RECORD OF SOCIETY OF ACTUARIES
1993 VOL. 19 NO. 1B

GROUP DENTAL

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MR. ROBERT BRUCE CUMMING: Dental coverage is receiving a lot more attention these days. There's a lot of uncertainty in the medical insurance market, and because of this, carriers are seeking to diversify their portfolios. One way they're trying to do this is by either expanding or introducing dental coverage. With that in mind, our speakers are going to talk about some current issues in benefit design, managed care, and market trends.

Our first speaker is Ed Kiernan. Ed is an associate actuary with Delta Dental Plan of Michigan, where he has worked for the last 18 years. He's going to talk about some benefit design issues. Our second speaker is Jerry Seaman. Jerry is a consultant with Jerome F. Seaman and Associates. He has worked with Delta Dental Plan of Illinois for many years. Jerry's going to talk about the pros and cons of different approaches to managed care, that is, the PPO approach versus the dental HMO approach. Our third speaker is Jeremy Conaway. Jeremy is senior vice president and general counsel with U.S. Dental Plan. U.S. Dental is a dental HMO (D-HMO) located in Phoenix, Arizona and is operational in a number of different states.

To wrap up, we have Ken Bernardi. Ken is vice president of underwriting, actuarial and research at Delta Dental of California.

MR. EDWARD P. KIERNAN: As a way of describing what dental plans are covering, and the trends in those dental designs, I'm going to use a cost-containment report as our outline. When I'm talking about trends, I'm not talking about costs; I'm talking about the changes in plan designs.

In the claim payment reduction category we have fee reductions, contract limitations (things that are generally caught in a computerized history cross-check plan), nonbenefit procedures, dental policies (I'll get into some examples of things that are dental policies), professional or dental consultant review, and coordination of benefits. In the area of subscriber coinsurance, there are deductibles, co-payments, and maximums. Last, we have a category for eligibility. I'm going to talk briefly about some of the eligibility issues that are going on.

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CONTRACT LIMITATIONS

Time Limitations

In the area of contract limitations, the first topic I have is time limitations. The first category listed is radiographs. The frequency of radiographs is a hot topic in the dental area. Typical plan designs have always allowed one full-mouth series every three years. We're seeing some trends now to reduce that frequency, and we're seeing some plans allowing only one every five years. Bite-wing radiographs has the same type of trend. The typical plans allow two in a year or one every six months. Now we are seeing some programs allowing just one set per year. They will allow some additional bite wings to be taken if there's been some kind of demonstrated need. The trend in bite wings and the other radiographs has been to decrease the frequencies.

In prophylaxis, there's a trend to allow additional cleanings. Standard programs have allowed two per year. We're seeing requests now for three per year and four per year, but generally they require some kind of documented need. Typically, you'll see a history of periodontal disease as being the documented need.

For fluoride treatments, there are some programs with no limitations at all. The reason for that is that fluoride treatments are generally only done after a cleaning. If there's a frequency limitation on the cleanings, you don't really have to worry about it on the fluoride treatments. With additional cleanings being allowed, we'll probably see some additional controls on the fluoride treatments. We'll talk a little bit about fluoride treatments when we talk about age limitations.

With respect to fillings, typical language would allow a surface of a tooth to be filled just once every two years. Some contracts have no time limitations at all for crowns and substructures. The more standard procedure is to limit crowns to one every five years. There are other limits that I call "once-in-a-lifetime-type benefits." This includes occlusal guards and orthodontic appliances. Generally, they're once-in-a-lifetime benefits most dental plans don't allow for the replacement of those devices.

Age Limitations

Fluoride treatments are commonly limited to patients up to age 19. I think there are a lot of dentists who see a diminished return of value beyond a certain age. As a result, they're looking now at limiting the fluoride treatments to age 14. Again, a lot of contract language will allow for some additional fluoride treatments if there's been a demonstrated need. Typically, it would be a high-caries incidence with that particular patient. With respect to orthodontic benefits, there's a lot of different language. Typical language is up to age 19. Some language will allow for the completion of the treatment if it's been started before the eligibility is lost. We've seen some language that places no age limitation on the dependent children for orthodontic treatments.

Optional Benefits

In the area of optional benefits, posterior composite restorations are generally not covered when they use a tooth-colored resin. It's considered a cosmetic benefit. Most dental plans will make an allowance towards amalgams. The same concept is applied to porcelain crowns. Porcelain crowns on posterior teeth have not been a typically covered benefit, but they do make the allowance for the full metal crowns.

Now, at least in Michigan, we've been seeing the fees for those two crowns becoming more and more similar. So, it's becoming less of a cost issue. For overdentures, most plans will make an allowance towards a full denture on overdentures.

Nonbenefits
Sometimes "nonbenefits" are covered and sometimes they're not. These are the things that are being looked at as possible changes. In Michigan, sealants are still not a standard covered benefit. Our plan offers it as an additional benefit, but the majority of plans do not cover sealants. For adult orthodontics, some plans cover it, but it's still infrequently seen. Treatment for temporal mandibular joint (TMJ) dysfunction is being tossed back and forth by the health carriers and the dental carriers. Neither really wants to cover it. The problem in covering it in the dental plans is the limited maximums, generally going to $1,000 or $1,200. A lot of TMJ treatments can get way beyond that. The cost has never been built into most dental benefit designs. Medical benefits are typically not covered under most dental plans. Implants is another procedure that's hot right now. We're seeing a lot of requests to get cost estimates for implants. IV sedation is generally not covered unless there's some specific need shown. Veneers is a hot area in cosmetic and personalized services. Veneers are used to cover discolored teeth.

