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Session 28PD
Dental Products—Do the Discounts Add Up?

Track: Health

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Summary: Panelists discuss the various approaches to providing dental insurance and the pricing implications. They compare and contrast the different models being used for dental insurance and discuss the related pricing issues for each approach.

Mr. Floyd R. Martin: I am a consultant with Tillinghast in St. Louis. The panelists joining me are Bill Billard with Delta Dental of Michigan, Michael Fradkin with Met Life, and Wes Weller who is a consulting actuary in the dental field.

I'm going to start off our session by just giving a little general overview of what the dental costs are today and what impacts some of the traditional designs have on those costs.

Obviously dental costs are going to vary quite a bit from location to location. On a national average we're seeing that an individual adult's annual cost will run about $420 on the average. This is an insured population. Similarly for a child, their cost would be about $345. This is where cost level would start, on an annual basis, if we were to cover dental services in full. This includes preventive, major and orthodontic coverage also. If we were to split the costs out, the split is quite a bit different between an adult and a child. The child, ages up to around 19, has almost half the costs (49.4%) are going for orthodontic treatment. The next big chunk would be preventive services (23.5%), with basic care following at 19.3%, which are going to be basically the fillings. There are very little major services (7.8%) going on for children. The adults, on the other hand, the major services are the biggest piece at 39.5% with orthodontics right now running at 10.4%. So the major category is where most of the services for adults are going, with preventive still at 20%, and basic services at 30.1%. You can see the big difference in where the costs are. With orthodontic costs as high as they are in relation to other types of dental benefits, you can see why the children costs were still $345 on an annual basis. Half of that is going for orthodontics.

Note: The charts referred to in the text can be found at the end of the manuscript.

What happens if we apply the traditional co-insurance approach for dental insurance–100%, 80%, 50% plan? That brings the adult cost down from $420 to $290 or a 31% cost savings. There is a similar percentage savings on the child side because of the 50% coinsurance on orthodontic benefits. The child cost is coming down to $235 a year, which is a little bit over 30%, about 32% savings just by applying the co-insurance adjustments.

From the Floor: Are these amounts based on current cost?

Mr. Martin: Yes, these represent costs as of today.

This changes the mix of benefits quite a bit because we're paying preventive at 100%. For children 34.8% of the costs are going to preventive, 22.8% are going to basic services and orthodontic drops from 49.4% of the total to about 36.5%. For children, major services drops to 5.8%. On adult the orthodontics still has a little bit there at 7.6% but the costs are split evenly between preventive at 29.0%, basic at 34.9%, and major services at 28.6%.

From the Floor: Is there a maximum benefit?

Mr. Martin: No, this is everything being paid at this co-insurance, no maximum. We'll look at maximums in a moment.

On Chart 1, I've done a comparison on the cost savings for applying different deductibles. It's hard to get annual dental services today that wouldn't meet a $25 or $50 deductible. This deductible applies to all services, as opposed to just basic and major, so it would also apply to preventive services. A $25 deductible would reduce costs about 4% and a $50 deductible is almost double that, about 7.9%. Even with a $100 deductible applied to dental services up front, we expect to save only 15.5% for an adult and about 13.9% for a child.

We've got 30% savings from our co-insurance area. If we were to go with a real high deductible of $100, which very few plans have, one might save another 15%. Theoretically the costs could get down to about 55% by applying $100 deductible with the co-insurance levels.

Finally, what is the impact of maximums? I've compared three common maximum levels in Chart 2. Once you get above $2,000 there are very few claims that are going to exceed that amount except the orthodontic claims. These adjustments are on top of the co-insurance adjustments that we had before, so you're paying orthodontic at 50%. Thus, even a $1,000 maximum limit would only reduce adult costs about 5% and would barely affect the children cost in total, at 0.5%.

There are some other things that have been going on in dental benefits to save costs. That's what our panelists are going discuss. A lot of these involve bringing in negotiated discount arrangements and various benefit designs to help steer people towards using networks. I'm going to turn it over to Bill Billard who is going to talk about passive network design.

Mr. William T. Billard: The title of this talk is, "Can an active Preferred Provider Organization (PPO) deliver more benefits for less cost than a passive PPO?" I'm going to discuss a few of the intricacies of this. I think first we should look at definitions because I've heard a lot of people have different ideas of what a passive PPO is. It's interesting that Michael Fradkin and I both did these definitions separately and we had the same definitions. That's a good start. He said, "Now if we can get the rest of the world dealing with the same stuff, we'll be getting somewhere".

The passive PPO means that all benefits are the same, both in and out of network. Co-payments, maximums, and deductibles, all have no differences. The in-network payments are based on the schedule that's been agreed to by the dentist to accept as payment in full. The out-of-network payments are based on reasonable and customary. The difference between passive and active PPO then is that in an active PPO co-payments, maximums, or deductibles are better for the patient who goes in network. This first part can be done actually two ways. We want the benefits overall to be better in network. You can either make the out-of-network program worse than the current plan or you can make the in-network benefit levels better. Obviously, if you're starting from scratch with a group that doesn't have benefits currently, you can design it anyway you want. The other way you can call it an active PPO is if you're out-of-network payments are based on the PPO schedule or lower. So in other words, you have the same co-payments, maximums, deductibles and so forth, but the payment is based on the schedule instead of reasonable and customary. Does that make sense? In any event, with the active PPO patients have an active reason to seek panel dentists. They have an incentive to go in-panel.

Passive PPO's are attractive to groups. Our marketing representatives love them. They have modest savings. You might get 2%, 4%, 5%, something like that in a passive PPO, depending on your network size and your discounts. There's no open enrollment so the customer doesn't have to deal with going through an enrollment period like you would with a Dental Health Maintenance Organization (DHMO). There are no changes in benefit booklets. All the benefits have remained the same. You don't have to redo anything. The group can decide how much they want to publicize this and how much they want to try to steer patients into the network. They can do a lot or a little of that, and Michael's going to talk a little bit more about this later. Finally, no employees feel disadvantaged. If you have an active PPO where there are better benefits in-network than out-of-network, and you happen to have a patient who's located in a remote area where you don't have a panel dentist, they can feel like it would be nice to get better benefits, but can't.

