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Session 9PD
Current Strategies for Insured Dental Products

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Summary: A panel of dental insurance companies discuss their approaches for paying dental claims and the reasons supporting their strategies for the dental product designs. This panel includes representatives from:

- *traditional fee-for-service reimbursement approaches,*
- *dental preferred provider arrangements, and*
- *dental maintenance organizations with providers on capitation or salary.*

Mr. Floyd R. Martin: We will discuss three approaches for providing dental coverage and some strategies for developing each. These are fee-for-service, preferred provider organizations (PPOs), and dental maintenance organizations (DMOs).

I will discuss changes in the dental market share between providers and strategies. Deanna Strable, Assistant Director of Dental Products at the Principal will present a background for fee-for-service products and their potential. Karl Whitmarsh, Director of Actuarial Services, dental products management of MetLife, will explain the dental PPO and related strategies. Finally, Dr. Dennis Spain, vice president with

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Pacific Union Dental, will describe the advantages for dental HMO arrangements. Since some of these panelists work with more than one approach, there may be some overlap. This may be support for companies to seek multiple approaches.

Table 1 represents two snapshots of dental coverage for 1990 and 1995.

TABLE 1
GROUP DENTAL MARKET SHARE-EMPLOYEES

	Indemnity	PPO	DMO	Referral	Total
	1990				
Insurers	39.5%	4.9%	3.1%	0.0%	47.5%
BCBS	16.7	0.7	0.5	0.0	17.9
Delta	24.0	1.7	0.7	0.0	26.4
Other	0.7	1.9	4.4	1.2	8.2
Total	80.9	9.2	8.7	1.2	100.0
	1995				
Insurers	30.0%	5.5%	6.5%	0.0%	42.0%
BCBS	15.2	0.8	1.1	0.0	17.1
Delta	23.7	1.7	1.3	0.0	26.7
Other	0.9	2.1	9.1	2.1	14.2
Total	69.8	10.1	18.0	2.1	100.0

The table shows a marked shift for dental coverage providers in just five years. There has been a shift from the insurance companies to what I call stand-alone dental organizations. The market share for both Delta Dental plans and Blue Cross Blue Shield plans have not changed that much over this five-year period. The next shift is by plan type of indemnity, or fee-for-service, to dental HMOs. There was a modest gain for dental PPOs during the five-year period. Indemnity plans decreased about 11% of the market share, while dental HMOs increased 9% over this five years. The total nonindemnity plans went from 19% of market to 30% of market. That's the dental HMOs and dental PPOs. Based on this shift, where might the market be in the year 2000? Where do you want to position your company?

I've tabulated a rough estimate of penetration for employees from 1990 to 1995. In 1990, 35–38% of employees were directly covered by dental insurance. By 1995, this had increased to 42–45%. I would like to also take into account that some employees may not have direct coverage because they were covered as a

spouse or as a dependent of another employee's dental plan. Making this adjustment, 43–46% of the employees and their dependents were covered by some form of dental insurance by 1990, and this had increased to 52–55% in 1995. Is the current market share saturated?

Is there more room for employers to offer new dental benefits? In the last few years, the dental trends have exceeded those of medical. Is the dental marketplace where medical was 10–15 years ago. These are some of the questions you might want to consider while listening to our panelists. With that, I will turn it over to Deanna Strable, with a discussion on fee-for-service dental.

Ms. Deanna D. Strable: I'd like to first point out, the Principal owns and operates about 20 PPOs across the U.S. Due to that, some of my discussion will probably extend over part of Karl's presentation. I'd like to cover four different points. First, I will give a definition of what I will be referring to as fee-for-service. I'll then explain the advantages and disadvantages of fee-for-service. I think those will lead into the strategy we have at the Principal for dental insurance, and why we think that's a winning strategy for us. Finally, I'll give a summary of some things that are happening in the dental industry that might not affect our strategy or the strategy of other people in the marketplace.

Fee-for-service means that we, as an insurance company, are really paying the dentist for every procedure that they perform. When you use a broad definition, fee-for-service covers both traditional indemnity insurance and PPO, with PPO being the same thing, except that we have negotiated some discounts with our providers, and we set up plan designs to provide an incentive for our insureds to go to a network provider for services. This is in contrast to capitation, which will be discussed under the dental HMO arrangement. Capitation is an arrangement where the dentist is not paid for every service they perform; rather they're paid a flat amount regardless of whether the patient sees them in a given month. In a capitation arrangement, the risk is really shifted from the insurance company to the providers when we're performing the services of dental insurance.

What are the main advantages of fee-for-service? It is a traditional approach to dental insurance, and it's easy to understand from an insured's perspective. When I'm talking about advantages, I'm looking more from a market perspective. Market meaning employees, employers and providers. Fee-for-service's main advantage is the freedom to choose any provider. There are no restrictions to a panel of dentists, and studies have shown that employees and people are less likely to change their dentist to a panel of providers than to change their member doctors. Part of that is probably a comfort factor, and part of that is probably the cost of care. You're not as likely to change for a little less cost. In addition, providers in many areas of the

country are against the managed care concept. I have a list of hate mail outside my office, letters which we have received from providers, trying to get them to join the network. I think a lot of that is driven by dentists. Historically, they have operated in a solo practice environment and are not as used to being influenced by external parties as a medical doctor might have been. The primary disadvantage of fee-for-service is cost. It's a lot more expensive than dental HMOs, and dental HMOs can be up to 50% of the cost of an indemnity plan, with PPOs falling somewhere in between.

