

2nd Edition

Fee-For-Service
DENTISTRY
with a managed-care component

Tom Limoli, Jr.



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Library of Congress Catalog Card Number 95-076086.

Published by Limoli & Associates, P.O. Box 899, Arlington, TN 38002

Printed in the United States of America.

This book is a revision and expansion of Limoli's original 1995 text.

Fee-For-Service **DENTISTRY** with a managed-care component

Chapter 1

The Evolution and Transition of Managed Health Care

Chapter 2

The Two Giants of Managed Dental Care:
Preferred Provider Organization (PPO),
Capitation Contract Dentistry (CCD)

Chapter 3

The Corporate Practice of Dentistry

Chapter 4

The Four Phases of Dental Treatment

Chapter 5

Fees and Surcharges

Chapter 6

The Empty Chair Syndrome and Scheduling

Chapter 7

Salary Compensation for Dentists/Hygienists
in a Fee-for-Service/Capitation Mix

Chapter 8

The Safety Net



Tom M. Limoli, DDS

1924 - 2006

Tom M. Limoli, DDS, graduated from the University of Pennsylvania School of Dental Medicine. He was widely recognized as one of this nation's foremost authorities on dental insurance and reimbursement. He successfully completed more than four decades of private practice with extensive academic, consultative, and professional accomplishments in dentistry. Dr. Limoli served as a consultant claims reviewer for indemnity coverage, capitation prepaid dental care, and malpractice claims. He adjudicated insurance claims as a carrier consultant for dental insurance brokerage firms and for insurance carriers.

He lectured in many dental schools and presented programs at most of the national and state society meetings, as well as the Canadian Dental Association. Through these lectures, Dr. Limoli greatly contributed to the profession's understanding of dental insurance and reimbursement. He chaired the Georgia Dental Association Council on Peer Review, as well as its Councils on Dental Health and Dental Care. Dr. Limoli chaired the writing of the Georgia Dental Association's Quality Assessment Manual on parameters of care.

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Dedication

To those in my profession
who have taught in the past,
who will learn in the present,
and who shall teach in the future...
as all of us must remain students.

– 1984

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At a Glance

THE EVOLUTION AND TRANSITION OF MANAGED HEALTH CARE

This introductory chapter opens with a statement regarding the excellent delivery of health care in the USA and follows with a discussion of the problems of financing and insuring the cost of health-care delivery. The main sections of this chapter are as follows:

- **The History of Health Insurance:** Origins of the philosophy in the Roosevelt administration of the 1930s and the implementation of health-insurance concepts in WWII and post-war years.
- **The Tax-Deductibility Issue:** A crucial issue in any proposal for health-care reform, as the IRS attempts to tax both the employer's portion of health-insurance premiums and the employee's portion of health-care benefits.
- **A National Health-Care System:** From the Clinton to the Obama Administrations, health reform proposals, including single payer system, managed competition, and hybrid alternative health plans.
- **Possible Choices in Health-Care Plans:** "Cafeteria-style" choices ranging from basic "first dollar" coverage to high-benefit plans; and the tax-deductibility of different types of plans.
- **The Role of Government:** Government's involvement in health care through Medicaid and Medicare, and the fears of taxpayers concerning governmental waste and the rising cost of health care for the middle class.
- **Issues Vital to the Dental Profession:** Tax deductibility; pediatric dental care; waste, overutilization and fraud; and universal electronic processes.
- **The Decline of Traditional Indemnity Insurance and the Rise of Managed Care:** Data showing the decline in traditional indemnity medical plans and the shift toward managed-care plans.
- **Conclusion:** Key elements to keep in mind when reading the subsequent chapters on combining fee-for-service dentistry with an element of managed care.

The Evolution and Transition of Managed Health Care

Americans have the best health-care delivery system in the world. We deliver more of the finest medical and dental care to more people than any other country. Patients from all over the world come to the Mayo Clinic in Rochester, Minnesota, to hospitals in Atlanta, Boston, Dallas, New York, Philadelphia, San Francisco, and many other locations to obtain the finest surgical techniques, treatments, and diagnostic services available, because we do it better here in America than anywhere else.

However, our health-care system is not without problems. Primarily, these problems do not involve the one-to-one doctor/patient relationship, but the inept financing and insuring of the cost of health-care delivery. Annual health-care costs were \$2.6 trillion in 2010, over ten times the \$256 billion spent in 1980. The number of people who lack health insurance climbed to 49.9 million, up from 49 million in 2009. Nationwide, 16.3% of the population was uninsured in 2011, statistically unchanged from

2009.¹ This figure is likely to increase as more and more employees lose benefits because of layoffs and other efficiency constraints imposed by their employers. With the U.S. being in a recession for almost a decade, more Americans are concerned over high unemployment rates and lower incomes.

Health insurance is not as clearly defined as traditional life or liability insurance. The intended purpose of all insurance is to protect against the economic consequences of catastrophic loss. In turn, insurance companies protect themselves by spreading the risk among their policyholders. In an effort to better understand this complex subject, let us begin by tracing the history of health insurance in America and the development of managed care. Later in this chapter, we will discuss the role of alternate systems of health-care delivery and reimbursement in the ongoing efforts to reform our nation's health-care system.

The History of Health Insurance

In 1936, President Franklin D. Roosevelt's Surgeon General, Thomas Parran, Jr., expressed the belief that all Americans should have an equal opportunity for health care as an inherent right, like our right to liberty and the pursuit of happiness. This new concept—that health care is a right—was the catalyst for the federal health-care programs that emerged during and following World War II.

In 1940, one of the most notable initiatives in employee health-care benefits began when Kaiser

Industries asked Dr. Sidney Garfield, a physician in the state of Washington, to form a group practice that would supply health-care services to laborers constructing the Grand Coulee Dam in that state. Kaiser contracted for health care at a fixed price per employee per year. Thus, managed care was born. Today, Kaiser Permanente is the country's oldest and largest health maintenance organization (HMO), providing health care for more than 12 million enrollees.

1. Les Christie, "Number of people without health insurance climbs" www.money.cnn.com, Sept. 13, 2011.

Employer-provided health insurance grew tremendously during the 1940s. With World War II came a labor shortage. Wage and price controls prohibited companies from using salary increases to attract workers. In 1942, the War Labor Board agreed that benefits of up to five percent of wages would not be ruled inflationary. Employers began to offer health-care benefits as an additional, tax-free compensation to employees. Employers could also deduct from taxable profits the amounts they paid (premiums) to provide these benefits. Together, labor and management received a double benefit – a tax-free gain in “income” for the employee and a

tax-deductible expense for the employer. Health-insurance plans soon began to be viewed as tax-free compensation.

