HPI Health Policy Institute

ADA American Dental Association®

Research Brief

Considering Large Group Practices as a Vehicle for Consolidation in Dentistry

Authors: Albert Guay, D.M.D.; Thomas Wall, M.A., M.B.A.

Key Messages

- *Large group dental practices, measured in terms of employee size, grew from 1992 to 2012. In 2012, large group dental practices accounted for 3.9 percent of dental practice employees, while very small dental practices accounted for 80.7 percent of dental practice employees.*
- *Large group medical practices, measured in terms of employee size, also grew from 1992 to 2012. In 2012, large group medical practices accounted for 29.6 percent of medical practice employees, while very small medical practices accounted for 33.6 percent of medical practice employees.*
- *The drivers of consolidation of dental and medical practices are very different; medical practice is not a good model for dental practice.*

Introduction

Open competition in relatively free markets has been the basic philosophy behind the organization of the United States economy; in fact, one of the prime responsibilities of the Antitrust Division of the Justice Department and the Federal Trade Commission is to assure that such a condition is maintained in American markets.[1] That market environment provides consumers products and services of the greatest value and fosters incentives for innovation and adequate and efficient production while minimizing prices.

Generally, businesses attempt to increase profits and/or stay in business by various means. Consolidation, through acquisitions and mergers, is one of the means utilized throughout the economy. The growing enterprise in consolidations aims to increase the market power of businesses by absorbing competitors and increasing the potential for future profits through enhanced internal efficiencies. Economies of scale may enable more efficient production, marketing, financial operations, and overall management.[1]

The Health Policy Institute (HPI) is a thought leader and trusted source for policy knowledge on critical issues affecting the U.S. dental care system. HPI strives to generate, synthesize, and disseminate innovative research for policy makers, oral health advocates, and dental care providers.

Who We Are

HPI's interdisciplinary team of health economists, statisticians, and analysts has extensive expertise in health systems policy research. HPI staff routinely collaborates with researchers in academia and policy think tanks.

Contact Us

Contact the Health Policy Institute for more information on products and services at **hpi@ada.org** or call 312.440.2928.

The *laissez-faire* regulatory business environment of the early 20th century allowed for unfettered consolidations within the general business world to the point where actual monopolies were constructed that harmed the public, most famously by the so-called "robber barons." As a result of these excesses, a series of antitrust regulations were enacted to prohibit economically damaging monopolies. However, consolidations that do not harm the competitiveness of markets are allowed.[1]

The practice of dentistry has most commonly been referred to as a "cottage industry," a term originally used to describe pre-Industrial Revolution craft-like manufacturing done in workers' homes (cottages).[2] Today, this term refers to any small-scale, loosely organized industry with relatively few employees and/or a limited customer base operating in comparatively small work sites using highly skilled labor.[3] Some use this term in a derogatory manner, implying that the cottage industry has not developed to the level of most other industries, which have evolved from the cottage model to the factory model of production.[2] However, several studies have documented increasing practice size and consolidation within the dental sector.[4,5]

This study compares recent consolidation within the dental profession to that experienced within the general economy and within medicine. This analysis also considers the likelihood of further consolidation in the dental sector of the economy.

Results

In 2012, large business enterprises (all sectors) employed 51.6 percent of all business employees, large physician offices employed 29.6 percent of all physician office employees, and large dental offices employed 3.9 percent of all dental office employees. Very small business enterprises (all sectors) employed 17.6 percent of all business employees, very small physician offices employed 33.7 percent of all physician office employees, and very small dental enterprises employed 80.7 percent of all dental office employees (Figure 1).

Figure 2 shows that the percentage of all physician office employees employed by large physician offices increased from 15.7 percent in 1992 to 29.6 percent in 2012, while the percentage employed by very small physician offices fell from 52.0 percent in 1992 to 33.6 percent in 2012.

Figure 3 shows that the percentage of all dental office employees employed by large dental offices increased from 0.5 percent in 1992 to 3.9 percent in 2012, while the percentage employed by very small dental offices decreased from 89.3 percent in 1992 to 80.7 percent in 2012.

