Group Prepayment of Orthodontic Care

GERALD W. MYERS, D.D.S.

For many people the cost of health care has been a barrier to utilization. In the past most attempts to lower this barrier have failed. More recently another approach known as third party prepayment has been increasingly successful. This has involved insuring consumer groups against catastrophic needs, budgeting usual needs and sharing the financial burden with government, commercial and philanthropic institutions through a fiscal agent.

This plan has been used by employers to attract and to hold employees. It has helped unions display the value of union membership and to secure nontaxable benefits.[27] For many health practitioners it has become a growing segment of their practice. To the consumer, who has received more health benefits than ever before, it has been a means for achieving a basic human right.

But the third party approach has brought perplexity as well as satisfaction. Fiscal agents have had to foster underutilization of care to avoid bankrupting their programs.[38] To secure adequate service at favorable cost, fiscal agents have also sought to influence the administration of care. Thus they have endeavored to determine the competence of those delivering care, the eligibility and choice of patients, the scope of services, the quality of care, and the payment of charges.

Except for health emergencies and situations of unusual distress or dependency, these matters have traditionally been reserved to the professions.[49] Finally, fiscal agents have influenced the kind of care delivered. By covering major but infrequent health risks which are more insurable they have diverted attention from the maintenance of health and the prevention of disease.

Thus third party fiscal agents have impinged on some of the most important prerogatives and responsibilities of the health professions. Inevitably tensions have developed. Fortunately, a mutual accommodation of interests is emerging. Society has maintained its right to receive care. The health professions have preserved their right to deliver care. They have jointly agreed to negotiate the administration of care.

DENTAL PRECEDENTS

Because society placed a higher priority on hospital, surgical and major medical care, the medical profession faced the issue of group prepayment before dentistry did.[39,50] Dentistry, however, foresaw its involvement with third party group prepaid care as early as 1943. In the report of a special committee the American Dental Association then urged the study of existing hospital prepayment programs to determine whether dental care could be provided on insurance principles. The report also suggested that dentistry gain experience with third party payment through experimental programs conducted in various parts of the country.[1]

Then in 1953 the American Dental Association endorsed guidelines for those establishing dental prepayment plans. These emphasized the necessity of dental counsel and advice in designing such plans, the importance of defining benefits and the conditions under which services are provided. They called for freedom of choice for the dentist and the patient. The guidelines also reserved the professional right to establish policies on dental aspects of

the plan. In particular they urged the delivery of high quality care. Finally, they recommended that authorized dental representatives determine the payment of fees.[2]

Not long after this professional action, the International Longshoremen and Warehousemen's Union-Pacific Maritime Association (ILWU-PMA) stimulated the organization of a group dental practice.[28] About the same time the Los Angeles Hotel-Restaurant Employees-Union Welfare Fund decided to provide its own dental clinical facilities and to contract with private dentists for their services. In effect, these unions decided to fully administer their own programs.

These arrangements immediately drew critical attention from organized dentistry, fearful that dentists would be deprived of their prerogatives, be reduced to hired technicians or be excluded from the health care market.[49] Faced with this challenge, the profession reserved the sole right to deliver care. In the interest of serving more people, however, it sensed the need to negotiate with organized consumer groups on the administration of care.

In these negotiations organized dentistry made it plain that closed panels, which only serve eligible patients at specific facilities by a limited number of dentists, were not the preferred method of health care delivery because they denied free choice both to the patient and the dentist. Dentistry therefore insisted that closed panel practices should be formed and conducted solely with the prior knowledge, consent and guidance of organized dentistry.[3,17]

The impact of this position has been to restrain the growth of closed panels. While these programs dominated the field in 1960 when they served nearly seventy-five per cent of those with dental coverage, they represented only eleven per cent of a much larger field by 1968.[28,50]

In this connection it is significant that large closed panel programs have not provided orthodontic care. Thus the ILWU-PMA, the Sheetmetal Workers' Local 170, American Metal Products Company (AMPCO) and the Warehousemen's contracts with the Schoen partnership covered all dental services except orthodontics. And the Hotel-Restaurant Employer-Union Welfare Fund Dental Plan eliminated orthodontic care after three years of inclusion.[29] These programs were apparently unable to recruit orthodontists in sufficient number or to secure adequate funding for elective orthodontic care.