In the postwar years, one labor union after another negotiated for health benefits in their labor contracts. The Congress of Industrial Organization and the National Labor Relations Board concurred that health insurance was a high priority. As a result of these postwar changes, the issue of tax avoidance has gradually replaced the issue of risk spreading as the principal topic of concern.

The Delivery of Medical Care

By Sidney R. Garfield, MD

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The U.S. system of high-quality but expensive and poorly distributed medical care is in trouble. Dramatic advances in medical knowledge and new techniques, combined with soaring demands created by growing public awareness, by hospital and medical insurance and by Medicare and Medicaid, are swamping the system by which medical care is delivered. As the disparity between the capabilities of medical care and its availability increases, and as costs rise beyond the ability of most Americans to pay them, pressures build up for action. High on the list of suggested remedies are national health insurance and a new medical care delivery system.

National health insurance, an attractive idea to many Americans, can only make things worse. Medicare and Medicaid – equivalents of national health insurance for segments of our population – have largely failed because the surge of demand they created only dramatized and exacerbated the inadequacies of the existing delivery system and its painful shortages of manpower and facilities. It is folly to believe that compounding this demand by

extending health insurance to the entire population will improve matters. On the contrary, it is certain that further overtaxing of our inadequate medical resources will result in serious deterioration in the quality and availability of service for the sick. If this country has learned anything from experience with Medicare and Medicaid, it is that a rational delivery system should have been prepared for projects of such scope.

The question then becomes: What are the necessary elements of a rational medical care delivery system? Many have proposed that prepaid group practice patterned after the Kaiser Permanente program, a private system centered on the West Coast, may be a solution. We at Kaiser Permanente, who have had more than 30 years' experience working with health care problems, believe that prepaid group practice is a step in the right direction but that it is far from being the entire answer. Lessons we have learned lead us to believe there is a broader solution that is applicable both to the Kaiser Permanente system and to the system of private practice that prevails today.

The heart of the traditional medical care delivery system is the physician. Whether he practices alone or in a group, he is still directly involved in the care of the patient at every important stage, from the initial interview to the final discharge. Any realistic solution to the medical care problem must therefore begin by facing up to the facts about the supply of physicians.

Of the active doctors in the U.S. a great many are engaged in research, teaching and administration. Those actually giving patient care, in practice and on hospital staffs, number about 275,000 (approximately 135 per 100,000 of population), and they are far from evenly distributed throughout the population. A preponderance are in urban areas, and within those areas they tend to be concentrated where people can best afford their services. Increasing specialization accentuates the shortage of doctors. If we were to augment the output of our medical schools from the present level (fewer than 9,000 doctors a year) to twice that number (which is scarcely possible), we would barely affect this supply in 20 years, considering the natural attrition in our existing physician complement. The necessity of living with a limited supply of physicians in the face of increasing demand forces us to focus on the need for a medical care delivery system that utilizes scarce and costly medical manpower properly.

The traditional medical care delivery system has evolved over the years with little deliberate planning. At the end of the 19th century medical care was still relatively primitive: there was the doctor and his black bag and there were hospitals – a place to die. People generally stayed away from the doctor unless they were very ill. In this century expanding medical knowledge soon became too much for any one man to master, and specialties began developing.

“Health education should not only be available, it should be unavoidable.”

- By Sidney R. Garfield, MD
Scientific American,
1970

Laboratories, x-ray facilities and hospitals became important adjuncts to the individual physician in his care of sick people. Since World War II a chain reaction of accelerated research, expanding knowledge, important discoveries and new technology has brought medical care to the level of a sophisticated discipline, offering much hope in the treatment of illness, yet requiring the precise and costly teamwork of specialists operating in expensively equipped and highly organized facilities (see Figures 1a on page 12 and 1b on page 13).

Throughout these years of remarkable medical achievement the delivery system has remained relatively unchanged, as though oblivious to the great need for new forms of organization equal to the task of applying new techniques and knowledge. Physicians have clung to individualism and old traditions. Their individual hospitals have continued on their individual ways, striving to be all things to their doctors and patients, creating their own private domains, largely ignoring the tremendous need to merge their highly specialized services and facilities. It is only in comparatively recent years that group practice by doctors has been considered respectable (and as yet only some 12% of all physicians practice in groups) and that regional facility planning boards have appeared to force some semblance of cooperation on hospital construction.

It is amazing that the traditional delivery system functioned as well as it did for so long, considering the stresses between old methods and new technology. Much of its inefficiency was absorbed by dedicated physicians working long hours and donating additional hours; much was absorbed by office and hospital personnel working for extremely low pay. Only recently, under the joint

impact of soaring demands for service and demands for competitive wages, has the system begun to break down, but it has been faltering for some time. In 1967, the National Advisory Commission on Health Manpower reported that "medical care in the U.S. is more a collection of bits and pieces (with overlapping, duplication, great gaps, high costs and wasted effort) than an integrated system in which need and efforts are closely related."

Let us look at another medical care delivery system: the Kaiser Permanente plan. This program had its origin in southern California in the depression years from 1933 to 1938. I was then in private practice, and I became involved in providing medical and hospital services and facilities for several thousand construction workers. Unable to make ends meet by depending for remuneration on the usual fee for service,

I finally tried prepayment and thus happened on our basic concepts of health care. Prepayment to a group of physicians in integrated clinic and hospital facilities proved to be a remarkably effective system for providing comprehensive care to workers on a completely self-sustaining basis. At the Grand Coulee Dam from 1938 to 1942, with the warm interest and counsel of Henry J. Kaiser and his son Edgar, these basic concepts were further developed, tested and broadened into a complete family plan for the entire temporary community built around that construction job.