Another disadvantage is that there could be an incentive for providers to overtreat in a fee-for-service environment. They are being paid for every procedure they perform. Going along with the expense factor, the insurance company has less control over the increase of services from year to year because you're not negotiating with the dentist and controlling costs in that way. Due to the lack of credentialing in a panel of dentists, it could be seen from the outside world that there's less quality control in a fee-for-service environment. However, within a fee-for-service environment, we need to temper these disadvantages. Some of these disadvantages can be addressed through a PPO, where we go out and negotiate discounts, credential the utilization review on the providers, and within the pure indemnity environment you can control some of these disadvantages through plan design features, which I will discuss later.

Before getting into the dental strategy at the Principal, I think it's important to look at a few characteristics of our company which affects our dental strategy. We're a national carrier. We sell dental in all 50 states and we sell within urban and rural areas. Rural areas tend to be less receptive to the managed care environment than the urban areas. Another difference from us and some of our competitors is that our target market is the small to medium-sized employers. Our average dental case is about 25–30 lives, and employees and employers of that size approach their employee benefit choices differently than the larger employer market. In addition, we're a multiline company. We're not a dental specialist, and the challenge for us is that our distribution forces don't just sell dental. They sell all products, including pension, 401(k), medical, and nonmedical. We approach the market differently than some of the specialty carriers.

To be honest, Principal really didn't have a strategy for dental until about two years ago. Dental, in addition to some of the other nonmedical coverages, such as life and disability, were really tag along products which were sold, with medical being the flagstaff product which we sold. About two years ago, due to some rating agency concerns and continuing effort to diversify our business, we created areas to focus on our nonmedical products, including life, disability, dental, and vision. Even though we've been in the medical insurance industry, from a traditional

standpoint for 20 years, we've also been in the PPO industry for the last seven to eight years. Our strategy is a dual strategy. Our strategy, thus far, has been on the fee-for-service side of the house and now has run over to the capitated market. Our strategy is to be open to what we feel is necessary to increase our market share, and we have done that over the last several years. Because we are national in scope, and because we service the rural market, we really feel that indemnity and managed care need to be done in tandem. Currently our offerings are a portfolio of both indemnity and PPO dental. If we are open to what's necessary for the market, we're not closed to the idea of entry into the dental HMO arena if that's what's necessary to compliment our portfolio.

I want to point out why we feel that strategy still works. I think the first thing to point out is that indemnity is still dominant. Seventy percent of the current market is still being delivered on an indemnity type of dental environment. The other thing to know, and really this comes back to us being a national carrier, is that dental HMO enrollment is still very concentrated. A 1996 study showed that 76% of all dental HMO enrollments are in 10 states, so that leaves the other 40 states comprising only 24% of the dental HMO market. Dental HMO enrollment is increasing, but there are a lot of states out which the dominant offering is still on the indemnity side of the house. This just reiterates that some states haven't been hit by dental managed care. This is due to many reasons, including provider, employee, and employer acceptance. A lot of these states tend to have low trends already. They haven't been hit by the large increases in trend, and when you're looking at a target market of 20–25 lives, and if you're in a low-cost area already, it's a 20–30% savings which might only account for $1 or $2 a month.

Is it really worth the disadvantages of restricting your employees to managed care? That's what we've seen in some of the rural areas, which haven't been hit by managed care. We have also found having a dual approach helps, not just your PPO sales, but your indemnity sales. Look at the areas of our organization. Our marketplace covers both a PPO and indemnity, and we've seen an increase in sales on both sides of the house. I think that approach means that a dual approach gives you a portfolio of products to show to your customers and then you can work with the needs of your customers to determine which plan best meets the needs of the marketplace.

What has given us a dual strategy is our national approach. It takes time and resources to build a network. We currently own all of our networks and build them from scratch. I need to allocate my resources to the places where we feel we're going to get the most bang for our buck in building the managed care alternative. The other thing I think is important and will probably come out in the other methods is, you need a dental specific strategy in the marketplace to succeed.

What has led to some of the decrease in market share from the traditional insurance carriers, which Ray mentioned earlier, is that a lot of the traditional insurance companies didn't have a specific strategy. They lumped their medical strategy with their dental strategy. Due to such things as health care reform, the mind sets of the provider and the employee community, and the cost of the dollars of dental, the strategy needs to be different.

It's important that even though we're operating on a fee-for-service environment, we can't ignore the competitiveness of our premiums. I recently made a presentation at our sales conference, and having competitive rates was probably the thing that was brought up most by our sales force. We feel there are things that we can do within our fee-for-service environment that can help keep our premiums at a competitive level. First of all, it's through our plan design. Focus on prevention can strongly lead to decreases in cost and increases in the competitiveness of your dental rate. Most dental insurance plans pay 100% for preventive dental care, and that is going to greatly decrease the probability of major work in the dental area, which is caused through neglect. In addition, building your plan design so there's restrictions on certain benefits can reduce the claim cost of unnecessary care. For example, if the American Dental Association says a crown should last 7–10 years, you shouldn't have a plan that will pay for the replacement of a crown every other year. As dental care improves, you need to keep your plan designs up to pace with what's necessary in the dental environment. Finally, make sure that high-cost, low-frequency procedures are put in the part of your plan where there's more cost sharing. Again, when we focus on the small case market, if we're paying a high cost procedure at a high percentage level, it could greatly impact the cost of the entire plan with the benefit of a few.

Other things that are going to affect your yearly rate are your claims systems. Having a claim system that adjudicates claims automatically without seeing human intervention can greatly decrease your administrative costs and increase the competitiveness of our rates. Currently, over 50% of our claims go through without ever touching a human. Processing those claims are 10% less costly than processing claims through human intervention. Second, negotiate discounts. Use a PPO or managed care type of approach where necessary to keep your costs down. Finally, you can't ignore dependable service. Rates and product design are only going to get you part way. If you don't have the service to back it up you won't be able to retain a profitable business.