Oral examinations are typically covered by almost all dental plans, but we are seeing some trends where dental plans are eliminating the coverage for the exam.

Coordination of Benefits
There are a couple of variances in what we're seeing on coordination of benefits (COB). We have some groups that do not want any coordination of benefits being applied. We're seeing requests for carve-out COB. In Michigan, we have some segmentation of groups. The group will actually go to their employees and find out who's got dental coverage and who doesn't have dental coverage and break the group up in that manner. To get more of COB savings, they give the group who has dental coverage a lower benefit plan, and the group that does not have dental coverage gets a higher dental benefit plan. We just received one where it's a typical "not-permitted-under-group-contract," unless it's a child of divorced parents.

DENTAL POLICY
These are things that are more typical with dental service corporations, such as the Blues where they can sign participating agreements with the doctors, and at some of the managed-care plans where the doctor is signing an agreement with the carrier or the plan administrator. These are things that you can hold the patient harmless against and make the dentist absorb the cost of those services.

A hot topic right now is infection control. Because of the Occupational Safety and Health Act (OSHA) requirements, there have been many dentists wanting to charge an additional fee for this service. Most carriers and plans are saying no since this is part of the cost of a dentist's normal operating procedure. If it's an overhead-type cost, you have to build it back into your normal service costs.

Retreatments are a quality-of-care issue. Retreatments would be covered within one year of a root canal, and within three years of any kind of periodontal treatment. When sealants are covered, there's some language that would require the provider to

repair the sealant if needed within three years of the original application. If a filling fails within two years, the provider would be responsible for making good on that.

We have another category called "unbundling of services." I'm sure we're seeing some of that in the medical fields. This includes such things as postoperative radiographs and the base or a temporary filling as part of the final restoration. There's a lot of fragmentation of services in substructures. By substructures, I mean the buildup and the things that they have to do to a tooth to make it ready for a crown.

In the case of periodontal procedures, flaps, and osteosurgery and grafts, some providers are trying to break out those services, and carriers are trying to combine them into one service. I'm seeing some carriers doing even more bundling of services. A nontraditional bundling of services is where they are lumping exams, prophylaxis, fluorides, and even radiographs all into one service. They try to get some savings from that. Then there are some other coding and nomenclature decisions generally made by dental consultants, and those would generally be done with a dentist looking at the claim and looking at the x-rays and deciding what work that provider is doing.

FEE REDUCTIONS

In the area of fee reductions, we have the standard usual, customary and reasonable (UCR) fee structure. In some cases, such as service corporations with par agreements or managed-care operations with par agreements, you can hold a patient harmless for any excess fee above the UCR levels. We have preferred provider arrangements where the provider has signed an agreement to accept some sort of discounted fee, and generally the patient is held harmless if he or she goes to a participating doctor. We have some table of allowance programs. Sometimes those are in conjunction with a UCR-type plan where the table of allowance is really used as more of a co-payment-type arrangement. I mentioned capitation and dental maintenance organizations. The other speakers are going to get into a lot more detail on that. That is a way of reducing the costs on a fee basis.

ELIGIBILITY

Typically, employees are eligible for dental coverage on the first of the month following one-to-three months of continuous employment. I think there are some companies that require 6 months or even 12 months. There are some contracts that require a one-year wait on major restorative and prosthodontic-type services. There's a lot of variation out there as far as defining the eligibility of dependents. You see some up to age 19 unless they're a full-time college student. Sometimes they'll go up to age 23, 25, or it may even go unlimited. A lot of contracts try to use the IRS's language for defining an eligible dependent.

LEVEL OF BENEFITS

Deductibles

In the area of deductibles, standard language is that the family maximum is three times the individual's maximum. We have some deductibles that are applicable to all dental procedures. A more common approach is that the deductible is not applicable to the diagnostic and preventive services. We have some that are applicable only to the major restorative and prosthodontic-type services. There's some language for carryover deductibles. There are actually some lifetime-deductible dental plans.

We've seen some plans in which the annual deductible is applicable to orthodontics. In most dental plan designs, orthodontics has generally been held outside of the dental plan.

Co-payments

In the area of co-payments, I've listed an incentive plan. In an incentive plan, the co-payments are stepped up over time. The subscriber must use the plan at least once per year to maintain the higher co-payment level. This plan is not new. I do not think this is an up-and-coming plan. I think, if anything, it's probably a dying plan. They've been inflationary, and on a cost-control basis it's not been a very good idea. Some of the variances in co-payments exists in how the services are grouped. In dental plans, you typically have three different levels of co-payment. They'll have 100% on diagnostic/preventive services, 80% on what we would call basic-type services, and 50% on prosthodontic and major services. But a lot of times they'll swing categories of dental services back and forth between those categories. You may see simple extractions up at the preventive level. You may see surgical periodontics at the major level. So there's a lot of swinging around going on.

With capitated dental maintenance programs, a more standard approach has been to use a published table of the co-payments. We're seeing some programs with a percentage of UCR as being what the patient's responsibility will be on these capitation plans.

Last, in the maximum category, standard programs have an individual person maximum. We've seen some plans now that want a family maximum. We're seeing some plans requiring a lifetime maximum on surgical periodontics. Typically, some benefits are experimental or might be covered, such as TMJ or implants. When they are covered, most plans try to work it in with some sort of lifetime maximum.

MR. JEROME F. SEAMAN: I want to talk about some variances from the traditional indemnity plan. I want to give you a perspective on what I've seen, as a consultant, in the area of demands for these kinds of plans on both a regional and national basis. By national I mean national accounts, not necessarily other regions. The two types of managed-care arrangements that are currently in vogue are what I will call dental HMO and dental PPO.

