The Dental Service Corporation

CALIFORNIA REPORT

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IN 1949 the House of Delegates of the American Dental Association, recognizing the need for "a more satisfactory financing plan to meet dental health service costs, especially for the medium and low income groups" (*1*), endorsed experimentation with voluntary prepaid dental care programs by dental societies. Such experiments would prove whether the prepayment principle which had been so successfully applied to hospital and medical care costs would be equally workable for dentistry.

Even in 1949, dental prepayment plans were not new, some having predated World War I. But the number of plans in operation was small, and none had been organized or administered in conjunction with the organized dental profession. They were administered principally through private clinics or on a group contract basis between the consumer and specific cooperating practitioners.

The action of the house of delegates in officially encouraging State and local associations to participate in prepayment plans was perhaps born of the recognition of a two-pronged challenge. Largely because labor unions had begun adding dental benefits to health and welfare programs for their members, prepayment plans were beginning to grow in number, in enrollments, in the scope of benefits offered. Should the profession disassociate itself from the movement, consumer groups could set up and operate their own programs, as others had done.

Failure to participate in prepayment plans, moreover, would be an abjuration of responsibility. As a profession dedicated to the advancement of oral health, dentistry was obliged to further arrangements which would make good dental care available to more people.

The first of the State dental associations to participate in the planning and administration of a prepaid dental care program were those of Washington, Oregon, and California. In May 1954, the International Longshoremen's and Warehousemen's Union-Pacific Maritime Association (ILWU–PMA) Welfare Fund announced plans for expanding its benefits by adding a dental care program for the children of longshoremen in port areas along the Pacific coast. The dental associations of California, Oregon, and Washington were asked for advice and assistance in setting up the program.

In Washington and Oregon the dental societies acted immediately, organizing dental service corporations through which they could deal with consumer groups wishing to purchase dental care. By early 1955 the proposed children's dental care program had been initiated through the joint efforts of welfare fund officials and the dental associations of the two States.

In California, however, a unique condition existed. California is the only State in the nation with two constituent associations of the American Dental Association, the California State Dental Association and the Southern California State Dental Association. Because

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of this dual structure, a number of special circumstances arose which delayed the inception of a statewide, professionally planned program for several years.

Problems and Progress

Neither of the two constituent dental associations was truly statewide: the roster of the California State Dental Association was made up of practitioners in the north; the Southern California State Dental Association represented the profession to the south. The division was philosophical as well as geographic; the two societies had conflicting outlooks on a number of professional and administrative matters. Opinion between them was sharply divided on the issue of a dental service corporation. Leaders in northern California generally favored the idea, while those in the south were, for the most part, opposed. After extensive discussion and negotiation, it became apparent that the two societies would not be able to act in concert in setting up a dental service corporation to implement the ILWU–PMA program. If there was to be a corporation, it would have to come from independent action by the California State Dental Association.

In reviewing the California story we shall pass over some of the technical details of the organizational process, since many of the same basic problems have been discussed elsewhere (*2*, *3*).

In April 1954, after receiving the opinion of legal counsel, the California State Dental Association House of Delegates voted to create a dental service corporation under section 9201 of the California Corporations Code. Before incorporation could become effective, however, State law demanded that a number of requirements be satisfied:

- At least 25 percent of all licensed dentists in the State must become members of the corporation.
- Membership in the corporation and the opportunity to provide professional services must be open to all licensed dentists.
- Proxy voting and cumulative voting by corporation members would be prohibited.
- The corporation must be certified by the particular professional board whose licentiates become members.

Beginning in June 1954, representatives of the California State Dental Association and the ILWU–PMA Welfare Fund held a series of meetings to work out arrangements for the operation of a program which would be acceptable to both parties. In July the full membership of the association was presented with the general proposal that had been made and a report on discussions that had been held up to that time.

Many members of the California State Dental Association were initially reluctant to enter into a situation which they felt might threaten the established patterns of professional practice. Some believed that when a third party entered the picture, especially when that party held the purse strings, some of the traditional prerogatives of the dentist might be usurped. The way might be opened, they feared, for a nonprofessional person to make professional judgments or to pass upon judgments made by professional persons. Still others feared that this might be the thin opening wedge which would gradually bring about socialized dentistry.

