Managing Without Managed Care

By Dr. Dean C. Bellavia

Managed care is a combination of big-business management and health care, created primarily by insurance companies. In the past, insurance offered protection against catastrophic accidents, fires, and thefts. Then came health insurance, which by now is considered almost a birthright. Then Henry J. Kaiser devised for his employees a successful program of inexpensive managed health care. Kaiser collected a fixed amount per person (capitation), gave the employees all the services deemed necessary, emphasized preventive treatment, and discouraged the use of specialists.

The first capitation programs did not include orthodontic treatment, but insurance companies got a foot in the door through dental insurance. This was initially a boon to orthodontists, since many patients who could not have afforded a $1,000 initial payment were able to start orthodontic treatment through their dental insurance. Aside from the annoying claims processing, all went well for orthodontists until the insurance companies decided to cut expenses - not by reducing benefits to their income-producing customers, but by cutting payments to the expense-producing orthodontists.

Managed-care providers say they came into being to cut the skyrocketing costs of medical care—which they have done, with an enormous profit left over for themselves and a significant drop in quality of care for their members. As with Kaiser's original program, three main methods are used to control costs under managed care:

1. Encourage preventive care. Orthodontic treatment is not preventable, although interceptive treatment can help.
2. Reduce costs by paying doctors less for the privilege of treating more patients. Orthodontics is already cost-effective: 25 years ago, you could buy an economy car for about $2,000, a three-bedroom house for about $30,000, and orthodontic treatment for about $1,500; today that car costs $10,000 and the house more than $200,000, but orthodontics costs only about $3,500, rather than a comparable $7,500-10,000.
3. Discourage payments to specialists. Managed care denies the usual $1,000 co-payment to reduce the amount the patient pays the orthodontist.

Orthodontics is already a model of efficient, effective health care, and none of these methods applies. Thus, while orthodontists can benefit from traditional orthodontic insurance, which helps the patient pay for treatment, managed care is a different story.

There are three levels of accepting managed-care patients:

1. Accept them all and "work the fee".
2. Accept a few and "work them into the schedule".
3. Don't accept any and "work for yourself".

Accept Them All:

As we will show, there is no way to earn a decent living with a totally managed-care practice, unless you become extraordinarily productive. The average fee-for-service orthodontic practice has about 125 full or Phase II cases at an average fee of $3,400 (including records) and about 50 Phase I or limited cases at an average fee of about $1,500. This generates about $500,000 per year, with operating expenses of about $300,000.

Under managed care, your average fee would be about $2,200 for a full case (some plans pay as little as $1,400) and $1,000 for a Phase I case. The gross income would be $325,000, the expenses would remain the same at $300,000, and the net would be $25,000 - one-eighth that of the fee-for-service practice.

What if your practice could become 50% more productive in the same facility? With a 50% increase in production, the gross income would be $490,000. Variable expenses (staff, lab, and supplies) would increase by $75,000, so total expenses would be $375,000. The net would be $115,000--much better than $25,000, but you would have: to work 50% harder to produce $85,000 less than the fee-for-service practice. By contrast, a 50% increase in production in the fee-for-service practice would result in $750,000 gross income and $300,000 net.

Some orthodontists think that by "working the fee" they can offset the lower returns of managed care. One example would be to add $150 for a headgear and $350 for an extra six months of treatment, thereby generating another $500 per case without additional chair time. In reality, such a practice is adding $500 worth of treatment to the workload to produce the extra $500.

For those who don't add headgear, but make the case 30 months long, with the same number of treatment appointments as in a 24-month case, there is no extra work, and the practice has gained $350. But extended appointment intervals tend to increase appliance breakage and lengthen treatment time, which can quickly eat up that $350. Even if the full $350 per case is added, it still produces a total of only $44,000 for 125 cases. The net would then be $69,000, compared to the $200,000 of the fee-for-service practice.

An extra $350 per case with a 50% increase in production would add $66,000 to the $115,000 net, for a total of $181,000. All you have to do is average 30 months per $2,550 case and increase your delegation and production by 50% without becoming stressed out. You would probably have to add on to your facility to handle the additional starts, at a cost of about $35,000 per year. Then the $2,200 fee might drop to $2,000, or more realistically, $1,800, once you have been hooked on managed care. With a 30-month extended fee of $2,350, you would net about $120,000.

