



*D Y PATIL DENTAL
SCHOOL*

DEPARTMENT OF
PUBLIC HEALTH DENTISTRY



Dental payments

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Health care systems of India

1. Public health sector

a) *Primary health care*

- Primary health centers
- Sub-centers

b) *Hospitals/ & health centers*

- Community health centers
- Rural hospitals
- District hospital/ health center
- Specialist hospitals
- Teaching hospitals

Health care systems of India

c) Health insurance schemes

- Employees state insurance
- Central govt. health schemes

d) Other agencies

- Defense services
- Railways

2.Private sector

- a) private hospitals, poly clinics, nursing homes and dispensaries
- b) General practitioners and clinics

Health care systems of India

3. Indigenous system of medicine

- Ayurveda and siddha
- Unani and Tibbi
- Homeopathy
- Unregistered practitioners

4. Voluntary health agencies

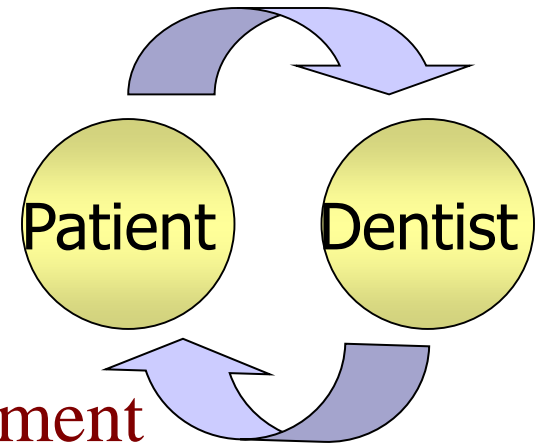
5. National health programmes

Mechanism of payment for dental care in US

1. Private fee-for-service
2. Post payment plans
3. Private third party prepayment plans
 - a. *Commercial insurance companies*
 - b. *Non profit health service corporations (delta dental plans & blue cross/blue shield).*
 - c. *Prepaid group practice, including health maintenance organizations and independent practice associations*
4. Salary
5. Public programmes

Private fee-for-service

- Two party arrangement



- Traditional form of reimbursement

- 1970, nearly 90% of payments was in this manner.

- But by 1988, dropped to 55% of all payment because growth in the various forms of prepayment.

Private fee-for-service

■ Advantages

- *Simple and Culturally acceptable*
- *Flexibility for dentist – price discrimination – robin hood approach*
- *Only system under which some expensive form of treatment will be provided*

Post payment plans

- Budget-payment plans
- Not true third party financing plans
- Dentist allow payments for dental care to be made at intervals over a period of time

Post payment plans

- Under budget payment plan, The patient borrows money from the bank or financing company to pay the dentist at the time he receive care
- The patient then repays the loan to the bank
- Disadvantages of post payments
 - *Mostly used by middle class people as low income patients were not considered as credit worthy by lending institutions*

Private Third party pre-payment plans

■ Defined as

- *Payment for services by some agency rather than directly by the beneficiary of those services*
- *As the party to a dental prepayment contract that may collect premiums, assume financial risks, pay the claims and provide administrative services*

■ Dentist – first party ; patient – second party; the administrator of the finances – third party.

Private Third party pre-payment plans

- also called as carrier, insurer, underwriter, or administrative agent
- The purchaser of the plan can be
 - *an organized private group such as a union, or an employer, a union-employer welfare fund, or a governmental agency*
- the term third party, refers to a
 - *private carrier such as an insurance company;*
 - *public financing of care when the government acts as the third party*

Private Third party pre-payment plans

- In private third-party plans, periodic premiums are collected to meet the costs of providing care as well as the administrative costs of the third party.