DENTAL HMO

What is a dental HMO? A dental HMO is similar to a medical HMO. It consists of a closed panel of dentists from the point of view of the purchaser. A purchaser chooses from a list of approved dentists; these are the dentists that participants can go to. From the point of view of recruiting and expanding the number of panelists available, the people who put these plans together would really consider this an open panel. Dentists who meet the criteria and qualify and are willing to agree to the financial terms can join. So, really, when you say closed panel it's a misleading term. The appeal of these plans to buyers is that there is a broad choice of dentists. So, the seller of these kinds of programs really would like to have as large a panel as possible.

Generally, the participant enrolls in the plan with a specific dentist. There is some variance in this. Sometimes the choice is made the first time that they go to the

dentist, but generally it's made up front. The primary care dentist often acts as a gatekeeper to specialists. If he can't treat the person, he refers the patient to a specialist. In many cases, the care is then covered out of a risk pool of the premium. For example, you may have a situation where the premium is $100, and somewhere between $60 and $80 of that will go to the primary care dentist. There might be an additional amount, maybe $5-8 that will go to the risk pool to pay for specialist dentists on a risk basis. The dentist is compensated on a proportion of the monthly premium. The term capitation has different meanings. Capitated premium usually means the premium that's paid by the subscriber. The capitated amount is usually the portion that the primary care dentist gets.

Sometimes the primary care dentist is put on risk with regard to specialty services. I think that is less common. It becomes a barrier to recruiting primary care dentists, which I think is the primary thrust of creating these dental panels. Unlike indemnity dental plans and PPO plans, the dentist is the primary risk carrier. In that case, how much a dentist treats a particular patient is a function of his decision as to what care is needed; the patient does not have any further financial responsibility except for stipulated co-payments.

Co-payments are very common in these kinds of plans in much the same way that they are for an indemnity plan. Typically, we have no co-payments for preventive or diagnostic services; smaller co-payments for minor restorative, oral surgery, and endodontics; and then very high co-payments, approaching 50% or more of the cost, for major restorative work such as crowns, surgical periodontics, prosthetic devices, and dentures. One of the advantages of this kind of plan is that co-payments are usually stated in a fixed-dollar amount, rather than a percentage of the usual and customary fee as in an indemnity plan.

The last item that I wanted to note is that the fixed per capita reimbursement to the dentist is an incentive to control the number of services provided to the patient. The less a dentist does, the greater his income per service; the more he does, the less incomes he receives per service.

DENTAL PPO

A dental preferred provider organization (PPO) also consists of an open/closed panel (a closed panel from the point of view of the purchaser). It can be provided like a dental HMO, on a stand-alone basis, or as a stand-alone option in a multiple option plan. But it is usually provided on what is called a point-of-service basis. The PPO will be an option along with an indemnity plan, although there are cases where a dental PPO is the only plan option that's available.

Unlike the dental HMO option, the dentists are compensated on a fee-for-service basis, and this is usually at a significant discount from prevailing fees. In this case, the insurer is the primary risk bearer, since the dentist is compensated on a fee-for-service basis. The adequacy of the premium is judged by how many services are provided and what the cost is. The advantage to the insurer in controlling those costs is that he has an agreement as to how the dentist will be compensated. Patient co-payments are often stated at a fixed-dollar amount, as in a dental HMO plan, but they're often stated as a percentage of the fee.

The typical incentive on a point-of-service basis is the lower co-payments that are available. To have a successful PPO plan, you really have to have a large benefit variance between the PPO plan and the indemnity. For instance, suppose you construct a panel that comprises about 10% of the dentists in a particular area. If there isn't that much difference between the indemnity plan and the PPO plan, in terms of benefit levels, only 10% of the people will use the PPO dentists. Thus, your cost savings is nil, because these dentists supposedly are charging other patients the same amount. However, if you can get a greater proportion to go to the PPO dentist, cost savings are achieved for the employer. There's a variety of experiences. Delta Dental Plan of Illinois implemented a PPO plan with very little differences between the PPO plan and the indemnity plan. They found that the rate of utilization of the PPO plan was about twice the level of the indemnity plan. That resulted in significant cost savings.

ADVANTAGES OF A DENTAL HMO

The main advantage of the dental HMO plan is that it is basically a lower cost plan. In fact, some people wonder if there's any cost trend in HMO plans at all. Their costs don't seem to increase, and they seem to be decreasing on a per-employee basis. That varies from region to region based on the competitive nature of those kinds of plans in a particular area. The real advantage that we've seen in the requests from large employers, particularly national employers, is that the employer would like to offer a very broad benefit option under the dental plan, but really doesn't want to pay for it.

So the real impetus is to provide a very generous dental HMO plan as an option. The challenge is to make many dentists available under that plan so that employees will feel that they really have an option to choose a much broader-based plan. This is the way in which employers are able to control their dental costs and to actually meet the demands of employees and union groups for broader dental benefits. Dental HMOs are also very popular with employee benefit plan consultants. We see things that seem to indicate that they don't know what a dental PPO plan is, that dental HMOs are really what they're looking for. I believe that relates to the advice that they are giving; that is, the employer can offer a broad plan to his or her employees, without having to increase the amount of benefits under the indemnity plan, which is quite costly. The specified co-payments enable the patient to understand exactly what his or her out-of-pocket costs are.

ADVANTAGES OF A DENTAL PPO

One of the advantages of a dental PPO is that the panel size can be controlled in using the fee-level reimbursements. If the goal is, let's say, to provide a program with about a 15% lower average fee than prevailing in an area, you can determine where that cutoff point would be. Through your selection process, you can identify dentists that charge at this fee level, and give them the opportunity to join the PPO plan. In some cases, you may be soliciting 10-20% of the dentists at higher fee levels. You would be soliciting maybe 20-30% of the dentists in a region. The higher the level of fee reimbursements, the more dentists will be attracted to the plan.