Finally, I want to touch on what has been happening in the dental market. Managed care is really only one piece. Ray pointed out that the market is growing. To answer his question, do we think the market is saturated? I'm one who believes it's not. Dental insurance lives have increased about 8% in 1996, so it's a growing

market. In addition, if we look at cases that we've put on the books, we would see that they're startup cases. They are employers that have never offered dental insurance before. As more employers are adding dental to their employee benefit portfolio, this market is just going to continue to grow. In addition, much of the marketplace is consolidating. You see this on the dental HMO side as the dental HMO has become more national in scope and larger in scope. In addition, you see it in the traditional insurance company marketplace. As more insurance companies sell off their medical business, they're becoming more strategically focused on their other products. Competition is increasing. Dental is no longer seen as a tag along product. When I look at our portfolio for 1996, about half of our sales were on a stand-alone basis. In addition, employers are becoming more concerned with getting a competitive rate and less concerned with the convenience of having all their benefits with one carrier. Finally, what's happening is voluntary products. Dental is offered more on a voluntary basis. What we mean by that is the employers are offering it, but the employees are paying for the benefit. To increase your market share, you need to be positioned in the voluntary marketplace, which has a lot different risks than the traditional insured plans.

To summarize, we feel that our strategy is winning, but we also feel that we need to be attuned to the marketplace and be flexible in our strategy development as we go forward. I don't feel that this marketplace is stagnant enough that you can have a strategy that can last you for a long period of time. You need to constantly reevaluate the strategy and make sure that you're on the right course. Our resolve is that we feel we can grow a profitable dental book of business, and one that can increase our market share as we go forward.

Mr. Karl G. Whitmarsh: I represent the PPO point of view on managed dental care. My approach is going to be to walk you through some of the experiences that we at MetLife have had with a managed dental PPO product. By the end of this session I hope that we will have answered some questions about MetLife. Hopefully, we can extrapolate to other PPO carriers. Those questions would be things like, why would you get involved in dental PPOs? Once you have a dental PPO how can you make that business grow? How do you know that you've made the proper choice of the health care model? Where is the PPO marketplace going? Where do we think the trend in dental fees is going?

My story starts in 1984, a very critical year at MetLife. There are a couple of things you should know about MetLife. At that time, we were, and we still are, predominantly in the jumbo group business. When I say jumbo, I mean anything over 10,000 lives. We probably still have more than 80–90% of our employees covered under jumbo groups. We have, in the past couple of years, made a concerted effort to bring on more cases. However, I would say in 1984 we had

very little business that had fewer than 100,000 employee lives. Another important thing to understand about Met's group business at that time is that, as Deanna has said, the other products tagged along after medical, and as a result, when we sold other coverages it was really only because we had sold the medical business first. I think you'll see that as we go forward.

The first question would be, why did we start a dental PPO at that time? When you consider that our dental was mainly bundled with other products, especially the medical, it makes sense that if you're going to offer a customer a medical PPO and he wants dental at the same time, that you will try to offer it in that format. That was the main reason why we got into the dental PPO business. Another attractive thing about dental PPOs is that they are relatively inexpensive to set up, compared to dental HMOs. When you think about it, as Deanna pointed out, PPO is really a modified fee-for-service type of model. As a result you may have to make some adjustments in your claims systems, but the major capital that you have to expend when you launch a PPO is basically to set up a provider network. That is still far less expensive, usually, than getting involved in a dental HMO.

Why didn't we start an HMO? There are two very important things we considered. The Prudential had gotten involved in dental HMOs early on, and they were very aggressive. They had strong sales and that was a bit scary, quite honestly, especially because we understood that they had spent about $50 million in order to get their dental HMO up and running. We had to ask ourselves, if we're going to be number two, we're going to be following through and spending the same amount of money. What kind of return on capital are we going to get out of this? Senior management didn't really think it was going to be very good. The other thing is dental, at that time, was a tag along product. We really couldn't anticipate that if we had a very strong dental HMO product that it would necessarily help us sell our other coverages. Those are the reasons that we didn't get into a dental HMO at that time. This is an issue that we look at every few years, as the dynamics of the marketplace change. It's never too late for us to get involved in dental HMOs. I think it's fairly safe to say that if MetLife did get involved in dental HMOs, probably it would not attempt something of a national scope, the way that Prudential did. We would probably target specific markets where we feel that we need a triple option type of capability.

What was our strategy in our early years of our PPO? We didn't really have a specific dental strategy that we used. It was a simple approach. We would mail out our solicitations to the providers everywhere once a year, saying our fees were flat discounts off the community average. It didn't matter what the procedure was, it didn't matter what the area was, whatever the community average was, we would take off 25%, something like that. One thing that we did decide very early, was that

we were not going to be simply a discounted fee-for-service operation. We did not want to be in the position where we said, "OK, dentists, you join our network and in exchange for these reduced fees that we're asking you to accept, we are going to offer you increased patient volume, or in some situations, we're going to allow you to keep those patients that you currently have." We wanted, from the very beginning, something extra in there, that I would call a managed dental care approach. That had to do with our relationship with the Independent Dentists of America (IDOA), who perform prescreening and utilization review functions for us.

Let's look at how the PPO did in the early years. It was very slow at first. We signed up about 5,000 doctors, and we couldn't sign up any companies. After about nine months, we did make one key sale in a large urban market, and after that it began to take off. Once we had a few sales, our products immediately gained a certain amount of credibility, and when that happened, we were able to convert a lot of our existing business. One big advantage of being a jumbo type of carrier is that if you have a lot of business in force, you can convert some of that business in certain key areas of the country, in one mid-sized city like Baltimore or Pittsburgh. If you have two or three employers that you have already and they convert, most of the dentists in that area will follow suit. The dentists do not want to lose the patients that they currently have. As a result, we grew very quickly and by 1987 we were the leading commercial PPO.