The passive PPO's, while they're good for the customers, they're bad for the dentists. First of all, there's no steerage for new patients. The dentist doesn't have an opportunity to have an increase in patients. I will acknowledge that people realize that there is some benefit, even in a passive PPO, to going to an in-panel dentist because there's a little out-of-pocket savings for the patient. Since the total charges are at a lower level, the patient's portion is paid at a lower level. There's some advantage, but it's very modest to the patients and in most cases it would

not be enough to steer at least an existing patient to the network. Maybe over a period of time though new people coming into a plan might seek out a panel dentist. The dentist who's involved in a panel where the vast majority of the business that he's getting from that panel is in a passive PPO has got kind of a double whammy. He's getting reduced payment on a lot of his existing patients and he's not getting any new patients. There's not much incentive for dentists to be involved in a company that sells only passive PPO's. Thus, they're good for customers, bad for dentists. To a carrier it's kind of good and bad. It's easy to sell. Our marketing people think it's just the greatest thing since sliced bread. They would love to have it all over the place. There is a tendency in fact to want to just convert your whole block of business to passive PPO because why not get the savings and get a little bit of a competitive advantage. However, you have to remember that the less steerage the PPO generates, the less benefits the dentists see. If a passive PPO becomes too large a part of your business, it's eventually going to erode your panel, the dentists are not going to see the advantages and so they're going to drop out of the panel. My sense of the balance of this is that passive PPO's are okay, but you really want to have a good block of active PPO business in each area that you sell this to keep the dentists encouraged about the number of new patients that they're seeing.

I'm going to shift gears here a little bit and talk about the beginnings of the model that I generated. I call this a 20/20 PPO, and I'm just using this as an example. If you have a 20% fee discount from average and a 20% panel, then average person would say. "Well, 20% panel/20% discount is going to generate 4% savings from indemnity." We actuaries know better than that. Let's talk about the fee discount part. The question is, "Do panel dentists have average fees?" If they had average fees, then you'd get the full 20% discount. But they probably don't. Obviously dentists with lower fees are more likely to sign up for the PPO. They have to take less of a discount than an average fee dentist would to sign up and so it's more attractive for a lower fee dentist. Let's look at active versus passive. If your company sells a lot of active PPO business, then the average or higher fee dentists are more like to sign up because they have a payback in terms of the incentives that the patients have to come to their practices. But if you have mostly passive PPO business, it's harder to recruit and keep dentists. It's more likely to drive out those who have the higher fees, because then there's no offset. The dentists who are more attracted to the passive PPO are those who have lower fees on average. I think you can make the case that two companies with everything else considered equal but one sells almost all active PPO business, the other sells almost all passive PPO business. The one that sells active will probably have a larger panel and probably have greater savings from that panel because they have more naturally high fee dentists in the panel and they're getting a greater discount.

The discount, I just thought of this, is not important if you are generating migration. If you're just talking about the patients going to the same dentist they used to go to and having a program that you had on an indemnity basis and now putting a PPO in, then it is important because you're not getting the savings. These are Billard's assumption on fee discounts. I'm just saying on a relative basis, if average fees are equal to one, using a 20% discount, the PPO fees are 0.8. You can argue with

these assumptions and you can use different ones if you want. What I'm using for the purposes of this discussion is that for dentists in the active PPO the average fees are 0.975, 2.5% off the overall average. They're getting an 80% payment from the PPO schedule and so there's a 17.5% savings. The savings need to be stated on the basis of the average fees starting point. For a dentist in a passive PPO the fees are 5% below average. Again, they're being paid at a schedule that's 80% and so the savings there are 15%.

Next is panel size and passive migration. I don't know if this term is in common usage anywhere, but I just made it up for this presentation. It's really descriptive I think. Passive migration refers to the percentage of patients that are already in a panel dentist's practice. That's the migration that automatically already exists and you've already been seeing in effect in your indemnity program. Now you're paying that dentist at a lower level.

The next piece of this maybe doesn't follow quite as easily. The percentage of patients that are in your program are generally going to be less than the percentage of your panel size. If you've got a 20% panel, you're probably going to have less than 20% of the existing patients in a group going to that panel. The logic is that the dentists wouldn't sign up for the panel if all their chair time were occupied. Dentists who have full practices are less likely to sign up for panels. So on average the in-panel dentists see fewer patients than the out-of-panel dentists do just because of selection.

Let's go to Billard's assumptions on passive migration. Again, these are just my assumptions, you can plug something different in if you like. I'm placing in-panel practice occupancy equal to 80% of out-of-panel practice occupancy. That might be a little aggressive or a little high, but I do feel fairly strongly that the dentists who are in the panel see fewer patients and you need to take that into account in terms of your finding out what your passive migration is. The calculation is as follows: 20% of the dentist are in the panel and have a factor of 0.8; divide this by the total, which is the same product again, 20% x 0.8, plus the other 80% having 1.0 occupancy. That works out to 16/96 or 16.7%. That's my assumed passive migration for this 20% panel model. Then our 20% x 20% equals 4% turns out to be 15% x 16.7% and the total savings, instead of being 4%, turns out to be 2.5%.

