

# The Insurance Game — Who Are We Really Working For?

• Robert M. Kaufmann, DMD, MS •

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Approximately 70% of Canadians have private dental benefits (according to CDA's most recent figures).<sup>1</sup> Dental benefits can help to pay the costs of dental care. However, when clinicians are forced by patients to confine their treatments to covered benefits, both the oral health of patients and the independence of dentists are threatened.

Canadians are not used to seeing a "bill" when they go to the hospital or consult their physician. Our patients often expect that dental benefits will work the same way. They fail to understand the distinction between "dental insurance" and "dental benefits." If a procedure recommended by the dentist is not covered by the benefits plan, the patient frequently elects not to have the procedure performed. That certainly is not the best way to decide on treatment; however, for many patients and the dentists who treat them, this is a fact. Work within the benefit limits or lose the patient.

By choosing this method of health care planning, some patients are now allowing insurance companies to decide which procedures they will receive. Our greatest failing as health professionals has been our inability to convince these patients that by partnering with us rather than with their insurer, they are more likely to attain optimal oral health.

## The Erosion of Real Dollar Values of Dental Benefits

Most benefit plans with a \$1,200-\$1,500 annual limit have had the same dollar amounts for the past 15 or 20 years. During that same period, dental fees have had to increase approximately 3 to 4% per year on average to accommodate increases in wages, new technology, supplies, changes to infection control and pollution control procedures, and inflation. It is unrealistic to expect that insurance benefit limits which may have been merely adequate a quarter century ago will be entirely adequate today. This phenomenon, which I call "creeping capitation," is merely managed care in disguise. The result is a steady erosion of

the real buying power of benefits. Insurers continue to lengthen recognized time between checkups, lower scaling allowances, limit cosmetic, prosthetic and implant treatment, and often deny retreatment due to frequency limitations. Yet their premiums have either remained fixed or increased, while their claims processing costs have dramatically decreased (thanks to the efficiency of electronic data interchange).

## The Fight Against Capitation

CDA representatives have said that their first priority is to combat capitation and preserve "the freedom of choice and the integrity of the dentist-patient relationship" (personal correspondence from Dr. Louis Dubé, chair of CDA's steering committee on dental benefits issues, January 7, 2001). The dentist-patient relationship means nothing if the patient's treatment choices are first and foremost determined by the financial limitations imposed by the benefits plan. Insurers are accomplishing the goals of capitation right under our noses by just holding firm on benefit levels. At the same time, dentists squirm as they try to attend to patients' increasingly costly treatment needs while their overheads increase each year. Whether treatment is performed by a specific group of dentists who work for a fixed fee per patient (capitation) or by a dentist of the patient's choosing who works under a strict benefits limit, the end result is the same: carriers control their costs while dentists' costs continue to increase.

## Consequences of the Current Situation

Certain endodontic and periodontal procedures will continue to consume higher percentages of patients' overall benefits. Rehabilitation or retreatment of one molar tooth (endodontic treatment and crown) will virtually exhaust a patient's benefits for an entire calendar year, leaving no benefits for any other routine treatment. The clinician is therefore faced with the prospect of:

- referring the case to a specialist and having no benefits to work with for the rest of the year;

- extracting the tooth to preserve the remaining benefits in case other treatment is needed; or
- attempting to perform a complicated treatment that may normally have been referred because of its level of difficulty.

The overall result will be fewer referrals, more extractions and a greater number of treatment failures requiring complicated, expensive retreatment. This is a situation our profession cannot abide.

It is interesting to note that some provinces with the lowest fee guides still have the highest levels of dentist production and incomes.<sup>2</sup> This occurs even though the vast majority of dentists charge at the fee guide level and accept direct assignment of benefits. The dentists in these provinces have learned to “play the game” well after decades of practice. If fee guide increases are kept low, insurers will keep benefit levels close to 100% of the guide for most routine dental procedures. The idea behind this philosophy is “Don’t get greedy and the status quo can be maintained.” Unfortunately, in these provinces one is much more likely to have 2 virgin anterior teeth prepared for abutments than to have a single implant, simply because the former is a benefit while the latter isn’t. This way of doing things can’t be very good for dentistry or for patients.

Rather than perform comprehensive treatment plans, clinicians begin to treat patients on a crisis-to-crisis basis. Dentists will consider a treatment that is covered rather than the treatment that is best for the patient. In extreme cases, some clinicians may perform one procedure but submit a claim for a different procedure of equal dollar value that is a benefit. Or they may alter dates of service to enable a patient to receive reimbursement. This is fraud, and it is a symptom of a problem that will not go away any time soon. Clinicians who are compelled to work within these limitations feel justified in stretching the rules. It is the insurance game.

Each individual dentist must educate his or her patients about the limitations of benefits. Unfortunately, in these days of high overheads, there is little incentive to do this. Most dentists see this effort as an unproductive waste of valuable chair time. Many would rather replace restorations that are covered by the benefits plan than discuss such difficult, complicated and unpopular topics with their patients, especially if these discussions are not claimable as an insured benefit. Dentists will need leadership, support and assistance from national and provincial dental bodies if they hope to convince Canadians to change their attitude.

