



Issues Regarding Insurance and Other Third-party Reimbursement for Behavioral Management Procedures

B. Alex White, DDS, DrPH, MS Michael P. Monopoli, DMD, MPH, MS

Dr. White is director, Oral Health Research, Dr. Monopoli is director, Dental Public Health Policy, Dental Service of Massachusetts, Boston, Mass. Correspond with Dr. White at awhite@deltadentalma.com

Abstract

Issues related to reimbursement for time and effort expended in providing behavior management services for children often result in confusion and frustration for the parent and practitioner. Multiple medical and dental insurance plans within a state or region frequently lack a common set of definitions that are fundamental in interpreting and applying contract language. Ambiguities and inconsistencies in state and federal programs and regulatory structures, as well as budget concerns, only exacerbate the problem. This paper reviews issues of third-party payment associated with dental care for children requiring behavioral management. An environmental assessment of the health care system identifies individual and societal challenges. A model that identifies stakeholders involved in third-party reimbursement is discussed, noting the incentives faced by each stakeholder and expected behaviors based on those incentives. Strategies for effecting change based on a thorough understanding of each stakeholders' concerns are discussed. (*Pediatr Dent.* 2004;26:137-142)

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The evidence base for behavior management techniques and philosophies targeted toward children changes over time to incorporate new information and reflect evolving societal and professional norms about what is effective, appropriate, and acceptable. New evidence may suggest certain techniques are more (or less) effective than previously assumed. Approaches that may have been the standard of care 20 years ago may no longer be appropriate or tolerable for children or their parents. As professionals, dentists are obligated to keep their knowledge and skills current and incorporate these approaches into their practices, as appropriate. A dentist's ability to do so may be facilitated or hindered by a number of factors.

Reimbursement for behavior management services potentially has a significant influence in changing accepted practice. The compensation received for one's time and effort in providing behavior management services will be assessed against the costs of providing them, including the opportunity costs associated with not doing something else. In some instances, the cost of such care will be fully reimbursed by a third party. In other instances, a parent or guardian may share the costs with private or public programs via copayments, deductibles, or annual maximums. In still other cases, a parent or guardian will be responsible

for paying the full cost of care—for example, when the child has no private health insurance and does not qualify for health coverage through public programs, or when the service is not covered regardless of whether the child has private or public insurance.

The plethora of reimbursement possibilities may result in confusion and contradiction for the parent and practitioner alike. Medical and dental insurance plans may not be well integrated, contract language may be interpreted and applied in different ways, and standardization may be lacking. Consequently, hospital and anesthesia expenses may be covered by medical insurance when nondental procedures are performed in a hospital or ambulatory care facility; yet payment for hospital and anesthesia expenses may be denied by medical plans when dental procedures are performed in the same setting.

The multiple medical and dental insurance plans within a state or region often lack a common set of definitions that are fundamental in interpreting and applying contract language. These entities may lack shared standards for processing claims and providing coverage information to the beneficiaries, practitioners, and hospitals. Multiple individuals may be involved in making reimbursement decisions, reducing the likelihood of consistency across plans.