This was followed by the increase in our PPO business over the same period. We started out at 5,000 in 1984, 8,000 in 1985, and 12,000 in 1986. Then, oddly enough, nothing really happened for six or seven years, and I think that's because what we had done to develop a network up to that point got us to a certain level, and then we were stuck there. Part of the fact was that we were still very much part of the medical product, and we had to do something different if we were going to make dental a much more important part of our group offerings.

The next critical year in the history of MetLife was 1995. A number of things happened that were very important for us. We acquired the Travelers Group business, and we basically consolidated it with our own. Then, when we had that combined business, we essentially built a wall between the medical business, on the one hand, and the nonmedical coverages on the other. By nonmedical coverages I mean dental, vision, long-term disability (LTD), short-term disability (STD), long-term care (LTC), and the various types of life and accidental death and dismemberment (AD&D) products. When we did that, we made a strategic decision that we were going to reorganize our group business in such a way that the focus would be on the product. We were going to have offices that were responsible for each of these individual products whether it was dental or LTD. If they had to, they would go outside MetLife in order to recruit professionals who had

real depth in these products. One other thing that we decided to do in 1995 is that we wanted to make the network grow. We wanted to put a real distance between ourselves and all the other carriers.

Let's look at what that strategy of 1995 consisted of. We wanted to retain as much of the Travelers Group's business as possible. We also wanted to retain as many of their dentists as possible. When Travelers ceased operations, they had about 16,000 dentists in their network, and about one-third of those were dentists that we did not have, and we were able to recruit most of those into our network. We were able to retain most of their business. The other was to take a very different approach towards how we recruited dentists into the network. This was basically to identify areas of the country where we felt, for whatever reason, we needed to build up business, and a network, and focus our efforts in those areas. By this time, we had certain major metropolitan areas, especially in the northeast, where we were strong, and it didn't really make any sense to expend any more resources there.

Another very important thing about our solicitation of the dentists was that we didn't think it was enough just to send them information in the mail. We actually built up a team of what we call our network development specialists. These are people located in different parts of the company. They actively get an appointment with the dentist, explain to him or her what our PPO is all about and try to get him or her interested. These are individuals who usually have worked in a dental practice, so they can communicate with the dentist on the same level. The third thing, which is very key, is the way that we set our fees was going to be determined in the future, depending on how strong our network was. Table 2 is just an example of that; it may not be exactly what we did.

TABLE 2
DENTAL PPO DEVELOPMENT AT METLIFE

Dentists in Network	Fee Discount
<10%	<15%
10–20%	20%
20–30%	25%
>30%	30%

If you determine that a particular part of the country was strategically important to build up the network and build up business, but you had less than 10% currently in the network, you would request a very shallow fee discount, hoping that most of the dentists, or at least one-third of the dentists would have no trouble, from a financial point of view, joining your network. Likewise, if you have a tremendous

penetration in a local area, you can afford to ask much more. In those areas, you're not worried if you're going to keep, retain, or recruit dentists. Overall, you're going to end up with an average discount somewhere in the 20–25% range. The combination of these various approaches which we used, in terms of soliciting dentists, building up product expertise, and coming up with a thoughtful fee strategy, created tremendous growth in our network dentists. In 1994, 17,000 dentists were involved in our PPO. That number increased to 26,000 in 1995. In 1996, the dentists included in the network rose to 35,000. We currently have over 36,000 dentists in our PPO network. My understanding is that's more than anyone else at this time.

We aren't complacent. We know that some of the other commercial carriers, especially Aetna and CIGNA are actively building up networks, and it's important for us to stay ahead in this respect. We don't expect that our network will grow by more than 3–4% a year. Table 3 shows the growth in our business. Some of these numbers reflect Travelers, but I think the increase in sales is especially impressive. We just have done a tremendous job of bringing in new business, and as you can see, the amount of lives that we have covered under PPO has increased from 20% as recently as 1994, to over 50%.

TABLE 3
BUILDING UP METLIFE'S DENTAL BUSINESS

Year	Member Lives	Sales	Premium and Equivalent	Ees Covered by PPO
1994	6.4	$ 58**	$ 700	20%
1995	9.3**	$ 74	$ 841	30
1996	10.1	$128	$1,288**	42
1997 (est)	10.9	$240	$1,460	52

**Includes Travelers

I would like to give you some figures that indicate where we think the market share was as of 1995. The total market was $2.1 billion in third-party payments. It's very difficult to get accurate numbers. The Delta plans, as a group, still command more than anybody else, at 20%. As far as the commercial carriers are concerned, we have been neck and neck with Prudential at 7% for a number of years. CIGNA and Aetna follow very closely behind at 6% and 5%, respectively. Since I tabulated these figures, things have changed. For example, you may have heard that Blue Cross of California, last year, acquired both the John Hancock and the Massachusetts Mutual lines of business. That probably would add about two points to the 11% I had figured for the Blue Cross. Also, as many of you may have heard, CIGNA has agreed to acquire Healthsource, and this will increase their market share, about 2%. The interesting thing is that almost half, or 44% of the market is

composed of carriers who collectively may only have 2%, 3%, or 4% of the market, and these are carriers that are probably mainly focused in the 200 life or under area.

How have we succeeded with the PPO? As Deanna has said, the focus on the product is really the critical aspect. To get credibility to your product as a stand-alone product is also critical. We currently sell at least half of our dental as stand-alone, and the rest is in conjunction with our other nonmedical coverages, such as LTD, and the various odd type of group life products. We had a unique advantage, in that we had a tremendous amount of existing indemnity business which we could convert. It goes to this sort of virtuous cycle whereas you have the groups that attract the dentists. When the groups know that you have dentists, that attracts more groups and so forth. Also, we focus on the network as the product and the quality of the product that we provide. As Deanna has pointed out, we all offer basically the same products. We offer 100-80-50 plans and they have certain restrictions, so the ability to which you can differentiate your network from others is very important.