If we are content to deal with patients who only choose treatments covered by their plan, then we will have surrendered our independence. If benefits are insufficient, then we will be placed in a position of having to convince patients to buy more “insurance.” At that point our transformation will be complete! Dentists will have become salespeople for

## The Advantages of Dental Benefits Plans

• Louis Dubé, DMD •

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One of the main advantages of traditional dental plans is that patients have the freedom to choose their treatment and their dentist. It is to preserve this freedom of choice that CDA and its corporate members have been fighting hard to prevent the establishment of managed care. Certainly, the fact that many Canadians have dental plans is a positive development, both for the population and the profession, since it means more people have access to dental care.

I agree with Dr. Kaufmann that the current benefits limit, which has been the same for almost 20 years, is completely out of synch with today’s world. Although it is easy for insurance carriers to blame dentists for the rising cost of plans, there are other factors involved. For example, public awareness about good oral health has meant increased utilization as well as increased demand for better treatment and elective procedures. These treatments cost more.

All stakeholders involved in benefits plans have their own concerns. Carriers continue to structure plans according to their needs, and for them, managed care is an appealing way to keep costs down. Employers want to provide plans that offer the best quality-cost ratio. (Too often, an employer’s financial capacity is what limits coverage.) Employees want the best quality plans possible for themselves and their family. Dentists want plans that contain less administrative barriers and ensure freedom of practice for them and freedom of choice for their patients. It is easy to see why sometimes the pieces of the puzzle don’t all fit together.

I also agree with Dr. Kaufmann that dentists should ideally always deal with the patient regardless of the plan. CDA has never favoured assignment but recognizes that it occurs. It is important here to distinguish between assignment and co-payment, which are sometimes used interchangeably. Assignment can be a

insurers because that is the only way patients will accept treatment. Who will we really be working for then?

In the same way that dentists must remain current with regard to techniques, training, equipment, wages and asepsis, insurance companies and their subscribers must recognize their obligation to alter coverage with the times. Should they not accept this, then dentists will have to convince patients to increase their out-of-pocket expenses.

solution in certain circumstances. If a dentist collects a co-payment and respects the usual fee schedule, the patient may have a bit more flexibility in paying his or her dental costs; that process is not much different from accepting a postdated check or a credit card. On the other hand, if a dentist allows assignment but doesn't collect the co-payment, or changes the fee or the treatment date, then he or she is committing fraud. This behaviour is unacceptable, not to mention unethical.

In my home province of Quebec, the percentage of patients who have access to dental plans is about 25-30%. The problem of having patients choose their treatment based on coverage is therefore less significant. With patients without benefits plans, the issue of insurance, assignment or co-payment doesn't arise. Instead, our patients sometimes have to decide between paying their dental bill, buying groceries or paying the rent! The key is for dentists across the country to communicate effectively with their patients regardless of their situation. We need to start educating our patients and yes, we need the support of our provincial and national organizations. Organized dentistry has been communicating with other stakeholders including carriers, employers and employees. At CDA, that work has been accomplished mainly through the steering committee on dental benefits issues (DBI). We have achieved positive results through DBI's work, including keeping managed care at bay.

I believe we must all work together to safeguard dental benefits plans that help patients pay the cost of their dental care without infringing on their freedom to choose their dentist or their treatment. We must take the time to talk with our patient and educate them. The days when patients would give dentists carte blanche are long gone. Dentists must be aware of their patients' needs and financial situation and be able to present different treatment plans accordingly. In the end, good communication will help patients make the right decisions. Dentists are the best positioned to make their patients understand the advantages (and limitations) of benefits plans and the dangers of managed care. ♦

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*Dr. Dubé is chair of CDA's steering committee on dental benefits issues.*

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ing that the best interests and health of their patients will be at risk. Creeping capitation will have won.

## Conclusion

Our first mistake was accepting assignment of benefits. Our second and last mistake will be failing to acknowledge that creeping capitation is actually occurring through the dual pressures of ever-increasing overhead and intransigent benefit limits. We must find a way out of this problem or face the unpleasant realization that our future mode of practice will be determined by what insurers (and their clients, our patients) will allow us to do rather than what we believe our patients truly need. Our independence will have been lost as creeping capitation slowly chokes us into submission. Are we prepared to live with that? ♦

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*Dr. Kaufmann maintains a practice limited to endodontics in Winnipeg, Manitoba. E-mail: rmk@endoexperience.com.*

*The views expressed are those of the author and do not necessarily reflect the opinions or official policies of the Canadian Dental Association.*

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## References

1. Manifest Survey on Managed Care. 1999. Commissioned by CDA.
2. Statistics Canada. Nation Series. 1996: Census of Population.

That will be a bitter pill to swallow, especially for those who for years have been used to handing a form to the receptionist and having their assigned benefits pay for 75-100% of their treatment costs. Dentists will need the courage and right tools to convince patients to make this transition. Failure will result in an untenable situation where dentists will be asked to work within financial limitations so confin-