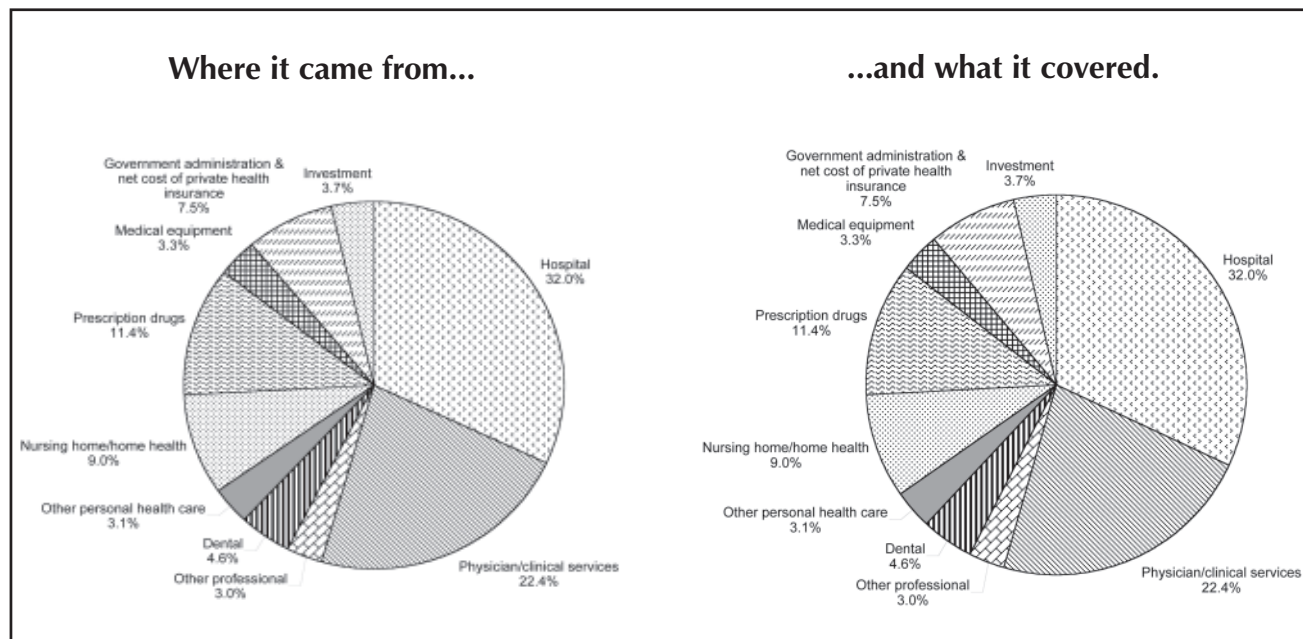


Figure 1. National health expenditures, by source of funds and spending category, 2003.

This paper aimed to review various issues associated with third-party payment for costs associated with dental care for children requiring behavioral management. The authors first provided a brief environmental assessment of the health care system to point out the many individual and societal challenges dentists face. Second, the authors discussed a model identifying the stakeholders involved in third-party reimbursement, the incentives each stakeholder may face, and expected behaviors based on those incentives. A full discussion of financing and reimbursement for dental services is beyond the scope of this paper. Significant variability in plan design, administrative rules and claims processing procedures, state policies, and corporate philosophies preclude such an undertaking. Those seeking additional information are referred to other sources.¹

Finally, the authors provided some suggestions about how such coverage decisions might be portrayed by decision makers. By being aware of and directly addressing this viewpoint, one increases the probability of a successful outcome.

The health care environment

Irrefutably, most Americans derive significant benefits from their highly advanced, technologically oriented health care system. Almost daily, practitioners learn of scientific advances that seemed almost unimaginable a few short years ago. The health and financial costs of this system, however, are significant.² Consider these data:

1. In 2003, the United States spent an estimated \$1.67 trillion, or about \$5,808 per capita, on health care—approximately 15% of the gross domestic product.³ Payments by private health insurers represented about 36% of the total (Figure 1). Federal programs—es-

pecially Medicare and the Medicaid program's federal portion—contributed approximately 32%. State and local program expenditures accounted for 13% of expenditures, and out-of-pocket payments represented nearly 14%.

2. About one third of national health expenditures went for hospital care, over 20% for physician services, and more than 11% for prescription drugs (Figure 1).³ Dental services accounted for 5% of total expenditures.
3. Despite this investment in health care, about 17% of the 250.8 million nonelderly population had no health insurance in 2002.⁴ Among children 8 to 18 years old, about 12% were uninsured, while almost 20% were uninsured among adults 19 to 64 years old. Most of the insured had employment-based health coverage (65%) or Medicaid (10%).
4. In 2003, premiums for job-based health benefits rose by 14%, the third consecutive year of double-digit premium increases.⁵ A family of 4 paid almost \$9,100 per year for health insurance coverage.
5. In 2003, when firms were asked to identify factors thought to significantly contribute to health insurance premium increases, roughly 61% identified higher spending for prescription drugs (Figure 2).⁶
6. In 2003, when firms were asked to identify plan features that were very important, approximately 80% identified plan cost (Figure 3).⁷ Less than 4% specified quality measures such as the National Committee for Quality Assurance (NCQA) or The Health Plan Employer Data and Information Set (HEDIS).
7. In fiscal years 2002 to 2004, all 50 states reported they had implemented or were implementing strategies to