World War II expanded our Health Plan concept into care for 90,000 workers of the Kaiser wartime shipyards in the San Francisco Bay area and a similar number of workers in the Portland and Vancouver

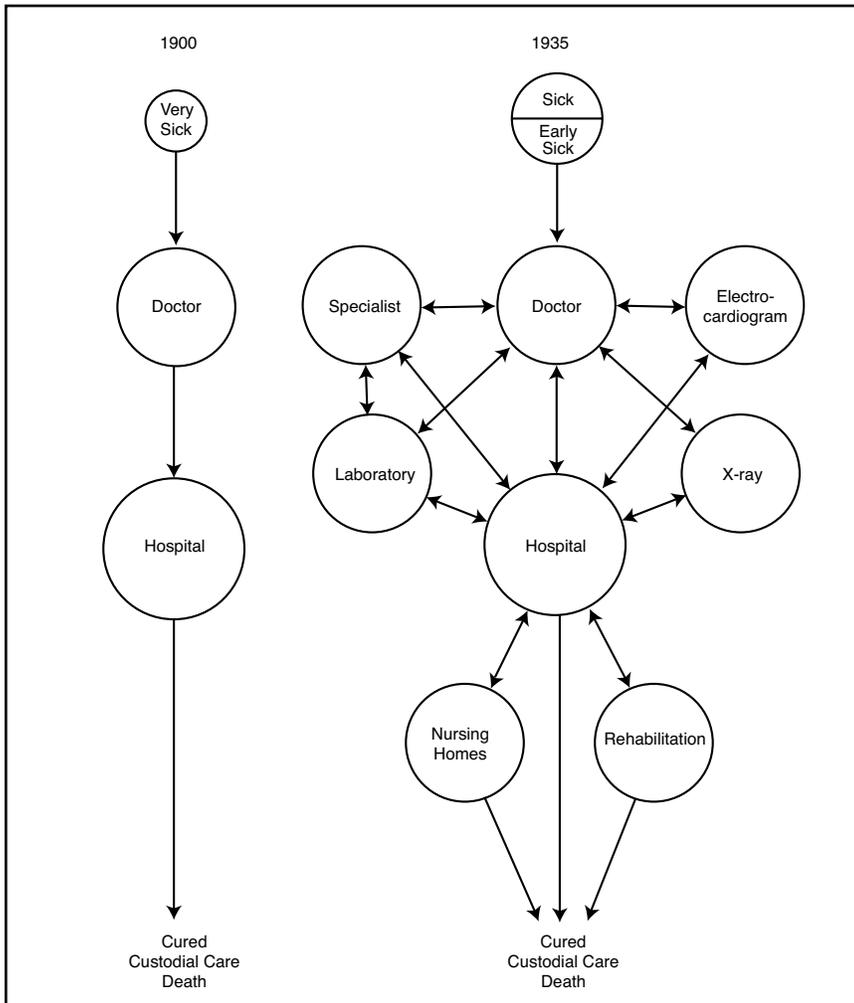


Figure 1a. Medical care has become more complex in this century and as it has become more effective the entry mix of people has changed significantly. Yet the entry point is still the doctor's appointment. Before 1900 medicine had little to offer and only sick people entered medical care. By 1935, as medicine began to have more to offer and as insurance plans appeared, some "early sick" people were entering the system.

area. At the end of the war these workers returned to their homes, leaving us with facilities and medical and hospital organizations. We decided to make our services available to the community at large. Since 1945 the plan has grown of its own impetus, without advertising, to its present size: more than two million subscribers served by outpatient centers, 51 clinics and 22 hospitals in California, Oregon, Washington and Hawaii and in Cleveland and Denver. The plan provides comprehensive care at an annual cost of \$100 per capita, which is approximately two-thirds the cost of comparable care in most parts of the country.

The plan is completely self sustaining. Physical facilities and equipment worth \$267 million have been financed by Health Plan income and bank loans (except for gifts and loans to the extent of about 2%). The plan income provides funds for teaching, training and research, and pays competitive incomes to 2,000 physicians and 13,000 non-physician employees.

The Health Plan and the hospitals are organized as nonprofit operations and the medical groups in each area are autonomous partnerships. This organization gives our physicians essentially

the same incentives as physicians in private practice have; they are motivated, in addition, by their belief in the rightness of this way of practicing medicine. In addition to prepayment, group practice and the integration of hospital and clinic facilities, we can identify three other principles that are essential to the plan's success. One is the institution of what is in effect a new medical economics, which flows simply from the fact that the total Health Plan income is turned over to the physicians and hospitals not as a fee for specific

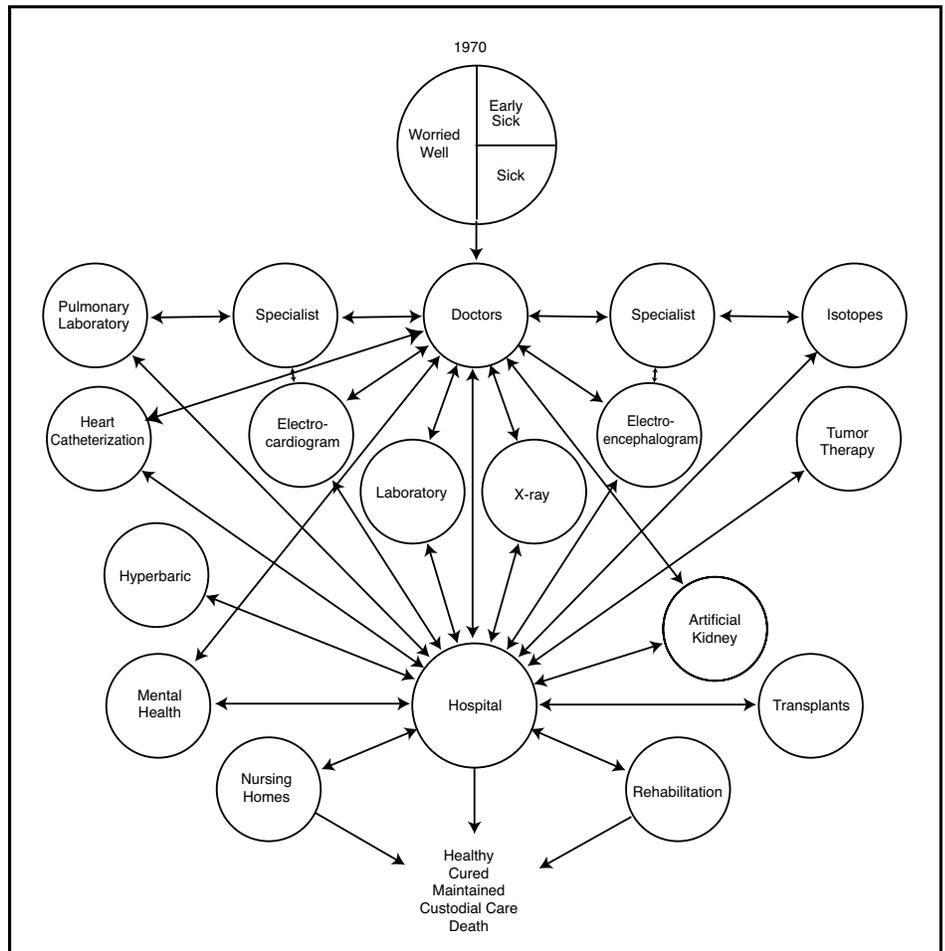


Figure 1b. Since World War II medical technology has proliferated, as indicated by the partial display of treatment components and well people enter, largely because of prepayment, insurance plans, Medicare and Medicaid.

services but as a total sum. This reverses the usual economics of medicine: our doctors are better off if our subscribers stay well and our hospitals better off if their beds are empty. Another principle is freedom of choice. We require any group that wants to enroll its members in our group to offer them a least one alternative choice of medical plan, be it Blue Cross or a medical society plan or something else. Finally, we consider it a fundamental principle that the physicians must be involved in responsibility for administrative and operational decisions that affect the quality of the care they provide.

