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this new class of products and what specific services at what rates of savings the enrollees are able to access once they sign up. It's saying, Let's see if we can add to the 60% who already have dental coverage with a product that leads them to say, 'Yes, this fits our dental needs and our budget constraints.'"

The challenge for the affected plans is, of course, if you reduce cost-sharing at the copay and deductible level, and instead the main charge to the member is through the premium, then the plan has to provide a package of benefits and pay for it mostly with those premiums. "Traditionally," Album continues, "dental plans have limited

copays and deductibles, funding the majority of care with premiums. But with the increases in the cost of care in the last several years, especially medical care, premiums have gone up to the point that there are fewer people currently uninsured who are joining the ranks of the insured."

And that's where the fact that "dental is different" isn't such a good thing. "People on the dental side are not so afraid of being uncovered," Gruenbaum says. "If you have a medical problem, the cost could be enormous. But if you have a dental problem, the cost isn't as threatening. So people are less prone to get a dental plan even if they don't need it right away. They'd rather incur dental expenses when they actually need care than

pay month after month without actually needing it. So they stay uncovered."

He adds: "Plans are now saying, 'Let us design plans that appeal to those who have no coverage because they cannot afford it.' If plans can get sufficient money from premiums, copays and deductibles to cover the cost of care, the market will work better for them and for patients." Indeed, he adds, "we're saying that there are many who don't want to pay for care until they need it. We want to design lower-premium programs -- which, by necessity, means we have to raise the copays and deductibles. When the premiums don't seem as burdensome, more people can access care."

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PLAN, DENTIST ACCREDITATION EYED BY CA REGULATORS

As California looks for ways to streamline health plan regulation, one strategy it's eyeing is granting deemed status to HMOs that receive voluntary accreditation from the National Committee for Quality Assurance. A step in the process could be allowing plans that outsource their dentist credentials verification operations to a company that's NCQA-certified to skip further Department of Managed Health Care oversight of that particular function.

At a June 8 public hearing, the DMHC focused on a proposal that would exempt Knox-Keene-licensed health plans operating in California from DMHC quality audits if the plans are NCQA-accredited. "Potentially," says a statement from Laguna Hills, CA-based VerifPoint/CreDENTALS Services Inc., "the proposal would also exempt plans from DMHC provider credentialing quality oversight if the provider credentialing is performed by a credentials verification organization certified by the NCQA."

The Department "has for many years performed periodic quality and financial audits of California managed care plans with the idea that doing so safeguards the public," notes **Richard B. Ryan**, CEO and president at VerifPoint. "It's a long, tedious process that I've heard from clients often takes weeks, if not months, of committed resources. There's an incredible consumption of staff and resources on both sides of the fence." Now that California's financial fortunes have changed, the DMHC decided to review that process.

"NCQA accreditation has become something of a *Good Housekeeping* seal of approval for health plans in this country," Ryan adds. "Some 30 states now recognize health plans accredited by the organization as the deemed quality standards for their states. So California formed a committee with the NCQA to compare and contrast their audits to see what overlap exists. They deter-

mined there was enough overlap to consider deeming all or part of an NCQA accreditation as meeting the state's audit requirements."

At the hearing, he continues, he also voiced support for "a natural extension" of the NCQA move: "If a dental plan outsources its credentialing operations to an NCQA-certified CVO, the credentialing functions of that plan should be deemed compliant, and thus be exempt from DMHC oversight." Some nodded heads, he reports, "indicating that would be the logical extension." The people opposed to his idea, he adds, were government employees -- who could see some of their auditing jobs moved to the private sector.

The NCQA has certified VerifPoint in "all recognized credentials verification elements" since 1996, Ryan adds. "We are proud of our continuous NCQA credentials certification over the past decade," he says. "The credentials verification process we perform meets the DMHC standards simply because we are, and will continue to be, NCQA-certified. Should the DMHC proposal under consideration be approved, any clients utilizing CreDENTALS' credentials verification services would be exempt from DMHC audit review for their credentialing processes."

At the hearing, he tells *Managed Dental Care*, the DMHC didn't answer any questions. It simply took comments and reported on where it is in the review process. "I did get the sense that deeming NCQA accreditation will be pushed through in some form or fashion," he says, "and part of that rationale is based simply on the admission by DMHC that there aren't funds available to continue on its present course. The DMHC noted that if its staff was relieved of some existing audit duties, it could better monitor problem areas and focus on enforcement."

