Insurance-odontitis: Our Greatest Handicap

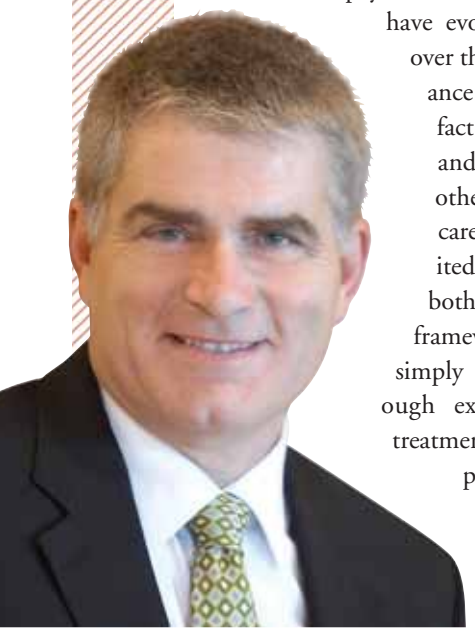
by Mark Murphy, DDS, FAGD

This article will provide a framework for a paradigm shift that you might wish to consider. Read this opinion and editorial piece carefully and understand the intent first. The suggestion is not that you change your current relationship with dental insurance, rather that you come to understand its potential role in impacting providers and patients' behaviors. The thesis is referencing dentistry's evolution and the stagnant, non-evolving function and role of dental insurance and how that has the opportunity to handicap caregivers and care receivers. The basic behavioral equation is pretty straightforward but how we got to where we are now is complex.

Patient + Dentist = Informed Choices Regarding Preferred/Optimal Care

If we substitute a patient with dental insurance, the costs of care, provider profitability, treatment choices, entitlement mentality and third-party influences all become variables that can mess with the solution. What was once intended as a simplifier that would improve access to care for our patients has often become a barrier or handicap to making patient-centric choices for both doctors and their clients.

When first introduced, indemnity plans did and were intended to help more patients seek care and transfer some of the cost to employers through third-party payers. As dentistry and restorative solutions have evolved and costs have increased over the last 40 years, the dental insurance coverage has not kept up, in fact, it has "devolved." PPO, HMO and UCR limitations along with other creative managed cost (not care) alternatives have further limited reimbursements and clouded both doctor and patient decision frameworks. No longer does a dentist simply do a comprehensive and thorough examination, craft appropriate treatment plan recommendation(s) and present that in an educational framework to the patient. All of the aforementioned variables that have been added to the equation might or might not come into play and impact the delivery of optimal dental care. Consider the following handicaps:



- Maximum coverage that has not kept pace with inflation and the cost of care.
- Discounts to reimbursement schedules designed to reduce premiums without considering quality of care.
- Pressuring caregivers to make financial decisions about patient care that protect practice profitability over the patient's best interest.
- The misleading use of the word "insurance" to describe a basic coverage "maintenance" plan.
- Almost fraudulent use of the term "managed care" to describe "managed costs" initiatives. Marketing and spinning changes to plans to make subscribers think they are getting more or better, not less coverage.
- Creating an entitlement mentality surrounding dental care reimbursement.
- Limiting freedom of choice in caregiver selection.

Maximums Unchanged

Years ago, $1,200 annual coverage allowed us to do much more. We never thought that something so wonderful would one day handicap us in our practice. Fast-forward 45 years and coverage is still at $1,200. If you were to adjust for inflation over the years, that coverage would be more than $7,000. How does this happen? Gasoline has gone from 29 cents to $4 a gallon! Where was the inflation adjustment for dental insurance?

Discounted Reimbursement

If a practice were operating with an overhead of 70 percent and accepted a PPO that required a fee discount of 15 percent, that dentist would have to do twice as many procedures (now only netting 15 percent) to make the same profit margin as he did when he was making 30 percent. Because we went to dental school instead of business school, these impacts are not often well thought out when we make these decisions.

Pressuring Caregivers

Alternatives to reduced coverage would be to use cheaper offshore laboratories, purchase less expensive materials, pay staff less or beat up dental supply companies' reps or landlords. If we were talking about a $700,000 fee for service practice (netting 30 percent =

continued on page 28

 continued from page 26

$210,000), that practice would have to grow to $1.4 million to keep the same net in the previous example. That is not fair. This is basically what happened recently in Washington State when its largest insurance cut reimbursements. Is your state next?