Meanwhile, the dental profession decided to assume fiscal management itself. State societies began to create nonprofit dental service corporations to administer prepaid plans on behalf of labor unions, government agencies and other groups. This mechanism allows freedom of choice for both patient and the dentist, reserves quality control to the profession and makes direct payments to participating dentists. It has irritated practitioners, however, for service corporations to discount payments to dentists by five per cent or more to provide for reserves and to cover their own operations.[47]

The first service corporations, Washington, Oregon and California Dental Services, were organized on the west coast in 1954 to administer a children's dental care plan initiated by the ILWU-PMA.[29,32] This approach has been extended until thirty-seven states now have active service corporations.[5] It is estimated that four million persons are presently covered by dental service contracts.[6]

Nonprofit and commercial insurance carriers were initially reluctant to as-

sume fiscal administration of dental plans because of consumer apathy and actuarial uncertainties.

The universal recurring and cumulative nature of dental disease, and hence of individual dental risk, seemed to make dental insurance (prepayment) actuarially unsound.[9] Later, the rise in consumer interest and the realization that actuarial planning could be based on utilization of care brought a breakthrough in the insurance industry. From 1960 with dental insurance coverage for only 17,491 persons there has been a steep rise with coverage for over 4.5 million persons at the end of 1969.[28] The insurance industry might well become the dominant fiscal agent for the dental market as it has for the hospital, surgical and medical care field. Hopefully, however, service corporations will maintain patterns for these insurance programs compatible with the profession and the public.

The Orthodontic Development

Both service corporations and insurance companies have written dental policies with coverage ranging from minimal to the most comprehensive benefits. The emphasis has been placed on recurring restorative care. Orthodontic services have been given the least attention because their high predictability has made them less insurable.[30] Nevertheless, rising consumer interest in orthodontic benefits has alerted orthodontists to the need for their involvement in prepayment planning.[19,22]

Because negotiations over prepaid orthodontic care are conducted by the profession rather than the specialty, orthodontists have developed closer liaison with the American Dental Association and its state and local societies.[20] First, the American Association of Orthodontists approved American Dental Association policies related to dental care programs.[43] The American Association of Orthodontists insisted, however, that local dental associations consult with the specialty before undertaking orthodontic programs. To facilitate consultation, orthodontic societies were quickly organized in each state.[11,21,31] In addition, the orthodontists in each state have sought for membership on state dental society planning committees and dental service corporation boards. The ensuing dental and orthodontic relationships have helped to resolve a number of important issues.

Competence

Defining the competence of those rendering orthodontic care in third party programs has occasionally been controversial. In its policy statement the American Association of Orthodontists declared that "orthodontic treatment under prepaid programs should be rendered by those having the requisite education, training or experience as outlined in the statement on qualifications necessary for the announcement of limitation of practice approved by the House of Delegates of the American Dental Association."[8] This does not restrict the delivery of orthodontic care to diplomates but does exclude those without thorough orthodontic knowledge or experience. Earlier board certification as customary with the medical specialties might help identify those qualified to practice orthodontics.

The power of the profession to specify the competence required for participation in third party prepayment programs, however, is only advisory. The precedent set by the Supreme Court of New York clearly showed that the fiscal agent reserves the right to designate who shall provide specialty service.[43] Not surprisingly, in 1967 only one commercial dental insurance carrier including orthodontic benefits specified that treatment should

be rendered by a licensed specialist.[10,41] This situation underscores the need for professional consultation to the prepayment industry.