A PPO is generally more attractive to a dentist because he is reimbursed on a fee-for-service basis, and the dentist knows what he is going to be reimbursed. If the incidence of dental use goes up, he gets paid more. Generally, PPO panels are larger

than dental HMO panels. By the way, dentists do seem to have a very strong bias in favor of fee-for-service, much like doctors had many years ago.

It's possible to vary PPO plan design options much like you could vary plan design options under an indemnity plan. Under a dental HMO, you don't have those options. I feel that a dual-option indemnity/dental PPO plan may actually be able to provide greater cost savings to an employer than a dual-option indemnity/D-HMO plan. The reason is the larger panel attracts more people to use the lower-cost services. For an employer who really would like to make broader benefits available to his employees by actually providing more dentists to provide greater care at lower cost, the dental PPO option seems to have some advantages. For small- and medium-sized employers in a particular area, particularly in the Chicago area, this seems to be an attractive option. The employee has greater freedom of choice. The employee can go to a panel dentist or a nonpanel dentist under a point-of-service plan. That gives the employee a lot of freedom. He doesn't have to select a PPO dentist until he actually goes to a dentist. My last point is, we've seen some cases where employees have selected a point-of-service PPO provider at a high rate. That is not a universal occurrence, but it has occurred in some rather significant situations.

DISADVANTAGES OF A DENTAL HMO

I'll now cover the disadvantages of the dental HMO. The same disadvantage applies to the dental PPO: It's difficult to establish a panel outside of large metropolitan centers. Dentists are used to these kind of arrangements in places like metropolitan Chicago. They are not used to them in places like Champaign, Illinois, where there is generally a much closer relationship among dental professionals. In such places, the standing of a dentist in his dental community is often very important to him. In a large metropolitan area, people are more nameless and faceless, so they can engage in arrangements which they perceive to economically benefit.

One of the problems with a dental HMO is a dentist is enrolled for specific types of plans. If you get an employer who wants only one type of plan, it's often difficult to deliver a customized plan. Standard plans are much more common in dental HMO than they are in dental PPO or in dental indemnity plans. A dentist may decide not to participate in certain plan alternatives. So, it complicates the listing of providers and maintaining the list.

Some people think because there is an incentive for the dentist not to treat patients, that the patient's dental health will suffer. I think that's probably a concern in medical HMO plans. Since a lot of dental work is more of an elective nature and not of a necessity nature, it becomes more of a concern in the dental area. I'm sure that certain safeguards can be installed and statistics can be kept to evaluate that. We have seen, in dual-choice programs, that is, indemnity plans with dental HMO plans, that opting for the dental HMO option has remained relatively low. The 10-20% range, or even the 13-17% range is more common.

DISADVANTAGES OF A DENTAL PPO

The disadvantages of a dental PPO are similar to those of a dental HMO. It's hard to establish a panel outside of the large metropolitan centers. A poorly designed PPO plan can result in no cost savings, and in some cases, cost increases. If your only dental panelists are the lowest-cost dentists in an area, and if the employees do not

elect to go to the PPO dentists more frequently than they go to indemnity dentists, then your costs will be higher.

The dental PPO is not popular with employee benefit consultants. They haven't been as widespread as dental HMO plans. They're not as well understood. Some of the employee benefit consultants, particularly those who are working with administrative-services-only plans, do not perceive the cost savings that can be achieved with a dental PPO.

Where you have the danger of underutilization with a dental HMO plan, you have the danger of overutilization with a dental PPO. By performing more procedures, the PPO dentist can circumvent the disadvantages of the cost discounts by increasing the number of services that are provided. In fact, many people believe you can't really have an effective dental PPO plan unless you have some fairly good utilization review in place.

I'll leave you with one final question, "Is there a real future for triple-option dental plans?" That's really a dual-option dental plan, one that would have a PPO point-of-service plan in conjunction with an indemnity plan and a dental HMO option. The reason I raise this question is because dental plans are probably the least understood of the health benefit packages with which employers have to deal. They're often an afterthought. To make them as complicated as possible is not the goal. Once the employer has gone through all of the costs and the considerations associated with medical plans, they have little energy left to consider all of the wonderful options that are available to the dental plan. The focus these days has been on managed competition and managed care in the medical care area, and people aren't all that interested in what's going to happen to dental plans in the next few years.

MR. JEREMY CONAWAY: I am here both as your token non-actuary and as a representative of the National Association of Prepaid Dental Plans, so I bring you greetings from that organization. It represents about 95 of the approximately 125 prepaid dental plans presently operating in the United States.

I think Jerry did a nice job of setting forth the traditional basis of a prepaid dental plan. Several of the points he made speak to what has been the elegance, indeed, of prepaid dentistry over the past 20 years of its existence. The prepaid dental plan has been a nationally available option for only about 10 years. But the simplicity of that original plan, where someone would pay in a premium (a capitation payment would be derived and paid out to a provider panel, which made for a very simple, easily administrated situation), has dramatically changed over the past 36 months. Simplicity is no longer the hallmark of prepaid or capitated dental programs. I want to review with you some of those changes and where some of that is going.

As I indicated, we have approximately 125 or so plans delivering services in most of the major market areas of the country right now. By and large, you can find this option available just about anywhere. U.S. Dental itself works in about 12 different states. We have primary plans in five different states. We work in networking arrangements in many more states with other prepaid organizations in dealing with national accounts.