Misleading Terms

If car insurance worked liked dental insurance and the Geico gecko only offered to pay $1,200 if you totaled your car, you would flip out. You would take that little gecko and choke him until he paid up. Dental insurance-type auto policies might only cover oil changes, lube jobs, filters, tire rotations, hoses and belts, and only up to a $1,200 a year maximum, not collision or catastrophic losses. My medical insurance policy has a $2,500 deductible. That is more than double the average dental insurance covers. Homeowners, medical and life insurances have kept pace reasonably well with the inflationary changes to their risk coverage and have no illogical limitation. Perhaps "dental assistance" or "maintenance plan" would be a more apt name. $1,200 is a worthwhile sum, but it is not catastrophic! If you had to have open-heart surgery, your home was destroyed by fire or you totaled your car, those would be unexpected and catastrophic losses. Dental insurance is not insurance.

"If we want to heal, we cannot continue our strong reliance on dental insurance."

Managed Costs!

If there were really managed care initiatives, people would be rewarded for flossing and seeking long-term solutions with the highest predictability! More frequent periodontal therapy visits to prevent the need for surgery would be covered! They would support the long-term savings of doing fixed restorative and implants over removables, crowns over the uncertainty of large composites or alloys, bite guards, sealants and more. Instead, the short-term cost-saving procedures take precedent over the long-term because the subscriber and employer might change carriers on a whim. The risk of investing in future savings and not being the carrier over time is too great. Another crippling effect for many of us is the insurance company's expectation that you pre-authorize and wait two to six weeks for determination of coverage. Meanwhile the float is carried as unpaid claims and the patient might change his or her mind. Both save the insurance company money. They manage their costs not patients' care.

Entitlement Mentality

We complained about gas prices hitting the $2, $3 and now the $4 mark but we forget that bottled water runs between $8 and $20 per gallon depending on the brand we choose. People will pay for what they want. As dentists, we need to do our job and help our patients understand and want what we know they need. People always seem to have the money for what they really want. Private schools are an example of making choices based on values rather than the entitlement of a public school education. Cadillac, Lexus, Mercedes Benz and BMW are another. In the United States, we spend more on gambling, cigarettes and alcohol than we do on dental care. Marketing trumps our one-on-one education every time if we do not invest the time in doing it. We owe it to our patients to help them want what we know they need.

No Choice

Patients' freedom to choose someone they trust and not just the least expensive provider and co-payments should be the rule and not the exception. When insurance companies supported by employers create economic penalties for choosing trust over cost, it is not fair. If a crown is a crown is a crown, and if all dental practices and teams were the same, it would be fine, but they are not. Trust is part of the equation in the individualized delivery of custom-manufactured restorations, solutions and oral health care. Patients deserve choice.

So What Can We Do?

Sometimes how we look at the problem *is* the problem. I believe that is the case with dental insurance. If we want to heal, we cannot continue our strong reliance on dental insurance. If we do, it can become a crutch that limits our capabilities and cripples us. Chasing the easy $1,200 case acceptance in lieu of creating an environment where patient education is foremost and informed choice as the norm would be a flawed model. We can keep insurance in place if desired as the maintenance system it truly is, but we need our financial treatment reward structure and systems to support what is best for the patient, not reward managing costs. Profits will come when we do what is best for the patient at fair fees.

Close your eyes and picture a dental world where your practice was free of these limitations. You could focus on patients and develop relationships that serve the mutual best interest. Your patients would be free to choose what they want done based on your education for them, their

continued on page 30

 continued from page 28

economic ability and the perceived value. Dental insurance would cover some maintenance costs and care, but not be perceived as the all-healing entitlement plan providing comprehensive care. Patients would have to learn to be more responsible for that or the premium/reimbursement structure would have to actually be adjusted for 40-plus years of inflation!

I would not recommend dropping insurance because it only covers $1,200 or creates an entitlement mentality. I would recommend that we take back the relationship as trusted caregivers. Stand up and be the voice for complete education for our patients regarding dental care. That might just include explaining how dental insurance works, how it doesn't and how it has not evolved during the last 40-plus years. Being our patients' oral health advocates is more than just doing good dentistry. It is also about helping them value good dental care. We have to market the value of individualized comprehensive and appropriate optimal dental health… not just sell crowns and cleanings.

This evolution, no let me say de-evolution, has occurred slowly on our watch (dentists, patients and employers). If we are to accept a leadership role in our profession and seek a preferred future for our relationship with dental insurance, we will have to stand up and be the voice for what is fair and right. It will not be easy, or quick. It will involve having real conversations with our colleagues, our teams and our patients. We will have to change behaviors. It will require us to shift the paradigm. Be the voice for change... one patient at a time. ■

Author's Bio

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