



**TESTIMONY TO THE  
SUBCOMMITTEE ON CIVIL SERVICE AND REFORM  
U.S. HOUSE OF REPRESENTATIVES COMMITTEE**

**ON**

**GOVERNMENT REFORM**

**By**

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***NATIONAL ASSOCIATION OF DENTAL PLANS***

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## **INTRODUCTION**

Good afternoon, Chairman Davis, ranking member, Danny Davis, members of the Subcommittee. Thank you for the opportunity to testify before this Subcommittee on the issue of providing stand-alone dental benefits to federal employees. My name is Jon K. Seltenheim and I am Chairman of the Board of Directors for the National Association of Dental Plans (NADP). NADP is the representative and recognized resource for the dental benefits industry. NADP's members provide dental benefits to 86 million of the 155 million Americans with dental benefits, i.e. 60% of the total dental benefits market. There is no other trade association, health or dental, that can claim this breadth of representation of the dental benefits industry. Our members include major commercial carriers as well as regional and single state companies that offer all lines of dental benefits including dental HMOs, dental PPOs, dental indemnity and discount dental plans.

Personally, I have over 20 years of group insurance and managed care experience. I am Sr. Vice President of Customer Service Operations for United Concordia Companies, Inc. where I am responsible for claims administration, customer service, professional relations, information systems and implementation. Prior to joining United Concordia, I was the Chief Operating Officer for MIDA, Inc., before United Concordia subsequently purchased it. Prior to MIDA, I was with CIGNA Healthcare for 15 years.

Today, the Federal Employees Health Benefits Program provides excellent medical insurance coverage to federal employees, their families, and retirees; however, unlike the majority of private sector programs, the FEHBP provides little in the way of dental coverage.

The FEHBP program does not make available separate dental policies, usually referred to as stand-alone dental policies, which are the primary vehicle for dental coverage in the marketplace. My understanding is that this Subcommittee's interest is in exploring the provision of stand alone dental coverage rather than the piecemeal, limited coverage that is provided through some of the federal employee's medical plans. As the largest representative of the dental benefits industry, we will provide testimony on the following:

1. value of dental benefits
  - a. relationship of dental care to overall health
  - b. supporting access to dental care
2. dental benefits market
3. trends in employer offerings of dental benefits
  - a. number of employers offering dental benefits
  - b. contributions to dental benefits
  - c. array & cost of dental benefit products
  - d. satisfaction with dental benefit products
4. broad recommendations for offering dental benefits
5. assistance in OPM's future analysis under HR 3751.

## **I. THE VALUE OF DENTAL BENEFITS**

Before discussing how the federal government could offer dental benefits to its employees, it's critical that this Subcommittee understand why dental benefits are so important. Therefore, I have devoted the first part of my testimony to the value of dental coverage. The information is

not simply anecdotal, but comes from federal government reports, empirical data generated from industry reports, claims data gathered from our member companies, and reports generated from impartial research institutes.

### **Oral health & overall health.**

The landmark 2000 Surgeon General report, “Oral Health in America” had as a primary theme that “oral health is integral to general health.” This report documented that the two primary dental diseases (i.e. caries and periodontal disease) are still common and widespread despite safe and effective measures to prevent them. The report goes on to document that the top barrier to dental care is cost and that the existence of dental benefits helps to overcome this barrier and promotes access to care. Beyond cost, research continues to support the association of dental disease, especially advanced periodontal conditions, with coronary heart disease, stroke, and low weight, premature childbirth. Dental disease does have broader health and financial impacts which must be considered in reviewing the value of dental benefits.

### **Promoting Access to Care.**

In the Surgeon General's report, it was estimated that in 2000, approximately 108 million Americans did not have access to a dental benefit, about 2.5 times the number who do not have medical coverage. The Surgeon General's Report noted that 70.4% of individuals with private dental insurance reported seeing a dentist in the past year while only 50.8% of those without benefits did. So you can clearly see that dental benefits facilitate people going to the dentist. And as the Report notes, preventive

care is essential to keeping down overall dental and medical costs because early detection of other diseases can be found through oral check-ups. The National Institute of Dental and Craniofacial Research estimates that for every dollar spent on dental disease prevention \$4 is saved in subsequent treatment costs. In conclusion, promoting access to dental care is essential to keeping up our nation's oral and general health.