The last point may be somewhat controversial, but I feel that when you only offer one network, that has a lot of advantages. I think that the dentists are a lot less confused. I'm thinking, in particular, of the Delta Dental plans where you have a primary network, which is based on usual, customary, and reasonable (UCR), and then you have a secondary PPO network laid over that. My own experience is that dentists find this existence of two networks confusing. I think you don't have as much influence over dentists if they're already in the primary network. I think it's harder to negotiate with them in the second network.

Why do people buy our PPO? One thing that I think has been very good for us, since we have 36,000 dentists, is that for almost any employer who comes to us we can run a geographical access report and tell them 80–90% of your employees live within ten miles of at least two of our PPO dentists. That carries a lot of weight. As I say, Aetna and CIGNA are rapidly growing their PPO networks, and that's why we feel to maintain size is important. Compared to a PPO, it's interesting that an HMO can really offer you a much deeper discount relative to a fee-for-service product, but if your HMO only covers 10% of the population and your PPO can cover 20% or 25%, your savings over the entire group can be just as large with the PPO. They also have the advantage of improved access. Employees definitely want access. When I say access, I mean being able to find a dentist that is nearby who is in the network, being able to schedule appointments, not having to wait a long time, and having the feeling that adequate services are being performed. We have also tried, as best we can, to differentiate our PPO from our competitors, especially where the dentists are concerned.

We don't want our dentists to think that all they're getting out of this sacrifice that they have to make in accepting reduced fees is, perhaps, increased patient volume. We want them to consider us as partners with them in developing higher standards of dental practice.

I'll discuss the process that we go through. We turn down about 10% of the dentists who apply to our PPO. We want to make them jump through a few hoops before they actually go into the network. We have a fairly rigorous process. We have a credentialing process, we look for evidence of sanctions, we check the history of malpractice insurance, and our relationship with the IDOA is very important. They help us screen the providers for utilization of services when they apply to be in our network, and then every six months or so we run reports on all the dentists in our network. If they're beginning to fall out of line or if their utilization profile is not where it should be, we will definitely warn them. We have been known to kick a number of dentists out of our network. Every year we probably kick out about 100 dentists. It's something that makes a strong impression, and yet, on the other hand, we want to be positive about this. We don't want to be seen like we're some kind of cop. We really want to be seen more as a partner. Under our quality management program, we send out surveys to the dentists in which they assess their own dental practice. We find that dentists seem to be very honest about this. Then, we will work with them in the points where their practice is weak, and we'll ask them to come up to compliance in six months or so.

Just a couple of quick notes about our other strategies. We talked about the strategies of getting dentists into the network. As I say, it's not only a negative type thing that we try to keep abusive dentists out of the network; we also offer member dentists discount programs on their supplies, and we work with them. Another one of our strategies has to do with fees, and we have a couple of very clear tactics. One is, as long as the network is growing, you can keep your rate of increase in your PPO fee tables at less than reasonable and customary trend. We have been successful in doing that. The other is that you look very carefully at every single area to decide how much you're going to increase fees in that area. We work with our field force, they will identify parts of the country where they really want to push to develop the network, and usually we will increase fees in those areas. We also want to encourage our dentists to perform preventive services. We increase our fees more in those areas where we want preventive services to be a profit center for the dentists, and on the other hand, for things like crowns, we want their margins to be somewhat less.

As far as specialists, as you all probably know, it's very difficult to attract specialists into the network (specialists such as endodontists, periodontists, or oral surgeons).

There are a couple of different approaches to that. One is to offer them a separate schedule. We don't do that. What we do is we identify certain procedures that we feel are performed primarily by these types of specialists, and we increase fees on those particular procedures. Another important characteristic is our fees are what they are. In a given zip, for a given procedure, we have a fixed fee. That being said, there are very few parts of the country where we will make arrangements for groups of dentists; it's more of a negotiated type of fee arrangement.

We are going to see much growth in our particular niche, which is over 200 lives in the employer paid market. We do feel that PPOs will probably do better than HMOs over the next few years in the over-200-life market. That's simply because, in a multi-site type of environment, PPOs just tend to be a little more competitive in terms of access. Larger groups tend to be more sensitive, I think, to what their employees feed them back about the quality of care. We think that the employee paid market is going to grow, but we are large enough, we have enough growth in the employer paid market, that we're not in a big hurry. We're not going to put all of our eggs into one basket. We're taking time to test the waters. We don't want to get into what I would call a crash-and-burn type of situation, where the plan starts out fine, but in a couple of years, it just dies because of the antiselection. We want to make sure that we're offering products that are going to last.

We feel that since the employers don't want to pay anything and the employees are willing to pay more the whole growth is in low-cost benefits, and specifically ones that are bundled. For example, we at MetLife are developing a strategy of bundling voluntary dental with optional life, optional LTD, and our other products, because you can control antiselection more if you can get people to sign up for many plans at once. We also think that in the discount card area, there's a good deal of growth, and that would also be when you bundle a bunch of products.

In terms of trend, we think there was a lot of recent trend because of HIV, the need to get all the extra supplies and the prophylactic type of procedures that the dentists had to pass on in the form of higher fees. That's the past. We feel that all the signs are the trend is going to be low and stay low. There may be an over supply of dentists in the future. I think that will push more of them naturally into accepting managed care arrangements. Eighty percent are currently in solo practice. I think there's going to be a lot of pressure for them to go into provider management type of arrangements and other types of group models.