Now I'd like to shift gears again. Does that make sense to everybody? Okay, everybody's following the math? Good. I do this for marketing people and so I'm sensitized to the questions. Let's look at generating active migration through benefit enhancements. I'm not going to spend too much time on this because Michael's going to deal with a little bit more. One of the problems with trying to do this is that if you've got a group that's got a 100/80/50/50 program right now and they want to put a PPO in, it's hard to generate a lot of migration by increasing the in-panel benefits. This is because there's not much you can increase into the preventive and diagnostic benefits, which get the best bang for the buck in terms of migration because benefits are already at 100%. Ideally you want to put the increases in the preventive and diagnostic area if you can. The next area would be routine basic kind of services like fillings and so forth. Lastly would be the specialist

or prosthodontics. We measure migration on our PPO's based on categories of benefits. We find that if we increase the specialists and prosthodontic benefits, you get people taking advantage of that. They won't migrate to a general practitioner (GP) but they will migrate to a specialist who's in the panel. This is okay with careful panel design, but we've had some poor panel design that's hurt us. Increasing 50% prosthodontic benefit to 70% generates a lot of in-panel migration, but we lose money when they go in-panel because the benefit differential is too great. That was one of the lessons we learned early on.

I'm going to discuss my model (Table 1). I said it's very simplistic, but it works and it's kind of fun to play around with. The way this is set up, at the top I've got the average fees. The shaded areas, are things that have to be entered. Paging down you can see that shaded areas are assumptions that I've made. The fee discount assumptions that I have used are active and passive PPO. These work, at least in terms of my model, if you're a company that is deciding whether you want to focus on primarily active PPO's or primarily passive PPO's. If you have one panel, a group that you're trying to sell this to and you want to know what the difference is between active and passive, you'll want to set the average fees the same. These are fees as a percent of total. The total as 100%, the out-of-network is just generated by what you punch in for in-network. If we decided that we wanted the passive PPO to be 0.96, you'd change the out-of-network and it would change the assumptions down at the bottom too. If you want to make it 0.975 so that it's the same as the active, then you can do that.

TABLE 1
ACTIVE VERSUS PASSIVE PPO MODEL

Fee Discount Assumptions:

Average Fees	In Network		Out of Net	Total
Active PPO	97.5%		100.5%	100.0%
Passive PPO	95.0%		101.0%	100.0%
PPO Fees	80.0%			

Passive Migration Assumptions:

% Panel Size	20.0%
% In-Panel Occupancy	80.0%
Passive Migration	16.7%
Passive PPO Savings	2.5%

Active PPO Savings:

In-Network Benefit		Total Migration (Active and Passive)			
Increases		16.7%	20.0%	25.0%	30.0%
2%		2.65%	3.28%	4.22%	5.17%
5%		2.25%	2.80%	3.62%	4.45%
10%		1.58%	2.00%	2.62%	3.25%
15%		0.92%	1.20%	1.62%	2.05%

Shaded areas = Assumptions

For PPO fees, if you've got a 20% discount, enter as 0.8, you can change that as well. Then the passive migration assumptions are based on panel size and in-panel occupancy. That occupancy I was talking about as being 80%, you might want to try something higher. That may not be quite that far off. At the bottom are the in-network benefit increases on the left-hand column. The in-network benefit increases can be changed if you like to, 2%, 5%, 10%, 15%. Obviously, if you increase the benefits 25%, you'll offset entirely the 20% fee discount. For the migration assumptions you can use whatever ones you want to also. The 16.7% I plugged in is the passive migration that is generated by the other assumptions that we make and that I just put 20%, 25%, and 30% to have some semi-even numbers.

Let's say you've got the 5% benefit increase and 20% migration. It says you're generating 2.8% savings. Let me explain that. You run benefit increases and then the total migration and that gives you the savings off of what you're indemnity plan would pay. So that's what the 2.8% is on the 20% migration and 5% benefit increases. If you change the PPO fees to a 25% discount, so you change the PPO fees to 75%. That moves the savings up to 3.85%. It's fairly sensitive to the PPO fees. Now if you make a change in that in-panel occupancy from 0.8 to 0.9, you pump that down to 3.8%. If you can change panel size, for a 25% panel, then you go to 3.65%. Let me just on the end here put migration at 25% and then the

savings is 4.75%. Put 0.8 in the in-panel occupancy, then it goes down. If you take the panel size up to 30%, then the savings go to 4.67%. It gives you an idea of what the elasticity is of some of these factors.

Mr. Michael A. Fradkin: I'm the dental pricing actuary at Met Life. Bill spent a lot his presentation on passive PPO plans, and touched a little on active PPO plans. I want to spend most of my time on the active plans. The topics I'm going to cover are an overview of the PPO framework and a comparison of active and passive PPO plans. Bill already did a lot of this, so I'll run through this quickly and then discuss the active PPO incentives and how effective some of them are. Then I'll touch on the advantages and disadvantages of active PPO plans and then summarize the presentation.

Here is a quick overview of the PPO framework. The PPO dental plan is essentially an indemnity dental plan where the in-network benefit is based on the in-network fee schedule as opposed to the dentist submitted charge. Everything else about the PPO plan is similar to an indemnity plan. Namely, the benefits are determined based on key plan design parameters around covered services and benefit limitations and cost-sharing parameters—deductibles, co-payments and maximums. The key difference between an active and passive PPO plan is in the plan design parameters include benefit cutbacks. A passive plan is going to have the same cost-sharing parameters—deductibles, maximums and co-payments on the in- and out-of-network plans. Whereas an active PPO plan is going to have differences in one or more of those on the in- versus out-of-network plans.

The active plan may or may not have differences in covered services between the in- and out-of-network plans. Whereas the passive PPO is going to have the exact same covered services. The in-network benefits are identical on an active and passive PPO plan. The benefit is based on the in-network fee schedule.

On a passive PPO the added network benefit is going to be based on the dentist charge. On an active PPO it may be based on the dentist charge, but it also may be based on a schedule. It could be the in-network fee schedule or some other discounted schedule.

The focus of an active PPO plan is really on reducing the cost of the plan and leveraging the value of the insurer's network. The passive PPO plan is really set up to generate savings based on your current network, but more focused on minimizing noise around employer and employee complaints.