## **II. DENTAL BENEFITS MARKET**

The **NADP/DDPA 2003 Dental Benefits Joint Report: Enrollment**, September 2003 (Joint Report)<sup>1</sup> conservatively estimates the total dental benefits market is at year-end 2002 to be 154.5 million or close to 54% of the US population. (**Exhibit I—Dental Benefits Market at a Glance**) This represents a 63% increase coverage (or access) from the 1989 HHS report of covered lives for dental. The products that comprise the market have changed over time with the most recent growth in the dental PPO and discount dental segments, but overall the market continues to expand.

The Joint Report not only estimates national enrollment, but enrollment by state as well. When analyzing states with the highest level of enrollment, California leads in enrollment with 77% of the total population or 27 million with no other state over one third that many lives. Following California is Texas with 45% or 9.4 million; New York with 49% or 9 million; and Illinois with 64% or 8.8 million. (**See Exhibit II—Top 10 States for Dental Benefits Enrollment**).

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<sup>1</sup> Delta Dental Plans Association (DDPA) is a national network of 39 independently operated not-for profit dental service corporations specializing in providing dental benefits in all 50 states, the District of Columbia and Puerto Rico.

### **III. EMPLOYER OFFERINGS OF DENTAL BENEFITS**

Another way to compare where the FEHBP stands in terms of providing access to dental benefits is to examine the popularity of dental benefits and the percentage of employers offering dental benefits by size of employer.

#### **Popularity of Dental Benefits**

The U.S. Chamber of Commerce Annual Report on Employee Benefits has consistently shown for the past 10 years that dental is one of the top 5 benefits included in employee benefit packages along with medical, life, long-term disability, and 401-Ks.

#### **Employers Offering Dental Benefits**

The most accurate look at what US employers provide in terms of benefits is the Mercer Survey of Employer-Sponsored Health Plans (ESHP). This report has been produced annually since 1986 and is based on a random, stratified sample of employer benefit offerings. Thus, it is a reliable representation of the benefit practices of employers and statistically significant results are available for many of the areas included in the survey.

The 2003 Report found that 66% of ALL employers, 96% of employers with 500 or more employees, and 98% of large employers (>20,000 employees) provide dental benefits. For county, city, and state government entities, the survey revealed that 95% of the aforementioned government employers with 500+ employees offered dental benefits with median deductible and maximums of \$50 and \$1,000 respectively. This would indicate that most are offering comprehensive plans, since high maximums are uncommon for

“preventive only” plans. This is significant as it definitively illustrates that the FEHBP is out of step in this arena with similarly situated large employers in the public and private sector.

If federal employees have dental benefits, they have largely preventive benefits folded in with medical plans. The Blue Cross Blue Shield (BCBS) Plan Standard Option, the most widely used of all the health plans under FEHBP, pays just a fraction of dental costs for preventive and minor restorative dental care. For instance, BCBS pays \$8 of a \$24 Maximum Allowable Charge for a periodic oral evaluation (check up). That’s just 33% of the Maximum Allowable Charge (MAC) under the plan for a participating dentist and a lesser percentage for nonparticipating dentists. For a filling, the plan pays \$31 of a MAC charge of \$120 and of a non-MAC charge of \$175, just 26% and 18% respectively. A typical stand-alone dental plan will cover all of these at a much higher level. The Standard Option plan does not cover any portion of the cost (usually running upwards of \$700) of a crown—a major restorative procedure; a stand-alone plan will cover 50% or more. This is not sufficient coverage to maintain oral health.

### **Trends in Employer Contribution to Benefits**

According to the Joint Report, one-fourth (1/4) of DPPO products and a third of DHMO products as well as Discount Plans were fully paid by the employees. Two-thirds (2/3) of dental indemnity products were fully paid by employees. These offerings are defined as “voluntary coverage,” i.e. employee-paid. (**Exhibit III—2002 Commercial Funding Sources for All Lines of Dental Benefits**)

When contributions are shared, NADP reports show that the employers' portion has been decreasing in recent years. According to our most recent reports, employer contributions decreased from 61% in 2000 to 58% in 2002. Employees' portion rose from 38% to 42% over this same period. **(Exhibits IV—Allocation of Shared Premium Cost)**

### **Array & Cost of Dental Benefit Products**

There are a wide variety of stand-alone dental plans on the market, which would provide a number of options for FEHBP participants to choose from, in terms of both premiums and benefits. Such plans include Dental HMOs, Dental PPOs, Dental Indemnity, and Discount Dental plans **(See Appendix A--Definitions)**. Premiums range from a few dollars a month for Discount Dental plans (where participating dentists agree to a lower charge but the member pays the discounted cost out-of-pocket) to an average of \$90 a month for family Indemnity plans (regular fee-for-service plans). **(Exhibit V—Dental Benefit Premium Trends Over Time)**

### **Satisfaction with Dental Benefit Products**

NADP has aggregated survey results on satisfaction from member dental benefit plans. These surveys routinely find overall satisfaction with dental benefits in the 80% to 90% range, with quality of care reported in a range 5 points higher. Consumers complaints to insurance departments about dental benefits are low, usually a fraction of a percent per 100,000 enrollees. This demonstrates that the OPM will experience minimal complaints and administrative issues with dental benefits.