The basis of a prepaid dental plan is that you solicit contracts and you identify a core group of dental services that will be provided as part of your plan design. In some states, regulations and statutes have been passed that determine what programs must be offered and what can be offered without co-payment. In Arizona, there's a certain basic package that must be included within the basic prepaid dental package. Over and above that, you can then move to the use of co-payments. Generally speaking, for every dollar that a provider receives in capitated payments, there's an additional 48 cents in co-payments. As Jerry pointed out, in that type of system, the primary risktaker is the provider. That characterization has a lot to do with the operation and performance of a prepaid dental plan.

Recently, many things have begun to change in these plans. We used to have simple relationships with providers. We simply sent them a roster every month and said, "Here's the number of folks you had, here's your capitation payment, one times two equals the amount of the enclosed capitation check." That was always very simple. Now we find ourselves having much more sophisticated relationships with our providers.

We have a generalist panel that agrees to cover the services listed on the benefit sheet for the capitation plus the co-payments. We also have a specialist panel. The specialist panel generally works on the basis of a reduction from usual and customary fees. They agree to provide services within a certain time frame or appointment-setting time frame for the members of the plan.

We have now found, for several reasons, that all of the relationships that we have with our subscribers, with our groups, and with our providers, are getting a lot more sophisticated. Also, I think we're finding, throughout the health care industry, that consumers are simply getting a lot smarter. We now deal with groups who negotiate with us, who want certain benefits. They are no longer strangers to benefit sheets. They're no longer strangers to the number of prophys or cleanings that they want, or what kind of an orthodontic benefit they want. They come in and negotiate, as opposed to a short time ago when we simply said, "Here is the standard product." That was dear to the simplicity of prepaid dental plans. We find ourselves being drawn into more customization because of the sophistication of our customers.

Many of the consultants and brokers that we work with have a specific idea of the particular needs of their groups, and they're demanding them. While we try to keep our product line down, we find that there's a lot of pressure to continually change it and make it a little different. We have recently introduced a program called Omnibus Plan Design. We are attempting to recognize that we're probably no longer going to be able to establish four or five products and just offer that. So we have created almost a menu plan. We might as well be in a position to allow our groups to purchase the benefits that they want, and then have our underwriting set up to reflect those selections, as opposed to having to go in and redesign each time. So our Omnibus programs are now in use in three different states, and we're in a pilot program with those.

What we're finding is that in addition to knowing exactly what processes they want, our groups are a lot more sophisticated about options. The use of brokers and consultants and other folks that are now proliferating in the health care field results in

requests for proposals being much more specific. We have two major programs going on right now with state government organizations for state employee groups.

When we talk about a point-of-service program in our company, we're talking about basically equipping the member with three separate accounts, an indemnity account, a PPO account, and a traditional prepaid account, and allowing them to actually choose which account they're going to use at the time they access services. The first one we did was at the request of a large hospital chain that we cover, and they were exceedingly sophisticated in the area of benefit design. This plan is less than six months old, and we have two more on the way.

So, we're seeing some very sophisticated plan design formats now. The problem with that, of course, is that we live in a world in which we have been unable to convince folks that they ought to have their teeth cleaned once a year. Now we're talking about approaching them with a nuclear-physics-style benefit program which raises serious questions about member education. How are you going to get people sophisticated enough to make the kinds of decisions that they have to make about this when we haven't been very successful in getting them to access care?

Another simplification that made prepaid dental plans work well was the lack of utilization review or, in essence, what we now call quality reviews. (We can't use the term quality assurance anymore.) But we now find that more and more we and our groups need utilization review data. We find that we have to get it because it is simply inherent to better understand our utilization and better understand the kind of underwriting policies we must have. We deal with more sophisticated groups that want to have the information. They want to know if they're paying too much, if they're paying too little, and what the fair rate of return is to the provider on these things.

So, we're now in the process of attempting to simplify utilization or encounter review materials with our providers, and this is a problem fairly common to most of the plans in the country. The provider is certainly not happy about this. As you know, providers and paperwork are not necessarily the best combination in the world. We're trying to make this as simple as possible, and we're hoping at some point to move to electronic reporting, which could be fairly simple. I think it's much less sophisticated than the medical reporting side.

We're finding that to maintain a leadership position in the industry, we must offer quality review, including credentialling programs. We have a fairly sophisticated credentialling program that establishes criterion for the providers. We monitor the national health practitioner databank, the licensure boards in our states (and actually track down complaints received by those licensure boards and actions taken), and our in-house member service program. The leading plans are finding it necessary to do a lot more in the area of quality review.

In terms of providers, we find ourselves entering into many new kinds of relationships with these folks. We once had a traditional capitation payment. Now we have cap, recap, retrocap, stipends, start-up fees, management fees, and supplemental cap. Almost all of the large plans have one-to-three staff people who do nothing but work with providers to dream up new compensation methods.

We have several large national accounts. It's one thing to have a group that has a lot of employees in a large metropolitan area, but it's another to have two large airline clients that end up having employees in the middle of nowhere. You find yourself in East Belt Buckle, Nebraska, attempting to explain to a traditional fee-for-service provider that you have a great opportunity for him. It is not unlike explaining the Communist Manifesto to the same person. It's a very difficult sales job. So you end up entering into alternative compensation, or reimbursement procedures, to pull that person on line.

Likewise, in the area of specialization, as you go across to any given market area, you find different availability. If you go to Denver, for instance, dental specialists are reasonably easy to obtain. It's a fairly competitive market. If you go to southern Nevada, on the other hand, and if you suggest anything more than a 10% or 15% reduction off of UCR, they laugh in your face. That is the kind of marketplace that exists there. In many places in northern Nevada, they won't even talk to you. So you're constantly looking at market forces and the finances or the economics of your plan to put these types of new relationships together.

