Taking a bite out of dental costs

Ontario plan sponsors aren't prepared to swallow painful increases in dental costs. Employer groups are working with the Ontario Dental Association to find solutions--organizations in other provinces can follow suit.

By Susan Bowyer

Employers regularly examine benefits programs, looking for ways to control and reduce costs. Dental plans are no exception.

The Ontario Dental Association (ODA) recently published fee guide reforms that will be phased in over a five-year period starting in 2002. Calculating the impact of the proposed changes to a dental plan with $1 million in claims, the ODA estimates an overall increase of approximately 16.5% over five years, or just over 3% compounded annually.

A similar exercise conducted by three large insurers reveals increases of 20% to 24% over five years. When the unexplained increase in dental plan usage is added, employers are looking at total increases of at least 40% over five years. Not surprisingly, this has raised concerns about the affordability of employer-sponsored dental plans.

Dental costs are approximately 25% of total employer health costs--ranked second only to prescription drugs. With drug and disability costs increasing, employers simply cannot afford the anticipated hike in dental plan costs. Increasing competition for group insurance dollars is resulting in situations in which employers may actually decrease the funds available for their dental plan relative to their overall healthcare costs. Employees, too, will have to assess the value of the various components of their benefits plans. In the case of flexible benefits programs, they will vote with their plan options and dollars.

Rising dental costs have, for the most part, escaped close scrutiny. But it's important for employers to question why costs are on the rise. The reasons for rising drug costs are evident--an increasing number of new drugs on the market and many significant breakthrough treatments have resulted in higher cost drugs and increased use.

The rise in cost and utilization under dental programs is not so easily explained. For instance, younger people should have less dental decay than young people had 20 years ago. It also appears that new technologies have not resulted in productivity gains and efficiencies that lead to cost containment. The positive effects that the introduction of dental plans should have had on dental health are clearly not evident based on plan cost data.

A review of insured programs indicates that increased utilization is not necessarily due to more plan members going to the dentist, but rather the move to more expensive dental treatments and other dental management concerns. While the ODA's 2001 winter newsletter states that dentists don't charge patients with dental insurance higher fees than those without insurance, some insurer data indicate that charges at the high end of the fee guide ranges for insured individuals are indeed common.

Patients and employers rely on dentists to perform treatments that are necessary to maintain good dental health, and to charge fees based on the level of work required and performed, not the level of benefits coverage. It is not the intent of plans sponsors to interfere with the dentist and patient relationship, but rather to ensure patients and employers know what they are paying for and make plan decisions based on that knowledge and understanding. Currently, it appears nobody is minding the store--and that needs to change.

There is growing uncertainty about our economy, with talk of some sectors heading towards a recession. Containing costs will be a larger factor than we've seen over the last few years, even for employers whose main focus is to attract and retain and be an employer of choice, says Maureen Premdas, a consultant with William M. Mercer Limited. When employers are advised that doing nothing will yield a 7% to 9% annual increase in dental costs, as Premdas predicts, they want solutions.

There is a range of cost containment options to consider. They include:

- An industry developed reimbursement guide.Many see this option as the most effective way for the insurance industry and plan sponsors to regain control over dental plan costs.
- New delivery models. Capitation plans, for example, involve a network of dentists who agree to be reimbursed a fee for each individual who signs up as their patient. The dentist is expected to provide good dental health to the roster of patients within the plan and within the capitation budget. Such an arrangement provides incentives on the part of dentists to keep costs down.

Dentists benefit from the volume of patients directed to their practice. Employees benefit from lower out-of-pocket expenses from a combination of controlled dental costs and higher reimbursement incentives compared to those who do not choose to participate in the capitation plan.

- Treatment guidelines and evidence based dentistry. Under drug programs, plan adjudicators and sponsors are assessing and moving toward plan design and management features that are aimed at ensuring the right drug gets to the right people at the right time. The absence of prescribing guidelines has necessitated the introduction of clinical protocols and pre-authorizations to assess appropriate payments.

We are moving away from formulary plans that pay for or deny a drug based on the list of covered drugs, regardless of individual circumstance. If such sophistication can be built into a complex drug program, which has more impact on overall health, quality of life and productivity, surely this level of sophistication can be brought into a dental plan. In fact, these plans already have predetermination and alternate benefits provisions that can be built on to achieve the desired results.

With predetermination provisions, plan members submit a treatment plan if the procedure is expected to cost more than a certain amount prior to having the treatment performed. The plan sponsors' insurance company assesses the treatment against the contractual provisions of the plan and then advises the member of the amount that will be paid in advance.

The alternative benefits provision is applied when there are several treatment options for a certain condition. The plan pays for the covered expense as if the least expensive course of treatment was used.

- Cost sharing. Increased cost sharing with employees, coinsurance, deductibles and maximums will need to be reviewed.

In addition to these solutions, some employers may even introduce defined contribution or health service spending accounts in place of dental plans.

Recently, the economics committee of the ODA invited groups such as the Employer Committee on Health Care in Ontario (ECHCO), the Canadian Life and Health Insurance Association (CLHIA) and employers from the automotive industry to meet with it. The main message to the ODA was that employers will not absorb the projected cost increases under their plans.

The group's intention was to offer the ODA an opportunity to work with employers and the insurance industry on a proposal with a more favourable outlook for the sustainability of dental plans. While the ODA did not reverse its new dental guide reform, it did extend an invitation to form a committee of representatives from ECHCO, CLHIA and its economics committee.

The first order of business will be to ensure an analysis of data, separating facts from any misconceptions. This is a step in the right direction. The sustainability of employer sponsored dental plans is a shared objective, and the benefits industry hopes to continue working with dental associations to find solutions to the rising costs that threaten that sustainability.