A new variant, called "direct assignment," or "DA," is very similar, McHugh notes, and uses a third-party administrator to

manage and pay claims.

Dentists prefer DR, he adds, for the obvious reasons:

- It encourages fee-for-service dentistry.
- Typically, all non-cosmetic procedures are covered.
- There are no networks to join and no restrictions on which providers a member can see.
- There's no need to submit X-rays to validate treatment decisions.
- There are no pre-treatment estimates and authorizations involved.
- Treatment decisions are between the dentist and patient, with no third-party involvement.
- It "reduces paperwork and red tape in the office."
- It "preserves the dentist-patient relationship."

Employers, McHugh continues, favor these features of a DR program:

- Employees can choose any dentist for treatment.
- The benefits are "simple to understand."
- Employees know the amount of reimbursement in advance.
- There are no insurance premiums to pay. Instead, payment is made only for employees who actually visit the dentist.
- An estimated 93% of the dental benefit dollar, on average, is spent on actual dental care.
- There are "fewer employee complaints."
- DR plans offer "simple and cost-effective administration."

• Cost control can be achieved through co-payments and annual maximums.

Enough employers, in fact, have made the switch to DR that it now covers an estimated 1.5 million lives, including employees and dependents, according to ADA data. Indeed, McHugh reports, as of March 24, 2006, there were 4,101 employers using DR. "It is estimated," he says, "that the accumulated dental expenditures of DR plan participants for 2005 was \$350 million, based on *National Health Expenditures Projections, Health Care Financing Review 2002* and ADA Survey Center calculations for per capita annual expenditures for a given year, multiplied by the estimated number of lives covered by DR plans in that year."

Growth has been slow the past two years, he concedes, "due to the sluggish economy and to employers faced with huge premium increases for medical plans." Still, he emphasizes, "the number of DR plans continues to grow. An average of 382 new plans have been added annually since 1997, with a renewal rate of approximately 92%."

A common plan design is structured like this, he continues:

- 100% of the first \$100 of any dental care, except cosmetic procedures.
- 80% of the next \$250.
- 50% of the remaining expenses, up to an annual per-person maximum of \$1,000 or \$1,500.

Another common plan design is 100% of the first \$150 and 50% of the remaining expenses, up to an annual maximum of \$1,000. The payout on that design is comparable to the payout of a traditional indemnity plan design.

But the similarities pretty much stop there, McHugh adds. "DR is different from managed care plans in several ways," he notes, including these:

- Benefits are based on dollars spent on dental care and not on the type of procedure.
- There are typically no waiting periods.
- There are no "least expensive alternative treatment" clauses.

"DR enhances patient involvement and awareness of dental costs and payment," McHugh adds. "Patients can decide whether charges for proposed treatment plans are acceptable. They become involved in the plan by their participation with coinsurance, annual maximums and up-front payment of the costs of treatment."

Dentists' charges are important to employees, he says, "because the plan design encourages them to make the most efficient use of benefit dollars. With DR, patients have the freedom to receive treatment from the dentist who they feel will give them the best value for their dental benefit allowance."

Approximately 65% of a covered employee group will utilize the dental benefit in a given year, ADA data reveal. The average dental expenditure per person per year is approximately \$246, again according to *Health Care Financing Review 2002* and ADA Survey Center calculations.

Because of its simplicity, McHugh stresses, DR is as good a fit with other benefit plans. "It's simple to administer," he explains, "because benefits are based on dollars spent and not procedures performed. So it's easier to integrate it with a medical plan. Also, DR

plans are the ultimate consumer-driven dental plans because treatment decisions are made between the dentist and the patient, with no third-party interference."

Further, he notes, more and more TPAs are researching Internet-based opportunities for eligibility and claims payment services. "Debit card technology is also being studied right now," he comments. "In addition, pre-tax benefit administrators are studying how DR plans can be successfully integrated into health reimbursement arrangements."

Dennis Riedmiller, president at Riedmiller & Associates, Cincinnati, says his employer clients focus most on access and cost in deciding to switch to DR. Some, he says, never offered dental before and others did, but grew dissatisfied with the way their dental plans were being run.

"One factor is providers dropping out of DHMO and dental PPO networks," he notes. "If a company offers a managed plan, access is always a big issue. In DR, there are really no restrictions." Cost, he adds, "is about increases. I've seen higher or lower annual costs for DR plans, but a lot of them don't have increases year after year." Indeed, says **Roger Schultz**, vice president at J. Smith Lanier & Company, Atlanta -- the nation's largest DR TPA -- "adjustments to plan costs occur only once every two or three years, and sometimes every five or six years."