The dentists were reassured to some extent by the statement of principles the welfare fund had drawn up to aid its own staff members in organizing the program. For instance, the document declared that the dental profession would be consulted on all aspects of the program, including the ages of the children who would be eligible for care. It set the broadest possible dental coverage as the ultimate goal of the program and called for an educational campaign to stimulate the highest rate of utilization.

In addition, the leaders of the California State Dental Association tried to show the advantages which would be realized by the operation of the corporation and were diligent in explaining how it would be organized and how it would function. They pointed out that the risks of doing nothing in the face of a rising demand for prepayment arrangements would outweigh the hazards, real or imagined, entailed in setting up a service corporation. However, in some cases, this same hesitancy persisted until the program had proved its worth in actual operation.

There were still other problems to be over-

come. One of these was the task of setting up a fee schedule for the program. The dental associations in Washington and Oregon used the schedule followed by the Veterans Administration in its dental program as a basis for setting charges. Because the California State Dental Association (CSDA) entered the program later than its Washington and Oregon counterparts, it had an opportunity to develop an initial fee schedule of its own, designed to fit the characteristics of dental practice in northern California.

As a first step in the construction of a suitable fee schedule, the CSDA surveyed its membership about their normal charges for various dental services. The survey results were used in drafting a fee schedule. The draft was submitted to the membership for review and approval and ultimately was presented to the ILWU–PMA representatives for their consideration. The schedule was accepted by the welfare fund as submitted. It was agreed, however, that fee schedules would be subject to study and revaluation at 4-month intervals.

Representatives from the California State Dental Association and the ILWU–PMA Welfare Fund continued to meet during July and August, attempting to outline a satisfactory program. General points of agreement were reached, but it became evident by midsummer that final accord would not be reached in time to take the necessary legal and administrative steps which would be required and still have the program begin on October 1, 1954, in keeping with the fund's original timetable.

From the beginning, the administrators of the ILWU–PMA Welfare Fund considered the dental care program an experiment, in the course of which they hoped to gain much valuable information and know-how. The original intent was to have two types of plans—group practice plans and dental service corporation plans. In the "group practice plan" the consumer organization contracts directly with a group practice. This type of plan, sometimes called a closed panel group practice plan, restricts choice of dentist to the dentists in a particular group.

The welfare fund contracted with a group practice to provide dental services for children in the San Francisco area. Later, on December 1, 1954, a dental group began rendering care to children in the Los Angeles area.

Because organizational difficulties delayed the inception of the service corporation in California, a substitute had to be found. To get the program started, the welfare fund contracted with an insurance firm to provide indemnity coverage.

In the first year of operation, it became clear that the indemnity plan would fall short of meeting the stated objectives of the program. The shortcomings resulted in part from the method of operation.

Under the indemnity plan all members of the American Dental Association or those eligible for membership could participate. However, participants were not obliged to restrict their charges for specific services to the amounts set forth in the fee schedule, as were those in the group practice and service corporation plans. As a result, it was sometimes necessary for parents to make payment to the dentists over and above those made by the welfare fund.

In addition, indemnity plan dentists were limited in the amount of service they could provide because a dollar ceiling was set for each child. Neither the group practice plans nor the service corporation plans had such limitation, and funds not spent for one child could be used to cover services for others.

Administrative problems were more difficult to resolve under the indemnity plan. It did not facilitate an orderly and centralized system of patient recall, and quality controls could not be easily established under a system in which the insurance company acted primarily as a business agent for the welfare fund, receiving deposits and reimbursing participating dentists.

Finally, the utilization rate was lower in the indemnity plan than in either the group practice plans or the service corporations in Washington and Oregon.

It should be pointed out, however, that all the measures adopted for the pilot year proved very popular with the fathers of the children who received care, and they requested that the program be continued beyond the 1-year trial period.

Plans for a dental service corporation in

northern California continued to move forward. The CSDA's House of Delegates, meeting in April 1955, reaffirmed its intention to form a dental service corporation. Articles of incorporation were subsequently filed and a nonprofit corporation, the California Dental Association Service (CDAS), was drawn up on May 31, 1955. There still remained the task of enlisting the necessary quota of dentists in accordance with statutory requirements before the corporation could be activated.

