Ep #6: Dental Insurance – Should You Take It or Not?

Full Episode Transcript

With Your Host

Dr. Tarun Agarwal

T-Bone Speaks with Dr. Tarun Agarwal

Ep #6: Dental Insurance – Should You Take It or Not?

Welcome to *T-Bone Speaks* with Dr. Tarun Agarwal where our goal is to change the way you practice dentistry by helping you achieve clinical, financial, and personal balance. Now, here's your host, T-Bone.

T-Bone: Hello and welcome to another episode of *T-Bone Speaks*. I'm Dr. Tarun Agarwal. I know we've been on a little bit of a hiatus and we missed some shows, but again, I wanted to bring you another episode. On this episode we're going to be talking about dental insurance. Actually, it's a unique episode in that it's a—I don't really want to call it a debate—but it's a conversation between myself, Gary Takacs, and Alan Mead.

Recently on Facebook, Gary was talking about how his practice that he's a part owner of has gone the insurance-free route and how wonderful that is. I wanted to chime in and say number one, that's wonderful. I wish we could all become insurance free. But I also wanted to take the opportunity to say that I don't necessarily agree that we all have to be insurance free. I wanted to talk about how honestly being part of a PPO can help build a great practice. That can be the foundation for building a wonderful practice.

Too often in dentistry we're led to believe that we have to be insurance free. Don't get me wrong, listen, the name of the game is to be independent but times have changed. It's not 1980. It's not 1990. It's not even 2000s anymore. We have to be aware of what today is and what the realities are. Honestly, for the vast majority of us, most of us are going to be insurance providers. That includes me.

What I wanted to do is share how we're using insurance not as a crutch but as a springboard to build our practice

and how you can look at insurance not as a negative but as a positive and how you can do the things in your office to make insurance less of factor in everything that you do. I think one of the things that we face in dentistry is this challenge that we're being led by people from the 1980s and 1990s.

I'll probably get a lot of flak for this. This is not about the age of the person but more about the mentality. Things were different in 1980. Things were different in 1990. Things were different even when I graduated in the 2000s. Our dentistry leadership still has the mentality of 1980s whether it's our instructors or whether it's the quote/unquote gurus that are out there speaking. They're speaking from a perspective of not owning or not operating or have been far removed from the modern practice ownership or the modern associateship.

So I call on each of you to make the attempt to start focusing and supporting those younger speakers who are living and breathing in the same fight that we each face. This insurance quote/unquote debate, the conversation, I thought it was a great episode and I wanted to share it with you.

It's unique in the fact that it's actually going to be shared on three different platforms. Through *T-Bone Speaks* podcast, through the Gary Takacs' *Thriving Dentist Show* podcast and through Alan Mead's *Dental Hacks Podcast*. It is such an important topic that we wanted to get it out there for everybody. We really hope that you enjoy this episode.

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If you want to see more episodes come, I know I've been behind. I really want to do more episodes but at the end of the day this episode isn't about me creating content, this is about you saying this is what we want to know more about. Whether it's clinical, whether it's business, whether it's life balance. If I can't answer it, I'm more than happy to find those who have the expertise and bring them on.

So what I need from you is two things. Number one, I'd love for you to join my email list. All you have to do is text tbonespeaks, that's T-B-O-N-E-S-P-E-A-K-S to the telephone number 44222. That will enter you into our email list. You'll receive a nice handout from one of my speaking events. You'll also receive regular email updates from me. At any point, you can opt out if you don't like the information. I want it to be totally free and valuable information.

The second thing I need you to do is I need you to visit www.TBoneSpeaks.com and submit your questions. What would you like to hear on the podcast? What's going on in your life? What's going on in your practice life? What are you struggling with? Where do you need help so that we can bring that message to you? Thank you again for listening and I hope you enjoy this episode.

Alan Mead: Hello, podcast listeners. We have an interesting thing going on today. This was sort of conceived by the three of us to come up and we all represent different podcasts. We have a conversation about dental benefits, about dental insurance, and taking it and not taking it.

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My name is Alan Mead, I'm from *The Dental Hacks Podcast* and the two other guys that are going to be doing this with me are Gary Takacs, hi, Gary, how you doing?

Gary Takacs: Hey, Alan, great to hear your voice. I couldn't be more excited about this. When this idea kind of percolated there on social media it sounded like just an awesome idea for all of our listeners. So I'm super excited about this.

Alan Mead: Yeah, it's like a three-way podcast share. Our other participant is Dr. Tarun Agarwal, he's on the *T-Bone Speaks* podcast. Hey T-Bone, how you doing?

T-Bone: What's up, Alan? What's up, Gary?

Gary Takacs: Hey T-Bone, glad to hear your voice as well. This is going to be fun, man.

T-Bone: I can't wait. I hate to call it a debate because I don't think it will be much of a debate, I'm clearly going to win this.

[Laugher]

It's going to be huge and I think the establishment is against me. I just don't like how this is working out.

Alan Mead: You're an insurgent candidate is what you're saying.

T-Bone: I'm leading a revolution.

[Laughter]

Alan Mead: Okay, so before we even jump in, the concept was Gary had mentioned on Facebook how their practice had transitioned into an insurance-free practice. He mentioned it on Facebook and T-Bone said, "Hey we should talk

about that. The difference between insurance and non-insurance and why all that stuff." I thought, man, this would be a great thing for pretty much all the listeners of our podcasts to hear because I think it affects most dentists.

Before we even start, Gary is a practice management guru/coach he also might be able to explain this in the shortest amount of time. I just want the listeners, we have quite a few listeners that are younger, maybe new dentists. When we talk about dental insurance as a term, there's like a lot of different things that we talk about. So let's just break that down a little bit before we start talking about our practices. Gary, dental insurance, what the heck is it? What are the different kinds? What are the ups and downs of all those things?

Gary Takacs: Great way to start this whole discussion, Alan. I'll make this as brief as possible. We call it dental insurance. When I think of insurance, like for example medical insurance or health insurance, life insurance, it's to insurance a risk that we can't afford to take on our own. When I think of dental insurance I think a better way to think of it is a dental benefits plan.

I mean think about this, on medical insurance, heaven forbid that any of us would ever end up in the hospital even for a short period of time because the charges could literally amount to hundreds of thousands of dollars if not even into the millions of dollars for any kind of a serious medical episode.

Let's face it, in dentistry, there certainly are risks and there certainly can be some coverage that amounts to

some serious investment but it pales in comparison to what exists over there on the medical side. So I like to think of it as a dental benefits plan provided by the employer rather than insurance but we'll use the word insurance because that's what everyone is familiar with.

Let me walk through maybe four of the most common types of dental insurance out there. I'll just rattle these off in no particular order. Capitation. Capitation is a plan that pays you so much per head. Think in terms of decapitation. That would give our listeners a little bit of an image.

Alan Mead: I kind of like that, yeah.

Gary Takacs: So you get paid so much per head to take care of X number of patients. About the only way you can make capitation work for you is to not see those patients.

Alan Mead: Not have a phone number.

Gary Takacs: Right, so you don't have a phone number. You get paid every month to take care of X number of patients. I actually met a dentist one time at one of my courses and I made a negative comment about capitation. He came up to me at the break and said, "Gary, I can show you how to make this work. We've got capitation in my practice and I found a loophole in the clause. The loophole was that I only need to have one line, one phone line."

So he said, "We should really have ten or twelve for the volume of my practice but I only have one. That way when the people call they can't get in." So there's capitation. You get paid so much per head to take care of patients.

Another form is HMO, health maintenance organization. Health maintenance organization are similar to capitation. They often in the contract allow you to get paid a certain amount of dollars to take care of a certain number of patients. It's a little bit different than capitation but it's along the same lines.

Now let's get to the two more common types of insurance that most of us deal with. The next would be PPO, that stands for preferred provider organization. That's where you would contract with a carrier to provide services at a contracted fee. That usually is quite a bit discounted off your normal fees in exchange for the insurance company providing you patients.

Then the last form would be indemnity insurance. Indemnity insurance in my opinion is the best type because it allows the patient to go anywhere. They can go anywhere for their benefits and it doesn't matter whether they go to an in-network doctor or not a network doctor. The insurance company will pay your UCR fees if you're an indemnity provider. Alan, did that help to outline those four?

Alan Mead: That was really good. So a couple things, like Delta Premier which is what we talked about, we should definitely get into that later too. Delta Premier might be considered somewhere between an indemnity and a PPO because they're better than the Delta PPO, but it doesn't sound like they're quite as good as—there can't be that many indemnity insurances for dentistry anymore. That's got to be pretty uncommon.