*Prepayment
plans*




*Dental
insurance*

Private Third party pre-payment plans

Insurance

 *involves a group of people making small payments in order to cover the risk of a few suffering catastrophic loss, such as the loss of a home through fire.*

Dental prepayment

 *is a mechanism to spread the financial load of dental care over a group and over time*

Principles of Insurance

■ To be insurable, a risk must

- *Be precisely definable.*
- *Be of sufficient magnitude that if it occurs, it constitutes a major loss.*
- *Be infrequent.*
- *Be of an unwanted nature, such as destruction of a home through fire.*
- *Be beyond the control of the individual.*
- *Not constitute a "moral hazard," which means that the presence of insurance itself should not lead to additional claims.*

Principles of Insurance

■ All health insurance violates some of these principles. For example,

✚ *benefits paid – small amounts of money, and*

✚ *people with insurance are more likely to use care than those who don't have it*

❖ To get around these problems Insurance carriers came up with

❖ *Deductible .*

❖ *Coinsurance .*

❖ *Range of health care services .*

❖ *Health insurance only to groups .*

❖ *Using preauthorization and annual expenditure limits*

❖ Deductible

❖ *is a set amount of money that the patient must pay toward the cost of treatment before benefits of the program go into effect .*

- Eg - "front-end" payment for auto-mobile insurance.

❖ Coinsurance

❖ *means that the patient pays a percentage of the total cost of treatment .*

- Eg -if a patient is to pay 20% of the daily cost of hospital care, the amount the patient must pay will vary depending on the actual hospital charges, but in any case will be 20% of those charges

❖ Range of health care services

- ❖ *some are available and some not, according to the plan.*
- ❖ *This range is termed coverage, covered charges, or schedule of benefits.*

❖ Preauthorization,

- ❖ *means that treatment plans for more than a specified sum must be reviewed by the carrier's dental consultants to ensure that the proposed treatment is reasonable and that the same quality of care could not be achieved at less expense*

■ Health insurance only to groups

- ✚ *because illness experience is reasonably predictable for a group, though not for an individual.*
- ✚ *The risk of adverse selection, was reduced because insuring only large groups "averaged out" the risks*
- ✚ *The probability of adverse selection was further reduced by the use of waiting periods after enrollment before any benefits became available.*

REIMBURSEMENT OF DENTISTS IN THIRD-PARTY PLANS

- The major forms of third-party reimbursement currently in use are
 - ✦ *Usual, customary, and reasonable (UCR) fee.*
 - ✦ *Table of allowances.*
 - ✦ *Fee schedules.*
 - ✦ *Capitation.*

Usual, customary, and reasonable (UCR) fee.

■ The ADA defines-

Usual Fee.

The fee that an individual dentist most frequently charges for a given dental service.

Customary Fee.

The fee level determined by the administrator of a dental benefit plan from actual submitted fees for a specific dental procedure to establish the maximum benefit payable under a given plan for that specific procedure.

Reasonable Fee.

The fee charged by a dentist for a specific dental procedure that has been modified by the nature and severity of the condition being treated and by medical or dental complications or unusual circumstances, and therefore may differ from the dentist's "usual" fee or the benefit administrator's "customary" fee

Table of allowances.

- is defined as a list of covered services with an assigned dollar amount that represents the total obligation of the plan with respect to payment for such service, but that does not necessarily represent the dentist's full fee for that service

■ For example,

- ✚ *if a dentist's usual fee - \$20*
- ✚ *the plan lists for that service a fee of - \$15,*
- ✚ *the dentist will provide the service, collect \$15 from the carrier, and may charge the patient \$5 to make up the difference.*

Fee schedules

- is also called a service plan
- is defined as a list of the charges established or agreed to by a dentist for specific dental services
- A program in which the payment is meant to represent full payment, with no additional charge to the patient

Dentistry's opposition to fee schedules is based on



- (a) *Their potential inflexibility, meaning that the fees listed can fall below customary fees, particularly in times of rapid inflation;*
- (b) *The implicit assumption that all dentists' treatment is of the same quality and therefore worth the same fee; and*
- (c) *The fear that autonomy is threatened, especially if the fee schedule is not controlled by the dentists*