Free Choice

Along with the profession, orthodontics has firmly held to the open panel arrangement which grants the patient free choice of an orthodontist. The specialty has also reserved the choice of patients to the orthodontist. In public programs, however, this choice cannot be prejudiced by race, color or national origin.[33] It can, however, be decided on the basis of administrative eligibility.

Eligibility

Unless limits are set on the eligibility of patients, the costs of orthodontic care would overwhelm entire third party prepayment programs. Various means have been used by fiscal agents to accomplish this limitation. One has been to require prior approval for treatment from the service corporations or other carrier. Another has been to restrict the age of coverage, e.g., excluding adults, or to specify the required duration of coverage. The Group Health Dental Insurance Company of New York, for example,[9] provides orthodontic benefits only to those enrolled in the plan from childhood.

A common expedient for limiting coverage has been to restrict the scope of services to those presenting either a handicapping malocclusion or a handicapping dentofacial deformity defined by a clinical index. Several prepayment programs have employed the Handicapping Labiolingual Deviations Index developed by Dr. Harold L. Draker.[34] The American Association of Orthodontists and the American Dental Association Councils on Dental Health and Dental Care Programs have officially endorsed the Handicapping Malocclusion Assessment Record devised by Salzmann.[31,41] The index should not only define priority conditions, but also prove helpful in establishing a limit to treatment, in controlling overutilization of service, and in proportioning the expenditure of funds.[13]

Quality of Care

The specialty has reserved the right to prescribe treatment procedures for all patients under orthodontic care. At the same time the American Association of Orthodontists recognizes the legitimate interest of third parties in the quality of care. The Association has, therefore, repeatedly emphasized the primary importance of maintaining quality care in all prepaid programs. Such quality, however, should be established in cooperation with, and acceptable to, recognized representatives of the American Association of Orthodontists or of its constituent or component societies.[25] Thus review of quality must be conducted by peers.[4,48] Forty-six states have already established peer review committees. Thirty-one states also have committees at the component or local level.[18] Annual review and authorization of treatment and plans to place nonprofessional personnel on peer review committees are alike repugnant to the profession.[24,31]

Claims and Payment

Policies with varying terminologies, coverages, service definitions and forms have provoked confusion over coverage and disputes over claims. They have also prevented multistate extension of prepayment programs. The uniform claim form with an optional orthodontic section developed in 1966 by the Council on Dental Care Programs helped bring order out of chaos.[14] Within two years it was adopted by companies covering more than eighty per cent of dental claims. Subsequent

development of a uniform code including orthodontic services has also been a clarifying advance.[15] In both these endeavors the American Association of Orthodontics has urged that orthodontists be included on an equal basis with all other specialty services.[23]

The Association has requested that payment mechanisms be established in cooperation with, and acceptable to authorized representatives of the specialty. In general, it consents to various methods for reimbursement in a health program while opposing capitation as the only system. The fixed fee concept, set on a state or regional basis, and the table of allowances are recognized as appropriate for use if provision is made for periodic review and readjustment of fee structures. The usual, customary and reasonable fee concept, however, is given priority.[4,41] In orthodontics a distinction is made between service fees for examination, diagnosis, and retention appliances on the one hand and monthly, quarterly, semiannual, annual or duration of treatment charges for full treatment on the other.[11,31]

Patient participation in the costs of orthodontic care through copayment is vital in orthodontics not only as a control on utilization but as a means of securing attendance and cooperation of the patient in treatment.

This is emphasized by the experience of Massachusetts orthodontists who recorded sixty per cent broken appointments in their public care program.[44] The need for a ceiling on benefits is recognized by the profession but the use of deductibles is discouraged because of its restraining influence on utilization.