Mr. Dennis Spain: I would like to explain a bit about Pacific Union Dental, our market, our strategy, and what we think our results are for the first go around. Thomas Jefferson was big to point out that the one thing about America that he really liked was all the choices people have. With the fall of the Clinton health

plan, we have many choices. Your companies and my company are in a variable cauldron of new ideas that are boiling up all the time. Several things are worthwhile noting as milestones in the last couple of months. One is, you now have four dental only HMOs that have been offered in the public market and have been well received. There will be some others, mine included, shortly. You've also seen, for the first time, the delivery of five dental service organizations (DSOs), who are going around buying dental practices and linking them together, as well as building. I know of seven more that are currently in the pipeline. They are not simply the West Coast crazies, of which I am certainly part of, but they also represent the East Coast; particularly Florida, New England, and other places where consolidation is present.

We see the industry in a huge rate of growth. I agree with my copanelists that membership is going to expand dramatically. I see that the dentists are offering a vanity of new services. If you haven't seen the laser offered painless drill on TV, be prepared for it. I think that's going to change demand in ways that our actuarial cost tables have never anticipated. We also have the *Reader's Digest*. Those of you who haven't seen the article, a reporter went and had a treatment plan drawn up on an academic-based university, or a university-based-dental school, and then went out and visited a bunch of dental offices. Of the 50 dental offices he went to, he had a very tight bundling of treatment plans that ranged from "You don't need any care at all," to "You need $28,000 worth of care." Apparently, there seems to be some running amuck among my professional colleagues. That's going on at a high level.

What's happening in the marketplace? What do we see? My colleagues come from larger institutions primarily based in the East Coast or the Midwest. I'm in California. Gravity doesn't work all that well out here. We now have 35% of the dental marketplace in DMOs. I am in a contrite, fully competitive marketplace on a day-to-day basis. My company has grown at an average of 18% per year, for the last five years, by internal same store growth. We will probably double our total revenues this year in acquisitions and same store growth. I have a marketing plan that will put me on that same track for the next two years.

Obviously, that's one of the reasons I'm interested in going public. So what's happening? It's the same change that's going on in the medical science field. We are shifting risk. Keep in mind that when you shift risk all bets are off. You cannot take an actuarial-based cost model of how dental services are delivered, tempered by industry groups, tempered by age and sex distributions, and translate that into the DMO market. When you transfer risk from the employee to the employer to the third party administrator you get ne set of configurations. However, when you put

it on the dentist, the whole thing goes crazy, and that's exactly what's going on in the California market.

First let's look at the market. What is it the employers seem to be looking for us to do? The first 19 items that come up are costs. Employers are looking for an organized competent system and member satisfaction. Cost drives the California, Nevada, and Oregon dental markets. It drives all sorts of markets. Those of you who underwrite in products that are sold in Los Angeles have watched, from what I can understand, a very interesting phenomenon. Per procedure costs have gone up rather dramatically in core Los Angeles (in the heart of the biggest managed dental care revolution that has ever occurred). Employers want us to design products primarily delivered to cost but with member satisfaction, and with some optimization of resources. Managed dental care is the optimal use of the available resources to care for the dental needs of a defined population. What do we see with that? First of all, we're trying to optimize our benefits. We're trying to reduce our costs. We're trying to use the dental manpower that we have to the best of their ability. It's a population-based system, not a case-based system. I am more concerned about what happens to 100 covered members than I am about what happens to one covered member. That shift, particularly if you enjoy going to your dentist, is currently palpable in the California marketplace, and quite frankly, the consumers are not happy about that. There is a large backlash inside the legislature concerning the super restrictive managed care strategies that concentrate more on population than they do on how the individual is taken care of. This is a fundamental change in the way we deal with our clients.

In dentistry, if we're going to look at cost, we have to first look at whether the cost is the summation of individual procedures, by how much you have to pay for that individual procedure times the number of times that it's done. As dental indemnity carriers, and as a PPO, you try to control the cost to the employee with the following techniques. You use fee profiling, a UCR rating, a deductible and a maximum, apply co-insurances such as 100-80-50 plans; and you do fee contracting like the PPOs. What we found in the marketplace is that those are either weak effectors of dental costs, or that they've reached their maximum. It's no longer possible to get additional discounting by modifying those procedures. If everybody offers 100-80-50 plans, you're going to have basically the same experience against similar populations with age/sex distribution. However, if I channel those members through specific offices, and I tell the dentist that I'm going to give him a fixed amount of money to take care of those people when they come through that office, all kinds of things change. When a dentist has risk, frequency is reduced. The frequency and distribution of services change.

You can make, through a PPO, any number of percentage changes you want. You change this and you change it by a magnitude. That's why risk transfer and particularly risk transfer which affects frequency decision-making inside the health care system is so incredibly powerful. That's why this company is growing like a weed, and I suspect that as I move out to other marketplaces I'll have the same effect.

If you transfer risk, how do you do it? What are the strategies you might use? Well, one, a fee-for-service or a PPO has virtually no risk on the part of the dentist. He or she can do whatever they basically want to do. They can decide to do a crown, a filling, or not do anything at all. They can make that decision, and it has no or only a marginal economic impact on them. Therefore, it's a relatively low-risk project. You can do a mailing in California right now and get every dentist, I suspect, to agree to sign up on a PPO schedule. It is because they are reacting to this against the risk transfer mechanisms that my colleagues and I are applying to their operation.

If you then pool the risk, which is what Pacific Union Denial does for the majority of our cases; individual dentists are not responsible for individual patient decisions, but the entire group of dentists are responsible. We take a portion of our premium and put it into a pool and then divide it up, based upon who does what. When the money's gone the money's gone, and the pool itself is then at risk to what happens. What this does is it gets the dentists all talking to each other about who's doing what and why. It's a very effective system, and it's one that we've used for about four or five years. It's probably one of the things that's contributed to our growth.