control prescription drug costs and to reduce or freeze provider payments in response to state budget pressures (Figure 4).⁸ More than half were simultaneously pursuing additional cost-containment strategies.

- For an uninsured person, health care access is difficult and has negative health consequences.⁹ The uninsured receive less preventive care, are diagnosed at more advanced disease stages, and, once diagnosed, tend to receive less therapeutic care (drugs and surgical interventions).

For some stakeholders (eg, businesses and governments), increasing health care costs and health insurance premiums invoke countervailing strategies resulting in higher premiums or taxes, reduced payments to practitioners, restricted eligibility, or shared financial risk. That stakeholders disagree is not surprising. Each has a vested interest in the outcome, and the health costs and consequences are enormous.

Stakeholders' perspectives

It has been said: "All models are wrong; some are useful." Such is the case with the dental insurance model shown in Figure 5. Four stakeholders are identified:

- beneficiary and his or her dependents;
- purchaser who finances the insurance on behalf of the patient (often the employer in the private sector and the taxpayer in the public sector);
- third-party payer (public or private) who administers these programs; and
- dentist (or other health practitioner or institution) who provides and seeks reimbursement for dental care.

Each stakeholder exchanges money, information, dental care, services, and/or financial risk with at least 2 other stakeholders. Additionally, each stakeholder faces a set of potentially conflicting incentives, which, in many instances, involve tradeoffs between cost, access, and quality. A number of factors will influence stakeholder relationships, including:

- advocacy and special interest groups that may have significant political clout;
- politics;
- professional organizations;
- new technologies;
- scientific evidence;
- domestic labor markets;
- legal contracts;
- reimbursement incentives and plan design;
- education and training; and
- insurance rules and regulations.

Understanding a stakeholder's perspective allows one to anticipate behaviors, avoid conflict, and develop strategies to achieve desired outcomes. All perspectives, except the beneficiary's, are discussed on the next page.

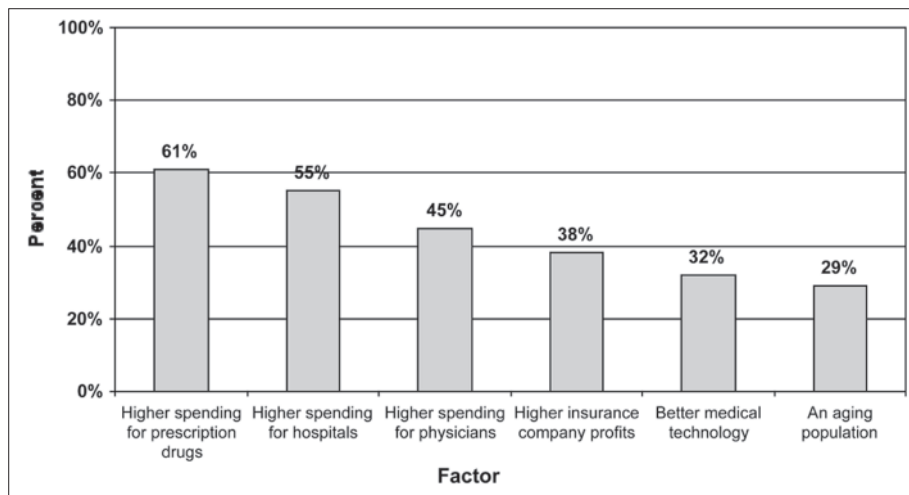


Figure 2. Percentage of all firms reporting the following factors as significantly contributing to health insurance premium increases, 2003.