### **III. RECOMMENDATIONS FOR IMPLEMENTING A FEDERAL STAND-ALONE DENTAL PLAN**

In the current dental insurance market, there are both regional and national carriers and plans that provide a wide variety of stand-alone dental products. As stated earlier, premiums for these various plans can range from a few dollars a month for Discount Dental plans to an average of \$90 a month for family Dental Indemnity Plans. With this variety of dental plans, in terms of both benefits and premiums, federal employees and retirees could choose the level of dental benefits appropriate for their individual needs and financial circumstances. Therefore, we urge that the legislation not impose a specific plan design nor select a single carrier but provide access to the range of products available in the marketplace.

If there are standards established, they should be broad in nature, focusing on general categories of coverage and desired benefit levels and not the minutia. For instance, DHMOs should not be required to have specific Point of Service coverage, but could be required to make available a general DPPO option. General qualifications for companies should recognize the state regulations to which most of these companies are subject which standardize time frames for claims processing, utilization reporting, and materials provided to consumers such as readable materials and toll free numbers for information.

### **IV. CONCLUSION**

The study requested of OPM is timely and important to the oral and physical health of federal employees. NADP hopes these comments have provided a framework for the investigation that

is required as well as preliminary evidence that provision of stand-alone dental benefits would place federal employees on a par with their private sector counterparts.

NADP is willing to provide additional detail in these and other areas of investigation by OPM in response to the study requested by HR 3751.

## EXHIBIT I: Dental Benefits Market at a Glance 1996 through 2002

Source: NADP/DDPA 2003 Dental Benefits Joint Report: Enrollment, September 2003

Line of Business	1996	1997	1998	1999	2000	2001	2002	2001-2002 Growth Rate	No. of Firms <sup>23</sup>	Market Segments 2002
<b>Dental HMO SubTotal</b>	24,455,225	26,970,659	27,686,519	27,163,914	26,366,494	23,455,747	23,282,273			
<i>Est. Underrprtd. HMO (0.9%)</i>	<b>24,668,084</b>	<b>27,205,413</b>	<b>27,927,504</b>	<b>27,400,350</b>	<b>26,593,150</b>	<b>23,657,381</b>	<b>23,482,415</b>	<b>-0.74%</b>	<b>77</b>	<b>17.21%</b>
Dental PPO Fully Insured	10,633,463	14,551,916	19,199,796	24,374,523	25,167,734	31,383,532	32,619,967	<b>3.94%</b>	<b>58</b>	
Dental PPO Self Insured	9,823,482	13,176,973	18,383,818	22,956,757	26,519,073	26,459,899	29,246,263	<b>10.53%</b>	<b>42</b>	
<b>Dental PPO SubTotal</b>	20,456,946	27,728,888	37,583,614	45,450,017	51,686,807	57,843,431	61,866,231			
<i>Plus 4.8% Est. Underrprtd. PPO</i>	<b>21,479,793</b>	<b>29,115,333</b>	<b>39,462,795</b>	<b>47,722,518</b>	<b>54,271,147</b>	<b>60,735,602</b>	<b>64,959,542</b>	<b>6.95%</b>	<b>67</b>	<b>35.11%</b>
<b>Discount Dental Plan Subtotal<sup>4</sup></b>	8,229,417	8,993,953	10,047,367	11,413,496	12,565,496	10,769,938	11,360,632			
<i>Plus Est. 5% Underrprtd. Discount Dental Plans<sup>3</sup></i>	8,640,888	9,443,651	10,549,735	11,984,170	13,193,771	11,308,435	11,928,664	<b>5.48%</b>	<b>30</b>	<b>8.54%</b>
<b>Dental Managed Care SubTotal<sup>3</sup></b>	<b>54,788,765</b>	<b>65,764,397</b>	<b>77,940,034</b>	<b>87,107,038</b>	<b>94,058,068</b>	<b>95,701,418</b>	<b>100,370,621</b>	<b>4.88%</b>		<b>60.85%</b>
Dental Indemnity Fully Insured	44,187,754	42,285,492	39,706,077	37,284,006	33,039,945	30,757,469	28,309,709	<b>-7.96%</b>	<b>53</b>	
Dental Indemnity Self Insured	30,117,221	28,820,689	27,062,627	25,411,807	24,630,544	25,356,215	23,326,705	<b>-8.00%</b>	<b>41</b>	
<b>Indemnity SubTotal</b>	74,304,975	71,106,181	66,768,704	62,695,813	57,670,489	56,113,685	51,636,414			
<i>Plus Est 5% Underrprtd. Indemnity</i>	<b>78,020,224</b>	<b>74,661,490</b>	<b>70,107,140</b>	<b>65,830,604</b>	<b>60,504,885</b>	<b>58,871,567</b>	<b>54,174,247</b>	<b>-7.98%</b>	<b>62</b>	<b>39.15%</b>
<b>EST. Total Dental Benefits Market<sup>3</sup></b>	<b>132,808,989</b>	<b>140,425,887</b>	<b>148,047,174</b>	<b>152,937,642</b>	<b>154,562,953</b>	<b>154,572,985</b>	<b>154,544,868</b>	<b>-0.02%</b>	<b>132</b>	<b>100.00%</b>
<b>% of Total Pop. with Dental Benefits</b>	<b>52.44%</b>	<b>52.44%</b>	<b>54.78%</b>	<b>56.08%</b>	<b>54.92%</b>	<b>54.27%</b>	<b>53.59%</b>			