If that still sounds good, consider that when the insurance company notices that your cases are taking 30 months rather than the usual 24 months, they will probably reduce your compensation accordingly when you sign on for the next contracted period. Of course, you can decline the new contract, have 30 months of treatment to complete with no new patients, and endure the hassle of trying to collect from the insurance company for those patients who have already started.

If you think you can replace the lost managed-care cases with fee-for-service cases, think again. Family dentists who do not accept managed-care patients in their own practices will not be sending you patients. As for patient referrals, who would want to pay $3,500 for the same treatment that their friends received for $2,000? Besides, you will have the reputation of 30-month treatments.

Accept a Few:

Some practices elect to take a few managed-care patients to "help with the overhead". This is just as destructive a philosophy, because it will insidiously transform your entire practice to managed care. Actually, managed-care providers expect a practice to handle all their patients, not just a select few, but you can probably limit your exam times to two per month and thus control the number you start.

The advantage to this scenario is that you can probably handle 24 more full cases (two per month) by being more productive without adding staff or becoming too stressed. If you do, you will probably net about 60% of the low managed-care fee. At $2,200 per case, you would receive about $32,000 more net income.

The disadvantage is that your practice is now infected by managed care, and patient and dental referrals will surely drop. If you replace two $3,500 cases, which generate $1,400 profit each, every month with two managed-care starts, which generate $100 profit each, your $32,000 annual extra net will drop to zero, leaving you with 20% more work for no additional compensation. The decline won't stop there, as more and more dentists and patients stop referring to you, and you need to take on more and more managed-care patients to fill the gap. Eventually, you become the practice described above—totally at the mercy of the insurance company.

Graph 1 represents an average, healthy fee-for-service (FFS) practice. The horizontal x-axis shows the number of full starts per month, from 1 to 32 (the average is about 10). The left y-axis is the profit percentage, and the right y-axis is the monthly profit in dollars. As the practice starts more cases per month (x-axis) and has to add one staff member, this causes an increase in overhead and a corresponding drop in profit percentage (left y-axis). As the new staff member becomes more utilized, the profit goes up until the next staff member is added.

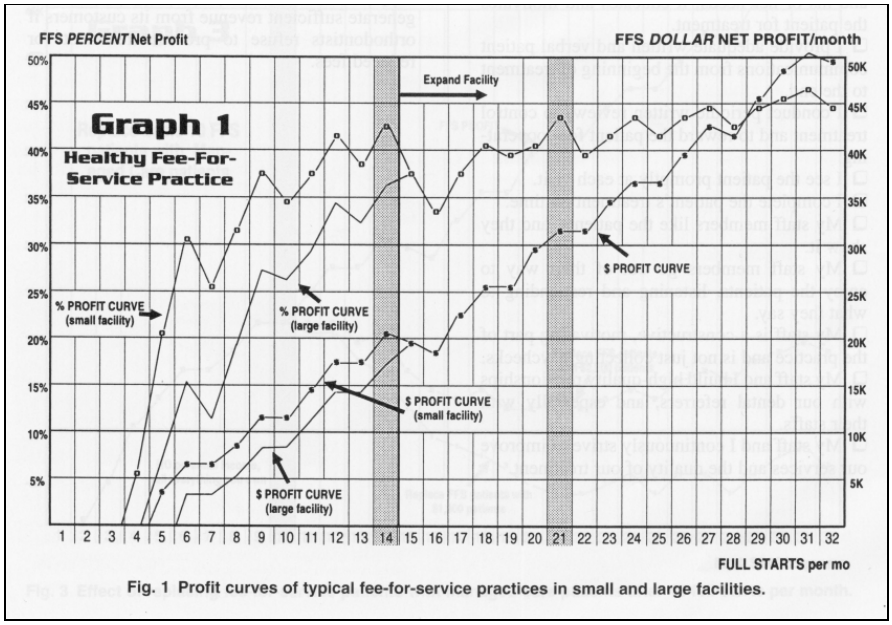

Fig. 1 Profit curves of typical fee-for-service practices in small and large facilities.