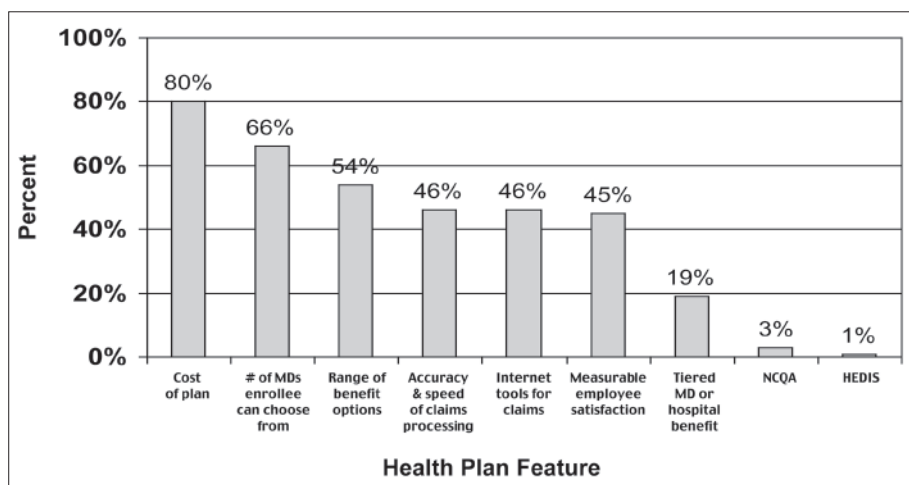


Figure 3. Percentage of all firms saying the following features are "very important" when choosing a health plan, 2003.

Purchasers' perspectives

Purchasers are those entities who pay for health care. For private programs, purchasers include:

1. employers, most often for entities with 2 or more employees;
2. purchasers of individual health insurance policies;
3. trade unions, professional groups, and other such entities offering benefits to its members; and
4. private health services, such as work-site health facilities.

For public programs, purchasers include Federal, state, and local governments administering an array of health care programs such as Medicare, Medicare, Department of Veterans Affairs, Department of Defense, and Indian Health Service, as well as federal and state employee health plans.

When opting to make health coverage available, purchasers seek several things. Private firms aim to encourage employee recruitment and retention, improve employee satisfaction, and enhance health for a group of employees. Ultimately, nonprofit firms are motivated by their mission, and for-profit firms seek to remain competitive in the marketplace and maintain and increase sales. Public programs look to facilitate access, increase satisfaction, and improve health for a group of eligible beneficiaries. All private or public purchasers seek predictability to more accurately budget from year to year by limiting annual health insurance premium increases or by controlling the program costs to avoid deficit spending and/or tax increases.

Purchasers are held accountable for their stewardship. Stockholders, nonprofit and for-profit boards, elected officials, and taxpayers have a vested interest in purchasers' success. As a consequence, purchasers employ a number of strategies to control health care costs, including:

1. increasing cost sharing with beneficiaries;
2. introducing or increasing copayments and deductibles;
3. limiting maximum payments (annually or over a lifetime);
4. creating incentives through medical savings accounts;
5. changing to plans with more effective cost control activities;
6. introducing disease management programs;
7. instituting bulk prescription drug purchases;