<sup>2</sup> Number of Firms includes both those directly reporting and those estimated based on secondary information sources.

<sup>3</sup> Thirty-nine Delta Dental plans are combined and included as one company.

<sup>4</sup> Previous to this report, some Health Plans include a limited dental benefit. In 2003, some health plans with this limited benefit were removed from the Discount Dental Plan Subtotal (2000-2002) which illustrates the dramatic decrease.

**EXHIBIT I:** Exhibit I provides a total dental benefits market estimate based on the data collected and estimates from sources cited in the methodology. This market estimate demonstrates that network-based dental benefits in 2002 jumped 3% to report to a total of 65% of the market. Overall, there was no market growth in Dental Benefits between 2001 and 2002.

**DENTAL HMO DATA:** Using NADP historical data and other industry sources as benchmarks, the 23.3 million dental HMO enrollees directly reported in this survey are judged to represent more than 99% dental HMO industry.

In 1999, contact with previously unrecorded plans with significant enrollment reduced the unreported enrollment estimate significantly. Thus, only 0.9% is added to the actual enrollment to account for future additions to the database. The total estimate of enrollment in dental HMOs in 2002 is 23.5 million which is down almost 175 thousand from 2001.

The area of growth in the dental HMO market continues to be in Medicaid and Medicare. Growth topped 10% in the DHMO Medicaid sector and 43% in the DHMO Medicare sector in 2002 which offset enrollment losses by some carriers.

**DENTAL PPO DATA:** The 62 million beneficiaries directly reported from plans that offer dental PPOs increased over 4 million from 2001. Two companies in the database added the PPO line of business in 2002. *NOTE: These companies do not include the consolidated Delta Dental PPO enrollment.*

Identification of insurers that offer PPO products and independent PPOs is a process that NADP is still refining. As a result, it is likely that the PPO market is underreported; thus 5% is added to this sector of market bringing estimated total dental PPO enrollment to 65.0 million in 2002 or 42% of the market. *Clearly the dental PPO market is the fastest growing segment of the dental managed market although the rate of growth is lower than that reported in 2000.*

**DISCOUNT DENTAL PLAN DATA:** Discount Dental Plans- previously referred to as referral plans are benefits not defined as insurance but are a network-based product that provides access to dental care at guaranteed costs. Typically, a small monthly fee is paid by either the employee or the employer on behalf of the employee for a list of dentists that have agreed to accept certain negotiated rates for services. The employee and their dependents may go to any of the dentists in the network but pays the full cost of the service out-of-pocket albeit at the negotiated rate. A Discount Dental product is sometimes provided by dental HMOs or PPOs as a different way to market the networks developed for their insured benefit products. It allows the employer to provide a low cost fringe benefit when funding is not available for an insured product.

Increasingly, there are companies that specialize in developing and marketing Discount Dental products alone. These companies are experiencing the highest rates of growth. The overall growth of the discount dental market increased to 8% of total benefits in 2002. Most of this growth is in the larger plans. Some smaller plans are showing losses.