Discussion

Consolidation in the general economy is occurring more often. Increased competition, especially in the wake of economic globalization, has spurred on consolidations to ensure profitability and, in many cases, the survival of businesses. Lately, the economy has experienced a wave of consolidations in the banking industry, in retail sales organizations, and in the automobile manufacturing and airlines industries. Approximately 50 percent of all workers in the U.S. are employed in companies with 500 or more employees.[6]

Recently, the health care industry has undergone a series of consolidations, both horizontally (i.e., within a sector such as health plans combining with other health plans) and vertically (i.e., across related sectors such as hospitals combining with various providers of care). The basic motivation for these consolidations is to respond to public demands for increased value for health care expenditures, which entails improvement in

the quality of care delivered and the outcomes of that care. Fostering integration and control of the entire continuum of care is the strategy for achieving that goal. Recent consolidations have resulted in increased market power in dealing with the other sectors of the system with which each must do business.[7] Consolidations have also attempted to generate or maintain a sufficient customer base to ensure survival as health care rapidly changes.

There have been two phases of attempts at physician consolidation. The first phase began in the 1990s and was characterized by the development of management service organizations (MSOs). MSOs were a response to an increased emphasis on the integration of treatment, increased cooperation among physicians, the consolidation of providers, and the stated aim of payers to shift reimbursement from the traditional fee-for-service basis to capitation.[8] MSOs contracted with physicians – solo practitioners and/or groups – to provide "facilities, equipment, staffing, contract negotiations, administration and marketing,"[9] freeing up physicians to provide care exclusively.

Physicians believed that contracting with an MSO provided increased security that allowed them to retain professional autonomy[9] since the physicians still "owned" their practice (patients) and MSOs were prohibited from interfering with professional judgment. Employed physicians had experienced a loss of control over their professional lives, however, as a tradeoff for the increased security they gained through employment. It should be noted that today, dental support organizations (DSOs) in dentistry are very similar in structure and function to the MSOs developed in medicine in the 1990s.

Many MSOs disappeared in the early 2000s, citing the following reasons for failure: paying physicians too much for their practices, inability to achieve economies of scale in operations, inability to coordinate care for the chronically ill, and inadequate information systems to manage risk-bearing contracts. MSOs essentially failed to live up to the expectations of physicians.[10]

Following the failure of the MSOs, a second phase of physician consolidation began and continues today. This phase is characterized by the large-scale direct employment of physicians by hospitals and other institutions – a strategy which had been tried previously and was abandoned, resulting in physician consolidation through vertical integration within hospitals. This second phase of consolidation has been spurred on by the current unsettled health care marketplace and particularly by some of the provisions of the Affordable Care Act (ACA). For example, with the introduction of accountable care organizations (ACOs), hospitals are seeking ways to ensure their survival. According to this model, hospital employment of physicians will encourage primary care physicians to admit patients to that hospital and/or refer patients to specialists that use that hospital, remove employed physicians as potential competitors in other systems, and increase the hospital's market power and ability to adjust to market changes, including entering into risk-bearing contracts.[11]

Employment, as opposed to practice ownership, is an attractive alternative for an increasing number of physicians. Some of the reasons cited for this growing popularity are income security in light of decreasing reimbursements and increased practice operational costs; potential for a less stressful work environment (81 percent of physicians who owned their own practices reported that they were "over extended" or working at "full capacity"[12]); better "work-life balance"; less administrative responsibilities; ability to overcome erosion of their referral stream occurring in private practice; and the need to belong to an organization with increased market power that enjoys significant economies of scale.[13,14] These advantages outweigh

the reduction in autonomy experienced with employment for some practitioners.