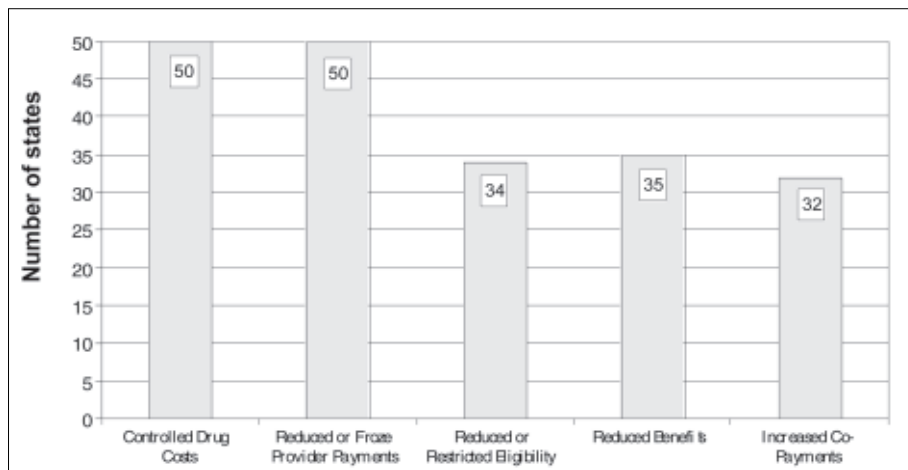


Figure 4. Number of states implementing Medicaid cost-containment strategies, fiscal years 2002-04.

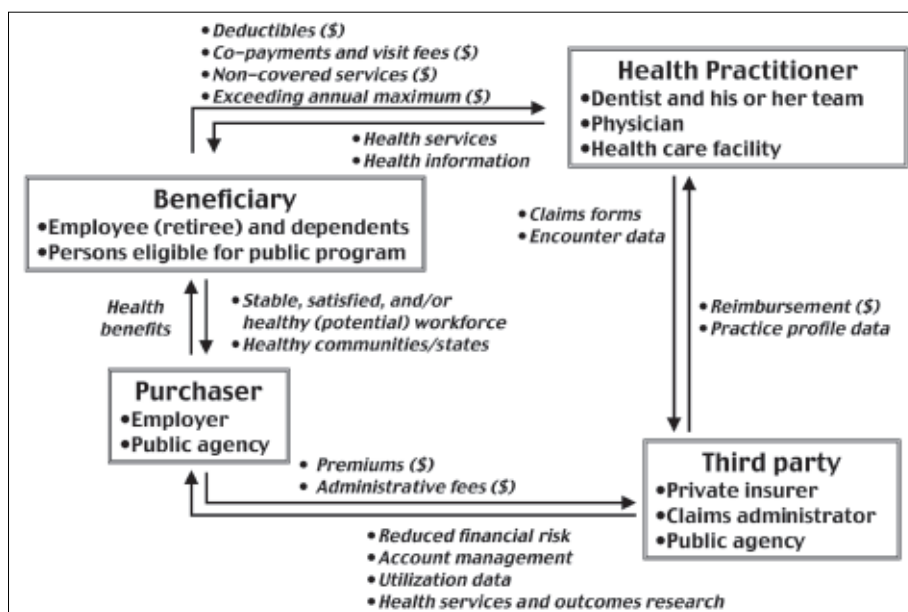


Figure 5. Key stakeholders influencing dental benefits.

8. reducing or eliminating benefits; or
9. moving to self-insurance.

Third-party payers' perspectives

Third-party payers are those entities that reimburse practitioners for health care services. For private plans, most third-party payers are private insurance companies. For public plans, third-party payers include Medicare and Medicaid, most commonly. The employer may sign a contract with 2 different types of entities offering private coverage¹:

1. State-licensed health-insuring organizations—including commercial health insurers, Blue Cross/Blue Shield Plans, and health maintenance organizations—are organized and regulated under state law (federal standards may also apply).

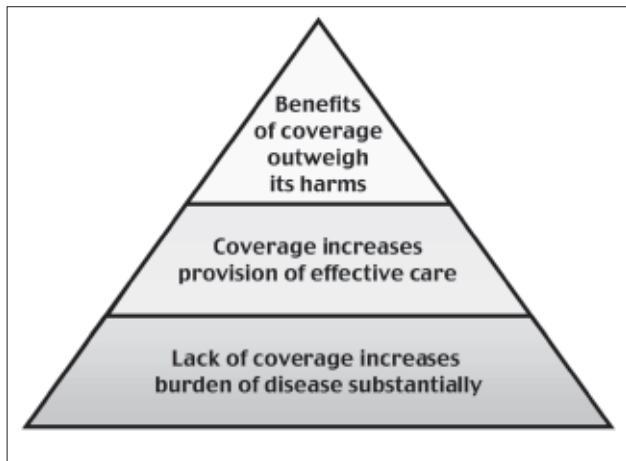


Figure 6. Evidence pyramid for assessing a coverage policy.