*Please note: previous to this report, some Health Plans include a limited dental benefit. In 2003, some health plans with this limited benefit were removed from the Discount Dental Plan Subtotal (2000-2002) which illustrates the dramatic decrease in Discount Dental Plans.*

**DENTAL INDEMNITY DATA:** NADP has significantly refined reporting of this sector of the market. In the 1998 report, 11 newly reporting companies identified an additional 37.8

million beneficiaries in the dental market through direct survey results rather than estimates. These companies were previously identified in the additional dental market estimates in the 1996 and 1998 NADP/InterStudy National Dental Benefits Census. Their historical data has been built into the data base back to 1994.

Overall, this market sector continues to decline. While many large dental indemnity insurers experienced losses, some small to medium sized companies often added indemnity as a product line and showed higher growth rates.

**ESTIMATE of the TOTAL DENTAL MARKET:** One of the key purposes of the 1996 NADP/InterStudy National Dental Benefits Census was to create a total dental benefits market estimate. Such an estimate had not been made since the US Department of Health and Human Services' (HHS) *estimate in 1989 of 95 million individuals with dental coverage*. Because of the broad demand for this estimate, this estimate is updated with the restatement of NADP's database.

To build this estimate, NADP examined the list of companies that responded to our surveys over the past several years. It was determined that the Delta, indemnity and self-funded sectors were undercounted by the survey. Since 2001, Delta Dental Association consolidated the enrollment numbers for all of the plans, and the under representation was eliminated.

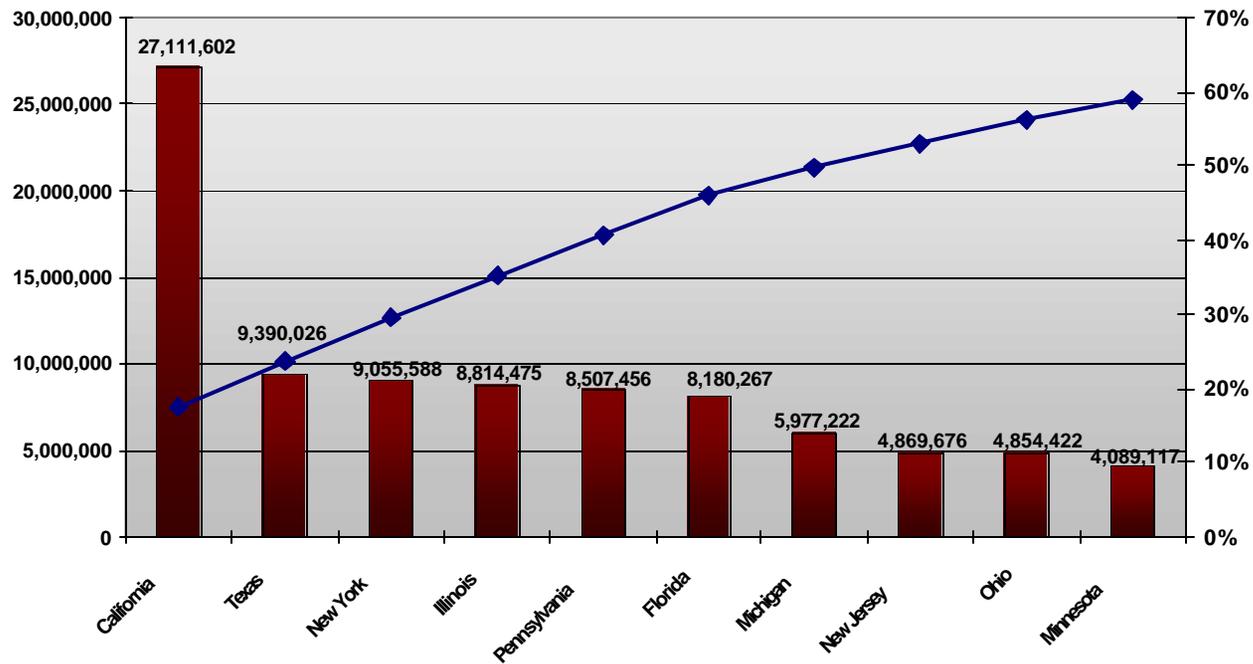
**OVERALL MARKET GROWTH:** With enrollment from estimated sources added to the specific enrollment reports, the total dental benefits market is conservatively estimated at year-end 2002 to be 154.5 million or close to 54% of the US population. This represents a 63% increase coverage (or access) from the 1989 HHS report of covered lives. This represents a basically flat line growth in the market over the past three years—primarily in the dental HMO and Indemnity sectors of the market. The Medicaid, Medicare and dental PPO market also continues to expand as previously discussed.