Capitation

- became more common during the 1980s
- Is defined as a fixed monthly or yearly payment paid by the carrier to the dentist in a closed panel, based on the number of patients assigned to the dentist for treatment.
- Dentist fear of
 - *High utilization*
 - *Demand of expensive treatment*

Delta dental plans

- A dental service corporation is a legally constituted not-for-profit organization that negotiates and administers contracts for dental care, incorporated on a state-by-state basis
- National Association of dental service plans (NADSP) was formed in June 1966, with the help of ADA



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- ❖ NADSP changed its name to delta dental plans association in April 1969 and the member corporations became known as delta plan for the particular state
 - ❖ So delta plan and dental service are synonymous
 - ❖ Most blue cross and blue shield dental plans are now also organized as dental service corporation

Reimbursement of dentists in delta plans

- Exclusively by UCR concept
- Reimbursing depends on whether the dentist is participating or nonparticipating (par or nonpar) in the delta plan
- Participating dentist – any duly licensed dentist with whom a delta plan has a contractual agreement to render care to covered subscribers

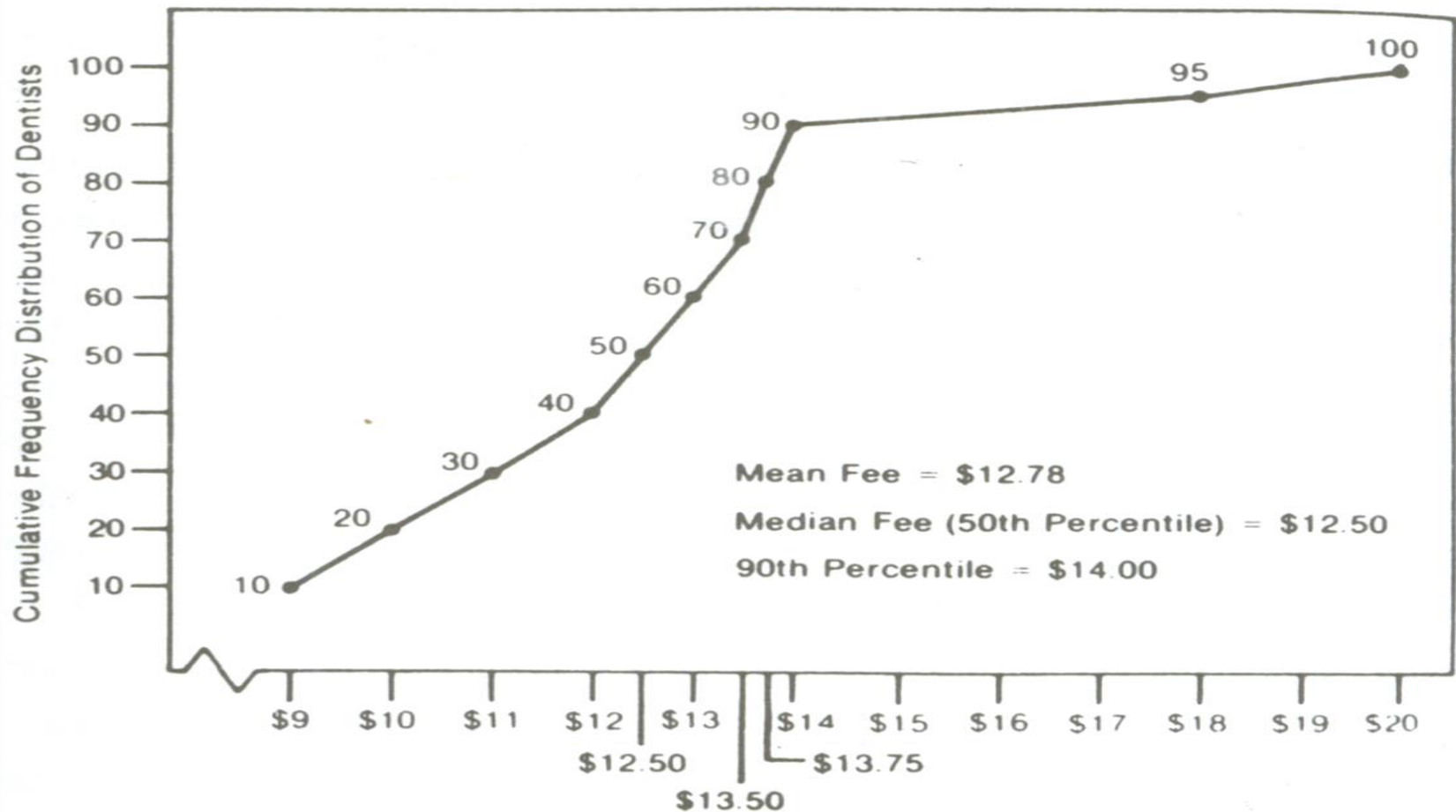
Rules of delta dental plan

- **By participating in delta plans the dentist agree the following –**
 - ✚ *Profiling of their usual and customary fees*
 - ✚ *Acceptance of payment for their services at the 90th percentile*
 - ✚ *Fee audits by auditors from delta, who may check their office records from time to time*
 - ✚ *Post treatment inspection of randomly chosen patients*
 - ✚ *With holding of a small amount of each fee, usually less than 5%, to go into delta capital reserve fund.*

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- Nonparticipating dentist can also treat the patients covered under delta plans, but they are reimbursed at a considerably lower percentile – median or 50th percentile

90th percentile

- 90th percentile is that value below which 90 percent of the observation lie



Health maintenance organization (HMO)

- Was defined in the act 1973 as “ a legal entity which provides a prescribed range of health services to each individual who has enrolled in the organization in return for a prepaid, fixed and uniform payment

Independent practice association (IPA)