In midsummer the ILWU–PMA Welfare Fund asked if the corporation would be in a position to take over that portion of the program in northern California then covered by the indemnity plan and convert it to a service plan by October 1, 1955. If the corporation would be ready to move on that date, the welfare fund wished to receive assurance of that fact by August 15. The date upon which the corporation could qualify under California law depended largely upon how quickly 25 percent of the dentists in the State would sign contracts with the new corporation. Because it was impossible to determine how long this might take, the association could not give the welfare fund the requested assurance, so the fund found it necessary to extend the indemnity plan to July 1, 1956.

Corporation Established

The California State Dental Association proceeded to notify its membership of the intended formation of the dental corporation, acquaint them with the proposed operational details, and invite them to join. The necessary number of signatures was received by October 10, 1955, less than 2 months after the invitations were mailed.

The articles of incorporation of the California Dental Association Service granted a wide range of authority to meet all probable contingencies. The authority included:

- Building, equipping, and maintaining dental clinics, including the hiring of auxiliary personnel.
- Contracting for services with individual practitioners or dentists who operate group practices.
- Accepting payment from either individual consumers of dental care or organized groups, and disbursing such payment to the vendor of service.
- Establishing reserve funds to meet the contingency of disbursements in a manner similar to insurance companies.
- Assessing professional members for initial financing as determined by the board of directors or trustees.

The board of directors of CDAS was to consist of 15 members so that dentists in all geographic areas might have equitable representation. Eight directors would constitute a quorum for the conduct of business, and terms of office would be staggered so that there would be some continuity from year to year.

A Program Evolves

Just prior to the incorporation of CDAS in May 1955, representatives of the dental service corporations in Washington and Oregon met in Seattle with representatives of the California State Dental Association to consider how they might mutually benefit by coordinating their activities, sharing experiences, and following similar administrative procedures in connection with the ILWU–PMA program. One outcome of this meeting was an agreement that the three corporations would, in the future, negotiate as a group with the ILWU–PMA Welfare Fund.

This decision had almost immediate application. Representatives from the three corporations met with representatives of the welfare fund later in May to draw up a contract for the program in California. At this gathering, representatives of CDAS attempted to implement two resolutions of their board of directors: (*a*) the contract should cover all ILWU children under 15 years of age in California; (*b*) the children would receive all the care deemed necessary or advisable by the attending dentist and the fund would be billed for all costs on a fee-for-service basis.

The ILWU–PMA representatives were not able to agree to either of these conditions. The first, an exclusive contract with the California corporation, was denied, and the following reasons were given.

1. CDAS had had no experience and there was no evidence to show that it would or would not run an adequate service program.

2. The group practice plans had been adopted when no other plan was available and from all reports were doing a good job of providing dental care.

3. There were no members of CDAS in southern California to provide care to eligible children.

The resolution relating to complete care was interpreted to mean unlimited dental care for eligible children. It was pointed out that the welfare fund was in no position to make open end commitments for every kind of care that might be needed. The fund agreed with the dental profession that a full-care program would be desirable, but budgetary limitations would not permit it to undertake such a program.

Once again, the inability of the corporation and the welfare fund to find a common meeting ground made it necessary to extend the indemnity program for another year, through June 1957.

The meeting was not, however, without benefit. One notable outcome was that the welfare fund indicated its willingness to advance the California group a quarterly amount on a capitation basis in order to provide the capital required to activate the corporation. Until that time, this method of initial financing had not been considered. The articles of incorporation provided for assessments, not to exceed $50, on professional members for original capitalization. If the members were not assessed, the alternative was to borrow. Since the new corporation had not established its credit rating, the only probable source from which to borrow capital was the dental association. The dental association finally did advance the funds to begin operation of the corporation; however, the offer made by the ILWU–PMA Welfare Fund had been well received, and it undoubtedly contributed to the eventual success of negotiations for establishing the program.

There was also agreement that dental health education should be handled through the service corporations but that the welfare fund would underwrite the cost of materials designed or produced at its request or used for its beneficiaries.