Now focus on incentives, how to get patients to utilize our network providers. One key incentive is reducing out-of-pocket costs if they go to the in-network plan. We're able to do this by having a richer in-network plan, either having lower deductibles, lower co-payments, higher maximums, or covering a greater amount of services. You can also create an incentive by creating a disincentive on the out-of-network plan. The primary way of doing this, even if the key cost-sharing parameters—deductibles, maximums and co-payments are identical, is to have the out-of-network benefits based on the something other than the dentist charge. If

the out-of-network benefit is based on a fee schedule then the in-network fee schedule, or some other discounted schedule, is going to increase patient out-of-pocket cost if they go to the out-of-network dentist.

Now look at how successful some of these levers are in migrating patients to our network providers. What we see is maximums tend to have a relatively small impact. That makes a lot of sense since very few people are impacted by maximums. Ray's initial presentation showed that. Deductibles also have a relatively small impact. It's slightly larger than maximums. Having a $50 deductible in-network versus the $75 deductible is not going to get someone to change dentists. It doesn't have too much of an impact.

Co-insurance levels do have a relatively large impact, particularly if there's a difference in the co-insurance level in Class A services. This is because Class A services are going to apply to basically every single one who goes to a dentist. Thus, we do see a larger impact there. Out-of-network claims based on something other than the dentist charge has a significant impact because it really does impact your patients' out-of-pocket costs. Many of our active PPO plans combine several of these different incentives in order to get a larger impact.

I want to talk about a group that already has an indemnity plan and is looking to convert it over to a PPO plan and how to do that most effectively and generate the greatest amount of savings. If you had a group that had a 100/80/50 indemnity plan and wanted to throw a PPO plan in there in place of the indemnity plan. If you throw a passive PPO in there, you generate savings based on the patients who are already going to network dentists. If we're looking to sell them an active PPO plan, you can really do that in one of two ways. You could keep the out-of-network benefit as the indemnity plan currently, so the out-of-network plan is on the 100/80/50 plan and then have a richer in-network plan, maybe 100/90/60. That's going to do two things. It's going to cut back on your savings because part of your in-network savings is going to be eaten up by the richer in-network plan. Then secondly, you really aren't going to get much of an impact on people migrating into your network because people are probably basically happy with their current plan design. They already have a 100/80/50. If you keep the out-of-network plan at 100/80/50, people are not going to change. What we see as more significant is making the in-network plan design equal to the current indemnity benefits. The in-network plan would now be 100/80/50 and the out-of-network plan something less rich, it could be a 90/70/40. There is now in-network savings and then savings on the out-of-network plan because it's a weaker benefit. Thirdly, I'm now providing an incentive for some of those patients who go to non-network providers to migrate into our network.

In trying to incent patients to use our network, communication is also a key. Providing both employers and employees with information on the benefits of the provider network, as well as explaining the network program and any kind of plans around it. If there's any quality program, such as credentializing or anything like that which focuses on the benefit of the network also provides assurance that the providers who are part of the network are quality dentists. If somebody's going to

change dentists, somebody they've been going to for a while, who are they going switch to? Is the insurer ensuring that these are quality dentists? Take advantage of any kind of communication opportunity. Use an explanation of benefits where you have an opportunity to display any realized savings if somebody had you on a network. You could say the claim cost is such and such, the out-of-pocket expenses $12, had you not gone to a network dentist, or the $12 cost reflects $8 in savings. Conversely, if somebody didn't go to a network dentist the out-of-pocket costs was $20, had you gone to a network dentist savings could have been another $8. Take advantage of any communication to let patients know about the value of using network providers.

Now let's look at some advantages of active PPO plans. The key advantage is more competitive rates. It will also help drive patients into our network and that helps strengthen our network as well as increasing the value proposition for network dentists. Bill talked about this a little bit. If you just sell passive PPO plans, the providers really aren't getting anything. If 20% of their patients are already part of our network, having them join our network really isn't going to do anything for them. In fact, it's going to hurt them unless we drive business into their network. Well, selling passive PPO plans it's pretty difficult to explain to providers what kind of value they're actually getting. If we sell active plans, we can explain that we're trying to incent more patients to go in-network, which should drive business into their practice.

Another advantage of active PPO plans is less pricing risk. With active PPO plans financial results are less sensitive to the migration assumption, which is the percentage of patients who are going to utilize in-network providers as opposed to out-of-network providers. Also if we can drive more business in-network, we do a better job of controlling trend and fees since we control the setting of our fee schedules.

As I just mentioned, the key pricing assumption on a passive PPO plan is the migration assumption, the migration of patients to network providers. It really does create a significant amount of risk because if you miss on that assumption, you can miss by a wide margin on the expected claim cost. Here's a real simple example. If your discounts in a particular area are 25% and your pricing assumption were that 40% of the patients are going to go in-network, then expected savings versus a comparable indemnity plan are 10%. If the actual migration is only 20%, then realized savings are only 5% and you've missed your expected claim costs by a full 5 percentage points. With active PPO plans the migration assumption is not as important. This is because the in-network discount is partially or fully offset by the difference in cost between the in- and out-of-network plans.

Here is an example of an active PPO plan. The in-network plan is a richer plan. Expected monthly claim costs are $20. On the out-of-network plan it's $15. But once I apply my discount on the in-network fees, I've got an expected claim cost equal to $15, which is equivalent to the out-of-network claim costs. So as the pricing actuary, I'm not sensitive in terms of financial results to patients going in- or

out-of-network. Now I do still want patients going in-network because it helps drive the strength of our network, but in terms of the financial performance on this particular group, it's insensitive to the migration.

Here are a few disadvantages of active PPO plans. Regulatory constraints are certainly a problem. Some states prohibit plans that have benefit differentials between the in- and out-of-network pieces, and other states restrict it. For example, states out there may say you can sell an active PPO plan, but if the in-network plan is 100/80/50, the out-of-network plan can't be more than 20% different. The out-of-network plan would have to be at least an 80/60/30 plan. Recently other states, Colorado is one of them, have set out standards around minimum access. If you're network doesn't provide minimum access in those locations, then the insurer must reimburse the out-of-network provider such that the patient's out-of-pocket costs on the out-of-network plan is equivalent to the out-of-pocket costs on the in-network plan. You can certainly see how an active PPO plan would cost the insurer a great deal of money there. If you had 80% co-insurance in-network versus 60% out-of-network, but had to keep the patient's out-of-pocket expense equivalent, you're reimbursing the out-of-network provider at a much higher co-insurance than 60%.