Since service corporations and the insurance industry have assumed fiscal management, there has been encouraging growth in group prepaid orthodontic care.[26,46] By 1967, seventeen of the fifty-five commercial carriers with dental coverage included orthodontic treatment in their policies. Orthodontic coverage has been increasingly represented in service corporation contracts as well. In 1970 forty groups with the California Dental Service included orthodontic coverage. In 1972 it was estimated that some practitioners in the metropolitan New York area were securing as high as one-third of their new cases from nongovernmental third party programs alone.[24]

The resolution of administrative issues, experience with orthodontic benefits, and greater consumer interest have stimulated the growth of orthodontic coverage. Formation of the National Association of Dental Service Plans (now Delta Dental Plans) by the American Dental Association in 1966 has given further impetus to group prepayment. This vehicle has made it possible for the entire industry to coordinate uniform nomenclature, benefit descriptions, contract limitations and exclusions and rating considerations. For state dental service corporations it has made possible interplan agreements and the extension of multistate and national coverage to sponsoring groups. The new Dental Service Plans Insurance Company (DSPIC) will assist Delta Dental Plans in providing such programs to states without service corporations.[18]

But perhaps the greatest thrust for orthodontic prepayment has come from the government.[10] The passage of the Social Security Amendments in 1965 and particularly Title XIX (Medicaid) authorized dental care for a large segment of the American lower middle class regarded as dentally indigent. The statute permitted either closed panel or open panel arrangements, and allowed reimbursement by fee per operation based on an agreed scale or by

the usual, and customary fee concept.[27] By 1969, thirty-five of the forty-one states providing care under Medicaid included dental services and about one-half of these also included orthodontic treatment.

While dental service corporations in Illinois, Washington, and Georgia succeeded in becoming the fiscal agents for dental benefits under Title XIX, the dental components of Medicaid programs are administered by Blue Cross or by insurance companies in most states.[42] Unfortunately, these carriers often failed to properly define the scope of orthodontic services with the result that some of the care was economically and professionally unsound and of questionable value to the recipient. This situation was undoubtedly a factor in the scheduled elimination of matching funds for "cosmetic orthodontistry" when the federal budget for Medicaid was reduced in 1969.[45] Loss of federal support for orthodontic coverage under the Medicaid program has not, however, stifled government interest in extending such dental benefits to more people.

The Champus Program

Beginning in 1950 the military provided health care to dependents of active duty personnel on foreign and remote assignments. Later, the provision of these services was formalized under the Civilian Health and Medical Programs of the Uniformed Services (Champus) which authorized comprehensive hospital and medical benefits to military dependents without restriction on the location of their duty assignments. This program was extended in 1967 to include the needs of seriously, physically handicapped dependents.[37] Among other features it provided for orthodontic treatment of physically handicapping malocclusions. Patients, 9 to 19 years of age, with a minimum valid score of twenty-five points using Draker's index are presently eligible for CHAMPUS benefits.

Through the director of dental affairs CHAMPUS authorizes treatment, reviews the quality of care and adjudicates grievances. It also provides the sponsors of eligible dependents with fiscal benefits. Once CHAMPUS decides which patients are qualified for orthodontic coverage, the Colorado Dental Service acts as the fiscal intermediary. This dental service corporation processes all claims, verifies patient eligibility, checks for duplicate claims, figures deductibles, conveys payment, explains benefits to both dentists and sponsors, and handles all other correspondence.

Participation in the CHAMPUS orthodontic care program is not limited to board qualified or licensed specialists. This has been shown to be legally unenforceable. As a result ten per cent of orthodontic coverage is serviced by general dentists. Since CHAMPUS, however, is obliged to provide treatment by the most effective means, it does recommend the delivery of orthodontic care by specialists. Virtually every orthodontist in the country has filed a claim with CHAMPUS. Performance and fee profiles drawn on these orthodontists have shown that board certification is beneficial.

With its large public funded and multistate orthodontic coverage, CHAMPUS exhibits the limitations as well as the advantages of the third party purchase of orthodontic care. It lowers the cost of care to the individual but increases the total cost to society.[49] It does not provide for the preventive, interceptive or comprehensive care more consistent with the profession's fundamental interest. Thus, it places a premium on the existence of deformity. Moreover, it does not take cognizance of the relative value of services to the patient.