And then there's the simple economic reality of a benefit that rarely involves big-ticket, catastrophic care. "Often, someone in a company's accounting department, or even the chief financial officer, will recognize that you don't have to have fully insured dental benefits," Riedmiller continues. "You can self-fund it. Once a company reaches that paradigm change, it begins to look for alternatives -- and self-funding is the best way to go."

In fact, he points out, "the worst-case scenario is you operate at a deficit the first year, because you didn't budget enough, and then change the funding factor the second year. If DR plans sell to someone with a knack for economics, that often sways him or her to give DR a try."

Companies that make the switch, he says, may even end up with money in the bank. "About 85% of DR plans have a surplus at the end of the plan year," he reports. And most companies will save on administration. That usually runs 20% or so at most plans, he comments, while DR plans generally cost 6% to 8% to administer. "That alone is a cost saver," he says. "And you can figure as well the time value of money. If an employer can save it in-house, that's better than transferring it to an insurance company."

Schultz adds: "DR reduces plan costs by an average of 10% due to the removal of state premium taxes, risk charges and insurance company overhead and profit."

Employees likely won't see that advantage, of course, but DR plans do tend to be popular with workers, Riedmiller says. "It's rare that I get a complaint unless the TPA doesn't pay in time or pays incorrectly," he tells *Managed Dental Care*. "Employees know up front how much they have to deal with. They don't understand UCRs and all, but they do understand dollars. They get that real quick. DR is the best consumer-driven product you can have. When you buy tires or a house or a candy bar, you have X dollars to deal with. You can shop. It's the same with a DR plan."

The educational component of most consumer-directed plans could be the responsibility of the employer in a dental DR situation, the experts point out, or it could fall to brokers to offer that service.

"Most employers," Schultz comments, "rely on their benefits bro-

ker to do that." Or, Riedmiller says, "it depends on how much access [to information] the employer wants to offer." There are a variety of websites, for example, that feature clinical and cost information on dentistry and dental providers. "I'd encourage and incent employers to teach people how to use the DR program and be good consumers," Riedmiller adds. "Employers should choose the educational vehicle."

That's apparently a small price to pay. Riedmiller and Schultz both cite few instances of companies ditching DR to return to managed dental or even traditional indemnity plans. "You do see situations where there's a buyout or merger and the new corporate parent has a competing plan," Riedmiller says. "Also, I had one public library client that experienced claims fluctuations in self-funding, which its board decided it couldn't handle."

Schultz adds that "seldom have I seen an employer leave DR and return to any other type of dental plan." Indeed, he says, most com-

panies would only return to other types of coverage "if they were simple in design and benefits were based on dollars spent and were not procedure-based, and if the many detailed exclusions and limitations were removed. The savings from most are so small they cannot be measured."

In general, he adds, "employers using DR would not go to a PPO plan because the dollars per person per year are so small. The average expense is \$250 a year per person, and the average claim cost is less than \$160 a year per person. What is there to manage?" Also, he says, "fixed plan costs go up with a PPO, and probably less than half the care is provided in-network." Dental PPOs, he adds, often suffer access problems outside larger cities.

And forget about DR plans losing customers to DHMOs. "None would go to a DHMO," Schultz states. "Poor access and, often, undertreatment are the result."

If they're preaching, **Colleen M. Carter**, PHR, director of human resources at Tampa's Kisinger

Campo & Associates Corp., is the choir. "Our firm has utilized the same direct reimbursement plan for about 10 years," she tells *Managed Dental Care*. Previously, benefits were provided by a dental point-of-service plan.

"In 1995," Carter reports, "our rates were \$18.98 a month. Our 2006 renewal rates are \$25.35 a month." That's a 33% increase in a decade -- or about 3.3% a year, which is less than dental benefits inflation overall. Her company made the switch, she adds, "based on the extended and restricting waiting periods on conventional dental plans."

And while everybody's delighted with the DR plan in place, nobody's saying it's perfect. "It typically saves money for individuals who actually utilize the plan," Carter adds. "If one does not use the benefits, it is not cost-effective. Those who have dental work performed like the plan. Others who are members and don't use the benefit think it is expensive -- which is true." ■