We believe any group of physicians or a foundation working with physicians, can easily duplicate the Kaiser Permanente success. It only requires a dedicated group of physicians with reasonably well-organized facilities, a membership desiring their services on a prepaid basis and strict adherence to all these principles.

All of this is not to say that U.S. medicine should change over to the Kaiser Permanente pattern. On the contrary, freedom of choice is important; we believe that the choice of alternate systems, including solo practice, is preferable for both the public and physicians.

Any change to prepaid group practice should be evolutionary, not revolutionary. Physicians in general have too much time and effort vested in their practice to discard them overnight. It will probably be the younger men, starting out in practice, who will innovate. Medical school faculties should point out the advantages and disadvantages of all methods of practice to these young men so that they can choose wisely.

Let us examine the functioning of these two systems – the traditional system and the Kaiser Permanente one. In the language of systems analysis, the traditional medical care system has an input (the patient), a processing unit of discrete medical

resources (individual doctors and individual hospitals) and an output (one hopes the cured or improved patient). Customarily the patient decides when he needs care. This more or less educated decision by the patient creates a variable entry mix into medical care consisting of 1) the well, 2) the “worried well,” 3) the “early sick” and 4) the sick. This entry mix has markedly increased in quantity and changed in character over the years as medical care resources have grown in complexity and specialization. One constant throughout this evolution has been the point of entry into the system, which is and always has been the appointment with the doctor. Moreover, in traditional practice the patient enters with a fee.

The Kaiser Permanente program alters the traditional medical care delivery system in only two ways. It eliminates the fee for service, substituting prepayment, and it organizes the many units of medical care resources into a coordinated group practice in integrated clinic and hospital facilities. We have come to realize that ironically the elimination of the fee has created a new set of problems. The lessons we have learned in seeking to solve these problems have a direct bearing on the difficulties besetting the country’s faltering medical care system.

The obvious purpose of the fee is remuneration of the physician. It has a less obvious but very significant side effect: it is a potent regulator of flow into the delivery system. Since nobody wants to pay for unneeded medical care, one tends to put off seeing the doctor until one is really sick. This limits the number of people seeking entry, particularly the number of well and early-sick people. Conversely, the sicker a person is, the earlier he seeks help – regardless of fee. Thus, the fee-for-service regulator tends to limit overall quantity, to decrease the number of the healthy and early sick and to increase the number of the really sick in the entry mix.

Elimination of the fee has always been a must in our thinking, since it is a barrier to early entry into sick care. Early entry is essential for early treatment and for preventing serious illness and complications. Only after years of costly experience did we discover that the elimination of the fee is practically as much of a barrier to early sick care as the fee itself. The reason is that when we removed the fee, we removed the regulator of flow into the system and put nothing in its place. The result is an uncontrolled flood of well, worried-well, early-sick and sick people into our point of entry – the doctor’s appointment – on a firstcome, first-served basis that has little relation to priority of need. The impact of this demand overloads the system and, since the well and worried-well people are a considerable proportion of our entry mix, the usurping of available doctors’ time by healthy people actually interferes with the care of the sick.