Since the recent Surgeon General's report on Oral Health in America notes that cost is a major impediment to obtaining oral health care, this expansion of the dental market—largely the result of growth in network-based dental benefits is responsible for reducing the cost barrier for millions of Americans. Taking down the cost barrier should result in long-term improvement in oral health

The 23.5 million dental HMO enrollees, the 65.0 million dental PPO beneficiaries plus the 54.2 million in indemnity dental plans and 11.9 million in Discount Dental plans allows the NADP to account for over 95% of the estimated total dental benefits market from its own resources and that of DDPA, without turning to other sources for supplemental information. This is a significant improvement from the 1998 NADP/InterStudy National Dental Benefits Census which accounted for about two-thirds of the estimated total dental benefits market through direct survey responses. **Thus, the reliability of the total dental market estimate provided by NADP continues to improve.**

## EXHIBIT II: Top Ten States for Total Dental Benefits Enrollment in 2002

Source: NADP/DDPA 2003 Dental Benefits Joint Report: Enrollment, September 2003



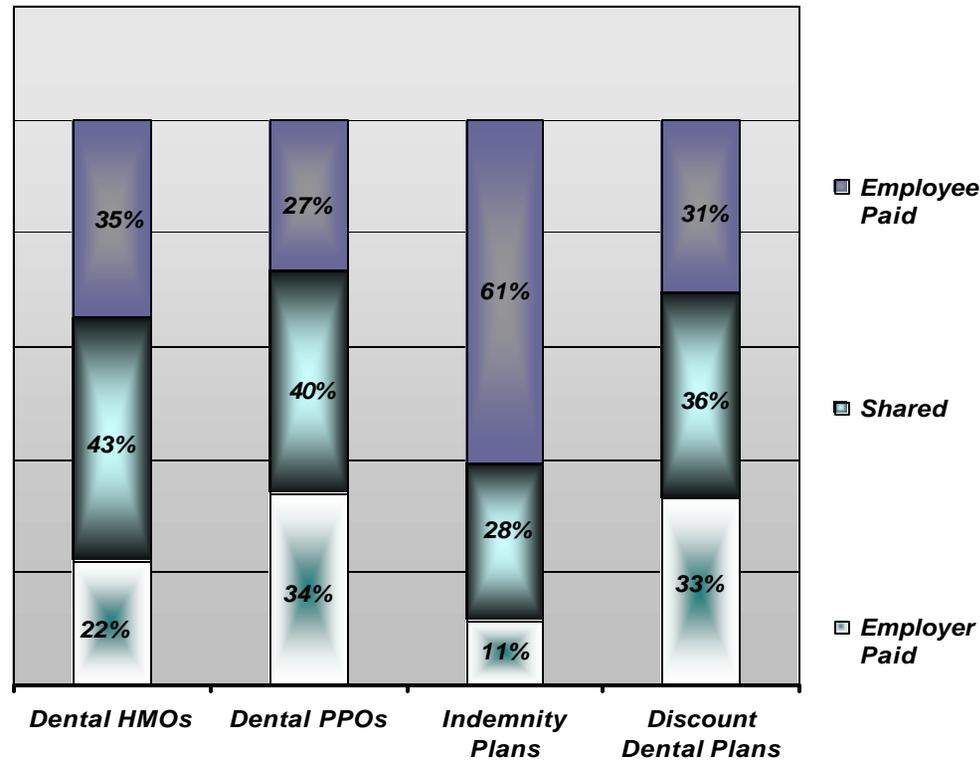
**EXHIBIT II:** Half of the top ten states for the total dental benefits market are also in the top ten for each line of network-based product reported in this survey. The exceptions are Massachusetts, Arizona, Georgia, Virginia, and Maryland. California dominates the total dental benefits market as it does in all dental product lines. Texas comes at a distant second in total market penetration.