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Gary Takacs: No, there aren't many. In fact, oftentimes we find that the indemnity plans are only written say for a certain class of employee, perhaps the executives or their board members. So that's very true. To clarify your question about Delta Premier, Delta Premier technically is a PPO but generally it has a higher fee schedule which then kind of fits your description of it being somewhere between the PPO and the indemnity.

Alan Mead: Sure. One other thing too is that like, I've always wondered this and you probably know, as far as assignment of benefits. When you participate with a dental insurance, typically the most important thing about being a participating member is that they'll send you the check. Is that essentially right? I mean when you hear "assignment of benefits" that's the reason to participate because they'll send you money directly instead of making you get it out of the patient all the time.

Gary Takacs: Well, yeah, but, Alan, you know, your wonderful patients in Michigan if it so happens that the patient gets the check from the insurance company, they drop whatever they're doing and drive right into your office to hand deliver you that check, right?

Alan Mead: Exactly. Actually what I've found is there's a lot of casinos pretty close by that are happy to take that check from them. It's amazing how that works.

Gary Takacs: But the assignment of benefits is exactly what you said, that simply means that the patient has assigned the benefits over to you and the insurance company will send the check directly to you.

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Alan Mead: So let's just say, we'll get into it in a sec, but if a practice doesn't participate with someone's insurance let's say. Someone comes in, they have Delta Premier or a Delta PPO and they don't participate or you're a non-participating dentist with Delta Premier. They get services by you then essentially they send the patient the check. The patient needs to pay you in full, that's the downside.

Gary Takacs: Correct, and of course, I was tongue firmly planted in cheek when I made the reference about Michigan residents.

Alan Mead: No, I get it. I get it.

Gary Takacs: But you know, that's one of the levers that the insurance company holds over providers is, "Well if you want us to send you the check, then you've got to be in our network otherwise we're going to send the patient the check directly." So from a business standpoint if you chose to go out of network and you're no longer going to receive the assignment of benefits, then essentially the patient has to pay at time of service. The only thing that makes sense is for the patient to pay at time of service.

Then the patient will get reimbursed back from the insurance company. Which frankly, many patients don't like that approach because they go out of pocket a little bit until they get reimbursed from the insurance company. So for some patients, that's not a popular policy.

Alan Mead: In fact, and we'll talk about this again later, but in fact I think that might be one of the main hang-ups of an office participating or not participating. But okay, let's move on a little bit. T-Bone, tell us about how your practice handles

insurance. In other words, you have been pretty outspoken about taking—not that you take every plan—but you are not in favor of dentists jumping off insurance necessarily. Maybe you come from that honestly because didn't your practice start out as like an insurance-free practice?

T-Bone: Thanks for asking that question. What I would say is the way we handle insurance is we are a PPO practice in the sense that we are network providers for I don't know the exact number, five or six different insurance companies. What we do is we participate in the network, we get those patients, then we work within their rules and the fee schedules that those insurance companies provide us.

So obviously, we also work with those people that have insurance that aren't part of a network. For example, on networks that we're not in network with, we see those patients as well. Then certainly we have a component of our practice that is what most people refer to as fee-for-service or our cash pay patients.

Alan Mead: So you are probably relatively typical. You described my practice too.

T-Bone: Yeah, probably 80 to 90 percent of the practices out of there.

Alan Mead: Yeah, that's pretty typical. How do you work with people when you're out of network, do people find that to be a pain? Does the insurance just pay less? What do you think about that?

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T-Bone: Well I want to back up for one second. I think the one thing that we didn't cover in the types of insurance plans is the government plans.

Alan Mead: All right, fair enough, yeah.

Gary Takacs: Yes.

T-Bone: So you know, Medicaid, Medicare, Medi-Cal, whatever the different things are. I think with this discussion I would assume that we're not really referring to that level of insurance.

Alan Mead: You know it's interesting that you say that though because typically they're state run programs and a lot of states do it differently. We've had guests on like if I remember correctly North Carolina where a lot of dentists in North Carolina have made that work in a way that they wouldn't in Michigan. I remember Dr. Brent Young has been, a 100 times he's talked about that. In his practice he makes that work.

T-Bone: Well, probably because in North Carolina for example Medicaid pays better than MetLife on many of the basic procedures.

Alan Mead: Yeah. So really it's a state by state thing because I can tell you without too much looking, Michigan doesn't. Not even close.

T-Bone: Yeah, like California may be like that as well. So what was your question again? I'm sorry.

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Alan Mead: Well you know what, we'll get to it a little bit later but I'm curious about when a patient wants to come to you but you're out of their network, how does that work out?

T-Bone: Truthfully, Alan, I don't even know.

Alan Mead: That's kind of the way I am too.

T-Bone: When I see a patient, I try not to know what their particular plan is. I try to in a certain way create a Chinese wall in the sense that I don't know what the patient has, whether they have insurance or don't have insurance.

Alan Mead: I generally am pretty hands off about it. Sometimes it will affect the treatment plan, but no, I agree. I don't look at it in that way.

T-Bone: It works its way into the conversation certainly at times. Then I become more cognizant of it when the patient wants to become cognizant of it. But generally speaking, I don't know what the patient has and certainly I would tell you that my guess would be, and I don't have hard numbers on this, this isn't that important of a number to me. But I would between that say 60 percent of our patients are in-network patients, probably about 30 percent of our patients are traditional commercial/I don't believe indemnity really exists that much anymore.

Alan Mead: Agreed.

Gary Takacs: Right.

T-Bone: Then 10 percent of our patients are non-insurance patients.

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Alan Mead: That's got to be pretty similar to my practice. But let's move on to Gary. Gary, the reason this came up is because Gary's practice made some changes recently. So tell us a little bit about your journey, Gary.

Gary Takacs: Sure. It's actually an interesting evolution. When Paul and I bought our practice in May of '07, one of the things we didn't understand well when we did our due diligence was simply how involved the previous dentist was with insurance. We quickly discovered that it was virtually overrun with PPO plans. I don't have an exact count but we're talking about over 20 PPO plans.

Basically the previous dentist, his only plan for marketing was to sign up with the PPO plans. Well we quickly learned that by looking at our adjustments every month, we quickly learned how involved this practice was with PPO plans. We made a decision that if we couldn't make a fee schedule work relative to the quality of dentistry that we wanted to provide, if we couldn't make it work, then we were going to resign from that PPO plan.

In fact, over a period of, it was about two years, we resigned from all but one. The one that we had left was Delta Premier. In fact, we had a negotiated fee schedule with Delta Premier that was pretty darn near our UCR fee schedule. We were able to have successful negotiation with Delta of Arizona and we had a negotiated fee schedule with Delta Premier.

But we went out of network with every other plan because we simply couldn't get them to work with our profitability and our costs of providing the quality of care that we wanted to provide.

Then we practiced for a number of years under that format. Where we were out of network with pretty much every plan with the exception of Delta Premier. Then recently, about three weeks ago, we resigned from Delta Premier. So we're completely a fee-for-service practice, or will be, I think there's a little bit of a waiting period yet until we're completely out of network with Delta Premier. But we'll be there very shortly.

Now I will make one comment. That is that you can be out of network as we are and as Tarun is with some of his plans and yet you can still be very insurance friendly. Our practice is insurance friendly. What I mean by that is we're happy to help our patients with their insurance benefits. We're happy to help although we're out of network. Does that make sense?

Alan Mead: It does. I want to actually spend a little time, we'll probably get into a little bit but I want to spend a little time talking about how you handle that and how if that comes down to splitting hair or whatever like the splitting hairs.

Gary Takacs: Well some dentists would think that, "Well if you're a fee-for-service practice that you're arrogant about insurance." Alan, if you're our patient, the arrogant approach would be, "Hey, we're the dentists, we take care of you. You pay us and insurance is your problem." I want to emphasize that is not our approach in any way, shape, or form. I think that's arrogant. I don't think that's very patient friendly. I wouldn't want to be subjected to that kind of approach if I was the patient.

So you can be outside of network, you can be not contracted with PPO plans and yet still be very insurance

friendly. We file our insurance claims for our patients. We have one of our team members who's essentially an insurance clerk helping our patients maximize their benefits. So I don't believe there's anything incongruent with being out of network and at the same time being insurance friendly. We're approaching it with the patients being very insurance friendly. In fact, I think that's the key to your success with it.

T-Bone: So Gary, let me ask you this. Are you guys doing assignment of benefits are you having patients pay for their entire treatment up front?

Gary Takacs: Correct. In most cases, almost every case, when we went out of network the insurance companies would then send the check directly to the patient. So we were not able to assign the benefits to our office because we're out of network. In order to make that work, we had to ask patients to pay at or before time of service then tell them they'll be reimbursed by their insurance company.

We also found out by the way and this makes perfect sense that if the benefits are assigned directly to the patient, we found that the insurance companies will pay the patients much quicker than they'll pay their providers.