Another disadvantage of active PPO plans is the amount of noise. This is particularly important if you don't have a strong network in certain areas. Selling an active PPO plan is going to generate noise even if you do have a strong network because employees are likely to complain if they have to switch dentists. Employees would say, "You know, I've been going to this guy for 10 years and I've got to switch dentists in order to get a richer plan but the guy next to me doesn't have to." You're going to have noise anyway, but now if you don't have an adequate network for him to go into, it's going to be even worse. Noise is also created by communication problems on plans with the out-of-network benefit based on something other than the dentist charge because the patient can't possibly know his out-of-pocket costs. A simple example illustrates this. If the out-of-pocket charge for a procedure was $100 and the in-network fee is $80, co-insurance might be 80%. If someone goes to an out-of-network provider and the plan is reimbursing based on the in-network fee and he knows his co-insurance is 80%, he's going to think he's paying 20% of that $100 charge. He's not paying $20. He's paying the difference between $100 and what the insurer is paying. The insurer on a plan like that is only paying 80% of the in-network fee, or 80% of the $80, thus $64, so his out-of-pocket expenses is $36. The patient doesn't know that. The patient has no way of knowing that so it leads to a lot of communication problems.

Active PPO plans may not be, and probably aren't, appropriate for employers that place a higher priority on employee satisfaction around benefits than on the cost of the plan. These active PPO plans also create a problem for national plans where the large national employer may have patients in 15 different cities across the country. If you don't have strong networks in all those areas, maybe you have strong networks in 13 of the areas, what do you do in the other two areas? You could split out those two areas and offer them a richer indemnity plan, but that leads to

increased expenses. It really is difficult to sell an active PPO plan if it's a larger national employer and you don't have coverage in all their major sites.

To summarize, active PPO plans can be an attractive alternative to passive PPO plans. They have the potential to improve competitiveness, reduce pricing risk and strengthen the provider network. But in order to be effective, you have to understand regulatory restrictions, work with the employer to understand objectives and add clear communication in order to minimize patient complaints.

Mr. Walter Wesley Weller: I worked for insurance companies for 20 years and 3 years ago I started consulting. What I'm going to be telling you is the story of my first and current best client. I'm not going to tell you who this client is because it's confidential. If any of you want to give me your business card, I'll give the card to the Chief Marketing Officer (CMO) and he may or may not call you.

I started consulting this client in the summer of 1997. He was an entrepreneurial dentist who had just finished putting a couple million dollars into the approval process. He didn't buy a shell, which is what I would have told him to do. He went the hard way through his lawyers and got a Department of Insurance (DOI) license in the State of California and got it approved. Thus, he had no business when I started consulting with him. I spent three months part time with him and in October of 1997, I went to work for him as his first full-time employee. I never sent him a bill for the three months that I consulted because, frankly, I learned more from him than he did from me. In January 1998, we hired our CMO, who was an old friend of mine. In April of 1998, we got our first sale, which was a furniture store with 100 employees. For the fourth quarter of 1999 we reported a profit to the DOI. I outsourced the reserves; I did not set the reserves. As of May of 2000, we have 50,000 lives enforce and it's growing at over 4,000 lives a month. We did in two years what should have taken 4– years according to the experts, and I won't tell you who those experts are because it wouldn't do my career any good to publicly disprove a couple of prominent actuaries.

The bulk of my presentation is to share with you the reasons the key people gave me for why the company was successful. The first person is an account executive that was with the company almost from the very beginning. He said success factors were sales follow-through and customer service to the brokers. In addition, it was flexible systems and in particular, he thinks the CEO's decision not to buy a system but to build his own system, hiring Information System (IS) people, and creating a system where the company was not slave to the system, but rather the reverse was key. The CEO's commitment to information technology was evident. A couple of months ago he went to Stanford for a two-week course in information technology for CEO's. People couldn't believe that while this company was going through the growing pains he would take that time. But he did and I think he made the right decision. The last factor this account executive described, was our product design and our network.

The next person I asked was a broker. He said it was the broad selection of plan designs. We have a series of fee schedule plans that are very affordable, kind of a

schedule benefit plan. We don't sell a lot of it, but the rates are very low and it gets the broker talking to the client. Another interesting thing this broker said was the flexibility, and particularly with respect to the company's prior authorization requirements. I think a lot of our competition are actually medical carriers that have gotten into dental and they bring some baggage with them with respect to the kind of things that need to have prior authorization and utilization management that's key to managed care. The CEO, who's a dentist, knows that we have a $1,500 or $2,000 maximum and it's just not necessary to do all that onerous kind of prior authorization that the customers and the brokers hate.

The next thing is the differentiated network. Part of my speech is if you build, they will come. That is the network. That was advice given to the CEO by a friend of mine early on and you'll see this network issue come up again. The broker thinks our pricing is competitive. He thinks another good reason that we're doing well is we're giving out loss ratio information on renewals. We're not buying business, but like any company, we make mistakes sometimes in the pricing originally and when we have a big rate increase, we work with the broker. We give him the loss ratio information and we help him help us sell it.

I asked another broker for input. I won't go over the same things that the first one said, but you remember the account executive, he is assigned to this broker. This broker feels that that particular account executive is one of the main reasons the company's been successful.

We identified the 900 pound gorilla in our local market, the key broker. Everybody has leaders, brokers are no different. This is a leader in the brokerage community. I spent a lot of time with him; the CMO spent a lot of time; even the CEO spent a lot of time with this key broker. Once he believed in us and started selling it, that was good enough for a lot of other brokers. We copied the competition. I think the truth is dental insurance just isn't very important to a lot of employers and it's not on top of the list even for some brokers. Even though this CEO is probably the smartest clinician I've ever worked with, and I've worked with a lot, and could invent something that is radically different and significantly better than what's in the marketplace, we knew that the customers and the brokers wouldn't give us time to educate them to the point so they would believe that it's better. Rather than invent something totally different, we copied the competition.