Like purchasers, third-party payers are accountable to stockholders, not-for-profit and for-profit boards, elected officials, and taxpayers as well as existing and potential accounts. Third-party payers design products responsive to a purchasers's need. When that need is drive by cost, third-party payers may:

1. design benefit packages limiting what is covered for whom, when, where, and how often;
2. shift some or all financial risk to patients and/or practitioners;
3. limit the type of practitioner who can be reimbursed; or
4. institute annual or lifetime maximums.

Practitioners' perspectives

Practitioners are dentists, dental hygienists, and other professionals who provide care to individual patients and who, in exchange, receive financial reimbursement. Practitioners are licensed to practice in a given state and authorized to deliver certain services based on specialized knowledge and training.

Accordingly, practitioners resist constraints on their professional judgment and advocate against administrative procedures that may have been intended to control costs. Practitioners expect adequate and timely reimbursement for their services and advocate for change when necessary. Practitioners may limit the number of new patients accepted into the practice or may choose not to participate in a Medicaid program; reimbursement levels may be inadequate (as determined by the practitioner), or the administrative burden may be too high. They are accountable foremost to their patients and to licensing agencies.

Should insurance pay?

A large number of interventions—some new and some familiar—and constrained resources preclude carte blanche coverage decisions. Decision makers increasingly rely on clinical evidence of effectiveness as a key criterion. Estimating a procedure's health consequences allows for explicit comparison of alternative approaches for a given condition.

Health outcome of the intervention	Cost to third-party payer (and purchaser)		
	Lower	Same	Higher
Better	++	+	?
Same	+	?	-
Worse	?	-	--

Figure 7. Possible outcomes following coverage expansion to a new intervention.

One such approach is shown in Figure 6.¹⁰ For a given population, one first determines whether lack of coverage increases the disease burden associated with a condition. If it does, only then does one decide if coverage increases the provision of effective care. If so, one should determine whether the intervention's benefits outweigh its harm. While such a systematic approach cannot guarantee success, it can significantly increase its likelihood.

One is challenged to determine whether, relative to current practice, the added benefits associated with a new behavioral management approach are worth the required additional resources (eg, personnel, training time, equipment).¹¹ In some instances, the new behavioral intervention may yield better outcomes at a lower cost (Figure 7). In other cases, the new behavioral intervention may be more expensive and less effective (Figure 7). Quite likely, however, many interventions will lie somewhere in between, requiring tradeoffs between competing goals.

Summary

For public and private programs, current state and federal regulatory structures and funding issues result in frustration and confusion. Efforts to obtain reimbursement for services such as behavior management techniques and philosophies for children are even more difficult because of dual insurance systems (medical and dental). Ambiguities and inconsistencies in state and federal programs and regulatory structures as well as budget concerns only exacerbate the problem.

Successful efforts to extend coverage and increase reimbursement levels require a multifaceted approach. Stakeholder incentives are often in conflict, and efforts to control costs by one stakeholder may work against efforts by another to expand benefits. Multiple stakeholders may hold different beliefs and motivations and may view a given outcome in very different ways. To be successful, one is obliged to focus on motivations rather than behaviors, for in doing so one may come to understand why certain stakeholders respond in the ways they do. Purchasers and insurers may view practitioner efforts to extend coverage for behavioral management services as self-serving, a way to increase income. Practitioners and parents may view

purchaser and insurer efforts to control costs as cold-hearted and insensitive.

Mutual success depends on one's skills and abilities to present a persuasive, compelling, evidence-based argument focusing on children's health and well being and is responsive to and respectful of other stakeholders' concerns.

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