One of the problems with recruiting has always been competing against UCR, that elusive number that only lives in dental heaven. All of us who have ever been in a private practice setting have this fantasy UCR. For a long time, prepaid dental plans have chased that number and have always made comparisons to that number. The trend today, actually, is not to do that.

There is a new software program that was developed by Periscope that is now being used by Prudential. I think we'll find it more wide spread throughout the industry. The program helps the provider analyze the management and financial characteristics of its practice. Using an airline analogy, how many empty seats are there. Empty seats are a major issue in dental care. It's one of the things that the average American dentist, certainly one who's not in a sophisticated group practice in a metropolitan area, lacks a certain level of understanding about. This software is something that we'll anticipate using in our recruiting and provider relations programs. If they have a lot of empty chair time, filling that chair time will be a significant economic advantage to them.

We are attempting to change the nature of our relationships with providers to be more substantive, to help them understand their practice a little better, and to find that it works out quite well to fill that space up. But, we continue to have problems with the paperwork issue. It's very expensive for them to deal with it, and it does complicate their efforts. That's something we need to figure out -- all of us in health care need to figure out how to handle the paperwork and to keep that expense under control.

In terms of plan design we find ourselves depending on our consultants at Milliman & Robertson more and more. It's simply a matter of fact, as we move into these new options, and as we begin to include PPO options. We are one of the few plans in the country that has its own PPO division. We not only rent those panels out, or make those panels available to indemnity carriers and other organizations that use dental panels, but we also use that in our own programs. We're finding that as we move

into these new areas, such as joint ventures with large indemnity carriers, that we're having to rely much more upon the sophistication of the actuarial community.

Finally, I'll share some ideas about this idea of managed health care. Prepaid dental plans are attempting to move into the areas of managed health care. Relative to health care reform, we recently testified at the Health Subcommittee of the Ways and Means Committee in the House of Representatives in Washington. We took the same position that the American Dental Association took, and that is that there is no crisis in dental care delivery, that the existing dental care delivery system has adequate resources, is distributed well, and can, in its present configuration, provide for the dental health needs of the American nation. But we continue to evolve the role vis-à-vis managed health care in prepaid dental plans and the idea of working with our groups, members, and providers to try to effect an economically responsible product. But we don't feel that there's a crisis.

There are two other issues that are looming on the horizon right now. The new OSHA standards have caused, as Jerry pointed out, a great deal of difficulty within the provider community. Generally speaking, it's recognized that the cost right now, per patient encounter, is somewhere between $11-15 to comply specifically with the new OSHA regulations. The issue, of course, is how much of that was already required by good dental practice. Many providers would have you believe that they basically incurred the entire charge because of OSHA regulations. Others in the field suggest that, while there are some additional requirements under the OSHA regulations, probably $9 or $10 of that was already good standard of practice.

Another interesting issue that you're going to be looking at in all of these plans, whether you're talking about PPO, indemnification, or capitated dentistry, is that the United States Justice Department is in the process of significantly enhancing its health antitrust division. The Clinton administration is quite clear that one of the problems that we're going to have is that we're going to see providers gathering together in ways that violate the Clinton Antitrust Act and the Sherman Antitrust Act in an attempt to beat back both health care reform and these emerging managed health care issues. They have significantly increased the staff, attorneys and nonattorneys, in that division. You're going to find yourself being faced with demands by groups who get together. It's happening all over the country; in fact, there are, at the present time, several investigations. Many of you may have heard about the case that just came out of Tucson, in which four physicians were found, in essence, guilty or liable under the Clinton and Sherman Antitrust Act. That's another unfortunate thing that's happening as we evolve into these new ways of doing business, and as people feel more pressured to try to maintain their status quo.

Other than that, we see a bright future ahead for prepaid capitated dental plans. We are seeing a lot of acquisitions and a lot of mergers. We note that indemnity companies are, in many cases, purchasing plans and starting plans. We're seeing mergers with those types of organizations. In many ways, we think that we are probably a permanent part of the future of group dental care provision. I think the real issue is to see what the ultimate is in terms of the best combination for the delivery of services.

MR. KENNETH E. BERNARDI: Listening to what Ed was saying earlier was interesting to me. The one point that you can draw is that dental insurance varies

dramatically across the country. What happens in Michigan or what happens in Arizona is not what's happening in California. There are different lead times with new products, new pricing, and we see the shakeout going on all the way across the country. Ed was commenting on how sealants and adult ortho benefits are not very common in his area. In California, we actually cover more adults for orthodontics than we do kids. Sealant benefits are a standard part of all of the contracts that we offer out there. So, there is a very dramatic difference.

I am presently employed by the Delta Dental Plan of California, which is a participant in the Delta Dental Network that has about $3 billion a year in dental benefits that are provided to approximately 20 million Americans. The Delta Dental Plan of California represents approximately half of those revenues. We underwrite about $1.5 billion. We cover about 10 million people right here in the state. Notable among those programs is the approximately five million people we cover who are on welfare in California. We have a very large welfare population here. Those five million people, in many cases, makes up more than the population of many states. It's a tremendous benefit, it's a growing benefit, and we think it is going to be part of the future in terms of national health care and in terms of long-term desirability on the part of employers.

I wanted to talk about three issues. What does the market demand right now, and how do we see that market demand? I want to talk briefly about the products that are available, and the market share that is occupied by those products, as well as some of the strategies that are being used by Delta and our many competitors in reaching that particular market. Finally, I want to talk a little bit about some of the challenges that are facing the insurance industry, of which Delta is a part.