Alan Mead: Interesting.

Gary Takacs: That's simply because who's in contract with the insurance company? Well you could say the patient is but technically it's the employer that is in contract with the insurance company and the insurance companies want to favor how they treat their employers and their employees because they want to renew. When it's time for renewal,

the open enrollment period and time for renewal, the insurance company wants them to renew.

So we found that if you assign the benefits to the patient, the patient often gets the check very very quickly. It doesn't represent much of a hardship in terms of the amount of time that they're out of pocket before they get reimbursed. I will say practically, patients aren't thrilled with that. They'd much as soon throw you an insurance card, Alan, and say, "Alan, here you go. I have insurance. It pays. Now you deal with it." You know, they'd much rather do that.

Alan Mead: That honestly is sort of to me, that's the nuts and bolts of it. I mean, okay, so the patients or their employers in most cases have paid for this policy so they damn well want to use the policy. In a way, it doesn't sound like this is how it works in your office, but if they're saying, "Look, we don't really deal with insurance." Well that could be something that could turn someone off.

Gary Takacs: Oh, absolutely.

Alan Mead: So the bottom line is it behooves you to at least understand that they want to use that benefit in some form or another.

Gary Takacs: Here's the fun way to think of it. It's like the patient is saying, "Hey, I have this coupon. Can I use it here?"

"Yes, yes. In fact, not only can you use it. We're going to help you absolutely maximize your benefits. We're thrilled you have that thing. We're thrilled you've got that."

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We're in Arizona. We can honestly say, "Hey, Alan, this is great. Many people in Arizona don't have any insurance benefits at all. It's great that you have this and we're happy to help you with it."

T-Bone: But it's not exactly a coupon. I mean the way you're describing it because like when I go to the grocery store, not that I go to the grocery store very often, but if I give them a coupon, it's the same as cash. It's an equivalent. I'm not giving the grocery store my two dollars and then somebody else is sending me a dollar back for my coupon. I mean just giving you a dollar plus the coupon which is the equivalent of cash. What you're saying with insurance is that I have a coupon in the sense, a plan that's a reimbursement versus more of a coupon.

Gary Takacs: Right. Yeah, that's true. The analogy gets a little weak.

Alan Mead: Understood, understood. But each time the rub is always the—Gary is going to be the practice that has really tight financial policies. Actually, T-Bone's is too. But I mean Gary goes all around the country teaching about that. So the bottom line is I kind of believe you're doing okay on that end of things.

Gary Takacs: Well when we first met many years ago, I gave a course at the Michigan…

Alan Mead: The Saginaw. The Saginaw Country Club.

Gary Takacs: Yeah, the Saginaw and I believe that course was titled, I have to go back in my memory, but this was over 20 years ago. I believe that course was titled "How to Get Paid in the 90s."

Alan Mead: I think so.

[Laughter]

That dates us both actually, yeah.

Gary Takacs: Trust me, the financial policies are pretty buttoned down in our practice. But they're also friendly, they're patient friendly.

T-Bone: So Gary, let me ask you this, again, so let me preface everything that I'm doing is a) I like to discuss and play devil's advocate.

Alan Mead: Sure, yeah.

T-Bone: Number two, I come from a position where I tried to be fee-for-service. Now certainly it was very early in my career and it miserably failed so I started taking insurance and suddenly I started having success in practice. Then we've taken insurance and really turned into a very success practice.

So to me, the question is I always say, "What is the motive of dropping insurance?" To me it is a matter of controlling your fees or is it a matter of controlling the cash flow in terms of getting your money all up front that one time. You're not on the hook for the insurance payment.

Gary Takacs: This is the crux of the discussion and the debate, Tarun, thank you for clarifying that. In my opinion, this is really the crux. What I'd like our listeners from my perspective to think of is that when you participate with a PPO, I want you to think of the adjustments that you are subjected to

by those contracts as being a marketing expense. Now your accountant would disagree with me on that because you're not actually paying the insurance company.

Alan Mead: And let's be honest, they're doing a horrible job of marketing my practice, but go ahead.

Gary Takacs: But you're paying them, the discount is rationalized by the insurance company providing you patients. I'm going to give you hard data. This comes from a client of mine, not our office, but a client of mine in our coaching firm that I have permission to share hard data.

This is a practice that was subject to about $30,000 a month of insurance adjustments alone. There were other categories of adjustments: refunds, some charity work, some team dentistry, some family dentistry, and so on. But just in terms of insurance adjustments alone, it was about $30,000 a month.

Now if you accept my definition or my analogy that that being a marketing expense, if this was to go on in the same volume every month and we annualized that, that practice was quote spending, and I'm using air quotes here, of course you can't see that on a podcast, but I'm using air quotes here. That doctor was spending $30,000 a month in marketing. $360,000 a year. I made the comment to him, I said, "Doc, you could spend a fraction of that in marketing and get a much better result." We've done just that in his own practice.

But to bring back to Tarun's question, I think the motivation, the reason to go out of network is to regain control of your fees. Not having a third party who has no

interest in your profitability. Let's face it, the insurance company has zero interest in Alan Mead's profitability or Tarun Agarwal's profitability. They are guided by their own actuarial accounting and they set the fees based on the premiums that they charge the employers.

So I wanted to regain control of our fees and have us be able to control that. I also want to emphasize, we want to be very affordable and very practical with our fees. So when I say I want to regain control of our fees, our fees are very modest in my opinion, for the quality of care that we provide because we want to be accessible. We want to be affordable. We want to be a practice where blue collar working class folks can come and afford the kind of care that we provide. But we want to decide those fees rather than having the insurance company decide them for us.

T-Bone: But what's wrong with the insurance companies deciding the fee? I want to back up again. So listen, I don't want anybody to mistake what I'm saying as like I'm a proponent that everybody should take insurance. That's not at all what I'm saying. I would say that if I really had the guts, let's say, not even the belief, it's more the guts, I would do what Gary is saying. But I don't have the guts to do it and I firmly in my heart don't believe 80 percent of the dentists out there have the guts to do what it takes to get there.

Now it's really easy to say that we can do it and that it can be done, I think most of us don't have the guts to do what it takes to become insurance independent. I don't even like using that word because I like to say I'm insurance independent even though I take insurance. So let me ask

you this, Gary, I'm a numbers guy and I know you are as well. So the average practice in this country let's say does $600,000, $700,000 would you say that's a reasonable number?

Gary Takacs: Yeah, according to the data that comes from the ADA, that's even a bit higher than what the ADA reports. But let's use $700,000 just as a ballpark.

T-Bone: Let's use $700,000. What do you think the average discount on general is from me taking a PPO from a $700,000 practice? 20 percent?

Gary Takacs: I can only answer it in terms of our experience with the plans that we had. It was deeper than 20…

T-Bone: 25 percent?

Gary Takacs: It was averaging 25 to 30 percent.

T-Bone: Ok, let's call it 25 percent, okay?

Gary Takacs: Sure.

T-Bone: So we're talking about 25 percent of $700,000. So what is that? That's $150,000?

Alan Mead: A touch more, but yeah.

Gary Takacs: Yeah, $180,000.

T-Bone: $180,000, let's even call it $200,000, okay? So no offense to anybody listening, but to me, if your sole goal is go from $700,000 to $900,000. You've got a bigger problem. I just don't look at it that way. I don't think it's enough. I

think we're setting the bar low and that's how I look at insurance differently.

I look at it as insurance this way, so here's my goal of where I would like to get to with insurance. I want us to continue taking the plans we're taking. What I don't like about insurance is that it values my time as a 15—what am I—17 year practitioner as the same value as my associate partner in our practice who's been out of school essentially 18 months now.

So we have the same equal value. That would be the equivalent of saying my older brother who's now been practicing law for 20 years should be billing out the same as his first-year associate. It just doesn't work that way in that world. Unfortunately insurance has done that to us. My goal with insurance is not to drop insurance from our practice but to drop insurance from me as a provider, as the senior doc in the practice.

Gary Takacs: Interesting.

Alan Mead: Interesting. Yeah, that's an interesting perspective.

T-Bone: What I want more people to do, and I think it's easier, that's why I want to do it this way. I look at the least common denominator and with complete respect, Gary, I think most practices don't have, being fortunate enough to have a Gary Takacs running their practice. So I think it's easier for people.

The mindset I want them to get around is I want them to build a business and not a practice. Now a practice, like Alan, and I've talked to you about this before. Alan has a practice. He's a solo doc. He goes to work. He lives a

great life. He makes a good living. He checks in and checks out of his office. He has a practice.

To me, the goal is I want everybody to build a business in the sense that you should be multiple docs. You should never be just one doc. I think we should all be at least two docs per practice and we should build a life around that. That's what we've done. Now, I'm able to take ten weeks off a year. I'm able to work three days per week when I'm actually seeing patients.