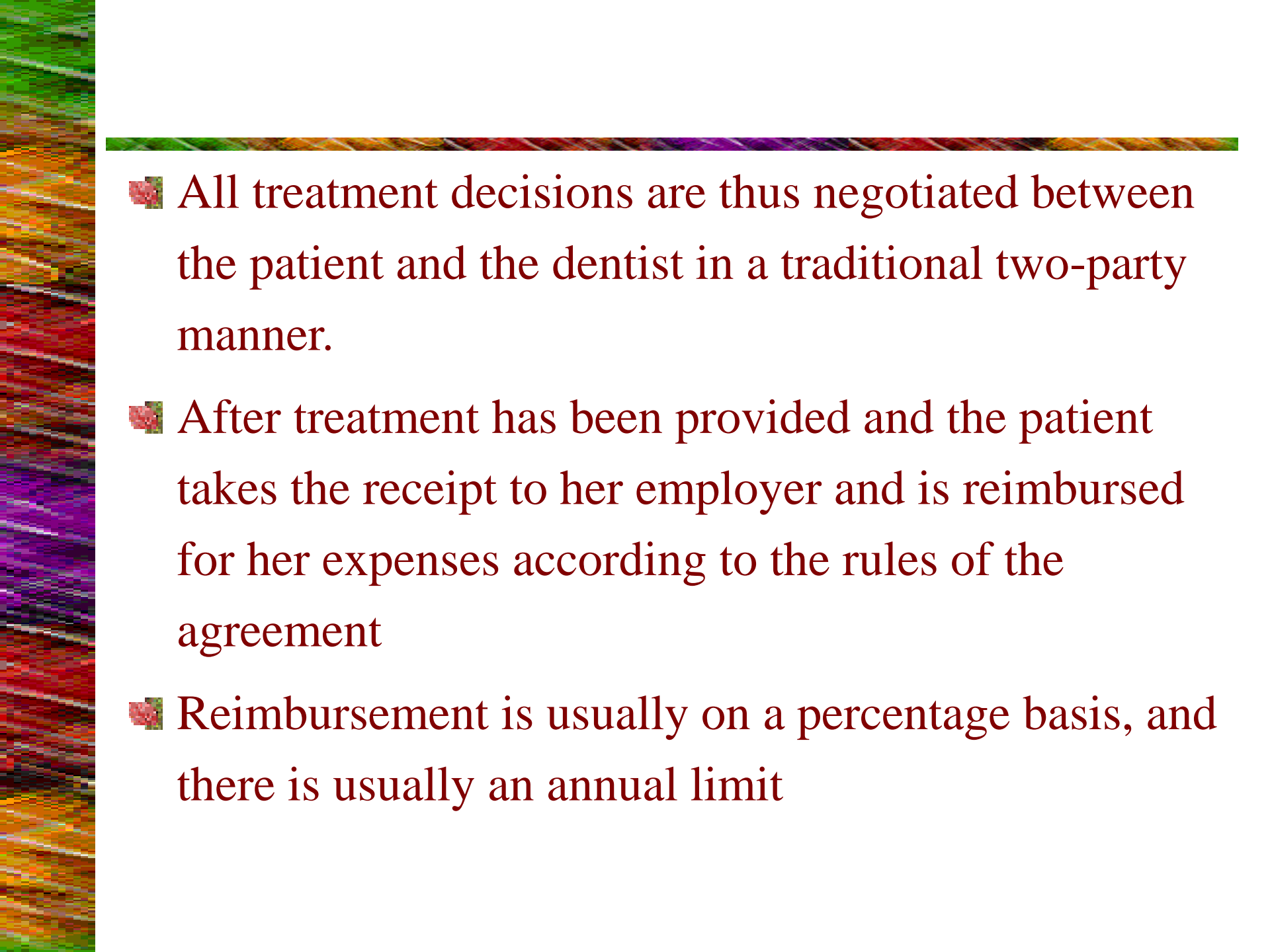
- Is a association of dentist (or physician) that develops its own management and fiscal structure for the treatment of patients enrolled in an HMO
- Dentist remain in their own office and continue to treat their fee for service and other patients
- The IPA receives its capitation premium from the HMO and in turn reimburse the individual dentist on either a modified fee-for service or capitation basis

Preferred provider organisation (PPO)

- PPOs typically involve contracts between insurers and a number of practitioners who agree to provide specific service for fees that are lower than average in that area

Direct Reimbursement

- Involves an agreement between an employer and a group of employees in which the employer agrees to reimburse the employees for some part of their expenses for dental care.
- The patient is responsible for paying the dentist from whom they get the service ,


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- All treatment decisions are thus negotiated between the patient and the dentist in a traditional two-party manner.
 - After treatment has been provided and the patient takes the receipt to her employer and is reimbursed for her expenses according to the rules of the agreement
 - Reimbursement is usually on a percentage basis, and there is usually an annual limit

Medicare

- Title XVIII of the Social Security amendments of 1965 is the program known as Medicare.
- Medicare had two parts:
 - *Part A, hospital insurance, and*
 - *Part B, voluntary supplemental medical insurance.*
- The dental segment of Medicare is limited to those services requiring hospitalization for their treatment, usually surgical treatment for fractures and cancer

Medicaid

- Title XIX of the Social Security amendments of 1965 is a joint federal-state program, with the federal government and state governments sharing the costs
- The federal government provides 50% to 83% of the funds used by each state, according to a formula that is based on the ratio of per capita income in the state to the national per capita income.