The brokers say our renewals are moderate. Even though I've put up with it for 23 years, I think the bait and switch that we do in this business is wrong. When we sell stuff at inadequate rates and try to make it up on renewals it is the wrong thing to do. We don't do that and that's why our renewals are not high. Again, it's the differentiating network.

The third broker thinks the reason we were successful is, even though the company had no track recorder, no reputation at all, we hired salespeople who did. They had existing broker relationships; they were highly thought of; they were people that the brokers knew kept to their word.

The only other thing is the making it his own plan. For some of the key brokers we actually gave our dental insurance to the key brokers and their employees for free. When these key brokers were out there making the sale to the customer, they could say, "I know this plan is good, it's my plan, I use it, and I'm speaking from experience."

The CMO thinks it's good because of his motto that he has printed on his wall and he has his team devoted to: "We treat our brokers and clients as if the world revolves around them because it does." Secondly, he says we don't act like experts, we listen to the brokers and we learn from our mistakes.

The last new thing concerns a big carrier in California that with the Internet and everything else, they decided that the future is to reduce costs, to cut broker commissions on small groups by a factor of three. I'm not sure if they're right or wrong, but it created an opportunity. It was a lot of turmoil in the broker community, and it created an opportunity for us to gain the loyalty of these brokers that are upset, so we took advantage of that opportunity.

Next is the Underwriting Manager. These comments are actually my favorite in the presentation because I hired this guy and I like what he said. He said, "Our manual rates require more information and they're more precise. We have a lot of pricing variables and our rates are high on bad risks and our rates are low on good risks." There was a side benefit that came out of this that I didn't anticipate and that was that the salespeople weren't happy at first with these complicated rates that they had to work with, but going back and forth with the underwriter they learned a lot. When they're out there and they come in high on a quote, they know why and they're able to talk "actuarialees" to the brokers. It gives them a story, it makes them feel good, and it makes them look good. Our claims people have clinical expertise. Our claims people are actually people that worked in the provider offices doing billing. They have worked next to dentists and next to hygienists and they have that experience so when they see a bill from a provider they know what that provider is thinking. Finally, our underwriter says our underwriting is good and there's a little bit of justified pride and self-confidence there.

Next is the Claims Manager. She says it's our salespeople, they work very hard. She thinks the underwriter prices the groups right. She also thinks that we are willing to adjust our premiums to get the sale. This is not true, but this is what she thinks. Our closing ratio is under 10% and we are not buying business.

Next is a Provider Service Representative, which is the highest level of employee that's not a management position. Next to the CEO, she is primarily responsible for building the network. She says the company has very dedicated people and it shows in their work. Some of us have been here for many years and have seen overall great results and it's all of the departments that make the difference.

The CEO has retained a very highly paid management consultant who is engineering the company for the future. Out of all her comments there's only two that I'm going to emphasize that other people miss. She points out that we are competing

in marketing in our own backyard and that people talk to people not just on the phone. When an opportunity comes I make broker calls all the time with the CMO and problems get solved face-to-face. Also, she points out that we're marketing to smaller groups as well as larger groups. I think a lot of the big, successful carriers focus on the larger groups, but we understand that the brokers control the small groups, the really profitable medium-sized groups, and the big groups. We take care of the small stuff even though sometimes I wonder why.

There's a retired underwriter, he's a real old friend of mine, and he's on the Board of Directors. One of the things he pointed out is he thinks the customer service of the company is outstanding, largely because the company is small and not fully automated. He also thinks the company has been successful because they just do one thing and that's dental.

Next is the CEO, the dentist. If you want to be successful, especially in a mature industry, you have to eat, drink and sleep your business. You have to care more than the others, so that you can know the details that the others take for granted. Doing that is caring for a business. Not doing it is just punching in and out every day. That makes more of a difference than anything I know of. I could never do his job. However, this is an actuarial meeting and there needs to be some actuarial work. One issue that occurred to me when the CEO built the network; eventually decided on the fee schedule and schedules that he would use; signed up the network; and presented it to me to do the pricing, was that it's for general dentists, not for specialists. The question was what difference do specialists make in the pricing model? Table 2 and 3 are my Excel model that I used to come to the bottom line conclusion that 18% of the claims go to the specialists. Bill actually has enough data to know the truth, but what I did is theory. I had that work peer reviewed and my peer reviewer suggested that I point out that an implicit assumption that I made in that model is that specialists don't do work outside of their own specialty. It is probably isn't 100% true, but I was willing to make that round off error.

TABLE 2
DISTRIBUTION OF DENTAL PLAN COSTS BY SPECIALIST TYPE

Specialty	Endo.	Oral Surg.	Pedo.	Perio.	Prosth.	Gen.	Total*
# of Providers (1)	3,000	6,000	3,000	4,000	2,000	82,000	100,000
Relative Fee (2)	125.0%	125.0%	125.0%	125.0%	125.0%	100.0%	
Insurance %(3)	100.0%	50.0%	90.0%	95.0%	80.0%	100.0%	
Plan $'s by specialist (1)x(2)x(3)/(1 Total)	3.8%	3.8%	3.4%	4.8%	2.0%	82.0%	99.6%
Normalize (4)	3.8%	3.8%	3.4%	4.8%	2.0%	82.3%	100.0%

* excludes ortho

TABLE 3
DISTRIBUTION OF DENTAL PLAN COSTS BY SERVICE CATEGORY

Category	Endo.	Oral Surg.	Pedo.	Perio.	Prosth.	Gen.	Total*
Cost pmpm	$1.40	$1.00	$1.00	$1.40	$2.40	$12.80	$20.00
Distribution (5)	7.0%	5.0%	5.0%	7.0%	12.0%	64.0%	100.0%
Category by Specialist (6): (4)/(5)	54%	75%	68%	68%	17%	N/A	18%
Cost pmpm	$0.75	$0.75	$0.68	$0.95	$0.40	N/A	$3.54
Category by General (7): 1-(6)	46%	25%	32%	32%	83%	100%	82%
Cost pmpm	$0.65	$0.25	$0.32	$0.45	$2.00	$12.80	$16.46