I'm making money and I'm able to build a business that supports more people in the practice and supports being open five days a week and supports having an associate dentist, which in my opinion will help us fight whether we believe it or not the large pressures we're going to face from large group practices. The reason the group practices survive is because nobody is hiring dentists other than group practices.

Gary Takacs: I love this perspective, Tarun. In fact, to me it just tickled me recently on Facebook when you and your family took that wonderful vacation out West. I felt like it was like the *Where's Waldo* except it's "Where's T-Bone."

Alan Mead: Yeah, showing up all over.

T-Bone: I just came back from Costa Rica. Listen, it's not about where I take vacations and stuff. So here's what I'm going to look out, okay? I'm going to use fake numbers, not actual numbers. But let's say I have a million dollar practice, it's more than that, but let's say I have a million dollar practice. Now I want to drop insurance. I want to go

insurance free. I want to be what you're saying because it makes sense, Gary. That's the way we should be.

We should be independent, true owners of our practice and have complete control. But then, why would I throw away what's made me good money all this time? Why would I not just give that to my associate dentist and let him or he or her or him or she run that part of the practice? Now I can focus on the bigger things in my practice and I can use the insurance pool of patients to feed that side of the practice, which is what we're doing.

Alan Mead: What's interesting about what you're saying is, I kind of love what you said when you're like if insurance is the hang-up between one number and the next number versus just growing your practice, I kind of like that. Your point is, okay, the insurance is always going to support the person doing fillings and crowns and basic bread and butter dentistry because that's essentially what insurance does cover.

T-Bone: Sure.

Alan Mead: So you're saying have a person, typically the associate or the less experienced dentist doing that and perhaps the dentist who wants to go in and do more complex procedures who doesn't have to sweat insurance. Because let's be honest, if you're doing a big rehab with implants and surgery and stuff, insurance isn't' going to touch that anyhow.

T-Bone: It's going to play a minor role.

Gary Takacs: Yeah, they're going to play such a small part of that.

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T-Bone: They will affect the fees because the contracted provider of those fees will still apply above and beyond the thousand…

Alan Mead: Yeah, talk to the listeners about that. Talk to the listeners about that.

T-Bone: So that is the one negative. I would say this, is that when you're a contracted provider if I do 20 crowns on you, now listen, there's ways around this, okay? But if I do 20 crowns on you, let's say the first crown is covered by insurance but the next 19 I don't get to charge my fee, my quote/unquote my fee. Listen, I call them fake fees anyway to be honest with you. To me, the fee is what you actually get paid.

Gary Takacs: Right.

T-Bone: So the next 19…

Alan Mead: That's very true, T-Bone. Say that again. Because whatever your fee, you know, it's what you get paid. I totally agree with you.

T-Bone: I say that with laughing because my wife, we practice together. She has a medical practice. They produce a billion dollars a day. I mean, literally produce. I look at the numbers and some days they have $50,000 in production next door.

Alan Mead: Yep.

T-Bone: But when you take a look at it and say what is your expected collections of that $50,000?

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Alan Mead: $2,200.

Gary Takacs: A thousand dollars.

Alan Mead: They take the fees that they have to charge in medicine and unbundle in medicine have literally no bearing on the service that they're providing. They're taking a cannon and shooting for as high as they possibly can and the insurance company goes, “Well, how about $500?” It’s ridiculous.

T-Bone: I don’t want to get on a tangent here, but you tell me this, okay? So maybe this is the Indian in me. So you're telling me, and I’m happy to do a crown for MetLife patients for $750. I think that’s the number roughly that we get for it. So you give me half, I fight to get my other half from MetLife. I don’t have to fight that hard but I’ve got to fight for it and wait a little bit.

Now the same patient who doesn’t have MetLife comes in, now you have to pay me $1,100 for that same crown and you give it to me all at once. I mean, to me it should be the opposite. The insurance fee should be higher and my patient paying me all up front in advance where I have no support cost to that, I should charge them less.

Alan Mead: That’s exactly where I come in on this stuff. On top of that, what about the insurance company? We had this in Michigan where the Michigan Dental Association was suing Delta over the fact that they would control the fee that you could charge if you're a contracted dentist with them on procedures that they wouldn’t touch. In other words, they would cap your fee for let’s say a veneer even though it wasn’t covered.

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Gary Takacs: An uncovered service.

Alan Mead: Yes, an uncovered service. That's a huge limitation as well. I have to say, just so the listeners understand. It's worth looking into what companies can and can't do in your state. Gary and I were talking about this a little earlier. In Michigan right now, Delta Premier is no longer enrolling Premier. The only way you can take Delta Premier patients is if you're new onto the scene is to be part of the Delta PPO. So in other words, I've grandfathered in. I can keep the Delta Premier without taking Delta PPO.

But anyone new who's come out in the last probably three years or so in Michigan has to sign up with Delta PPO. So that limits a little bit on what you were talking about with saying, "Hey, I'm going to give my associate the insurance stuff and I'm going to work on the bigger stuff." Because all of a sudden the associate because they got their license at X date may have a harder time being able to take advantage of some of those benefits. Gary, do you read that the same when I say that or not necessarily?

Gary Takacs: No, absolutely. Tarun's doing a great job of explaining some of the challenges that come up when you're in network and when say your associate doc is the one that your contracted doc in network and then the senior doc is the one that's doing the other services.

But I want to bring a point up that we sort of danced around a little bit ago. I want to sort of take a minute and amplify that just a little bit. That mythical practice that we said the average practice producing about $700,000. The reason why the overhead is so high in a practice like that

is the office isn't producing enough to bring their overhead down.

The truth is, I've been in over 2,200 practices as a coach. I can go into any practice, including my own, and save nickels and dimes by taking a fine-tooth comb and going through line item by line item of expenses. But the bottom line on that is we're not going to create financial success for the doctor by saving two bucks on a box of gloves. So really the answer is to become more productive. Tarun, in that case, you make a compelling argument, Donald Trump.

T-Bone: [Impersonating Donald Trump] Huge.

Alan Mead: Huge.

[Laughter]

Gary Takacs: You make a huge argument, Donald. But in all seriousness if the ADA said the average solo dentist last year in the U.S. in 2015 had 74 percent overhead, let me define overhead for just a minute. Overhead is defined as all your expenses necessary to run the practice with the exception of owner doctor compensation.

T-Bone: You should be paid nothing apparently.

[Laughter]

Gary Takacs: Right. It's my opinion that if your overhead is 74 percent, doc, you're working way too hard for too little, in my opinion. But if you look at this and say wait a minute, we've got extra capacity. We've got extra room within our facility. We can produce more with the current team that

we have, then your challenge should be to grow the practice.

In that case, Tarun, you make a compelling argument for kind of this blended practice. It's really a hybrid practice in that's that it's fee for service/PPO. You make a compelling argument because that maybe your quickest way to grow.

T-Bone: You know, along those same lines. The other thing I was thinking is often as speakers, as podcast runners, or whatever we are, we make these arguments sometimes like insurance keeps us from doing complex cases. I don't agree with that. I think it's our stupidity as dentists keep us from being able to do complex cases. Like the argument I just said, if I do a 20-unit case, insurance is going to dictate my fee on all 20 units even though they're only go to pay for a portion of one or two units.

The truth is most dentists never do cases over $2,000 or $2,500. Honestly, I don't think it's because of insurance. We can say it's because the insurance limits us. I don't believe that. I don't truly believe that. I think our own minds limit us. I would say 90 percent of dentists never do anything more than three or four teeth at one time anyway.

Gary Takacs: Hey, Tarun, can I brag on you for just a minute for our listeners' sake?

T-Bone: Please don't.

Gary Takacs: As a listener, if you've never gone out and take a course from Tarun, run, don't walk. Go out and take a course. He is doing some amazing things with dental implants, with

CEREC dentistry, multi-unit CEREC dentistry, with sleep dentistry, some amazing things.

So if that's you when he described that, when he said, "The truth is most dentists have never done a case more than a couple thousand dollars." If that's you, run don't walk. Take a course from Tarun because you will not get any more practical, real world advice and wisdom from anyone other than Tarun. So let me brag on you for just a minute.

T-Bone: Thank you, Gary. Let me ask you this, I know Alan, you're running the questions here. But let me ask you this. So let's break this down a little bit simpler. I would argue that my practice or a practice like mine is probably more suited to go let's call it insurance independent, okay? Even though I believe we're insurance independent in our practice but let's call it insurance independent. Let's call it fee-for-service. I would say that the average practice is not ready for that.

Gary Takacs: I would completely agree. Especially having been in so many of those practices myself. In many cases, and let me just share this with both of you, Alan and Tarun, many times I'm called into a practice as a coach. I take a look at the analytics. The doctor says, "Gary, the first think I want to do is I want to get rid of insurance in my practice."