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Under the program, those new plans will have to show the DMHC what kind of information they're going to give consumers about cost-sharing. But those details haven't been worked out yet. "The disclosure element is a work in progress," Gruenbaum says. "The CADP continues to work with the Department. It wants us to increase disclosure in 'evidence of coverage' documents in all plans, not just the new, more flexible plans. Toward that end, it has embarked on an effort, with input from the CADP working group, to improve the quality of disclosure in EOCs and any brochure given to a plan member.

What's also unclear at this point is the ultimate impact on managed dental care plans in California. "It's important because as dental plans one of our goals is to offer programs that will attract enrollment by meeting the needs of enrollees," he says. "Their needs are really quite different from person to person, so the

challenge to plans is providing different options that address those needs." The new rules, he adds, mean "we now will be able to design plans that offer more choices that, we think, will meet the needs of more people than the plans we now offer."

Plans, he emphasizes, "are constantly trying to come up with products that meet the needs of the market -- but we have to do so within the limits of Knox-Keene. The Department wants more people covered, so we said, 'Okay, give us more flexibility than you've given us to design products we think will meet people's needs.' The Department said, 'Okay, but we still need to see that people achieve real, verifiable savings and understand the true costs of a high-copay dental product.' We said, 'Okay, we can comply with that.'"

Nobody's predicting how the move will tip the scales as far as the ascendancy of dental PPOs and the stagnation of dental HMOs. Indeed, nobody's predicting much of any-

thing about the effect the new rules will have.

The regulatory guidelines, Album stresses, "should not be seen as a silver bullet for resolving the problem of covering everyone without dental insurance. By encouraging plans to provide more flexibility, I think more people will be encouraged to try an affordable dental product, and maybe even buy up over time to more traditional dental coverage. We don't really know. What we expect is by giving people more choices we can meet more people's needs. It remains to be seen how much of a dent in the marketplace we can actually make with this kind of approach."

The numbers will tell the story, he adds. "Once we get people enrolled in flexible benefit plans approved under the new guidelines, we'll provide information annually to the DMHC that documents the cost savings, the kinds of services delivered, and whether we've succeeded in taking people from the rolls of the uninsured." ■

Accreditation *continued from page 5*

The dental piece could be accepted even if the whole concept is not. "That might be a baby step they could take," he comments. And if it flies, he concedes it could be a real boon for his company. "It would give the NCQA certainly more strength and more credibility in California," he says. "And I would presume that, given the choice of putting their considerable energies into DMHC compliance or NCQA accreditation, many California dental plans would rather work to achieve NCQA accreditation and/or outsource their provider credentials verification responsibilities to an NCQA-certified CVO rather than continuing to face the ongoing, almost continuous audit and response process that has become the norm with DMHC oversight. If more plans become accredited, that would have a positive impact on us.

Plans could outsource the credentialing aspect of their quality assurance functions to us and remove any further state oversight."

Dental accreditation is such big business already that the Accreditation Association for Ambulatory Health Care is promoting its long-term presence in the game. "Dental practices that become accredited by AAAHC accrue benefits beyond attaining a high level of quality care in their organizations," comments **Francis DiPlacido**, DMD, FACD, AAAHC board president. "Insurance and managed care organizations are looking for ways to assure that patients served in the ambulatory care setting receive safe and appropriate care that meets high quality standards. So accreditation becomes the 'seal of approval' required by those payers. In addition, accreditation satisfies some states' oversight regulations for relicensing. And perhaps most impor-

tantly, accredited dental practices send a strong message to patients and general consumers that they meet high safety and quality standards. Accreditation becomes a competitive advantage."

That's been the case for almost 20 years, he tells *Managed Dental Care*. In 1987, the American Academy of Dental Group Practices voted to discontinue its own accreditation program and instead became a member of the AAAHC, he reports. In 1989, the American Association of Oral and Maxillofacial Surgeons joined. And in 1994, the American Dental Association began sending official observers to meetings of the AAAHC Board of Directors. "The Association accredits a variety of healthcare organizations that provide dental and related services," he says. "That includes solo practices and those that are members of group

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practices, as well as oral and maxillofacial surgery practices. Other dental practices accredited by AAAHC include ambulatory care organizations that offer dental services, such as the U.S. Coast Guard and Indian Health Service.