Up to 15 starts per month, there are two graph lines for profit percentage and two for dollar profit, depending on the size of the facility. If a practice starts out with a large facility (around 3,000 square feet), there is initially less profit than with a smaller facility. At 15 starts per month, the smaller facility has to be expanded, and the cost of expansion causes a large dip in the profit curves, so that both facilities are the same after 15 starts per month.

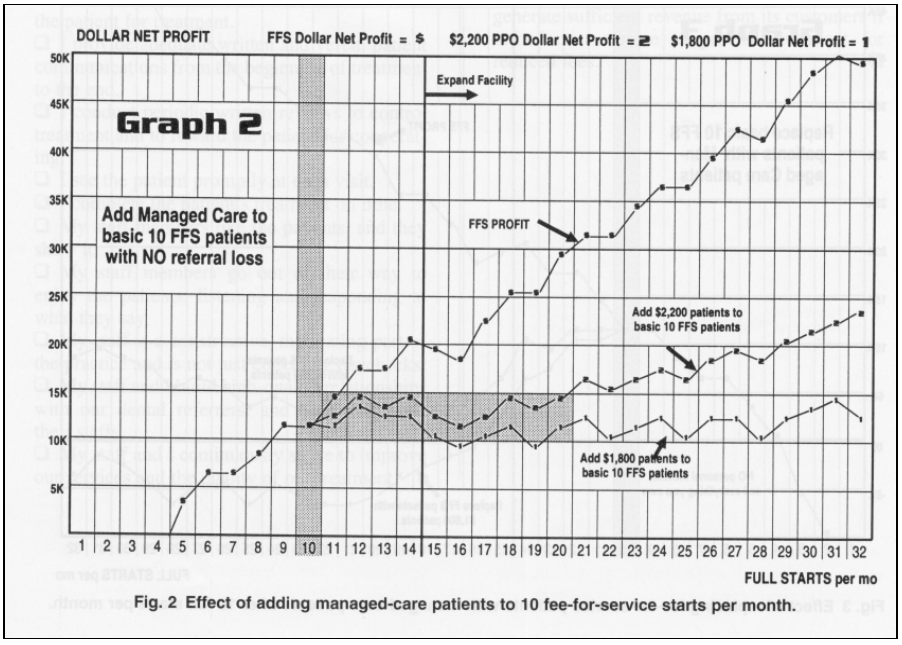

Fig. 2 Effect of adding managed-care patients to 10 fee-for-service starts per month.

It may seem illogical, but it isn't worth expanding to a larger

facility unless production increases by about 50%. It is better to grow by adding days to the month or hours to the day instead of expanding the facility. If a practice can't grow beyond 14 full starts per month, it shouldn't operate a large facility, unless it owns the building.

Graph 2 shows what happens when a healthy fee-for-service practice grows to 10 full starts per month, then decide to add managed care patients. Two graph lines are plotted: one showing the dollar profit for $2,200 managed care patients, and one for $1,800 managed care patients. The small-facility graph from Figure 1 is included, with an expansion to the larger facility at 15 full starts per month.

The rationale is, "Since I have just hired another staff member at 10 full starts per month, I might as well get more value out of her by putting her to work on managed-care patients." Indeed, this strategy pays off between 10 and 12 full starts per month, with an increased profit of $3,000 for two $2,200 starts, or $2,000 for two $1,800 starts. Thus, you can start two managed are patients per month and make an extra $25,000-35,000 per year, instead of an extra $72,000 per year had the two starts been fee-for-service.

It won't help to start more than two managed-care cases per month; you have to triple your caseload, from 10 to 30 full starts per month, before you can make significantly more net income. You only need to start four more fee-for-service cases per month to produce the same net profit as 20 more managed-care starts.

Graph 3 shows what happens when a practice starts losing fee-for-service referrals and replacing them with managed-care patients after reaching 10 full starts per month. The $1,800 managed-care fee puts you into bankruptcy by the time you replace five fee-for-service starts with five $1,800 starts. The $2,200 fee scenario is a little better, but still totally unacceptable.