I will look them right in the eye, him or her, right in the eye and say, "Do not do this. Read my lips. Do not do this. Your practice is in no way shape or form prepared for that radical move. Don't do this."

T-Bone: How would you define…?

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Alan Mead: Yeah, what practices are ready for that? That's the question.

T-Bone: Let me define it and then I'll ask you, Gary. I'll let you answer that question. So to me, a practice that is ready to be insurance independent, true fee-for-service practice, okay? Not participating with any practice. One, you have to a B+ and above team. You have to have team members who are themselves not afraid of talking about things with patients, non-insurance related.

You have to have firm financial arrangements in place within your practice. You have to have an unbelievable mix of services so that way you can now offset what you're going to lose because I do believe you lose patients and production when you drop insurance. You may gain it back with increased fees and increased services but you need to have a mix of services.

You need to have an ability to market and get new patients. That doesn't necessarily mean externally. It could just be good internal. I would say before you market externally, you've got to have good internal marketing. I would say those are the main things that I look for in terms of being ready to even consider dropping. Oh, and probably the most important thing—you have to have no open time on your schedule.

Gary Takacs: Excellent. So you listed five points there. I went ahead and wrote those down. Let me go ahead and repeat those for our listeners' benefit.

T-Bone: Please do because I've forgotten all five of them already.

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Gary Takacs: I'm doing this for Tarun's benefit because he forgot them already. But in all seriousness, I'll number them one through five in the order that you gave those, Tarun. Number one, you have to have a B+ or better team. A team that can actually communicate with patients. That can handle resistance and objections when the patients have those genuine questions.

Number two, you have to have great financial arrangements and great payment options so people can afford this. Number three, you have to have a mix of services that allow you to do some really cool things that we can do today in dentistry. Number four, you have to have some marketing acumen, both internal as well as external, as well as digital. I'm going to add the digital side to that to bring patients in.

T-Bone: Absolutely.

Gary Takacs: Number five, it would be wise for you to have some open time on your schedule so that you can add more treatment in some capacity is what I call that. I'm going to absolutely echo every one of those points. I'm going to amplify the fourth one, marketing, because I think that's the key.

If you want to reduce the insurance dependency in your practice, then you want to master marketing. Here's the reality, if a patient has MetLife insurance, the way they tend to find their provider is in the little booklet, the analog booklet that their employer gave them, or online. They go to the MetLife online resource to find a list of dentists.

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If a patient doesn't have insurance, then they tend to go to Google to find a provider. So mastering marketing is one of those things that's a very important element of reducing your insurance dependency because that's the way people will find you.

Furthermore, there are patients that participate with a plan, they're members of a plan, patients now, that will still go online to find their provider. But when they go online, they start to find their providers for reasons other than their online insurance. In other words, Tarun, they might be drawn to your practice because of your technology. They might be drawn because…

T-Bone: Or because I'm brown.

Gary Takacs: There we go.

Alan Mead: Perhaps.

Gary Takacs: In all seriousness.

T-Bone: Yeah, of course.

Gary Takacs: They look at your last name and identify with it. Or they may like same-day dentistry. Or they may like your location. It could be a variety of reasons. But there's a sixth that I'm going to add to that and this is something I want to take a minute and talk about a little bit.

That's that they've got to provide such compelling reasons for the patient to come to your practice for their care. In fact, I'm going to phrase it this way, such compelling reasons that the patient wouldn't want to go anywhere else. They have to be reasons that the patient

can touch and feel, not in the way that most dentists measure the experience in the practice.

Most dentists measure it through the clinical lens and the truth is most patients don't register their experience in the practice through the clinical lens. They measure it through the behavioral lens of how they're taken care of.

So one of the ways I start with an office when we start to reduce insurance dependency—and by the way, I don't think for a minute that our practice model is right for everyone by any way, shape, or form. But I do think everyone could benefit from this. Anyone listening to this could benefit. What if we just resigned from the two or three most caustic plans in your practice today? The two or three? The ones that have a much deeper discount than we've talked about today.

Alan, you asked me early on what kind of discount we were experiencing. You said is that around 20 percent. I said, well I'm going to push that a little higher. Our experience was between 25 and 30 percent. But there were plans that it was approaching 50 percent discount.

So if you're listening to this and you've got a couple of those, the plan would be to eliminate those. Then stay in network with the others. So let's use a more normal number of plans. Let's say there's ten plans that you're a participating provider of. I'm making up numbers here.

Let's say two of them are the ones that cause you to lay awake at night. Well let's figure out how to bail on those, keep the other eight as a practical sense of keeping your

associate busy, growing your practice, and ending up with a blended kind of practical approach.

What I always start with with clients when we work on that project is let's work on some things we can do customer service wise in the practice that will absolutely knock our patients' socks off. The wow customer service. So they simply don't want to go anywhere else. I believe if we start there, you'll have more success with your existing patients that are on the plans as well as attracting other people out of network because they want to come to you.

Any practice can do this if they'll make the commitment to that. Now if the doc and team don't have a perspective there, then that's a hard challenge. If dentistry is a commodity to them and customer service isn't part of the equation, then they're probably not the right practice to start to reduce insurance dependency.

T-Bone: Gary, what dentist ever says, "I provide crappy customer service?"

Alan Mead: That's a great point. I think everyone always believes that it is. You almost need the concrete example of what you're specifically talking about. But yeah, no dentist admits to that.

T-Bone: Or no dentist admits that they do bad dentistry.

Alan Mead: Exactly.

Gary Takacs: Right, same thing. Yet the bar is pretty darn low, guys, in healthcare. I mean, it can be as simple as recognizing the patient's name when they walk in. I mean the bar is so darn low in healthcare in terms of customer service.

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T-Bone: How about just not having cobwebs in your office?

Gary Takacs: There we go. Or I mean literally just looking at the list of amenities that you have in your practice. If your office is the only place in your town where they can read a 25 year-old *National Geographic*, that needs to change. I mean, you know? That just flat out needs to change.

So just look at it through the lens of what the patient experiences. I've walked into practices where our front desk, our administrative team member or team members don't even look up to glance a look above their computer monitor to greet. "Alan, it's good to see you. I'm glad you're here. Please have a seat. We'll be right with you." Don't get me started on this.

Alan Mead: Actually, if you need tips on some of these things and what you could do differently, just go to any physician's office and do the opposite of what they're doing and then you're in good shape is what I'm figuring.

T-Bone: Listen, on this note, I'm sorry I want to interrupt before I lose my thought because I lose it so easily. So we're talking about marketing. So again, I'm going to give you my argument why I'm hesitant to drop any—listen, financially I can afford to get rid of all my insurance companies, me personally. But I still don't want to do it.

So here's how I look at it, I look at marketing externally, and even internally, it's two things. One, marketing general dentistry, in other words, "Hey, we have a dental practice. Come see us for your family care."

Then I look at marketing as true niche services. See the way I've designed my practice is, and we've just started

marketing again externally. For the last four years, we didn't do any marketing. So now we're just beginning to market externally and I'm only marketing niche services. I look at insurance, again, as marketing my general practice. It will bring me enough patients to support my general practice and what I call pay my overhead, my fixed costs of practice.

I don't look at insurance as anything above gravy. I look at insurance as providing patients to do those procedures that create the gravy for me. So while I'm on those procedures, let me give you some examples. Gary, I think we talked about this on our podcast earlier this year, on your podcast.

I would ask practices, what ortho are you doing? What sleep apnea or sleep dentistry are you doing? What type of implants? How much implant work are you doing? Are you doing anything with sedation dentistry? Are you doing anything with medical billing? I don't understand our need, and I'm not talking about you, Gary. I'm just talking about our profession in general to focus so much on like insurance is our problem. When it's not insurance. We are our own problems because most of the practices can't even do these four things for god's sake.

Gary Takacs: You just provided a brilliant tip for our listeners in terms of how to think of your marketing and marketing segmentation. I completely agree with you that you don't need to be marketing fillings, root canals, single unit crowns. Let the insurance company market that for you because that's great. But instead, spend your marketing strategy and your marketing budget on marketing the more comprehensive elective type services that you do.

For us, it's about five things. For us, there's five. In no particular order it would be adult orthodontics, sedation dentistry, we do oral conscious sedation, so sedation dentistry. Dental implants, number three. Number four would be cosmetic dentistry. Number five would be complex restorative dentistry. So our marketing budget goes into promoting those five things.

Like you said, if you're a preferred provider, let insurance market you for toothache patients and for everyday regular dentistry, which by the way, there's nothing wrong with that dentistry. That dentistry is great. A toothache, it can be a great patient. They're here, they need something, and you can help them with it. There's nothing wrong with that. But spend your marketing budget around the elective things. It could also be sleep apnea. It could be treatment of TMD, TMJ. It could be a number of different things. But for us, it's those five things.