By late spring of 1957, the officers and directors of the California corporation had decided that the differences which still separated the ILWU–PMA and the dental profession were not critical. It was agreed that the corporation would replace the indemnity program in northern California on July 1, 1957, under essentially the same conditions included in the ILWU–PMA proposal the previous year. This meant that in the San Francisco area, eligible children would have a choice between the dental service corporation and the group practice plan. In addition, CDAS was to take over the program covering the dependent children of staff members of the International Longshoremen and Warehousemen's Union, and a similar plan for the East Bay Marine Terminal Association, covering members of an ILWU local.

Fees and benefits under the three plans were identical. The program began operation through agreement by a letter of understanding dated June 5, 1957. Actually the first formal contract between CDAS and the ILWU–PMA Welfare Fund was not executed until January 30, 1959.

Under the terms of its agreement with CDAS, the welfare fund paid the corporation a deposit of $85 per child for newly eligible children or children who had not previously received service under the ILWU–PMA program. After children had received services and were on a recall basis, they were covered by a deposit of $65 a year per child (*3*). CDAS billed the welfare fund for these deposits monthly at the time each child made his first visit of the year to a dentist. Eight percent of the total deposits paid by the fund were to cover administrative costs of the corporation. The plan included all dental services except orthodontic care, cosmetic dentistry, and major oral surgery. Although services were limited to those specified in the agreement, patients were entitled to all of these services that participating dentists felt they should have.

In addition to performing its primary function of arranging the financing of dental services, the corporation worked closely with the fund in operating a continuous program of dental health education and assumed responsibility for assuring the quality of care provided under the program.

Public Assistance: A New Dimension

The State of California meanwhile had enacted legislation authorizing a complete dental care program for needy children between the

ages of 5 and 12, and an emergency dental care program for other public assistance beneficiaries. With the program scheduled to begin on October 1, 1957, representatives of the State social welfare department approached the California State Dental Association for advice about services, costs, and the like. The association suggested that the entire program be handled through the dental service corporation. After extensive negotiations, a 2-year contract was signed calling for the service corporation to handle the program in 35 of the State's 58 counties (included 31 northern and 4 southern counties). The program in the remainder of the State was placed under the direction of county authorities. It was administered through contracts with a limited number of dentists in private practice.

The public assistance dental care program of the California Department of Social Welfare promises to remain the largest single program administered by the corporation. From its inception, when the program offered fairly comprehensive dental care for about 77,000 indigent children between the ages of 5 and 12, the scope of coverage has spread progressively. On July 1, 1960, a 1-year trial program covering California's needy children from birth through age 17 was begun.

Growth has been horizontal as well as vertical. On November 1, 1960, the public assistance program underwent further expansion as all old-age assistance recipients became eligible for dental care. It has been estimated that this single aspect of the program, dental care of the elderly, will involve services valued at approximately $7 million annually.

Administrative Arrangements With CPS

The breadth of the public assistance dental care program and the fact that potentially hundreds of thousands of persons would be eligible for services made it clear that new administrative procedures were needed. Among other things the corporation was faced with the prospect of possibly having to equip and staff a large claims processing unit. Although such a step certainly would have been feasible, an investigation of the situation revealed that the California Physicians Service (CPS) had the capacity to perform many of the corollary functions which the dental program would entail. Conversations between the CPS and CDAS led to a subcontract under which CPS would handle the major portion of the accounting and processing aspects of the public assistance dental care program. The arrangement, in short, called for CPS to receive bills from dentists, disburse payments to them, and handle the forms and recordkeeping.

Decisions of a professional nature and those matters dealing with the type, standards, and quality of dental care remained the prerogative of the dental service corporation. It was responsible, also, for determining whether specific treatment was appropriate and reimbursable under the program's service limitations.

After CPS had been handling the processing for the public assistance dental program for 2 years, CDAS officers felt that a broader alliance between CDAS and CPS might be advantageous for future private dental programs involving large numbers of beneficiaries. There were, however, both assets and liabilities connected with effecting a more comprehensive arrangement. Some of the deterrents were possible weakening of CDAS control over program policies, a reduction in personal contact with consumer groups, and a possible loss of identity. After a careful consideration of the pros and cons, CDAS decided that the possible benefits of lower operating costs, access to a wide market among CPS clients, the use of an established sales and promotional mechanism, and affiliation with an established health organization were valuable enough to overshadow the disadvantages.