As you move up the line from pool risk and you go to a capitation payment that's paid to an individual dentist, there are two additional risk modifiers. If you raise the copayment on the part of the member for individual services, then the frequency of services becomes more dependent upon that member's willingness to pay the higher copayment. Therefore, this strategy is very useful in the voluntary dental market. You raise the copayments on some procedures to allow the dentist to lay off the adverse risk of adverse selection onto the membership. Finally, if you end up with a high capitation, low copayment or no copayment plan, where the dentist is simply at risk, you get the maximum frequency reductions in shifts internally.

Let’s discuss types 1, 2, and 3 benefits. Type 1 is your basic and preventive; type 2 are fillings and some oral surgery; and type 3 is crowns, bridges, partials, dentures, etc. There have been a number of studies done in California concerning what the affect of risk transfer is. This is a composite of several studies because I didn't have access to the ones I wanted to use. We found in our fee-for-service system, as a percentage of value of the cost of providing the services about 25–30% goes to

diagnostic and preventive services, approximately 15–20% goes for basic fillings and extractions, but a whopping 45% goes towards crowns and bridges. I often say to my dental colleagues, more crowns were done in California on a fee-for-service basis between 1990 and 1997 than in the previous history of dentistry combined. We used to see, when I was a consultant back in the mid-1980s, the ratio between fillings and crowns between 4:1 and 5:1. I have seen evidence in California on indemnity and self-insured plans that it is 1:1 or 1.5:1. There's a huge shift in the way dentists operate.

A pure capitation plan has some very stringent shifts. You get a sharper increase in the amount done in diagnostic and preventive care. You get a real increase in terms of basic fillings. You also get a sharp decrease in advanced services. If you go with a high capitation plan, and a low copayment plan, these are even more accentuated as a percentage of them. It turns out, a lot of the advanced procedures aren't terribly effective, don't last very long, or are not things we ought to be doing. In our pooled system we get moderation. We're halfway between. The major point of the information we're going to be publishing in Fall 1997, is that as we move risk to the dentists, either a little bit of risk, a lot of risk, or a whole lot of risk, we're going to change the way dental decisions are made. That will get us into the questions of benchmarking outcome studies, quality assurance, etc.

Finally, what's the effect? What happens? Remember that my first 19 issues on the part of most purchasers was cost, so what happens? If you have a fee-for-service current 100-80-50 plan with a single rate of about $20, expect to have about $13 of that going to actually paying dental services. In the managed care plan, we expect to see, first a 20% reduction in the procedures which are done, across the board. We then turn around and pick up an average 25% reduction per procedure in the same way that PPOs do with their channeling. We end up with a composite health care cost of about $7.80 compared to the $13 for the fee-for-service plan. We have about the same $5 administrative profit line as in the full service plan, or the fee-for-service plan, but the end result is that at $12.80, I can blow the doors off of most indemnity marketing plans. Most PPOs can't come within a shout of that distance. If you want to see where I think the trend in dental benefits are going to go, given all kinds of caveats about quality and member acceptance, etc., look at the primary issue that most employers are making purchasing decisions. It's cost. There's just simply no way for PPOs and fee-for-service plans to stay in the marketplace in that regard. That's what has happened in California. We have simply knocked the socks off of the old fee-for-service model. We've done it in Nevada, and I suspect as it starts to happen, it's going to happen more and more often.

From the Floor: Are you able to sell any PPOs in Georgia or in Texas?

Mr. Whitmarsh: We have several different designs of our PPO. We have what's called an overlay plan. For example, a 100-80-50 overlaid plan in network would be based on the PPO schedule, out of network it would be based on UCR. We can sell that kind of plan in Georgia, Texas, Louisiana, and Mississippi. We also have something called a Mack Plan, where we would also sell 100-80-50, but both in and out of network would be based on PPO schedule. As a result, the plan is paying the same amount to a dentist, whether he or she is in or out of the network. It is our belief that in those same states that kind of plan can be sold.

From the Floor: That's the same thing we do at the Guardian. When Tillinghast or the Milliman & Robertson surveys come out, there are PPO numbers by some of the carriers, so I was wondering what was being done there.

My second question is, is most of your indemnity block on a passive PPO basis, which is an indemnity plan? Should the insured go to an in network dentist, so you only reimburse the dentist up to the fee schedule, or up to reasonable and customary?

Mr. Whitmarsh: If I understand your question correctly, we still do have a lot of indemnity business, and I didn't focus on that. It's indemnity for very much the same reasons that Deanna has identified, which is that there are large portions of the country that are resistant to any kind of managed care. We have a certain amount of what we call silent plans, in which, for various reasons, the employer really does not want to advertise the fact that this is a PPO, so those discounts will be available to a patient if the patient goes to an in network dentist.

Mr. Henry W. Frantz, III: My first question is for primarily the smaller end of the market, under 200 lives. It has to do with agent compensation. What do you do when the product is no longer linked to medical and where there are fewer dollars to apply to a commission rate?

Ms. Strable: That's a struggle. As you do it on a stand-alone basis, compensation is going to be a larger basis of your expenses. A few years ago, as we began to focus on dental at Principal, we went to a top of scale commission regardless of it's focused package, with medical or without, so we actually are paying the same commission regardless of whether it's being packaged with or without. We are still able to offer it on a competitive basis. We have the issue with compensation with our agents and brokers, but it's the same issue regardless of whether it's packaged with medical.

Mr. Frantz: The dollar amount would be approximately the same as if they were a medical plan generating ten times as much.

Ms. Strable: The amount that's being paid on the dental product would be the same regardless of medical to go with it.

Mr. Frantz: Another question related to PPOs. I notice that much of the initial growth was cannibalizing, if you will, an existing block. Is that a good thing? If it's a good thing, what is it compared to?