T-Bone: Again, I would say this. The insurance plans provided me a great fundamental foundation for me to expand my practice. I honestly could not imagine letting go of insurance in my practice. To me, the only reason to let go of insurance is fees because they do limit and control your fees to a certain degree. But that would be the only legitimate reason in my mind to get rid of insurance is the fees.

So let me say this, and I'll ask you this, whoever said that when we participate with PPOs that we have to only take the patient portion?

Gary Takacs: Well, there are some contractual, you have to look at the contacts, they do vary. But many times, you're

contractually obligated to their contracted fee schedule and only accepting the patient contracted copayment and in turn subjected to that write-off.

So for example, if you had a $1,000 UCR fee and your contracted fee was $800. Let's say it's a service that's covered at 50 percent, then insurance company pays $400, patient pay $400. You experience a $200 adjustment or write-off in the example that I provided. Does that make sense?

T-Bone: Yes, but what I'm saying is who has said, or is there a requirement—and I'm going to somewhere with this. I get that I have to take the $200 off. I'm happy to do that, okay?

Gary Takacs: Yeah.

T-Bone: For having zero cost of patient acquisition. Okay, so who says that I have to only take $400 from the patient? Why can't I take my full $800 and let the patient get repaid for the $400? The reason I say this and this goes into the patient payment plans that we've been doing in our office with great success.

One of the things that we're going to move towards in 2017 is I'm going to stop allowing only taking the patient portion at that point. I'm working towards putting all my patients on an in-office patient payment plan where they contract with me for the entire $800, using your example. When the $400 comes, we'll just reduce their payments by that $400. So that way, the patient is going ahead and making an agreement with me for all $800 rather than just the $400.

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Alan Mead: You don't have to monkey with what the insurance may or may not come through with.

T-Bone: That's correct. So to me, again, this goes to my thing. I try to be very practical about it. I look at it, why do I want to get rid of insurance? Like what are the evils of insurance? The evils are going to be fees and the irritation of dealing with them. In other words, the hoops that we have to jump through, correct?

Gary Takacs: Although I will say this, Tarun, the hoops today given electronic claims processing and EDI and digital process in terms of attachments to documentation, the hoops really are very solvable in terms of training a team to efficiently process insurance. Very, very solvable. If you're listening to this and that's not the case in your practice, go get some help. There's folks out there that can help you with that. Alan, would you agree?

Alan Mead: Definitely.

Gary Takacs: I mean there's folks that can—it's just a step-by-step bullet point process.

Alan Mead: There's a lot of front office training there. But Tarun, I want to go back to what you're talking about. So you are essentially going ahead and acting as if you're not going to get assignment of benefit from that person. I'm trying to figure out why you'd do that.

T-Bone: Listen, I'm not saying I've done this. I'm saying this is where we're working towards. So again, let me go back to what I think are the evils of insurance, the fees. When I say hoops, you're right, Gary, all that stuff makes it easier than it used to be.

Gary Takacs: Than it used to be, yeah.

T-Bone: To me the hoops are, “Well we estimated that 60 percent and it really turned out to 50 percent.” Now I've got to go do statements and crap to get my 10 percent from my patients.

Gary Takacs: Yeah.

Alan Mead: Yes.

T-Bone: That’s what I mean by hoops. Or, this, “Well, the missing tooth clause that we forgot or they forgot.” Or this waiting period where they forgot or we forgot. Now I've got to go after my patient and worry about this and that and blah, blah, blah. To me, those are the evils of insurance.

Alan Mead: The other thing that comes along with that is an angry patient. They're angry at you even though it wasn’t you that caused the issue. Exactly, I’m with you on that for sure.

T-Bone: Let me finish my thought, if you don’t mind. So if I said to you, Alan, for example, “I will get rid of the hoops and all that nonsense if you give your patients a discount. If you accept the PPO fee.” Would you be more apt to stay in network with insurance companies? Or maybe add more insurances to your practice?

Alan Mead: Potentially, yeah.

T-Bone: Okay, so then why don’t we just do that? Why don’t we just get rid of the hoops? Why don’t we move towards becoming a fee-for-service PPO practice? By that I mean, I will give my patients a discount. Just to use the easy

examples, the easy math, a $1,000 crown, my contract rate is $800.

So Mrs. Jones is going to pay me $800. I'm not saying, "Mrs. Jones, don't even pay me all of it up front. Sign my financial agreement for $800. Let's do my down payment. Let's do my three-month monthly payments. When your insurance sends me the check for that $400, I'll credit it automatically to your account and now you'll just have to pay me less the rest of those months."

Gary Takacs: So in terms of listening to this, it's very patient friendly. It eliminates some unknown. I'll give you a real practical example. Alan, this could happen every day in your practice in Michigan. Let's say you have a patient that is a construction worker. It's a root canal. It's in-network.

It looks like everything is really straightforward so your team goes ahead and estimates the patient copayment, collects that copayment at or before time of service. You think everything is copacetic. Your team now files an insurance claim and you discover that unbeknownst to you at the time, the patient was ineligible because they didn't work enough hours last month because of the weather conditions. Right?

Alan Mead: Yeah.

Gary Takacs: That's the type of hoops that you're talking about, correct, Tarun? Something like that just as an example?

T-Bone: Yeah, the hassles of insurance.

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Gary Takacs: Right, and your team was innocent when they said, “You know, Gary, your copayment on this is going to be $200. I can take care of that.”

T-Bone: And we used all the words, “This is only an estimate. You’re responsible.” All the nonsense that we’re all taught to do that we do. But then we still feel bad and three quarters of the time, we just write that crap off.

Alan Mead: That’s so true.

Gary Takacs: Well when you contact the patient at this point, the patient has a legitimate right to be upset because they thought that they weren’t going to have an obligation and they say, “Well I wish I would have known that at the time.”

T-Bone: Yes, “I wouldn’t have done this work. My tooth didn’t hurt before I started.”

Gary Takacs: So I love your solution. Absolutely love it. I really do believe that that represents a way forward. It’s kind of like you said, a blended PPO, fee-for-service plan. The only thing I’m going to challenge you on is, what if we could get the whole $1000 instead of the $800?

T-Bone: Okay, you know me, yeah, absolutely. Absolutely, Gary. But what I’m saying is to me everything is a stair step. If I can get my practice to that point and maintain my patients, I can promise you I can just drop the insurance.

Gary Takacs: Yeah.

T-Bone: To me, what I wrote down was is why do we make this so hard on ourselves? In other words, which is easier, to maintain insurance and get rid of some of the hassles of

insurance or updating my facility, updating my team, and all these other things that it truly takes to be good at being fee-for-service in a competitive market. Now if you're in a small town where there's two dentists and there's 10,000 people, it's a different story. But that doesn't represent 90 percent of the dental population.

Gary Takacs: No.

T-Bone: Most practices are generally speaking what I call a semi-saturated area with one dentist for anywhere from, in my area, its 975 people up to 2,000, 3,000 people.

Gary Takacs: Yeah, our is hyper-competitive here in Phoenix, as you know. I know you spend a lot of time out here, Tarun, but it's hyper-competitive. The interesting thing about that. So look at the competition from a macro perspective for just a minute. We're a two-doctor practice. We have twelve days of hygiene. We have three hygienists that each work four days a week. We're a five-day a week practice.

A very productive practice and hyper-competitive. Now I want to make a statement that I'll have disclaim very quickly. You could literally swing a cat, now what I want to say is just for the cat lovers in the listening audience, I would not swing a cat. Alan, did you hear me say that?

Alan Mead: I heard it.

Gary Takacs: I would not actually swing a cat, that was a figure of speech. But you could swing a cat and hit ten offices around my office. It's that competitive. Yet, how many patients do we need? We have about 3,500 active patients. So in our community, we've been able to attract 3,500 patients. That's a large patient base. We've been

able to attract about 3,500 patients that want to keep coming to us regardless of how we handle their insurance. Although I will say that we're very friendly with it and we're very helpful with them.

That's the only difference that I want to make is coming back to our example that we've used throughout this discussion, that $1,000 example. I just want to get a $1,000 if we can instead of the $800. But the path of least resistance is to get the $800 and not have all the fiddle farting around.

Alan Mead: Interesting. I guess the one thing, I want to ask, T-Bone, tell me just for the listeners who are listening and they wanted to get, tell us more about what would a fee-for-service PPO office in the T-Bone model look like?

T-Bone: Let me back up, because I know when I listen to podcasts I hear an idea and then I can't rewind back.

Alan Mead: You miss it, yeah, exactly.