Under the new contract, consumer groups were to make payment to the dental service corporation which in turn paid to the CPS each month an amount equal to the charges for services performed by dentists during the month. The CPS would perform a number of administrative functions for the CDAS, including supplying each dentist participating in the program with an identification card, receiving and organizing bills and invoices, determining whether authorization was required for the service prescribed, and seeing that charges did not exceed the fee schedule ceilings. CPS was also to make payment for approved bills and

invoices, maintain eligibility files, advise public assistance beneficiaries of the dental services available to them, and provide evidence of payment according to accepted accounting procedures.

CDAS was to establish underwriting policies and requirements; perform all actuarial activities; underwrite all dental programs, including the actual cost of the administration of the services performed by CPS; and reimburse CPS monthly upon submission of a statement of costs. The agreement became effective July 1, 1960.

Unification and Expansion

At the same time that the new contract with the California Physicians Service was being discussed, another series of talks was underway between CDAS officials and the Southern California State Dental Association to see if their differences might be settled so that southern California dentists could take part in the corporation program. The overall objectives of the meetings were to broaden the corporation's activities so that they might be statewide, bring the entire ILWU–PMA dental care program under the guidance of the dental societies, and eliminate the necessity for indemnity coverage in southern California. The indemnity plan had already been eliminated from the ILWU–PMA dental program in Oregon and Washington.

By late January 1960 there was general agreement among the representatives of the corporation and the southern society, although minor differences still persisted. Chief among these were:

1. The question of schedules of maximum allowances (favored by the southern component) against set fee schedules (preferred by the northern group).
2. The question of southern California representation on the board of directors of the corporation.
3. The matter of geographic location of annual meetings of the board.

By early 1961 these matters had been resolved and an agreement had been drawn up which would integrate operations throughout the State. The issue of a set fee schedule versus a flexible schedule of allowances was settled by instituting an arrangement different from any used in the program up to that time. In the southern part of the State, each participating dentist registered his customary fees with the California Dental Association Service. Bills for services rendered were to be checked for conformity with the submitting dentist's individual fee schedule, and payment was to be made on this basis. The individual schedules were to be in effect a minimum of 1 year from time of submission.

A committee of the service corporation made up of local dentists in various geographic areas was organized to review any apparent discrepancies in fees and to insure that there was no abuse of the program in any manner.

Representation by southern California dentists on the board of directors was settled as follows: Of the total of 15 directors, southern California would have 4 the first year, 7 the second year, and 8 the third. Subsequently, the 15th, or odd-numbered director, would alternate between north and south from year to year. Annual meetings of the board would be held alternately in northern and southern parts of the State.

An invitation to the Southern California State Dental Association to join the corporation was extended in the spring of 1960. By mid-June more than 2,500 southern California dentists had signed, bringing the total CDAS enrollment to more than two-thirds of the practicing dentists in the State.

On July 1, 1961, southern California dentists officially began to render service to eligible ILWU children under the dental service corporation plan. Indemnity coverage was dropped at that time.

Further Expansion

In the intervening period the CDAS had forged ahead by making contracts with two additional union groups: the Hotel, Motel, Restaurant and Bartenders Insurance Trust Fund of Santa Clara County and local 535 of the Culinary Workers, Bartenders and Hotel Service Employees Union in San Bernardino. Both plans provided a wide range of benefits, excluding orthodontics and purely cosmetic

dentistry, and payment of 75 percent of the cost while the patient paid 25 percent. The Santa Clara group, because of its limited budget, did not cover prosthodontics.

Still another contract was signed midway in 1961 with a group of 161 employees of the Mechanics Bank of Contra Costa County.

A new development arose in the negotiations for a contract with local 535 of the Culinary Workers Union in San Bernardino. When this group decided to extend its benefits to include dental care, it asked the insurance broker who was handling their medical care program to find a suitable plan. The broker, in turn, took the matter up with the CDAS, and subsequently, as agent for the union, negotiated a contract with the corporation. After the contract was in force, the broker continued to provide services of an administrative nature for which he continued to receive a commission or fee.