On the other hand, the program provides needed orthodontic services to thousands of children and youths who would otherwise be deprived of care. It accomplishes this by involving virtually all the orthodontists in a manner which least impinges on their professional prerogatives. The success of this program provides a pattern of care not only for all military dependents in the future but perhaps a wider segment of civilian society as well.

Thus health insurance is history. The profession and the specialty of orthodontics must accept it or be excluded from the market. With the rapid growth of existing programs and the prospect of national interest in such developments as capitation payments, closed panels, health maintenance organizations and professional standards review organizations,[17,48] it is time to get involved and to favorably influence the inexorable course of events.

3737 Moraga Avenue, A202
San Diego, California 92117

REFERENCES

1. American Dental Association: Transactions of the Eighty-Fifth Annual Session, Cincinnati, 1943.
2. ————: Principles for determining the acceptability of dental prepayment plans. Transactions of the Ninety-Fourth Annual Session, Cleveland, 1953.
3. ————: Closed-panel system of dental practice, *Am. J. Orthodont.* 48:781, 1962.
4. ————: Guidelines for dentistry's position in a national health program, *J. Am. Dent. Assoc.*, 83:1226-1232, 1971.
5. ————: Dental service plan activated in Alaska, *ADA News*, July 30, 1973.
6. ————: News of Dentistry, *J. Am. Dent. Assoc.*, 87:276, 1973.
7. American Association of Orthodontists: Prepaid dental care programs, *Am. J. Orthodont.*, 48:778-781, 1962.
8. ————: Policy of the American Association of Orthodontists Relative to Dental Care Programs (Adopted: New York, April 26, 1966; Reviewed: St. Louis, March 20, 1972).
9. Avnet, H. H. and Nikias, M. K.: *Insured Dental Care*, Group Health Dental Insurance, Inc., New York, 1967.
10. Brophy, J. E.: Private and governmental programs for payment of orthodontic services, *Am. J. Orthodont.*, 53:42-48, 1967.
11. ————: The American Association of Orthodontists and Its Role in Prepayment Programs, *Am. J. Orthodont.*, 54:683-8, 1968.
12. Bureau of Economic Research and Statistics: Use of the American Dental Association Dental Health Care Plan During 1966 and 1969, *J. Am. Dent. Assoc.*, 81:723-728, 1970.
13. Byrne, J. J.: Assessment of malocclusion: implications for dental prepayment programs, *Am. J. Orthodont.*, 54:766-768, 1968.
14. Council on Dental Care Programs: A matter of form. *J. Am. Dent. Assoc.*, 75:567, 1967.
15. ————: Uniform code on dental procedures and nomenclature, *J. Am. Dent. Assoc.*, 79:814-817, 1967.
16. ————: The profession's fiscal intermediary, *J. Am. Dent. Assoc.*, 85:767, 1972.
17. ————: New policies on dental care programs, *J. Am. Dent. Assoc.*, 86:176-178, 1973.
18. ————: National dental health conference explores peer review, manpower planning, responsibility to consumers, *J. Am. Dent. Assoc.*, 86:960-1, 1973.
19. Dewel, B. F.: Orthodontic challenges as seen by constituent society presidents, (Part I), *Am. J. Orthodont.*, 57:186-189, 1970.
20. ————: Orthodontic challenges as seen by constituent society presidents, (Part II), *Am. J. Orthodont.*, 57:299-303, 1970.
21. ————: Potential association policies for constituent and component societies, *Am. J. Orthodont.*, 59:193-194, 1971.
22. ————: Orthodontic issues as seen by constituent society presidents, (Part II), *Am. J. Orthodont.*, 59:293-297, 1971.
23. ————: AAO upholds old policies and solves new challenges, *Am. J. Orthodont.*, 60:79-82, 1971.
24. ————: AAO constituent society presidents consider orthodontic health proposals (Part I), *Am. J. Orthodont.*, 61:188-192, 1972.
25. ————: AAO constituent society presidents consider orthodontic health