T-Bone: I think we should review this. I apologize if we go long or this is a long episode. I think it's an important episode.

Alan Mead: Remember, the three of us own our shows, so we can do whatever we want.

Gary Takacs: That's right. I mean, I'll talk to the boss, but yeah.

T-Bone: So let's backup here. Again, this is all about practicality to me. I want us to ask the question, or the listener, why do you not want to take insurance? If you believe that they're discounting the fees is what's holding you back, I will tell you that 90 percent of you are wrong, 10 percent of you

are right. For example, Gary, he's right. His practice, he's right. My practice, honestly, I'm probably right. But what I'm telling you is 90 percent of you are wrong in that your insurance fees is what is holding you back.

What's holding you back is yourself. So before you can get to a point where you can truly drop the fee restrictions of insurance, let's go to the step of dropping the hassle part of insurance. Now let's go back, what are the negatives, the patient negatives, of going to a fee-for-service model? Now your patients have to pay all up front, correct? Would you say that's the number one negative?

Gary Takacs: Yeah, that's a strong negative that people don't like that. That's a strong…

T-Bone: The dentist doesn't like it. The team members don't like it. The patients don't like it. Nobody likes it. Right?

Gary Takacs: Correct.

Alan Mead: I mean, I like it when they do it but besides that, yeah.

T-Bone: You know what's sad? I don't even like it when they do it. I believe in a cash flow model.

Alan Mead: Yeah, you'd actually rather have the regular monthly payments, I get it.

T-Bone: Absolutely, no question.

Alan Mead: Just teasing.

T-Bone: I'd rather have the monthly income. So to me, remember Gary listed six things that you have to have in place before you can consider doing that. One of those is firm

financial arrangements. To me, one of the most firm financial arrangement options that practices should have and practices should consider, let me not say have, they should consider. Is having an in-office payment plan that's automated with a credit card on file. So when you give patients the choice of making payments over a short period of time, not months and months, but I'm talking about three to six months, they'll do more dentistry.

Now what I can do is I can present to my patient, Mrs. Jones, "We take your insurance, no problem. We're going to do a financial arrangement for all $800." Let's say it's 25 percent down. So now you're going to give me $200 down. I'm going to finance out the $600 for the crown. Let's call it six months, so that's $100 a month.

"I'll file your insurance. I'm in-network, they're going to send me the money. When I get your $400 that I expect from your insurance company, it will go directly to your account and your monthly bill will go down by $400 right away. So now I've financed you $600, your insurance paid $400 of it right away. So now I'm just financing out the $200 for you." Your patient never sees paying that money out of pocket to them.

Gary Takacs: Very, very patient friendly. I can't imagine a patient on the planet not smiling saying, "thank you, doctor."

T-Bone: I never have to go after a patient for missing tooth clause or not qualifying for benefits, none of that stuff. Getting money from patients after the fact is terribly hard. It's hard actually physically to get the money and it's actually customer service wise, PR-wise, it's hard on your practice and your team members.

Ep #6: Dental Insurance – Should You Take It or Not?

Gary Takacs: Little sidebar for just a minute, if you look at negative reviews online besides simply the spurious haters that are out there writing negative reviews on dental offices, they tend to fall into two categories. The one biggest category is some confusion over the payment expectations. That's the number one category for negative reviews.

The second one is a little different category, it's a feeling of indifference by the provider. So the patient felt like there was indifference, they didn't care about them. So either the dentist or the hygienist or the team member treated them with a level of indifference. But that's the second category. The number one category is some financial confusion.

T-Bone: Of course. Let's focus on, again, 10 percent of you don't have this issue. You're ready to go fee-for-service but 90 percent of us are not. I would tell you while I believe I am ready to go fee-for-service, I don't want to. I want to create a business. Because that business allows me to create residual income for my lifelong revenue stream and it allows me to create a lifestyle that's going to give me more time off because my practice is going to stay open and I'm going to allow my associate partner to see those patients.

When I say "those patients" it's not like he's doing bad dentistry. He gets to do fillings and crowns and root canals and not just large fillings. He gets to do ideal insurance-based dentistry. Again, that's why I say I don't see why we have this rush to drop insurance. I think there are ways around it.

Ep #6: Dental Insurance – Should You Take It or Not?

Gary Takacs: Tarun and Alan, may I throw a curve in this discussion based on our experience?

T-Bone: Yeah, I would love that.

Gary Takacs: This comes from a case study recently about a year ago. I have the reflection of time on this particular practice. This was a practice that went out of network with 20 plans. They literally made the transition to a fee-for-service practice. They had 20 plans in place.

In this particular practice, this is an actual case study, completely unbeknownst to me and not expected on my side nor expected on the doctor side, this doctor discovered that when he went out of network, 15 of the 20 plans paid him more from the insurance company when he went out of network. 15 of the 20 paid more.

Let me give you an example, so come back to our $1,000 crown in the example we've been using. $800 contracted fee. Insurance company pays $400. Patient pays $400. We have an insurance adjustment of $200. This practice discovered that when they went out of network, and I believe this only works if your fees are within the bounds of reasonable as defined by the insurance company.

So when he submitted his $1,000 fees, now out of network, the computer recognized 50 percent because it was a crown and cut a check to the patient for $500 instead of $400. How does that affect your thinking on this or does it impact the way you might think about this? Assume that the case study that we found was actually widespread and that was common all over the country.

Ep #6: Dental Insurance – Should You Take It or Not?

T-Bone: To me, what I would say is, I still don't want to drop insurance.

Alan Mead: What's interesting about that, I guess I'm not 100 percent sure, why was it? Why do you think it was?

Gary Takacs: I think it's run by a computer model inside the adjudication process of the insurance company. As long as your fees fit within the boundaries, I don't believe this would work if you had a $1,500 crown. I don't think the checks going to spit out a $750 check for that.

T-Bone: So what the insurance company considers UCR and what they consider a contracted rate are not the same.

Alan Mead: I get it.

T-Bone: The insurance UCR is much higher than the contracted rate.

Gary Takacs: Right, so think about this for just a minute. What if we created an out of network policy for our existing patients that have that policy? So Alan, can I roleplay with you for just a minute? Can you be the patient for my example?

Alan Mead: I'll try.

Gary Takacs: Let's say, Alan, you have a large family and every nickel counts. You'd love to stay in the practice but it's going to cost you more now and you're saying, "Gosh, I guess I'm going to have to change dentists because the family budget is just kind of tight." So what if I just said, "Hey Alan, what if we could set it up so that you wouldn't have to pay any more than with us being out of network than

when we were in network. It would be the same to you. Would you continue to come to us?"

Alan Mead: Of course.

Gary Takacs: Right, in that case, go back to my model. $1,000 crown, $500 gets reimbursed by the insurance company, collect $400 for the patient. I love the way you would do this, Tarun, in a prearranged setup. Then we got $900 instead of $800. That's not the $1000 that I want if I was pure but I think we'd all agree the $900 is better than the $800, right?

T-Bone: Yeah, of course.

Gary Takacs: I guess what I'm saying is we could maybe add that curve or that wrinkle into it.

T-Bone: Yeah, but those patients are going to get a letter from the insurance company telling them to go somewhere else.

Gary Takacs: Good point. No, that's true. That's not a trifle point. We should talk about that because in fact, the only negative to that approach is third party pressure saying, "You ought to go somewhere else because this is costing you more."

Then also, having to either collect in advance like we have or having to subscribe to some kind of financial policy like you would do instead. But I simply throw that in as a wrinkle because I have to tell you, I did not expect to see that in the practice. This is an office, let me really dive into the metrics and the numbers, I was blown away to see that 15 of the 20 plans actually paid more when we

went out of network. The other five paid the same. In no case was it reduced when we went out of network.

Alan Mead: Interesting.

Gary Takacs: So I simply throw that in there as a wrinkle but I think you're on to a much more practical approach, Tarun, for most of our listeners and for most of the dentists out there. I completely concur with the fact when you said that if doctors if you think the issue is the difference in the fee schedule, it's not really that.

It has more to do with your diagnostic ability, your communicative abilities, your ability to present comprehensive care in a way that has the patient desiring that. Those are the things you should be solving before we get into too deep with trying to solve the insurance macro challenge in your practice.

T-Bone: Those deficiencies become amplified in a fee-for-service model.

Alan Mead: Oh, yeah, definitely.

T-Bone: Okay, so I know we're getting towards our time, whatever we're allotting or not allotting, I'll go forever. It doesn't matter to me. So again, I'm going to give you my big problem that we have with our whole conversation is we're arguing about pennies essentially.

So we're taking a $700,000 practice and we're saying that you could be an $880,000 practice if you went fee-for-service. To me, that's not the point. To me the point is we're fighting for $200 on 20 crowns a month. We're fighting for $4,000 or $6,000, $8,000, $10,000 a month.