And it's not like states are just beginning to recognize the power of dental accreditation. Currently, Texas, Georgia, Pennsylvania, Florida and Nevada consider AAAHC accreditation adequate for dentist relicensing. In December 2002, DiPlacido points out, the AAAHC was granted renewal

of its deemed status for Medicare by the Centers for Medicare & Medicaid Services. As a result, ambulatory surgery centers have the option to choose AAAHC's accreditation survey or an AAAHC Medicare deemed status survey that counts for Medicare certification.

The Association has also been recognized and accepted by all types of third-party payers, including BlueCross BlueShield plans, commercial carriers, HMOs, and government agencies. "Most of AAAHC's concentration is with ASCs," DiPlacido says, "but increasingly, dental practices are

seeking AAAHC accreditation. Indeed, in the last six months alone, there has been a more than 150% surge in the number of dental organizations accredited by the AAAHC."

Part of the survey process, he adds, is careful consideration of practices' relations with dental plans, their information systems, and their compliance with plans' operational requirements. "It's all part of the survey process," DiPlacido comments. "Those areas are covered under Governance, Administration, Clinical Records and Health Information and Quality Management and Improvement." ■

Contribution *continued from page 1*

"there are still some sloppy plans out there that can tighten up in several areas. They can change their provider reimbursement structure or revamp their exclusions and limitations -- which are often subtle and which often don't affect everybody." An example: If a plan covers three prophys a year, it can very likely switch to covering two a year without anyone noticing. "Very few people use all three," she explains. "So if the company goes to two, it won't generate complaints -- but it will save money."

Another factor in the slow move to changing contribution strategies is the fact that "if you have employees who are collectively bargained, you can't talk about contribution strategies at all," Smithwick emphasizes. "And for some companies, it's just a touchy subject. They're making dramatic changes on the medical side, and they often see dental as a small part of the overall benefit dollar, and thus don't want to touch it."

For companies that want to tinker with dental benefit contribution strategies, "the first thing they need to try to think through is how the dental piece fits into the company's overall benefit strategy. If you have a company that has no contribution on the medical side and none on the dental side and then all of a sudden

it adds them for everything, that's one scenario," she says. And don't think workers don't see things that way, she cautions. "With benefit packages in general," she says, "we find that they really are viewed by employees as a package -- and so they need to be presented to them as a package."

For employers, she adds, that means being "really, really careful" when making changes in dental "that it's put in the context of everything else. One way employers do that -- especially lately -- is actually showing employees what the dental benefits are costing the company. A lot of times the employees have no clue. If the firm is paying \$600 to \$700 per employee a year and the employee is paying the remaining \$60 a year, or the employer is paying \$700 and the employee is paying nothing, the employees need to know that."

That bears repeating, she stresses. "My advice to any employer thinking about making a change to its contribution strategy for dental is to look carefully at the communications piece of it," she says. "The company needs to look carefully at the story it's going to tell -- and what the story is that it should be telling."

One way to make that job easier, she points out, for firms whose contribution strategy is on the low end

-- meaning, in her view, that the employee contribution "is a lot lower than it should be" -- is to "get some benchmarking information and show the employees that, actually, their contribution right now is much lower than the industry average." That tally, she notes, is roughly one-third. "It varies," she explains, "but it's usually in the low 30s." Having that information available to show workers, she adds, "is important from a strategic point of view. You can say, 'This is what dental is costing us right now, per employee and in total dollars.'"

Sometimes, of course, employers need to ratchet employee contributions down, not up. "Companies really need to be mindful of the fact that if the employee contribution is too high, it's using everybody to subsidize the few who use up their annual maximum. That's the other side of the coin -- and we don't like to see that, either. You may have the entire group paying more than they should for the few who will hit that max every year."

Developing an equitable contribution strategy, then, is "really a balancing act," she stresses. "An increase in the employee contribution means their out-of-pocket cost should be lower. You've got all those things to consider." That, she emphasizes, is another aspect to consider in chang-

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