Dental Insurance: Will It Help or Hinder Adoption of Caries Management Practices?


Abstract: Whether public or private dental insurance will provide benefits for caries management practices is a business decision. The foundation for this decision is multifactorial and continually changing as the values of the purchasers and health care consumers evolve. Understanding the dynamics involved in allocating finite health care resources will help those who advocate for caries management inform decision makers about the potential benefits of these strategies.

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Key words: dental insurance, cost efficiency, value, consumerism

This portion of the Caries Management Symposium addresses the following question: “Will payment systems adopt coverage strategies and policies that support modern caries management practices?” This question is framed in the context of a desire to increase the adoption of caries management practices by the practicing dental community and the belief that payment for these services will increase their adoption.

To answer this question, this article presents the conditions under which caries management is likely to be adopted by both public and private “insurers.” To set the stage, it first discusses “insurance” and the different “insurance” entities and then examines the current health care funding environment and the pressures on payment systems. It closes with a discussion of proposed adoption requirements and some general conclusions.

Insurance

There is an ongoing argument that “dental insurance” is not insurance at all, but rather prepaid health care. That argument is outdated in many populations and accurate in others. When outdated, it reflects a time when dental diseases were pandemic. In a pandemic situation, buying dental insurance is like buying haircut insurance. Since everyone is going to need a haircut, you are simply prebuying the haircut you are going to need. Today, dentistry’s two primary diseases are not pandemic in many segments of the U.S. population. Not everyone has an equal risk for carious lesions or periodontal diseases. In this situation, dental insurance acts as insurance for the insured person. A purchaser of dental insurance contributes a premium for the eligible persons. Those who incur dental needs use the aggregate funds contributed (or set aside).

In other segments of the U.S. population, the penetration of dental caries is epidemic and nearly pandemic. Funds set aside for care are prepayment funds. In pandemic situations or populations, the risk assessment portions of caries management are likely moot and may not be considered for payment. If virtually everyone in a population has the infection and the clinical manifestations of the infection, then no risk assessment is required and everyone is treated as high risk.

There are a number of “payers” in the dental industry covering both the public and private sectors. Within the public domain, examples of entities that act as payers are SCHIP and Medicaid programs. These programs are generally entitlement programs, rather than commercial insurance programs. Individuals who qualify are “entitled” to specified services based on societally defined criteria. Other publicly sponsored entities provide direct services such as community health centers and the Veterans Administration. These “direct services” also act like insurance payers, and these public entities are important in the consideration of their support for caries management practices. Private or commercial insurance is generally provided as a benefit of employment.

Current Insurance Environment and Identifying the “Payer”

Today there is high cost pressure on health care resources. A number of considerations will militate for or against adoption of coverage for caries manage-
ment practices. This article focuses on the economic decisions. These are decisions that judge the value of a practice or procedure by the resources it/they consume(s) compared to the benefits that could be derived if those resources were used for competing services.

To examine whether caries management will be adopted, it is important to understand whose money is being “valued.” The purchaser or payer is the body whose funds are “at risk.” In the public sector, the purchaser of health care services is ultimately the public itself. State legislatures and elected or appointed officials represent the public and design benefits programs; but, ultimately, it is the public’s money. Using taxes and other revenue sources, funding for health care services is available to those who qualify for care, thereby “insuring” them.

Within the private payer sector, there are two basic types of purchasers. The payer may be the entity (company or consortium) that purchases the health care services or the insurance company. In the United States, many large employers are self-insured. They hire the “insurance” companies to manage their health care payment and records-keeping systems since they do not have that expertise resident within their businesses. Insurance companies, in this situation, provide administrative services and advise on benefits designs, but do not act as insurers. The insurance companies are paid a flat rate to manage the health care payment system. In the self-insured case, the “at-risk” funds are those of the company. The insurance entity itself bears no “risk” in this arrangement. These “purchasers” are increasingly interested in analysis of their spending and whether that spending is cost-effective and has cost utility. (The monetary cost of an intervention is directly related to the outcome obtained. Cost utility is the same as cost-effectiveness; however, the unit of analysis is the quality-adjusted life year, or QALY.)

When traditionally insured, the insurance entity is the “payer.” That is, the insurance company has agreed to pay for services up to a contractual maximum for the insured population. It is the insurance company’s money that is at risk when care is required. This compels insurance companies to analyze their data for cost-effectiveness and cost utility.