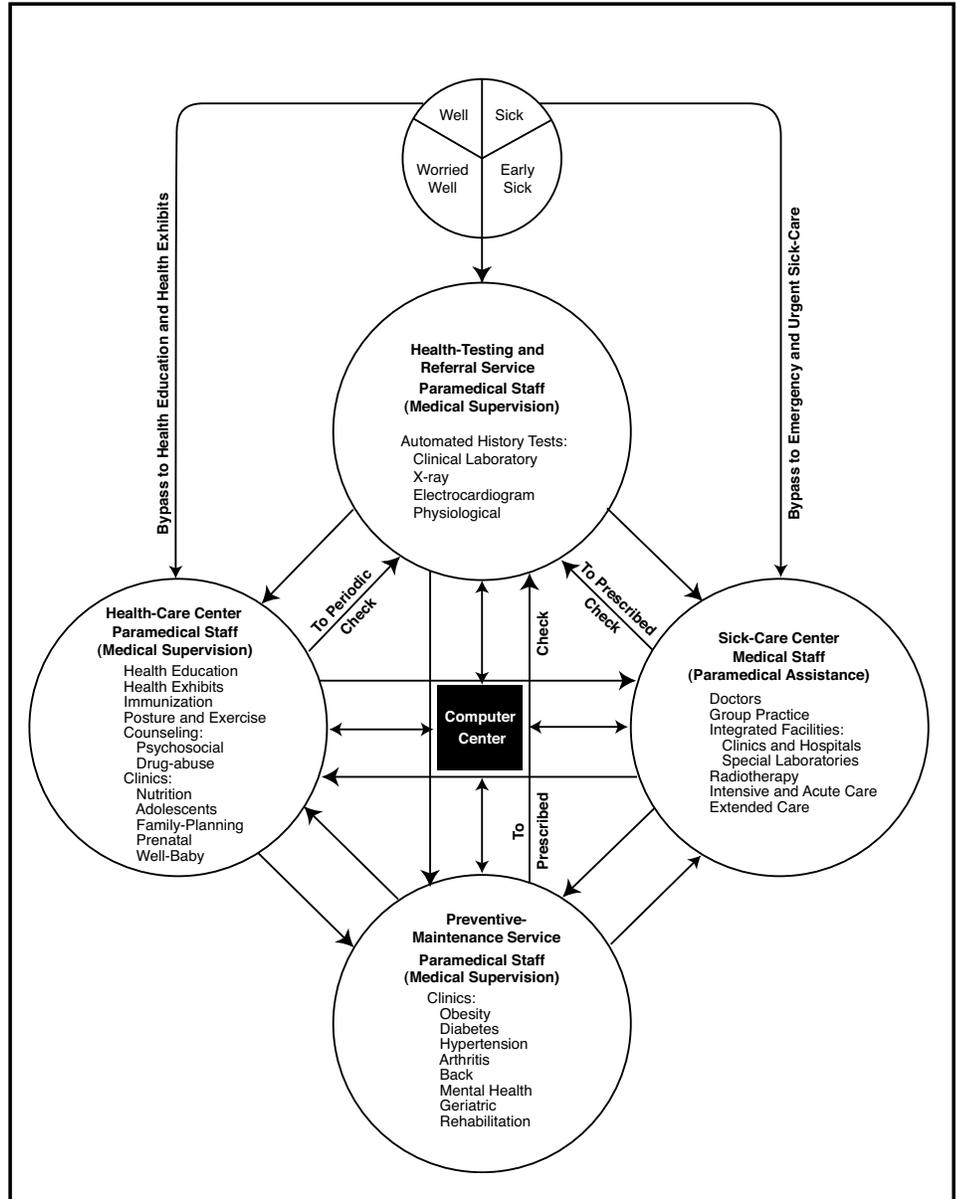


Figure 2. New delivery system proposed by the author would separate the sick from the well. It would do this by establishing a new method of entry, the health-testing service, to perform the regulating function that was performed, more crudely, by the fee for service. After health testing the patient would be referred for sick care, health care or preventive maintenance as required and would be transferred among the services as his condition changed. The computer center would regulate the flow of patients and information among the units, coordinating the entire system, which would depend heavily on paramedical personnel to save doctors’ time.

The same thing has happened at the broad national level. The traditional medical care delivery system, which has evolved rather loosely over the years subject to the checks and balances of the open market, is being overwhelmed because of the elimination of personally paid fees through the spread of health insurance, Medicare and Medicaid. This floods the system not only with increased numbers of people but also with a changed entry mix characterized by an increasing proportion of relatively well people. For this considerable segment of patients the old methods of examining and diagnosing used by the doctor become very inefficient. He spends a large portion of his time trying to find something wrong with healthy people by applying the techniques he was taught for diagnosing illness. This reverse use of sick-care technology for healthy and comparatively symptomless people is wasteful of the doctor's time and boring and frustrating for him.

The obvious solution is to find a new regulator to replace the eliminated fee at the point of entry, one that is more sensitive to real medical need than to ability to pay and that can help to separate the well from the sick and establish entry priorities for the sick. We believe we have developed just such a regulator. Our Medical Methods Research Department, headed by Morris F. Collen, who is an electrical engineer as well as a physician, has successfully developed and tested techniques for evaluating the health of our members. The system that has been developed, which is variously called multiphasic screening, health evaluation or simply health testing, promises to solve the problem of a new regulator to flow into our medical care delivery system.

Originally designed to meet our ever-increasing demand for periodic health checkups, health testing combines a detailed computerized medical history with a comprehensive panel of physiological

tests administered by paramedical personnel. Tests record the function of the heart, thyroid, neuromuscular system, respiratory system, vision and hearing. Other tests record height and weight, blood pressure, a urine analysis and a series of 20 bloodchemistry measurements plus hematology. The chest and (in women) the breasts are x-ray'd. By the time the entire process is completed the computerized results generate "advice" rules that recommend further tests when needed or, depending on the urgency of any significant abnormalities, an immediate or routine appointment with a physician. The entire record is stored by the computer as a health profile for future reference. This health-testing procedure is ideally suited to be a regulator of entry into medical care.

Certainly it is more sophisticated than the usual fee for service or our present first come, first-served method. As a new entry regulator, health testing serves to separate the well from the sick and to establish entry priorities. In addition it detects symptomless and early illness, provides a preliminary survey for the doctors, aids in the diagnostic process, provides a basic health profile for future reference, saves the doctor (and patient) time and visits, saves hospital days for diagnostic work and makes possible the maximum utilization of paramedical personnel. Most important of all, it falls into place as the heart of a new and rational medical care delivery system (see Figure 2 page 15).

As I have indicated, much of the trouble with the existing delivery system derives from the impact of an unstructured entry mix on scarce and valuable doctor time. Health testing can effectively separate this entry mix into its basic components: the healthy, the symptomless early sick and the sick. This clear separation is the key to the rational allocation of needed medical resources to each

group. With health testing as the heart of the system, the entry mix is sorted into its components, which fan out to each of three distinct divisions of service: a health care service, a preventive maintenance service and a sick care service. Compare this with the existing process, where the entire heterogeneous entry mix empties into the doctor's appointment, a sick care service.

Health care service is a new division of medicine that does not exist in this country or in any other country. Medical planners have long dreamed of the day when resources and funds could be channeled into keeping people healthy, in contrast to our present overwhelming preoccupation with curing sickness. Yet health care has been an elusive concept, and understandably so: well people entering medical care have been hopelessly mixed into and submerged in sick care, the primary concern of doctors. Doctors trained and oriented to sick care have been much too busy to be involved in the care of well people. True health care never had a chance to develop in that environment. In fact, not even the highly socialized governments with socialized medicine have created any significant services for the healthy other than sanitation and immunization. These governments swamp the doctor with the entire entry mix of well and sick and thus are unable to provide adequate care for either.

The clear definition of a health care service, made possible by health testing, is a basic first step toward a positive program for keeping people well. It should be housed in a new type of health facility where in pleasant surroundings lectures, health exhibits, audio-visual tapes and films, counseling and other services would be available. Whether or not one believes in the possibility of actually keeping people well, however, is now beside the point; this new health care service is absolutely essential in order to meet the increasing demand for just this kind of service and to keep people from overloading sick

care resources.

Preventive maintenance service, like health care service, has been submerged in sick care. Essentially it is a service for high-incidence chronic illness that requires routine treatment, monitoring and follow-up; its object is to improve the patient's condition or prevent progression of the illness, if possible, and to guard against complications. This type of care, performed by paramedical personnel reporting to the patient's doctor, can save a great deal of the doctor's time and (because it allows more frequent visits) provide closer and better surveillance.

The use of paramedical personnel with limited knowledge and limited but precise skills to relieve the physician of minor routine and repetitious tasks requires that such tasks be clearly defined and well supervised. Procedures are automatically defined and structured in the new system by the clear separation of services. Three of the four divisions of the proposed system – health testing services, health care services and preventive maintenance service – are primarily areas of paramedical personnel.