*Please note: the enrollment numbers in this graph represent an estimate of the entire dental benefits market. Previous to NADP/DDPA 2002 Enrollment Model, state and regional enrollment number were reported, not estimated. Therefore, these penetration rates cannot be compared with previous NADP reports.*

*Also, previous to this report, some Health Plans include a limited dental benefit. In 2003, some health plans with this limited benefit were removed from the Discount Dental Plan Subtotal (2000-2002) which illustrates the dramatic decrease in Discount Dental Plans.*

## EXHIBIT III: Commercial Funding Sources for All Lines of Dental Benefits

Source: NADP/DDPA 2003 Dental Benefits Joint Report: Enrollment, September 2003

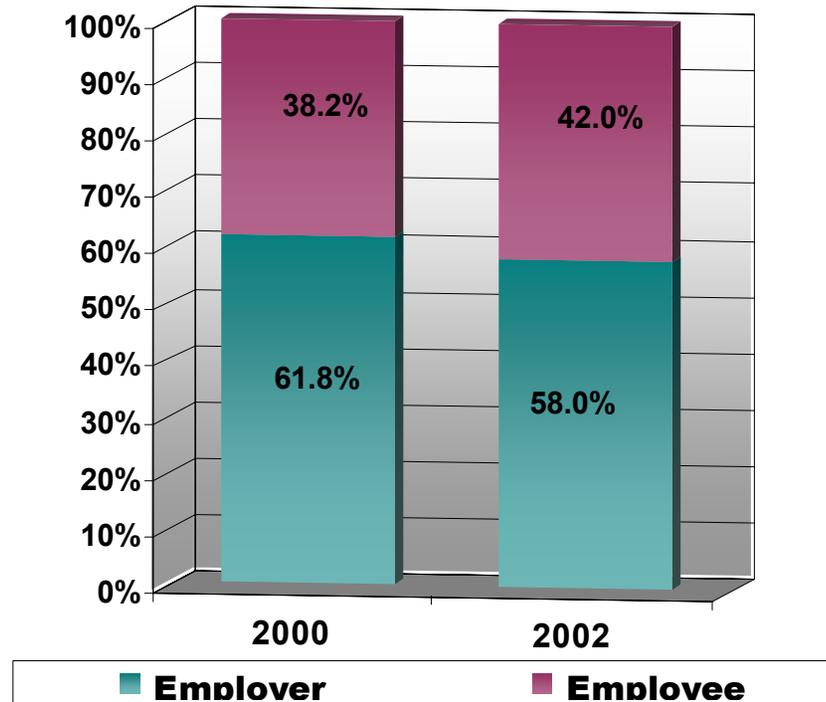


**EXHIBIT III:** Historical information indicates that employees are paying greater shares of dental benefits. In 2002, about one-fourth of DPPOs and one-third of DHMO & Discount Dental plans were paid for exclusively by employees. Almost two-thirds of employees in dental Indemnity plans pay 100% of premiums. This data shows that employers pay all dental premiums for employees in less than half the cases.

*Note: Although, there were a few Delta plans that reported individually, this chart does not contain consolidated Delta Dental data.*