First, in terms of the demand for dental products, the demand is very simple. People want the very best level of benefits, they want the maximum access to dentists. In particular, they want access to their dentist; that's a very key issue with purchasers. Finally, they want an absolutely rock-bottom price. As long as you can provide that rock-bottom price in conjunction with the free choice of dentists and the maximum benefits, then you will win the contract. The Delta system competes very successfully against the other fee-for-service or indemnity-type carriers that are out there. We do not view capitation as our competition. We view capitation as an alternative. It's a product with a niche that is in demand. Fee-for-service is not really a legitimate competitor of that product; it's truly an alternate delivery method. The Delta system also delivers, or has the capability of delivering, all of these products. For example, in California, Delta owns Private Medical Insurance (PMI). I believe it's now the largest provider of capitation in California. I think they just surpassed Safeguard in terms of the number of lives that they cover. The products and the prices are extremely key issues to our clients. Everywhere we go, price has become more important. During a recession, it obviously becomes even more important. We feel price pressures. The real price pressures are coming from the medical side of employee benefits. Dental, being kind of the tail of the dog, is squeezed very hard just for that issue. Even if your prices are not escalating in dental, you're still feeling the pressure in that competitive market to keep prices down.

The fee-for-service benefit that Delta provides does encompass some of this fancy UCR referred to a little earlier. Our particular system manages price through a filed-fee

system. Dentists file their fees with us, and then those fees are compared to the fees that come in on treatment forms. If there's a charge greater than the fee that's been approved, then that fee is reduced. Our membership agreement prevents dentists to pass that on to their patients. They have to agree to that price cut. One of the things that makes that work is that, in California, even though it's a very major market for dental, it's still a free market. We still have a free market economy operating for dental fees. I think that's totally untrue for medical. I think one of the things that truly distinguishes dental from medical is that you have that free market operating. There are plenty of people who don't have dental insurance. Dentists set their prices according to whatever the local standards are. As part of these filed-fee agreements, the charge that they put down for a Delta patient can be no greater than what they charge for their noninsured patients. From that standpoint, that is our fantasy UCR, and it works. The only reason it works is because it is in that free-market environment. If that changes at some point in the future, under a national health insurance approach, we will be facing some of the same kinds of price escalations that medical has had to deal with over time.

The fee-for-service model is still very much in demand. Over 90% of the business that is written in the state is on a fee-for-service or an indemnity basis. The capitation market probably has less than 10% of the market share at this time. I'm not totally sure what that is right now. The dental provider organization (DPO), as we call it, is a new area in our market. We've seen PPOs in the distant past that have not worked particularly well. We have a large number of consultants and clients that are very leery of them. The DPO panel structures have been discounted panel structures. Dentists tend to compensate for any fee cuts by adding a few more procedures to the treatment they provide. As a result, the cost under a PPO panel, especially ones that had been implemented early in the 1980s, actually exceeded what the trend-adjusted costs of a regular UCR program would have been. So the bottom line is that they didn't work.

However, there are newer panel designs that are coming along that tend to seek out the lower price dentists and seek out providers that have normal or fairly conservative practice patterns. We're looking at those areas as being the way to save some money. The key to some of the cost reductions that we're seeing seems to be the idea of establishing a model of managed care in which the dentist manages the care. I think capitation dentistry transfers much of that to the primary panel provider that's out there. But as Jerry mentioned, that's also an area where benefits could be underprovided to patients. Looking at that particular managed care model, there is some concern that the trend is towards undertreatment. As a result, clients and purchasers have said, "Show us how benefits are being utilized, we want to know how many crowns were put in, how many bridges were put in, and so forth." That means that dentists have to get back into the paperwork business again, which they don't like. So, it's a real problem for them in that area.

The other trends that we see, in terms of demand, other than this so-called free choice of dentists and benefits, is trends by employers to shift costs. On one hand, you have the need to reduce costs or keep overall costs for delivering services down. On the other hand, employers have been shifting costs to employees through a variety of mechanisms. Probably the most prevalent at this point would be through Section 125 plans, where employees are able to buy benefits with their pre-tax

dollars. But most of those plans were structured early on to really hold the line on the employer's contribution for benefits, whether it's medical or dental or what have you.

Another area in which we're seeing trends is increasing employee contributions for benefits on an after-tax basis. This is somewhat more risky for a carrier than a Section 125 approach.

Finally, we're seeing a very strong surge in demand for what we call voluntary enrollment products. I think the demand for those particular products was strongest in the south and in the east and that has gained a lot of momentum, especially since about 1989 or 1990, when the recession kicked in. These products provide a means for employers to provide benefits to their employees, but they don't have to pay anything. This would be a situation where an employer would simply play a role in providing eligibility information to a carrier, doing payroll deduction, and then not worrying about it from that point. One of our challenges has been to come up with products and administrative mechanisms that respond to these kinds of demands that we have in the marketplace.

Some of the products that we have looked at have been discussed here. I guess we haven't discussed the traditional fee-for-service plans much. As I mentioned, the fee-for-service, the D-HMOs, and the so-called PPO delivery, are all taking their emphasis from the managed-care environment. Every one of those products is a managed-care product. However, some of the prices that are emerging aren't coming from management of the care in a particular way. When we first became affiliated with PMI here in California, an equivalent level of benefits for a capitation product, compared with a fee-for-service product, would run about 25-30% less in price. Today, the capitation prices in California are approximately 55-60% less than fee-for-service. That means that dentist is taking patients into his practice and essentially receiving reimbursement at what that dentist's incremental costs are. So the price pressure is really there. Once an employer decides they want capitation, then price is the bottom line. The price is what gets it. And I think that the price competition in California is ultimately what has driven these prices down. I think the price competition had a very negative impact on the overall quality of care that's available through some of the panels. It's a real challenge that we're going to be faced with in the future.