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To me, the real insurance independence, if that's what we're after is not in fillings and crowns. It's in everything beyond fillings and crowns. I think that is my big problem in dentistry right now. That's my big message right now. I had the podcast with you guys, Alan, that you've got to stop doing fillings and crowns. Obviously that's an exaggeration to a certain degree but you've got to stop doing fillings and crowns. Fighting for fillings and crowns I am telling you is a losing battle long term. It may work short term. This insurance thing may work short term.

For those of us that are 60, I'm not 60, but those of us that 60 or 50 or whatever it is and we can just look for the next ten years, maybe can be insurance free for ten years. But for those of you that are 25 to 30, 35, or my age, 40, and you got another 15 to 20 years, there's not 15 to 20 years that a good percentage, not even majority, a good percentage of us can be insurance free. I just firmly believe that.

Call me doomsday, call me whatever you want to call me, but I firmly believe that. This arguing over a few dollars on fillings and a few hundred dollars on crowns is not the point. Let's talk about raising the ceiling of our fees. It's not our fees that we get allowed, it's by the procedures that we can do.

Why are we not taking out wisdom teeth? Why are we not doing implants? Why are we not doing sleep appliances? Why are we not doing adult orthodontics? Why are we not looking to medical insurance that reimburses way better than dental insurance? And allowing us to keep our dental benefits toward dental procedures?

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Why are we not spending more time in dentistry focused on those things that will take a $700,000 practice and take it to $1,000,000 in a sustainable way and not just trying to go from $700,000 to $870,000. To me that's my problem with this whole argument is I don't want to mess with going insurance free. I want to mess with getting beyond the $1,000 procedures.

Gary Takacs: Tarun, thank you. It's one of the reasons I love you like a brother, man. You're like my brown brother, is that okay?

T-Bone: Yeah, man. I'm definitely brown.

Gary Takacs: After recording this, I'm going to go outside and get a tan so your family might accept me more as your brown brother.

T-Bone: Stay light. Indians like light people.

Gary Takacs: Okay. But in all seriousness, it's one of the reasons why I love you like a brother because you really just distilled the discussion into the meaningful takeaways for our listeners. Yeah, this is a fun little side discussion about insurance independence, non-independence, being friendly. So it's a fun side discussion.

But really the bigger discussion is get more productive, man. Be more thorough in your diagnosis. Be able to offer more services. Man, if there's something you love doing in your practice, for us, it's those five things. It's adult ortho, it's dental implants, it's sedation, it's cosmetic, it's full mouth rehab. Man, do those things because first of all it's going to really enhance your bottom line.

Ep #6: Dental Insurance – Should You Take It or Not?

By the way, we just radically leap frogged past that goal of going from $700,000 to $880,000. Went way past that and solved the profitability for you in one fell swoop. Alan, could we finish the discussion with a very practical tip for any of our listeners that if you chose to go outside of network with two or three of your plans, just hypothetically, how do you answer the call when the patient says, “Do you take my insurance?”

Alan Mead: Yeah, let’s finish with that because that’s kind of the big deal. I think a lot of offices have that concern. What are some of the verbal skills you use there?

Gary Takacs: So the question is, “Do you take my insurance?” Can I start by showing you what not to do?

Alan Mead: Yeah, please.

Gary Takacs: Would that be okay?

Alan Mead: Yeah.

Gary Takacs: So Alan go ahead and ask me that question as a patient would on the phone.

T-Bone: Ring, ring.

Alan Mead: So, doc, do you take my insurance?

Gary Takacs: No.

Alan Mead: Okay, thanks for letting me know, bye-bye now.

Gary Takacs: You think I’m kidding. I’ve heard that too many—I used to have hair. Alan might remember back when when you picked me up at the airport 25 years ago in Michigan, I’m

not even sure I had it then. In any case, that's the wrong way to answer that question. May I go ahead and actually roleplay as I'd like to?

Alan Mead: Yeah, give it to me.

Gary Takacs: By the way, my name is Carly, who am I speaking with?

Alan Mead: This is George.

Gary Takacs: George, thank you so much for the call. We love seeing new patients. I look forward to meeting you face to face. Let me answer your question. Although we are not a contracted provider with MetLife, you can absolutely use your insurance benefits in our practice.

Not only can you use them, but you're going to meet Lori when you come in. Lori is our insurance coordinator. Lori is going to work her tail off to help you maximize your benefits. In fact, George, we have many patients that have your very same insurance, your MetLife insurance. We're happy to help them with those benefits. Do you like mornings or afternoons?

Alan Mead: I like mornings. I'm a morning person.

Gary Takacs: Great, I've got an 8:00 or 10:00 on Thursday, which would you prefer?

Alan Mead: Let's take 8:00.

Gary Takacs: There we go.

Alan Mead: That's pretty good because I've heard a lot of people that—they're not as direct as that.

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Gary Takacs: They want to tap dance.

Alan Mead: Yeah, exactly. The tap dance is an ethical problem I think but that was not a tap dance, I didn't think.

T-Bone: They want to scold the patient, "Did you know your insurance only pays $1500?" It's like I don't give a [beep] quite honestly.

Alan Mead: That's going to go over really well. "You're dumb for having this insurance."

Gary Takacs: Thank you, Tarun. In all seriousness, my grandmother taught me if someone asks you a question, answer it darn it. You asked a question, "Do you take my insurance?"

Alan Mead: Yeah, but yours wasn't the tap dance. I've heard lots of people, I've gone to the mat on this question with a few people because of that. But yours is pretty good because you are answering directly. You're not jerking them around.

T-Bone: I like my answer better.

Gary Takacs: Tarun, there's always room for "you bet ya."

T-Bone: If Alan called me, it would be like, "Do you take my insurance?"

"Yes, unless you have Medicaid or an HMO we take your insurance, we'd love to see you."

Gary Takacs: May I simply say that I believe Tarun's answer is better.

[Laughter]

I mean, truly, I believe that answer is, you'll get 100 percent. You'll get anyone that doesn't have the state insurance.

T-Bone: To me here's the challenge, how many of us can get a team member that can actually sound like Gary on the phone?

Alan Mead: That's a good—actually, you've got to hire Gary.

T-Bone: I can barely get somebody that doesn't smack their gum out there.

Alan Mead: Oh my gosh.

Gary Takacs: This is another podcast episode for another time. Can we do that one?

Alan Mead: Yeah, we definitely should.

Gary Takacs: Can the three of us do that one?

Alan Mead: Wow, you guys, we killed this. This was really good. Who would have thought that in almost an hour and a half of insurance talk would be this entertaining but I actually really enjoyed it.

Gary Takacs: You know, it's kind of interesting, sometimes businesses are not in the business you think they're in. For example, when you rent a car, you think that the rental car company is in the business of renting you a car. They're not in the business of renting you a car. They're in the business of selling cars.

They actually make more money selling cars when they're done with having them in the rental fleet than they make

actually renting the car. I always say that as an analogy because here we were talking about the discussion about insurance and we had some deep, wonderful discussion and debate about that. But the real topic was about Tarun really nailing it.

Alan Mead: Productivity.

Gary Takacs: About productivity and…

Alan Mead: Adding new procedures, the whole…

Gary Takacs: And becoming more accomplished. Becoming more competent and rounding out your suite of services. That's really the broader discussion here. You know, one of the things I love about educators and, Tarun, I think of you as a master educator, is you're able to take a very complex topic and distill down to something that's actually very simple. I think nailed it.

Alan Mead: Really good you guys.

T-Bone: Thank you. My last statement is this: stop listening to the idiots down the street from you because they're doing things the way the 1960s people taught them how to do it and from the 1980s people. So I live my practice this way, if somebody else is not doing it, it's probably a damn good idea to do it that way, okay?

Gary Takacs: Contrarian.

T-Bone: So just think about any time you have a problem, I want you to write down what your problem with it is and figure out how could you make it not a problem for you. That's really the answer. Then, listen, my goal for everybody is I

want you to get insurance independent. To me insurance independent doesn't mean insurance free. Gary would probably tell you that it's not insurance free in his practice either, just less insurance dependent.

Insurance is an important part of working with your patients and making it convenient for your patients. I just think this whole argument over a couple hundred bucks and $10 on prophies is the stupidest argument I've ever seen when there is such bigger fish out there. There are whales that we need to be catching and we're trying to catch minnows. It's just driving me crazy.

Alan Mead: Very good you guys.

Gary Takacs: Well said. Hey, this has been fun.

Alan Mead: Thanks a lot you guys for including me. Let's do it again real soon.

Thanks so much for listening to *T-Bone Speaks* with Dr. Tarun Agarwal. Remember to keep striving for excellence and we'll catch you on the next episode.