Supervising physicians will be involved in varying degrees: least in health testing and most in preventive maintenance. This leaves sick care, with its judgments on diagnosis and treatment, clearly in the physician's realm. Even here, however, he will be aided by the three other services in diagnosis, by health testing; in follow-up care, by preventive maintenance; in repetitive explanations and instructions to patients and relatives, by the audio-visual library of the health care service.

We believe, incidentally, that the doctor-patient relationship, which is suffering from the pressure of crowded schedules today, would gain under this system. Giving the doctor more time for care of

the sick can help to preserve the relationship at the stage where it counts most.

Implementing the new delivery system should be relatively simple in the Kaiser Permanente program, since there are no basic conflicts: The subscribers will benefit from better and prompt service to both the well and the sick; the doctors will have more time for their sick patients and their work will be more interesting and stimulating. Although the complete system remains to be tested and evaluated at each step, our hypothesis, on the basis of our research to date, is that we can save at least 50% of our general practitioners', internists' and pediatricians' time. This should greatly enhance our service for the sick and improve our services for the well.

Implementing this new medical care delivery system in the world of traditional medical practice will be more difficult, but it still makes sense. Many forward-looking physicians will see in these new methods an opportunity to improve their services to patients. Most doctors these days have more work than they can handle and begrudge the time they must spend on well people.

The assistance they could get from health testing and health care services will be welcome to many of them if such services are carefully designed and planned to help them. The sponsorship of health testing and health care services for private practice logically falls to the local medical societies. Some have already moved in the direction of health evaluation. A few local medical societies in northern California have for several years been operating a mobile unit evaluating the health of cannery workers. Some leaders of other medical societies have expressed interest in health testing as an entry into

medical care. They realize that improvement of the delivery system is essential for the preservation of the private enterprise of medicine in this country.

The proposed delivery system may offer a solution to the hitherto insoluble problem of poverty medical care in many areas. The need is to make health services accessible to poor people. To this end neighborhood clinics are established, but staffing these clinics with physicians has proved virtually impossible. Physicians in general want to be in a stimulating medical environment; they like to associate with well-trained colleagues in good medical centers and tend to avoid isolated clinics. In the system being proposed a central medical center, well staffed and equipped, would provide sick care.

It could have four or five "outreach" neighborhood clinics, each providing the three primarily paramedical services: health testing, health care and preventive maintenance. Staffing these services with paramedical personnel should be much less difficult than staffing clinics with doctors; many of the workers could be recruited from the neighborhood itself. Such outreach clinics, coordinated with the sick-care center, could provide high-quality, personal service – better service, perhaps, than is available to the affluent today – at a cost probably lower than the cost of the inferior service poor people now receive.

The concept of medical care as a right is an excellent principle that both the public and the medical world have now accepted. Yet the words mean very little, since we have no system capable of delivering quality medical care as a right. This is hardly surprising. Picture what would happen

to, say, transportation service if fares were suddenly eliminated and travel became a right. What would happen to our already overtaxed airports and what chance would anyone have of getting anywhere if he really needed to? National health insurance, if it were legislated today, would have the same effect. It would create turmoil. Even if sick care were superbly organized today, with group practice in well-integrated facilities, the change from "fee" to "free" would stagger the system.

Quality medical care as a right cannot be achieved unless we can establish need, separate the well from the sick and do that without wasting physicians' time. It follows that to make medical care a right, or national health insurance possible, it is mandatory that we first make available health testing and health care services throughout the country. It is our conviction that these services should be provided or arranged for by the physicians themselves in order to be responsive to their needs and not just a commercial operation.

A basic cause-and-effect relationship is directly responsible for much of today's medical care problems. The cause is the elimination of a personally paid fee for medical service. The effect is a changed, unstructured entry mix into the delivery system that wastes scarce medical manpower. The

suggested solution, a new method of entry through health testing, serves as the heart of a new medical care delivery system for the future.

The entry of healthy people into the medical care system should not be considered undesirable. It opens the door to a great opportunity for American medicine: If these well people are guided away from sick care into a new, meaningful health care service, there is hope that we can develop an effective preventive care program for the future. The concomitant release of misused doctors' time can significantly slow the trend toward the inflation of costs and mal-distribution and unavailability of service. There should be little shortage of manpower if manpower is utilized properly.

Medical care stands at a critical point. One choice would be to adopt rash legislation that can only depreciate the quality of care for both the sick and the well. The better choice is to create a rational new medical care delivery system that will make it genuinely possible to achieve the principle of quality medical care as a right. Matching the superb technology of present-day medicine with an effective delivery system can raise U.S. medical care to a level unparalleled in the world.

The Tax-Deductible Issue

While labor and management found employer-provided health insurance to be a mutually beneficial arrangement, the Internal Revenue Service (IRS) was noticeably being deprived of two sources of revenue:

- corporate tax on employer's portion of premium payment; and
- income tax on employee's portion of health-care benefit(s).

Only now is the IRS attempting to remedy this inequity. This effort is the driving force behind all the "procompetition" health bills that have been introduced in Congress. The taxation issue continues to be a predominant problem as Congress wrestles with the cost of health-care reform.

The National Governors' Association is pushing to cap the tax exemption for employer-provided health benefits. The Association's health-care policy states that insurance premiums should be tax deductible to the value of a federal core-benefits package, regardless of who pays the premium, and that policies affording benefits above the designated

limit should be subject to taxation. The governors propose that revenues from a tax on "Cadillac" insurance plans will help finance health-care reform.

Although many congressional proposals differ in detail, it seems likely that the current tax deductibility of health-care insurance premiums will soon be a thing of the past. Some members of Congress on both sides of Capitol Hill agree that this tax deduction:

- sacrifices tremendous revenue for the U.S. government; and
- decreases patient awareness of the cost of health care, particularly if covered at 100 percent, hiding the overall cost of care.

These Congresspersons attribute the escalation of health-care costs to the tax-exempt status of health insurance. Whatever direction health-care reform takes, taxation of benefits will be among the key decision-making aspects of selecting the right health-care plan.

A National Health-Care System

What began with Roosevelt morphed into Clinton's and Obama's administrations and has attempted to develop a national health-care system. Proposals have ranged from the single-payer or Canadian/European system, under which all health care would be paid for by the government and financed by taxpayers, to a managed-competition system, whereby hospitals, doctors, and all other health-care providers would compete for patients.

Under a system of managed-competition, patients may be able to choose from either a traditional fee-for-service plan or from a number of hybrid alternative health plans. With the conventional fee-for-service option, the subscriber visits the doctor or other health-care provider of his or her choice; the provider performs the necessary services, then bills the patient and/or the insurance company according to the provider's fee schedule.