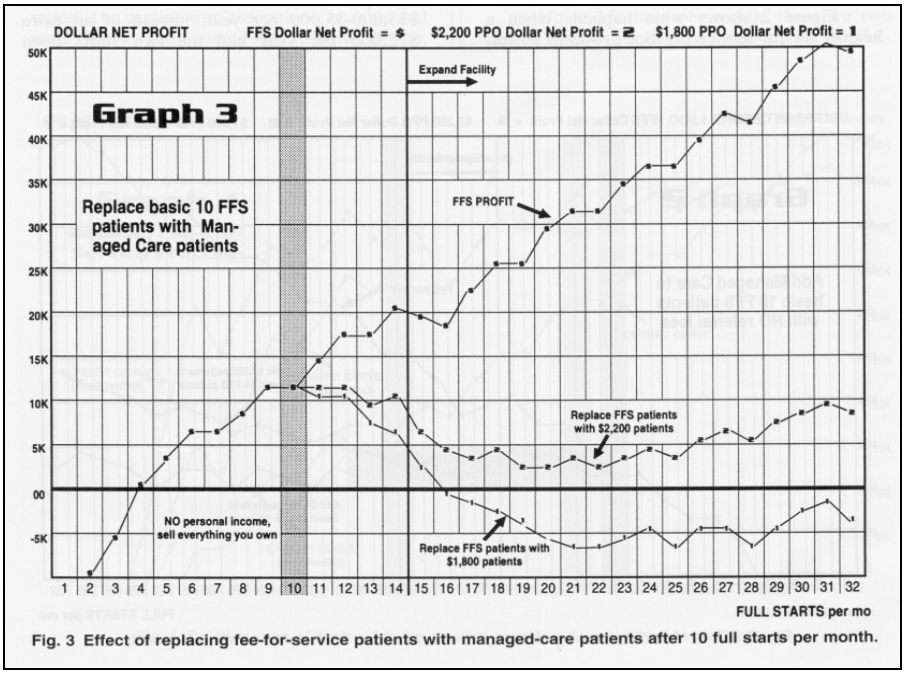

Fig. 3 Effect of replacing fee-for-service patients with managed-care patients after 10 full starts per month.

Avoiding Managed Care

To manage without managed care and still have enough patients to generate a reasonably good living, you must become an exceptional practice that builds relationships by exceeding expectations. If you give patients less than they expect, they will think little of your practice. If you give them exactly what they expect, they will think you average. But if you give patients more than they expect, they will become missionaries for your practice.

This checklist can help you determine whether your practice is exceptional:

- My facility is clean and attractive.

- My receptionist sounds glad to receive new patient calls.
- The new patient is the subject of the exam instead of the object, with all attention given to him or her.
- I have a Treatment Coordinator who provides new-patient services beyond the patient's expectations.
- I do not make the new patient wait for me at the new-patient exam.
- At the new-patient exam, my mind is on the patient instead of on the clinic.
- I have fully flexible financial arrangements, including zero-initial-payment options.
- My case presentation focuses on the patient and his or her needs; it educates and motivates the patient for treatment.
- I provide adequate written and verbal patient communications from the beginning of treatment to the end.
- I conduct periodic written reviews to control treatment and to reward the patient for cooperating.
- I see the patient promptly at each visit.
- I complete the patient's treatment on time.
- My staff members like the patients, and they show it.
- My staff members go out of their way to enjoy the patients, listening and responding to what they say.
- My staff is a constructive, motivating part of the practice and is not just collecting paychecks.
- My staff and I build high-quality relationships with our dental referrers, and especially with their staffs.
- My staff and I continuously strive to improve our services and the quality of our treatment.

If you checked all of these items, your practice is exceptional. If not, you may need to improve your practice management to avoid managed care.

Conclusions:

Once a practice accepts any managed-care patients, it is at the mercy of the insurance company. The program will eventually drag down the doctor and staff, who will have to work harder for less compensation, and will drag down the quality of care, because expensive supplies and equipment will be unaffordable.

Professionals caught up in managed-care programs have somehow forgotten that managed care cannot exist without them. If all orthodontists refused to sign managed-care contracts, there would be no managed care in the orthodontic profession. An insurance company will not generate sufficient revenue from its customers if orthodontists refuse to provide treatment for reduced fees.