Subsequently, the California corporation became aware that many trust funds employ insurance consultants or brokers to explore the possibilities for obtaining various services. Recognizing that one of the corporation's greatest problems was in making the public aware of its plans and services and in maintaining close liaison with contracting groups, the matter of working with brokers was considered at length by the CDAS board of directors. It seemed to the board that the advantages of CDAS dealing with brokers outweighed the disadvantages, since this approach would provide statewide "exposure" of its services at considerably less expense than the employment of a large sales staff. On a $1 million contract, for example, a commission of approximately 0.5 percent would be paid to the broker or consultant for arranging the contract and servicing the group throughout the life of the contract. After careful analysis the board decided that CDAS could not possibly perform these functions for such a nominal cost and indicated its willingness in the future to deal with brokers as well as directly with employers or consumer groups.

The latest step taken by CDAS was to contract for a comprehensive dental care plan with the Bay Area Retail Clerks' Trust Fund, an organization representing eight local retail clerks' unions. This program, which began operation in January 1962, covers 9,700 employees and their dependents, a total of about 25,000 persons. Beneficiaries in San Francisco and Oakland may elect service under the service corporation plan or under either of two group practice plans. The remaining beneficiaries, located in six counties of the Bay area, receive service through the corporation. A procedure was used whereby the patient pays 30 percent of his dental bill. All necessary dental care is provided with the exception of orthodontics and purely cosmetic dentistry.

At the present time, several other consumer groups in California are showing serious interest in starting plans similar to this one, and there appears to be little doubt that this interest will be translated into active programs of dental care.

Conclusion

The history of the California Dental Association Service illustrates some of the problems in the establishment and operation of a dental service corporation, but more importantly it illustrates the role which service corporations can play in promoting the extension of dental services.

The acceptance of this approach to the financing of dental care on the part of the public and the dental profession is not surprising because it offers features obviously desirable to both. The variety of dental services and the several financing arrangements provided in contracts between the CDAS and consumer groups, including welfare recipients, serve to point out the highly flexible nature of a dental service corporation which enables it to offer a wide choice of plans and broad geographic coverage. Another attribute of the corporation is the generally high percentage of the consumer's dollar which goes into actual dental care. From the experience thus far, administrative deductions may be expected to average only about 8 percent or less of premiums. In group programs of commercial insurance firms covering physician services, the retention rate averages about 16 percent of income (*4*).

Still another basic advantage of the service corporation method, demonstrated again in

California, is that the patient retains almost unlimited choice of practitioner and at the same time has the benefit of meaningful quality controls.

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New Jersey's Arthritis Program

A series of workshops on arthritis, bringing together professional workers in related fields to discuss specific problems of the arthritic, has been a prominent element of the arthritis program established in March 1958 in the New Jersey State Health Department.

In addition, seminars and lectures have been held for physicians and nurses. A symposium on the rheumatic diseases was cosponsored with the Seton Hall College of Medicine.

A directory of services in New Jersey for arthritic patients was compiled and lists of available literature on arthritis were sent to public health personnel. Copies of "Strike Back at Arthritis," purchased from the Public Health Service, were made available to physicians, nurses, and physical therapists.

Support of arthritis research at Seton Hall College of Medicine for the past 4 years included provision of special laboratory equipment and technical and nursing services.

In 1960, an experimental screening project based on serologic testing for the rheumatoid factor was conducted in the East Orange Health Department Laboratory. Of 5,086 persons screened, 38 had reactive serums, and 7 of the reactors were reported as having arthritis by their physicians.

A study of the attitudes and information that arthritic patients have about arthritis was completed in 1962 at the Jersey City Medical Center Arthritis Clinic.

A review of the arthritis program conducted in April 1962 concluded that, while the program lacked many facets and met but a fraction of the needs of arthritics, it had opened the way for future development and had brought together many key persons and agencies that could participate in this activity.

The program's basic policies were planned according to recommendations made by the New Jersey Arthritis Project, an advisory body representing professions and voluntary and official agencies concerned with arthritis. The recommendations dealt mainly with activities in arthritis research, education, and services.