■ In order to qualify for the federal government's share of Medicaid financing,

✚ *every state cover a set of basic services for everyone receiving federally supported financial assistance.*

✚ *States offer early and periodic screening, diagnosis, and treatment (the so-called EPSDT program) to needy children at least up to age 18. Dental care is mandatory under the EPSDT program.*

Third parties in India

Government

Life Insurance Corporation (LIC)

General Insurance Corporation (GIC)

Employees' State Insurance Scheme (ESIS)

Central Government Health Scheme (CGHS)

National Insurance Corporation (NIC)

New India Assurance (NIA)

Oriental Insurance Company (OIC)

United Indian Insurance Corporation (UIIC)

Central government health scheme (CGHS)

- Introduced in 1954 in New Delhi to provide comprehensive medical care to central government employees and their families
- 320 Separate dispensaries for the employees covered by the scheme



❖ Covers

- ❖ *Central Govt employees*
- ❖ *Retired central Govt employees*
- ❖ *Widows receiving pension*
- ❖ *Members of parliament*
- ❖ *Ex-governors and*
- ❖ *Retired judges*



■ Facilities under the scheme

- a. *Out patient care thro network of dispensaries*
- b. *Supply of necessary drugs*
- c. *Laboratory and x-ray investigations*
- d. *Domiciliary visits*
- e. *Hospitalization facilities at Govt and private hospitals*

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- f. *specialist consultation*
 - g. *Pediatric consultation including immunization*
 - h. *Antenatal, natal and postnatal care*
 - i. *Emergency treatment*
 - j. *Supply of optical and dental aids at reasonable rates*
 - k. *Family welfare service*

Employees state insurance scheme (ESIS)

- Established in 1948, ESIS is an insurance system which provides both the cash and medical benefits
- Managed by employees state insurance corporation (ESIC) – a wholly Govt owned enterprises
- The scheme cover
 - ✚ *Non-power using factories employing 20 or more members*
 - ✚ *Power using factories employing 10 or more persons*
 - ✚ *Road transport establishments*
 - ✚ *News paper establishments*
 - ✚ *Cinema theatre, hotels and shops*

- Only employees earning basic salaries of less than 3000 Rs (recently enhanced to 6500) are eligible
- Premiums are paid thro pay roll tax of 4.75% by employer and 1.75% by employee