As health costs continue to grow at a rate greater than the Consumer Price Index, purchasers of health care services are seeking new ways to control their spending on health services. An emerging trend is the shifting of more health care expenses to employees. This cost-sharing takes the form of increasing employees’ contributions to the health care premium, increasing the copayment percentages, increasing deductibles, or combinations of these practices.

In another emerging industry cost-sharing strategy, the employers distance themselves from making decisions about which companies and which benefit packages employees receive. The employers make available to the employees a specific amount of money for all their health services. The employees are responsible for deciding how to spend their allocated funds. The employers generally make several health and dental plans available to the group of employees at known costs, and the employees choose their services from these plans or find other insurance in the marketplace. Here the employee is clearly the customer and “purchaser” of the health services. As employees incur an increasing portion of their health care costs, they become more interested “purchasers.” This economic awareness is part of the trend of consumerism that extends to health care. This group will need to be convinced of the value of specific services included in caries management programs when making the purchasing decision on a dental plan’s design.

The focus on “purchasers” is a necessary part of the discussion of whether or not “purchasers or payers” will adopt plan designs and practices that support caries management. The entity whose money is being sought to fund caries management policies and practices is important. By knowing who is acting as the payer and what the interests of the payer are, we can begin to answer the question of whether caries management practices will be remunerated.

**Adoption Criteria**

Whether or not the purchaser/payer will adopt caries management policies and practices turns on whether caries management can make the business case for the specific practices that fall within the caries management domain. A discussion of whether dentists will adopt caries management practices is not part of this discussion. However, it is generally acknowledged that payment for specific services has a positive influence on adoption of those services if the remuneration rate is sufficient to allow the dentist to make a profit.

Setting the framework for making the business case is important. The case will likely be different for different populations and hence for different
purchasers. An example of a difference that will likely engender variation in coverage adoption is considering the incidence of pit and fissure caries in an insured population. If the caries incidence is high, then benefiting sealants on permanent molars will likely make economic sense. If the incidence is low, it may not. The point drawn here is that different purchasers serve different populations and the incidence of disease in the population will generate different choices.

A brief, and admittedly incomplete, list of factors that should be considered follows:

- The incidence of events triggering the need for care (as noted above). In our case of caries management, this is an examination of the caries disease burden of the population receiving benefits. This includes incidence and prevalence of restorative services and their physical location.

- The health “effectiveness” of the proposed caries management programs in the payer’s population. Does the procedure or intervention yield more good than harm under the real-world condition of the payer’s population? (Health effectiveness is the extent to which an intervention does more good than harm. An effective treatment or intervention is effective in real-life circumstances, not just under ideal conditions.)

- How long does it take to realize the benefit for the caries management intervention? (This is tied to the next item.)

- The amount of time an insured person will be in the payer’s health care system. Those payers with high turnover need a more rapid return on their investment in caries management. The practical concern is that investing finite resources in caries management practices that do not provide tangible benefits for eight to ten years with a complete turnover of employees every two years is not, on its face, a good economic decision. It may be altruistic, but does not make economic sense. There is an increasing trend among chief financial officers to be part of the benefits decision process.

- How accurate (in terms of sensitivity and specificity) is the caries management risk assessment program for the payer’s population? Payers, as well as clinicians, are seeking higher levels of prediction than have heretofore been available. This reflects a slow but steady movement toward individualized benefits based on validated risk rather than the one-size-fits-all plan designs of the past. Metrics with high positive predictive values are likely to be adopted.

- Do the interventions in the at-risk population save “time lost from work”? If a specific treatment or series of treatments keeps a person from more extensive work loss within the time he or she is employed, it is a benefit to an employer. This is one example of the indirect costs of health care that need to be considered.

All of these factors and more (depending on the groups involved) contribute to determining whether a payer will adopt caries management practices or programs. If a program, procedure, or series of procedures has a positive impact on oral and systemic health and the costs are either neutral or cost-saving, payers will adopt caries management programs or practices. If caries management practices do not improve health outcomes at equivalent or lower costs, adoption will not occur. If caries management programs cannot make the business case, payers will not expend their finite health care resources for caries management practices.

Conclusions

Caries management practices and researchers are making available a number of resources that may benefit those in our populations who are susceptible to the physical damage caused by dental caries. A part of the adoption of these practices in general practice is determined by whether these protocols will be remunerated by payers. This article has presented a brief economic view of what both public and private payers will likely consider in making coverage decisions regarding caries management programs. If health services researchers or the paying community can demonstrate both health improvement and cost-effectiveness, caries management practices will be adopted. If they cannot make the case, adoption is unlikely.