The products that we are presently providing to meet some of the voluntary markets creates a brand new area for us. We are experimenting. We're trying out ideas to see if there is a way to deliver a good fee-for-service program to people on a voluntary basis. My first experiment with that was rather unfortunate. It's still going on. It's an experiment that involves some retirees and their credit union. It had nice features available such as you could get credit union contributions directly reimbursed from the plan. The problem was we were paying out about $1.50 for each dollar in premiums on that account. We're still paying out $1.50. We've paid out millions of dollars on this particular plan. The utilization rate that we're getting in this program is staggering. Other areas in the voluntary market that I mentioned are the dental assistance programs that we're looking at. Those are programs that are set at very low levels of reimbursement. These seem to be a vehicle that is available in the voluntary market and will be financially viable also.

Finally, Delta and many other carriers are entering into partnerships or strategic alliances. They're doing all sorts of things to try to reach markets that they have traditionally not been a part of. In California and in a number of other states we have teamed up with the Kaiser HMO to provide a dental product for small groups. These are employers that have two or three employees that have been traditionally locked out of the insurance market. That is an upcoming trend, and I think you'll find more and more carriers being involved with that. We also are involved in doing a strategic alliance that provides vision care to people. We're looking to package these things so that we get a tighter relationship with the clients that we have. We give them more of a reason to stay with us when renewals come up. So, these are all things that we're attempting to do to really meet some of these market demands. These market demands are feeling much price pressure and competitive pressure right now.

The last thing I wanted to mention are some of the challenges that we are going to be facing. We're trying to define just what the whole managed care issue is. The opinions vary -- fee-for-service doesn't do it, and capitation does too much of it. I think that we are going to be experimenting a lot in the future with different delivery systems and administrative systems to satisfy market demand. Our biggest question is, how are we going to continue to deliver comprehensive dental care? We're lobbying to keep dental care out of national health insurance. But that's just not going to happen. Even if dental care is left out in a physical sense, any legislation that comes out is going to bring dental care right along with it. The people who are buying medical care from the health insurance purchasing coalitions are going to be buying dental care from those same sources. We're going to be right in there in a highly competitive environment, trying to get that business. I think that those are probably some of the more strategic issues that we have. I think that they're strategic issues from the standpoint that a lot of carriers are not going to be here in another ten years. I think that there's a very definite shakeout taking place. Hopefully, the end result of that is going to be the ability to deliver a better level of benefits to the insured population.

MR. TILAK R. GROVER: I have a few questions for Ken Bernardi. Do you get any discount from that dentist?

MR. BERNARDI: We do not get a discount from the dentist on our fee-for-service product. The standard indemnity fee-for-service product is UCR. However, we monitor that UCR to make sure that Delta always gets the best deal in the dentist's office. We don't care if he charges other people more money, but we must receive the lowest charge. In terms of our PPO product, yes, we do get dental discounts. Approximately half of our 2,000-member dentist panel provides us with discounts of up to 20-25%.

MR. GROVER: What kind of claim trend are you observing on the fee-for-service?

MR. BERNARDI: You're talking about the inflation rate in a dentist's fees?

MR. GROVER: Yes.

MR. BERNARDI: In California, it's 6.7%. That was our inflation rate in 1992. It looks like it'll be just modestly higher than that in 1993.

MR. MARK ALAN CHESNER: About two to three years ago, there was a big hullabaloo about the danger of mercury coming out of amalgams. People sought to replace, en masse, their fillings. Did you see much of that, and would that be a covered expense?

MR. BERNARDI: It would not be a covered expense, primarily because the Centers for Disease Control regulations said it is not a health hazard. So replacement of existing amalgam restorations by composites or other things would not be covered. Even after the "60 Minutes" interview, we didn't have a surge in replacements going on. We monitored that very carefully, over approximately a one-year period, and didn't find any impact at all.

MR. WAYNE V. ROBERTS: Jerry, you indicated, I think, that in a dual-choice plan, 10-20% of the people will choose the capitation program. Does that increase or decrease the costs for the fee-for-service for the rest of them? Who chooses the capitation, the people who don't go to the dentist or the ones who are going to use it a lot?

MR. SEAMAN: I really haven't analyzed that. I think there's a general feeling that it doesn't increase the cost associated with the indemnity plan.

MR. BERNARDI: I would agree with that.

MR. CONAWAY: Our experience in Nevada, which has a statutory dual choice, is quite the opposite. We've been seeing a 90% selection of capitation, and a 10% selection of indemnification. One of the things I think you have to look at when you consider that is the fact that it depends on what the primary emphasis is of the group you're presenting to. If it's a very rich capitation plan and a badly-offered indemnity plan, that changes the choice. So you have to really look beyond just the generic choice and see who orchestrated it, in terms of that selection.

MR. ROBERTS: Jeremy, you indicated you're offering a triple-choice point-of-service plan. How would you compensate a capitation dentist, if he doesn't know he's going to be used until the point of service?

MR. CONAWAY: The assumption is that is the choice. So he gets the capitation payment up to the point of entry. If the individual chooses to go onto one of the other options, then at that point, they've made that choice. But up to that point, the provider gets the capitation payment.

MR. ROBERTS: They'd have to enroll, initially, in one of the options?

MR. CONAWAY: Yes.

MR. ROBERTS: Could they change later on?

MR. CONAWAY: Yes.