Mr. Whitmarsh: I think there's always that risk when you try something new that it is going to cannibalize the things which you have been doing. I think it was important to us because we could convert a large part of our own business. We immediately made the network more attractive to the dentists. Once we got more dentists, we broadened our access and we could really outdistance most of our competitors, in terms of the number of dentists that would be available in an area. At that time we were able to go outside our current business and say we have a tremendous network with very good discounts. We can offer you a better deal than anybody else. We have been fairly successful in getting business from a wide variety of competitors. It's not just the traditional insurance companies, such as Aetna and the Prudential, but to a certain extent, Delta Dental Plans and Blue Cross Blue Shield.

Mr. Frantz: The profitability of the business is regarded as profitable enough to take the risk of converting your indemnity block?

Mr. Whitmarsh: We also charge what's called a PPO network access fee. I know that not all the carriers do this. For example, for a mid-sized employer that might be as much as $0.60 per month, per employee. That could easily be about 2% of the total premium on an insured case. If they're expecting savings of 6–8% or something like that, that seems like a fair price to pay.

Mr. Frantz: Has there been an improvement, or at least a change, in the persistency in groups in the PPO versus indemnity?

Mr. Whitmarsh: We've always had good persistency, but I think that's just a characteristic of our type of business. We just find that large cases just tend to stick around a little bit longer.

Mr. Frantz: What about the smaller end?

Ms. Strable: I don't think we've seen any difference in the persistency rate between the PPO and indemnity, but the smaller case market probably has lower persistency.

Mr. David Nussbaum: Each of the panelists briefly mentioned voluntary dental. Could you give me your opinions on whether you think this is a growing market? Do you see this as a profitable market over the long term? What techniques are you using to prevent antiselection?

Mr. Spain: We're seeing a growth in the voluntary market in a couple of strange ways. One is the Medicare Risk Contract that the HMOs are taking on. We sometimes see a dental product put along side without any extra premium to it, other than a network access fee. We're now seeing over 80% of our individual type plans, in other words where there would be a selective process, coming from that senior market. We also see a large growth of the individual plans which are very similar to Karl's comments concerning access to the PPO. We convert our networks into, in essence, PPOs by taking the copayments and registering them as a fee schedule, and then selling access to that product. I think we're going to see a lot of HMO sponsored individual plans in the next four or five years from those two sources.

Mr. Nussbaum: Your benefits are no different?

Mr. Spain: No, the benefits are different. They usually have a much higher member co-insurance or copayment responsibility to them. By law, we can't do maximums or deductibles. It's a different product. There's a higher member responsibility.

Mr. Whitmarsh: I would just amplify my earlier comments that this is a field we feel is going to be important down the road, but we feel that the appeal is mainly going to be more in relatively small employers. This is not a market that we have special strength in, but we are experimenting. One interesting thing I would say, though, that I did not mention earlier with regards to our experience in voluntary, is that we basically look at the voluntary market as two parts. We do have a series of voluntary plans that we sell, which are primarily targeted at groups which have had no prior dental benefit. We also are very interested in acquiring voluntary business from other carriers. We do that by having a very stringent set of underwriting rules about what type of business we will accept. So far, we haven't taken on a lot of cases, but those that we have taken on have always had very good experience.

Mr. Nussbaum: Is your benefit structure basically the same?

Mr. Whitmarsh: If we're acquiring business from someone else, of course, we're just basically going to continue what they were offering. When we offer our own product for a group that has not had a prior benefit, I would say that our benefits tend to be extremely on the conservative side. We really don't think that in a stand

alone situation you can easily insure crowns and things like that; you really need coverage that's bundled with other types of products.

Ms. Strable: I agree it's a growing market for the small employer markets. Normally what you do see is a more restrictive plan design for the voluntary market; usually with some waiting periods put in. For that reason, you're not going to see people jumping in or out, but they have to be in the plan for a while before they get some of the more major procedures. The plan design has to be structured in a way to try to control some of that risk.

Mr. Robert M. Levitas: We're in the voluntary marketplace. We use graded benefits. We use graded maximums and waiting periods. Does anybody do medical assistance business? We have some run away costs in the medical assistance fields. We're owned by Pennsylvania Blue Shield. We do a lot of medical assistance in Pennsylvania and we're also doing it in Maryland. We have a lot of problems with fee-for-service medical assistance programs.

Mr. Spain: It's not something that we happen to be involved in.

Mr. Levitas: You may not want to be.

Mr. Steven P. Clay: In the PPO and the indemnity, when you start getting into voluntary products, do you have different participation requirements than for nonvoluntary?

Mr. Whitmarsh: Absolutely. Our experience with voluntary is comparatively small, but we went, for example, to market initially with a participation requirement of 35%, and even then we thought that we would want to make it a little bit higher. What we found out was the groups which we actually sold to tended to be fairly well above that. They averaged, this year, 60%, and I've noticed a real change over the past five or six years. Before I came to MetLife, I worked at one of the Delta Plans, and we looked at our voluntary business at that time, and to get participation levels at 10–15% was typical. I think that employee attitudes have changed; I think that employees are much more willing to sign up for this type of benefit. Obviously, if you can offer it in a PPO environment, you can offer the employee two advantages that he or she can't get off the street. He or she has a fee, which will probably be under what he could get from his own dentist, and he or she also may have a pretax advantage under Section 125. We have set fairly low participation requirements at 35%. I think they have probably not been as important as we thought they were. What we may end up doing is actually reducing that, just because we don't want to scare off some of our prospective clients in this market.

Ms. Strable: I would agree with what Karl said. I think on our employer paid plans we require 75% participation. I've seen some voluntary plans that have participation requirements down to about 20%, but many times, if they're graded, co-insurance, or maximum scale, it is based on the participation of the group.