* excludes ortho

I'd like to read a couple of e-mails that I exchanged with the CEO after he reviewed this, he gave me permission to present them. I wrote to him, "The most common thing people thought made us successful was the way we differentiated the network. You will remember that you and I and the Chief Marketing Officer ruled out this idea in the beginning. The first person who saw the opportunity was Daphne Lang. She was that older British broker that we had on the Broker Advisory Committee. I called her yesterday to tell her that she was right all along and saw it before any of the rest of us or the other brokers." And he wrote back to say, "The lady saw the opportunity that all of us missed. However, ideas are easy to come up with. You made the numbers work in practice by setting up the underwriting rules and products that make sense. Richard and his team went out and gave it their best to sell a good product. Lisa and her team have been doing a miraculous job of paying claims for 50,000 members using rudimentary systems. Ideo and his team did another miraculous job keeping track of the billing and eligibility. We also happen to have multiple advantages that we didn't realize. But you know, when you're in business that's the way it always is. When you stick your neck out you see the opportunities and you also realize the risk that you are taking when you're out there. It's natural to take a look at your operations and see how you can make it work together better. I would still say that our success has been much more because of the people and not any single idea."

Mr. Martin: We have a few minutes for any questions.

Mr. Thomas Jacob Leibowitz: One issue that didn't really seem to be addressed that much other than kind of vaguely with Wes Weller's presentation was the various cost differentials among different providers and the impact that things like profiling and credentialing have on overall costs. I was just wondering if you could elaborate on how that fits into your pricing model and how much of that is actually done in practice.

Mr. Billard: Okay, cost per patient not cost per procedure. I'm looking at Bob Michaelson in the audience here and without giving anything exciting away he's the actuary for Delta Dental of Minnesota. He and I and a bunch of other people have looked at some of this cost per patient issue to see if there's the potential for some sort of product in it. There probably is, but it needs a lot of development. What happens when you look at these statistics and the data that shows you what the big issue to me is a dentist's cost per patient is on the patients he's been treating.

But you don't know if you give him a whole different set of patients that's part of a particular group, whether he will treat them the same way. You don't know for sure whether his past treatment patterns are the result of the way he practices or the draw of patients that he gets. To me that's the most critical thing that we need to sort out before we can really use that in terms of product development. I'm trying to think of a way we use it in pricing and I'm not coming up with anything just offhand. Michael, I don't know if you have any information.

Mr. Fradkin: Well, we actually look at provider practice patterns and not so much from a pricing perspective but in terms of adjudicating our claims. We take a look at the provider practice patterns and those providers who tend to have patients who utilize high cost services more often are looked at a little bit closer. We have a claim review process that looks at high cost procedures, and also providers who tend to have patients that utilize high cost procedures.

Mr. Weller: I don't know how many of you have seen the Reader's Digest article back in 1997, I think it was in the July or October issue, but I think this is a huge issue. I think that there's a huge opportunity and that's all I have to say about it.

Mr. Harvey Sobel: Two questions. I guess my first one is for Wes. I enjoyed hearing your start-up story and I've worked on my share of start-ups. I wish they could all have the same outcome as yours did. I'd be curious though, in my experience with start-ups you have a lot of people running in a lot of different directions and shortage of maybe start-up capital. It seems like you had an organization that was motivated and kept all the employees working together. I'd be curious as to how the CEO was able to motivate people and was the start-up capital sufficient to really fund the thing during that period when you didn't have the business.

Mr. Weller: I can't really answer that without giving away what this company is. If you give me your card I'll pass it on.

Mr. Sobel: Okay. I also have a general question, mostly for Bill and Michael. Maybe I missed it in the talk, but do you have networks where the active network is not necessarily the same dentist as the passive network.

Mr. Fradkin: I'll let Bill answer that because we only have one network so that's not an issue for us.

Mr. Billard: Yes, that's the case for us also. We only have one PPO network so we use the same network for both active and passive PPO's. We have tried, I have tried I should say, with the help of our professional relations people, to discourage passive PPO's because we're concerned about the erosion of the network. We have sold them on occasion when our competitors force us to. We'll try to quote them on groups that don't have a real high concentration of employees in one area where they could have a big impact on a dentist practice. We try to do what I said, try to have a good base of active business in an area before we'll sell a passive program there. It's only one network.

From the Floor: I'll just make an editorial comment because I know both of you are predisposed for an active PPO. It seems to me that we see representing employers quite a lot of quotes to go to either a passive or active PPO. Of course they'd like active but a lot of times you have union negotiations that make it difficult. Thus we do get a lot of passive quotes. We even get in some cases some vendors saying, "You have to move to the network on a renewal." So I think, and maybe it's your marketing people, we do see the pressure coming to the employer through the carrier.

Mr. Fradkin: Yes, I would agree.

Mr. Sobel: Thank you.

Mr. Michael B. Yarmish: It's been theorized that network dentists on average charge lower fees than those that are not willing to enter into a network. Have you seen this in your experience? Do you have any hard numbers to judge by how much that is true?

Mr. Billard: We have not tested this recently. When we first started our PPO, which was in the late 1980's, we saw the dentists in the network were about 3% lower than the average. I just heard a statistic recently from another Delta Dental plan that has a very large panel, but in that panel as well they're 2.5% below the average of all dentists.

Mr. Yarmish: Has Tillinghast done anything in this respect?

Mr. Martin: No, we haven't done any kind of study like that.

Mr. Fradkin: We actually looked at this recently and the network dentists do charge less than the average. It's somewhere around 2–3% and if you look at the network dentists' average charges versus non-network dentists, the differential there is more like 4 or 5, so the non-network dentists are slightly above $1 and the network dentists are slightly below $1.