Though it is also increasing, the movement toward consolidation in dental practice compared to medical practice has been much less intense. For one thing, the increased concentration in medicine has been hospital-driven while dental care is not centered on hospitals as is medicine.[15] Also, because of the relatively small proportion of money that dentistry commands within health care – about 3.8 percent in 2013[16] – its impact on the overall system is not threatening, though it is of vital concern to those establishments within the dental care system itself. The ACA pays relatively little attention to dentistry.

The results presented above show modest growth in the size of dental practices during the past 20 years and that the dental sector continues to be dominated by very small business enterprises. The dispersal of dental facilities and the lack of concentration in dentistry may be partly attributable to the fact that the location of small dental offices coincide with where dental patients are located. The dispersal actually enables dentists to establish and maintain strong personal relationships with long-standing patients.

Consolidation is predicted to continue in health care.[17,18] Because of the differences in the factors driving dentistry towards consolidation compared to those driving medicine (i.e., a low level of vertical integration of dentistry within large health care institutions, significant unused dental system capacity,[17] and a reduction in the prevalence of dental disease), in our view, dental care will most likely not follow the same pattern or extent of consolidation as medical care has.

Despite the fact that the survival of hospital-like institutions does not depend on alliances with dentists and dentists are not overworked (between 1/3 and 1/2 of surveyed dentists are not fully busy),[19] some level of consolidation will continue in dentistry. For decades, new dentists entered the profession as employees of large group practices, particularly governmental agencies, for the same reasons that new dentists do today: to gain clinical experience and immediate earnings, to repay educational debts, and to overcome lack of resources to establish a private practice. That will continue.

Increase in the size of the dental market will also occur, primarily through the inclusion of children's dental benefits in basic care defined in the ACA, the expansion of Medicaid in some states to include poor adults, and the increased utilization of dental care by seniors.[20] That expansion will mostly occur among the lower socio-economic populations eligible for government assistance where reimbursement has historically been well below market levels and dentist participation has been low. Most likely, downward pressure on reimbursement levels will continue. However, the dental market is shrinking for working-age patients who pay privately for dental care.

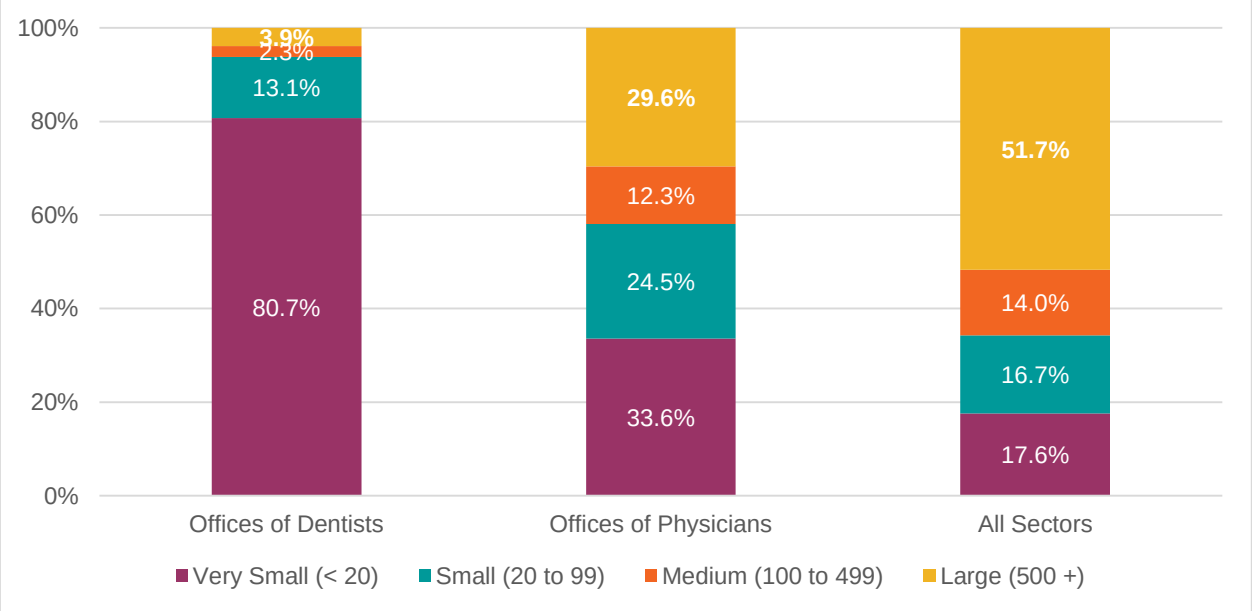
The regulatory environment is not favorable to the increased involvement of non-dentists in the ownership and/or operation of dental practices. Efforts are underway to make the legal and regulatory environment for non-dentist involvement more hospitable. Antitrust concerns have arisen in the medical care world because of consolidations in hospitals and health insurance organizations. That is not currently the case in dental care.