## EXHIBIT IV: Allocation of Shared Premium Costs 2000 to 2002

Source: NADP/DDPA 2003 Dental Benefits Joint Report: Enrollment, September 2003



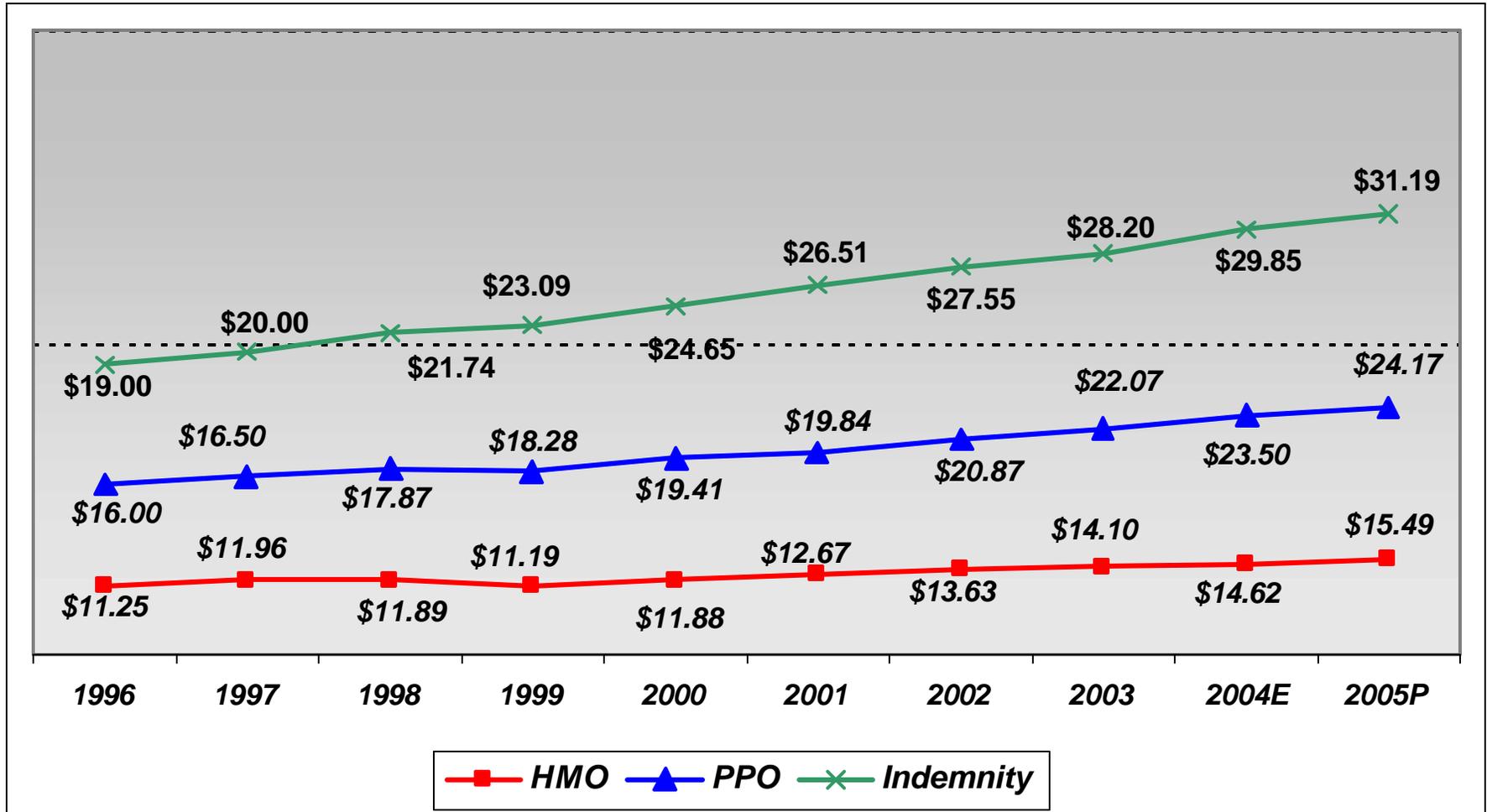
**EXHIBIT IV:** Of the employee/employer shared contributions, employers paid an average of 58.0% of the premium in 2002 and 61.8% in 2000. Employees paid an average of 38.2% in 2000 and 42.0% in 2002.

These results were not weighted by enrollment. Data was taken from 14 companies that provided 2000 data and 18 that provided 2002 data.

*Note: Although, there were a few Delta plans that reported individually, this chart does not contain consolidated Delta Dental data.*

**EXHIBIT V: Comparison of Employee Only Monthly Premium Trends by Product  
(with Orthodontia) 1996 to 2005P**

Source: NADP 2003 Dental Benefits Report: Premium Trends, October 2003



## APPENDIX A—TERMINOLOGY

A common set of definitions is helpful in seeking dental benefits coverage. The terms used in this article are defined below:

**Dental HMOs** --refers to dental benefit plans that provide comprehensive dental benefits to a defined population of enrollees in exchange for a fixed monthly premium and pays for general dentistry services primarily under capitation arrangements with a contracted network of dentists. Enrollees must use network dentists to obtain coverage except where a point of service provision allows them to opt out of the network but at reduced coverage.

**Dental PPOs** --refers to dental benefit plans that have contracts with providers for the express purpose of obtaining a discount from overall fees. Enrollees receive value from these discounts when using contracted providers but may go outside the network of discounted providers but with a reduction in coverage. Providers are reimbursed on a fee-for-service basis after care is provided at either the discounted rate or the “ucr” (usual, customary, reasonable) rate recognized by the plan.

**Dental Indemnity Plans**--refers to benefit plans where the risk for claims incurred is transferred from employer to a third party insurer for a specified premium and providers are reimbursed on a fee-for-service basis and there are no discounted provider contract arrangements whereby the provider agrees to accept a fee below their customary fee.

**Discount Dental Plans** --refers to non-insured programs in which a panel of dentists agrees to perform services for enrollees at a specified discounted price, or discount off their usual charge. No payment is made by the discount plan to the dentists; dentists are paid the negotiated fee directly by the enrollee. These plans are sometimes referred to as “access plans” or “referral plans.”