Mr. Yarmish: Do you incorporate that into your models?

Mr. Fradkin: Yes. I would just make one comment that I think it might be more likely that a dentist with empty chair time would sign up for a PPO and I would be worried about the off-setting effect of over utilization for dentists that sign up with PPOs. If you've got a dentist that's real popular, he has no need for a PPO. He has all the business that he can do, he's probably not over-utilizing.

From the Floor: I'm observing this presentation with more of a medical background and I'm curious on any comments you might have as to why Dental Health Maintenance Organizations (DHMO's) were not mentioned and whether or not they're a thing of the past. Maybe some comments of how you see the medical industry going that way as well.

Mr. Billard: Michael and I don't know anything about medical so we're not great people to ask that one, but I'll take a shot at it, anyway. We do have a DHMO. It frankly has not been that successful. I don't know if I've got an inside track on anything, but my sense is that if you look at national statistics, you'll see that the growth of dental HMO's has been sputtering over the last couple years. I don't think they're going to necessarily go away, but I think they've had their day in the sun and they're going to kind of phase out a little bit. I don't think you have the same situation to make that happen as in medical, it's just my opinion. In medical practices you can generate more savings than you can in dental practices, there are bigger dollars.

My theory from day one about dental HMO's versus PPOs is that the PPO is ultimately going to win out because it's a more efficient product. In dental, the administrative costs are very critical and very important and if you're running a dental HMO you have to do two things. First, you have to process claims because you have to be able to report to the group, so you don't lose that part. Then you've got this whole new different thing, linking the dentist to the patient, which is an administrative expense that you don't have for any of your other business, if you're a dental carrier. If you come in as a dental HMO, then you start off with that and develop expertise in it. At the PPO you don't have to do that linkage and that extra administrative expense added on to a dental HMO. A dental HMO kind of gives it just that extra little weight that it needs, I think, to make it less competitive.

Mr. David G. Fitzpatrick: This is a very nice presentation by all of you. You worked hard and it showed. I've just a couple general questions. First of all, in your discussions on the discounts you talked about 20% discounts for PPO dentists, and I was wondering how you handled the cost of maintaining the panel, if that was an explicit charge or if you just included it in your general expenses? Then the second one is if any of you have looked at your lapse experience at the policy level on PPO versus non-PPO plan?

Mr. Fradkin: On the first one we build the cost of our panel into the expense scale for PPO plans. On the second one, lapse rate on PPO plans versus indemnity plans, or active PPO plans versus passive PPO plans, we haven't done an extensive study on that recently. What we've seen in the last few years is a lot of indemnity plans converting over to PPO plans.

Mr. Billard: Yes, we've also seen that. A lot of indemnity plans converting to PPO. I haven't looked at our lapse rate, that's a really interesting question. I think it'd be interesting to see that. Our overall retention rate is about 97.5%, so I doubt that it's much different for the PPO. We've always maintained panels. I mean, before we developed our PPO we had a panel in our indemnity premier product, so the additional expense to maintain the PPO panel is not probably as great for us as it is for other carriers. We do maintain those costs separately and we charge separately for those costs to our PPO patients. Of course as the PPO has grown a lot of them are fixed, flat expenses. So they've kind of decreased on a cost per subscriber over time.

CHART 1
Effect of Deductible

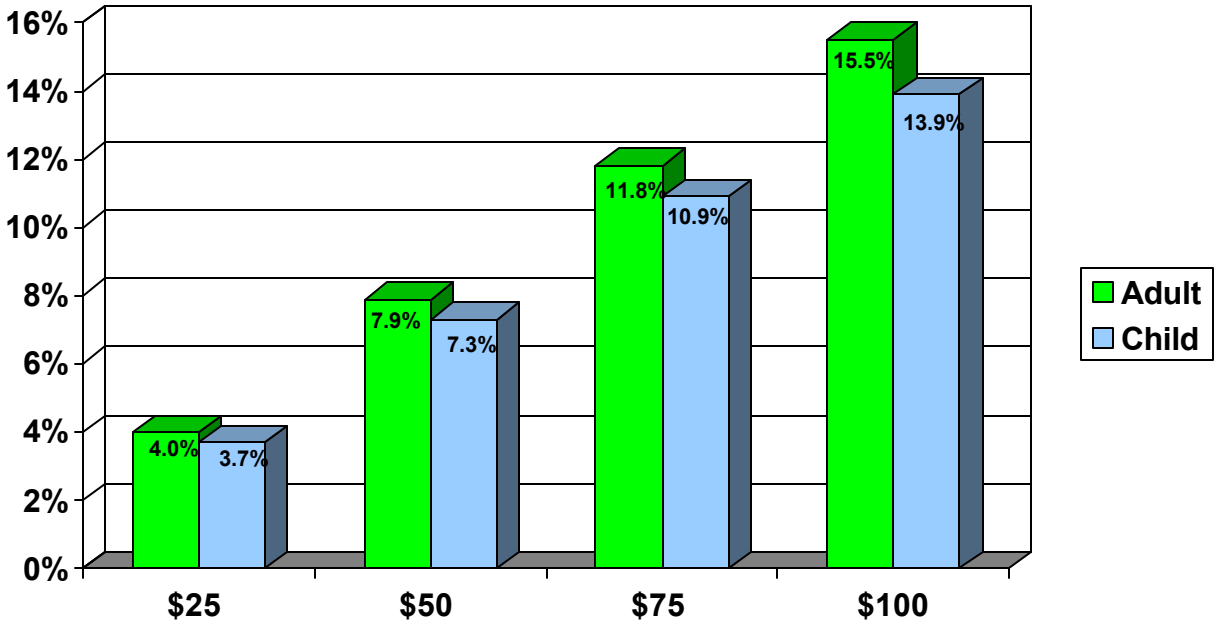

CHART 2
Effect of Maximum