Hybrid alternative health plans include variations of the managed-care approach to health-care cost containment. These plans typically limit patients' choice of providers, restrict or limit treatment options, and control fees and payment options. There are numerous types of organizations administering alternate forms of health-care delivery and reimbursement. Such organizations include insurance companies, third-party administrators, trade union trust funds, private corporation perk plans, private "for-profit" companies, government agencies, and health-care providers themselves. These entities are involved with capitation plans and preferred provider organizations (both of which are discussed in Chapters 2 and 3), the individual practice association and corporate model, the staff model, and a plethora of others.

Possible Choices in Health-Care Plans

In almost all workplace scenarios, the worker, or “labor,” may be given some cafeteria-style choices as to how much to spend on health insurance. The employer, or “management,” will soon be required by law to provide basic medical and hospitalization insurance, which would be at least partially tax deductible. For example, imagine that an employer is required to offer \$85 of coverage per month per employee through a health maintenance organization (HMO). If the employee selects the \$85-per-month plan, there will be no out-of-pocket premium expense to the employee – a true HMO model plan.

It is made clear to the employee, however, that this “Plan A” is basic, preventive, routine, “first dollar” (no deductible) coverage. This HMO plan may not cover emergency-room fees or maternity expenses. It may cover some prescriptions and some primary-care delivery. It will not, at least initially, cover optical or dental expenses.

The employer may also offer a “Plan B,” one that will cover dental care – even orthodontics. Still, this plan is essentially preventive in nature, with some corrective benefits added. It may cost \$125 per month; however, management is still only obligated to pay \$85 per month. The remaining \$40 per month will come out of the employee’s pocket. At this writing, employees are allowed a tax deduction on their entire portion of the premium; but with enactment of health-care reform, the out-of-pocket expense may not be entirely tax deductible.

As yet another option, management may offer the employee a “Plan C,” which offers even more benefits. This plan may cost \$165 per month; however, management will still pick up only the first \$85. The remaining \$80 per month will be paid by the employee; and, again, whether the employee portion (and/or the employer portion) will be tax deductible, partially or totally, is currently under congressional scrutiny.

The Role of Government

In 1988, Carl Schramm, then president of the Health Insurance Association of America (HIAA), now America’s Health Insurance Plans (AHIP) was asked about his predictions for the role of government in health-care delivery. He responded: “Government has to be a partner in any policy step, not only because it is the largest single payer, but also because...it can move under its constitutional

authority to stimulate more efficient behavior on the part of providers.”²

“When all parties compete to achieve the best medical outcomes for patients, they are pursuing the goals that led many individuals into the profession in the first place.”³

2 Dean Mayer, “Carl J. Schramm,” *Healthweek* (October 3, 1988): 22.

3 Michael Porter and Elizabeth Teisberg, “Redefining Health Care, Creating Value-Based Competition on Results,” (2006): 13.

These thoughts are echoed by Rashi Fein in his book, *Medical Care, Medical Costs*. He suggests that government's responsibility is "to seek equity." It is government's duty to make sure that citizens who cannot afford health care receive it anyway, at least to some degree. "Government," Fein continues, "will have to monitor the interplay of HMOs with the total health-care system."⁴

Of course, the government's involvement in health-care delivery is nothing new. For the past five decades, the federal government's contribution to health care has been characterized by two major social programs: *Medicare*, which primarily insures the elderly and disabled, and *Medicaid*, which insures the poor. Both programs were established in 1965 under President Lyndon B. Johnson.

Naturally, many Americans fear that any expanded role by the federal government in the financing of health care will cause serious problems. Working, middle-class taxpayers, who may very well bear the brunt of future health-care costs, believe that government is already doing a poor job of administering Medicaid and Medicare; and they fear that any federally run health plan would be inefficient and ineffective.

Too much of the dollar would be spent on administration and too little on effective treatment and services. These middle-class citizens have grown weary of being "caught in the middle" between the rich, who can afford to pay for their own health care, and the poor and elderly, who can receive free services through Medicaid or Medicare.

The disposable income of the middle class cannot keep pace with the rising cost of private health

care; yet they abhor the waste and inefficiency of government-run health delivery systems. New leadership in Congress is listening to their grievances, or are they?

The Patient Protection and Affordable Care Act (PPACA), commonly called Obamacare or the Affordable Care Act, is a United States federal statute signed into law by President Barack Obama in 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant government expansion and regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid by President Johnson in 1965.

The PPACA is aimed at increasing the rate of health insurance coverage for Americans and reducing the overall costs of health care. It provides a number of mechanisms – including mandates, subsidies, and tax credits – to employers and individuals to increase the coverage rate. Additional reforms aim to improve healthcare outcomes and streamline the delivery of health care. The PPACA requires insurance companies to cover all applicants and offer the same rates regardless of pre-existing conditions or sex. The Congressional Budget Office projected that the PPACA will lower both future deficits and Medicare spending.

Congressional action in the foreseeable future may abolish or greatly modify Medicaid and Medicare, offering instead more cost-efficient plans with some form of accompanying work ethic. The other side of the coin could be a rapid expansion of these concepts.

4 Rashi Fein, *Medical Care, Medical Costs: The Search for a Health Insurance Policy* (Cambridge, Mass.: Harvard UP, 1986).

Issues Vital to the Dental Profession

There are certain issues of particular relevance to the dental profession that must be addressed by dentists themselves. For example, it has already been noted that the degree to which employer-funded health insurance is a viable benefit may well depend on the extent to which it is tax deductible.

Another major issue is pediatric dental care. Some legislators are calling for preventive pediatric care for all children, while others favor preventive care for indigent pediatric patients only. Which children should receive preventive dental care? What about children on Medicaid? Should we not also consider senior citizens, those nursing home occupants who may have paid taxes all their lives but who now find, with limited or no funding, that their dental needs cannot be met? Can the voice of organized dentistry be heard by members of Congress?

How can waste, overutilization, and fraud be reduced in the dental insurance industry? We must pay particular attention to the dilemma of multiple coordination-of-benefits (COB) coverage with only singular reimbursement. Premiums are determined by factoring in all the different services covered by the policy. For example, an employee insured

under a traditional, fee-for-service, group dental policy may also be covered for at least some of the same services under a working spouse's group dental policy, a homeowner's policy, an automobile policy, workers' compensation policy, and perhaps one or more school policies.

Whether employees realize it or not, they are paying these, and perhaps other, multiple overlapping premiums for the same or similar health coverages.