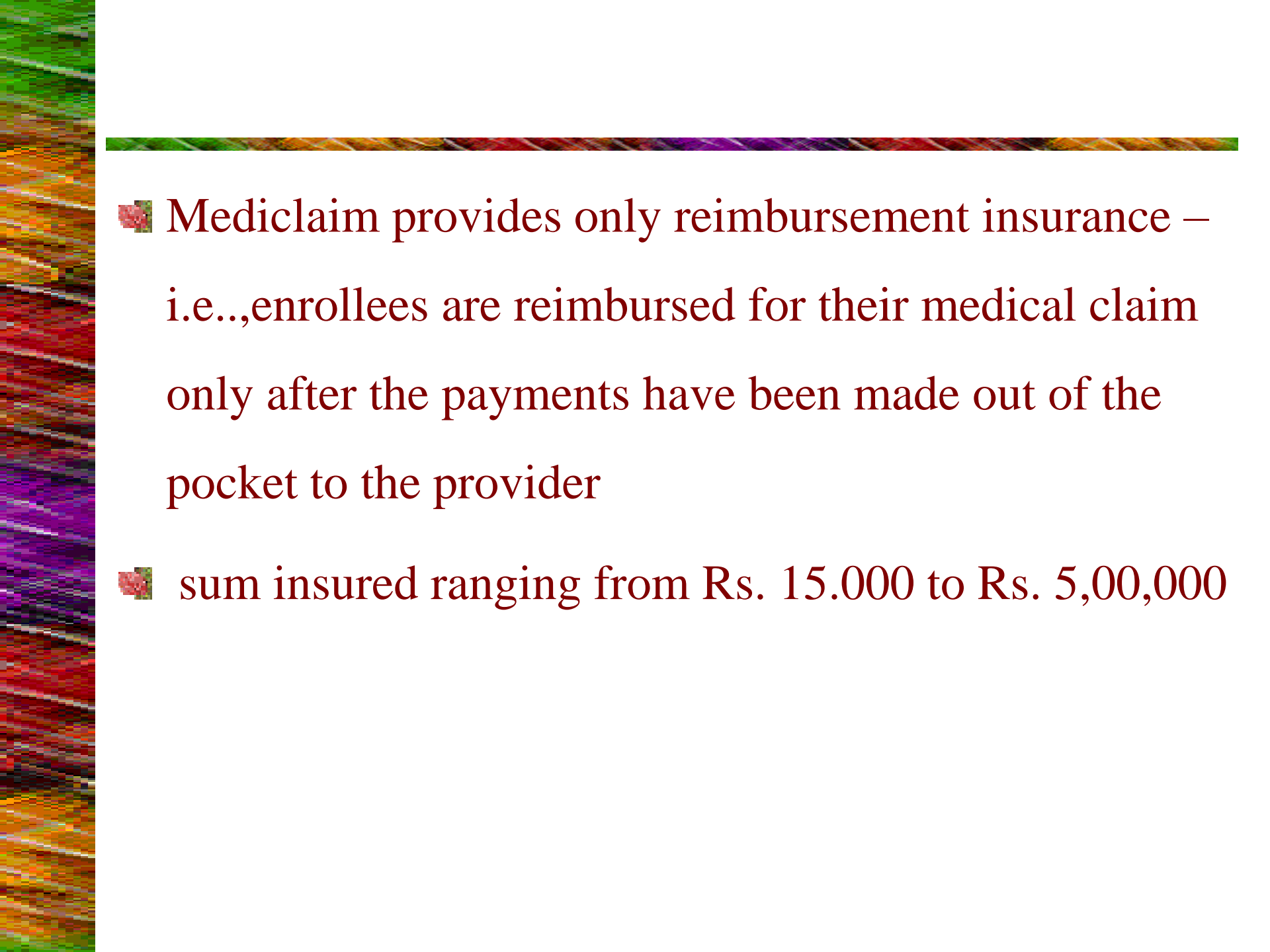
❖ Benefits

- ❖ Sickness benefits (in cash) – $7/12^{\text{th}}$ of the rate of daily average pay for a maximum period of 56 days in a year
- ❖ Maternity benefits (in cash) – at the rate of full wages for 12 weeks
- ❖ Disablement benefits (in cash) – temporary disablement – 72% of the wages for the duration of disablement ; permanent disablement – in the form of pension

- Dependent benefit (in cash) – is payable to the dependents of insured person dying as a result of employment injury
- Funeral benefit (in cash) – paid to eldest surviving member upto maximum of Rs 500
- Medical benefits – out patient treatment; domiciliary treatment; provision of drugs; specialist service etc
- Rehabilitation benefits

Mediclaim policy of the GIC

- GIC was set by Govt in 1973 as a public sector organization to market a range of insurance services
- It introduced mediclaim insurance scheme in 1986, and became active in 1987
- Policy was modified in 1996 to allow for differentials in premium for six age groups – 5-45; 46-55; 56-65; 66-70; 71-75 and 76 plus
- Policy was framed for both groups and individuals

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- Mediclaim provides only reimbursement insurance –
i.e., enrollees are reimbursed for their medical claim
only after the payments have been made out of the
pocket to the provider
 - sum insured ranging from Rs. 15,000 to Rs. 5,00,000



■ Salient Features

- Provides cover, which takes care of medical expenses following hospitalization from sudden illness or accident
- Cover extends to pre-hospitalization and post-hospitalization for periods of 30 days and 60 days respectively
- Domiciliary hospitalization is also covered

❖ Major weaknesses of mediclaim –

- ❖ It covers only hospitalization leaving out out-patient care
- ❖ The coverage is subjected various exclusions, limits and restrictions on eligibility
- ❖ Premiums are high in relation to claim payments – claim payments are only 58% of the premiums

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Thank U
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