proposals (Part II), *Am. J. Orthodont.*, 61:302-306, 1872.
26. Dixon, G.: Orthodontic treatment included in prepayment dental plans, *Bull. Pac. Coast Society Orthodont.*, 59-60, November, 1970.
27. Dunning, J. M.: *Principles of Dental Public Health*, 2nd Ed., Harvard Univ. Press, 1970.
28. Friedman, J. W.: The Dental Care Program of the Los Angeles Hotel Restaurant Employer-Union Welfare Fund, Division of Health Administration, School of Public Health, *Univ. of California*, Los Angeles, p. 46, 1970.
29. Group Health Association of American Inc., Group Dental Care and Prepayment, International Hotel, Los Angeles, California, p. 72, Nov. 3-5, 1965.
30. Hillenbrand, H., Dollar, M. and Hudson, A. L.: Prepaid orthodontic programs: A panel discussion, *Am. J. Orthodont.*, 51:98-111, 1965.
31. Johnston, W. D.: Orthodontic prepayment plans, *Am. J. Orthodont.*, 55:286-293, 1969.
32. Joseph, L., Dental Insurance: A developing success story, *Today's Health* March 1970.
33. Kain, P. F.: Dental Care Program, Department of Public Aid, State of Illinois, July 1, 1970.
34. Landefeld, W. E. Jr.: The CHAMPUS orthodontic program, *Am. J. Orthodont.*, 60:281-289, 1971.
35. ————: Dental Care CHAMPUS Basic Program, *OCHAMPUS FACT SHEET*, April 1, 1972.
36. ————: Personal communication, April 16, 1973.
37. ————: Orthodontic Benefits Under the CHAMPUS Program for the Handicapped, OCHAMPUS Memorandum of June 27, 1973.
38. Mulvihill, J. E., Bear, W. S., Dunning, J. M. and Giddon, D. B.: Utilization of a prepaid plan of commercial dental insurance, *J. Pub. Health Dent.*, 32:187-196, 1972.
39. Pelton, W. J.: *Dentistry in Public Health*, 2nd Ed., W. B. Saunders Company, Philadelphia, 1955.
40. Report of Special Committee on Prepaid Orthodontics, *Bull. Pacific Coast Society of Orthodont.*, 39:10-11, 1964.
41. Salzmann, J. A.: Orthodontic planning in prepaid dental programs, *Am. J. Orthodont.*, 52:56-58, 1966.
42. ————: The threat of "social orthodontics:" in prepayment programs, *Am. J. Orthodont.*, 55:302-303, 1969.
43. ————: The third party and "free choice" of a doctor *Am. J. Orthodont.*, 55:525-526, 1969.
44. ————: Is prepayment the answer to increased dental care? *Am. J. Orthodont.*, 56:303-304, 1969.
45. ————: Orthodontic treatment problems under prepayment programs, *Am. J. Orthodont.*, 56:525-526, 1969.
46. Smith, W. S.: Orthodontic prepayment principles, *Am. J. Orthodont.*, 50:389-390, 1964.
47. Wasserman, A.: Dental insurance, it's impact on your practice *J. Acad. Gen. Dent.*, 19:30-33, 1971.
48. Watson, C. G.: Peer review, *J. Am. College Dent.*, 38:103-111, 1971.
49. Young, W. O.: Chapter 1, Dental Health pp. 67-76, in Hollingshead, B. S., Director, The Survey of Dentistry: The Final Report, American Council on Education, Washington, D. C., p. 603, 1961.
50. ————: Chapter 11, The Purchase of Dental Care, pp. 208-235, in Young, W. O. and Striffler, D. F., *The Dentist, His Practice, and His Community*, 2nd Ed., W. B. Saunders, Company, Philadelphia, 1969.