In addition, as much as (and sometimes even more than) 30 cents of each health-care dollar is being spent for a combination of administrative overhead costs (including profit), duplicated and unnecessary services, and administrative and health-care provider waste in the form of fraud and abuse! President Clinton addressed this issue in the fall of 1994 when he condemned health-care reform proposals that would immediately tax a portion of the health-care benefits employees receive, insisting first on reduction of administrative waste: "Why take something away from hard-working people before you squeeze the system of its unconscionable burdens on hospitals, doctors,

nurses, and the American people themselves? That's where we ought to start."

The dental profession (indeed, all health-care providers) must keep up with demands. Legislation provided universal electronic processes for health-care enrollment, eligibility, coordination of benefits, billing, and claims follow-up, as well as payment and reimbursement protocols.

There are certain issues of particular relevance to the dental profession that must be addressed by dentists themselves. For example, it has already been noted that the degree to which employer-funded health insurance is a viable benefit may well depend on the extent to which it is tax deductible.

The Healthcare Financial Management Association (HFMA) supported the Health Care Information Modernization Act that was known as HR 3137/S 1494. This legislation provided universal electronic processes for health-care enrollment, eligibility, coordination of benefits, billing, and claims follow-up, as well as payment and reimbursement protocols.

The HFMA supports formation of an independent commission that would recommend to the federal government standards for the creation of a universal claims process. Standard claim forms are already available but are not used consistently. There is as yet no convention for the use of data transmission standards that have already been developed. The HFMA feels that it will take a federal mandate to develop and put into use electronic claims processing and administrative streamlining procedures.

Since 1994, the National Association of Insurance Commissioners (NAIC) has introduced and supported the Standardized Health Claim Form Model Regulation (#30-1). This legislation provides for standardization and encourages the use and implementation of an electronic data interchange of health-care expenses and reimbursement.

The Decline of Traditional Indemnity Insurance and the Rise of Managed Care

According to the NADP 2012 State of the Dental Benefits Market, DPPO continued to expand market of commercial dental benefits, particularly at the expense of Dental Indemnity products.

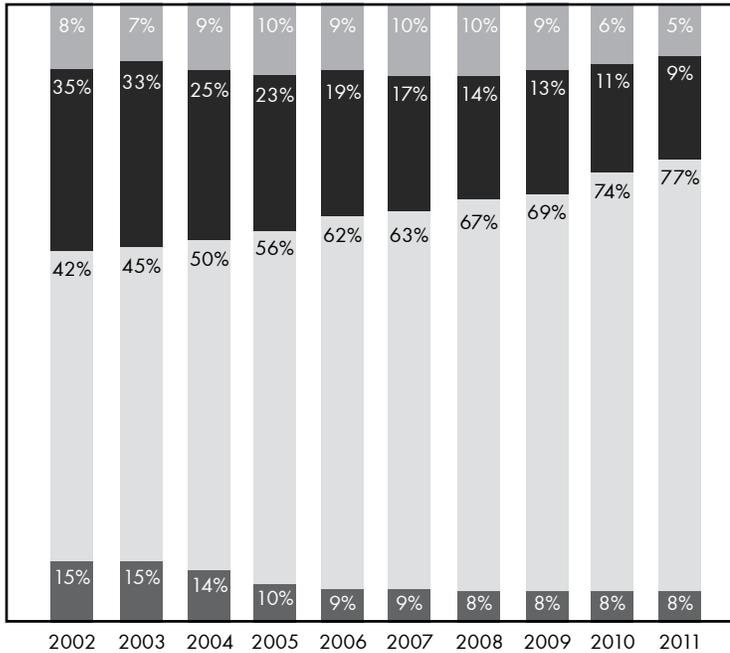


Table I-1

- Discount Dental
- Dental Indemnity
- DPPO
- DHMO

2013[©] National Association of Dental Plans, Inc.

Enrollment in 2011 improved slightly compared to 2010 (less than 1/2%), but the percentage of Americans with dental benefits remained unchanged.

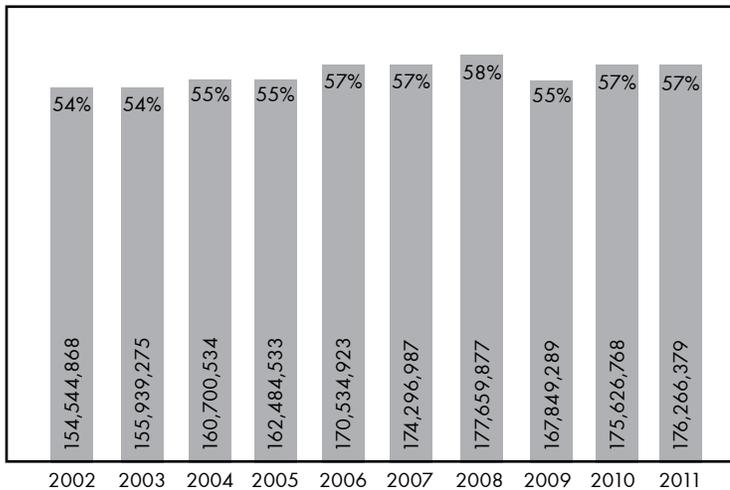


Table I-2

2013[©] National Association of Dental Plans, Inc.

Conclusion

As we explore the subject of managed dental care in the chapters that follow, we must keep these five overriding concepts in mind:

1. Undoubtedly the finest health care in the world is found here in America. Our attention is not needed primarily on health-care quality, but should be focused on the related problems of financing, insuring, and controlling the cost of health-care delivery.
2. No matter which plan is finally enacted by Congress, the issue of the tax deductibility of insurance, both for the employee and the employer, will be of paramount importance.
3. The health-care industry must seriously address the issues of waste and fraud. We must stop pushing paper claims data back and forth and begin to streamline the administration of health-care information by using universal electronic processes when feasible. Managed health care is cost-contained, cost-conscious health care; and one of the best ways to cut costs is to cut wasteful paperwork and to eliminate overlapping premiums for the same or similar benefits.

4. All parties concerned must move into a new era of universal electronic records transmission. Patients' records (under restricted, regulated access controls) must be made available for doctors and hospitals in California, New York, or Florida – anywhere they are needed.

5. Managed care is here to stay. It is, and will continue to be, increasingly more difficult for many dentists to maintain a 100 percent fee-for-service practice. As dentists join managed care and become part of the bill-paying mechanism, the cost-effectiveness of dental delivery will be greatly affected.

Keeping these key elements in mind, we can now begin to deal with the brave new world of fee-for-service dental care with a managed-care component.