Large group practices offer advantages that are appealing to some practitioners, especially new and young dentists. Such an appeal is likely to continue. We believe that the most critical factors that will determine the degree of dental market penetration will be the ability of large groups to significantly improve the efficiency of dental practice beyond that which can

be employed by small practices. In addition, the formation of networks of dentists that can be leased to dental benefits organizations or local group dental benefits purchasers may also increase market penetration if employed.

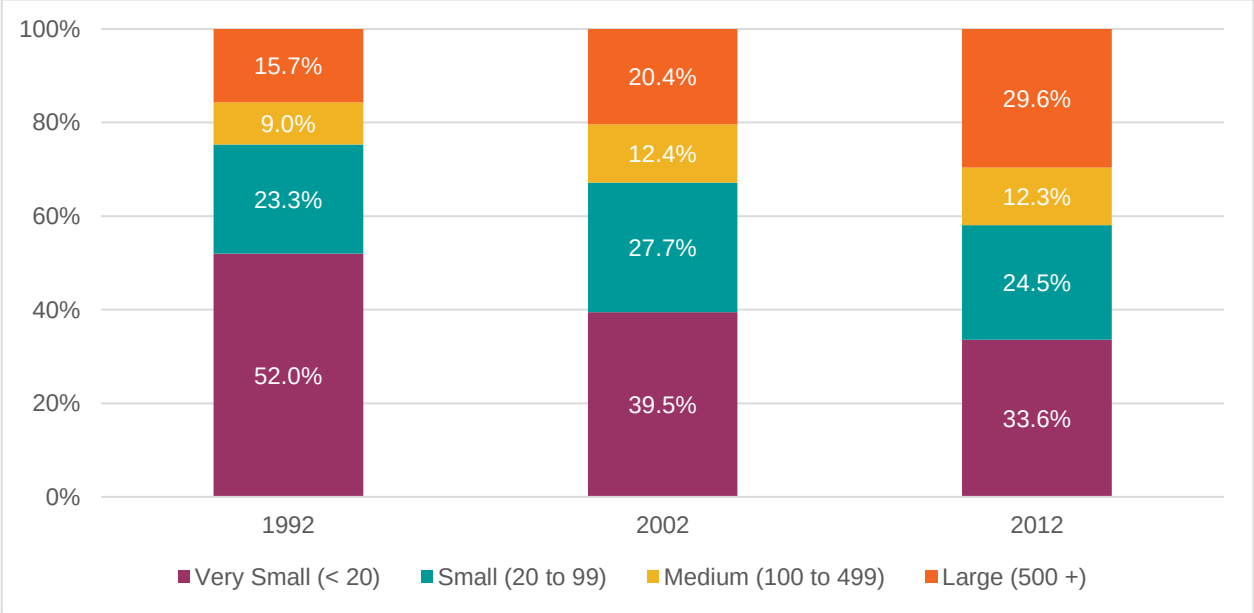
Even with the strong motivations for consolidation within the medical-hospital community, Deloitte predicts[17] that, after all is said and done, about one half of the practice structure will remain relatively unchanged. Although consolidation will continue in dentistry, because of the lack of a powerful organizational incentives like that in medicine, it is unlikely that large group practices or private networks of dental practices will dominate the entire dental care delivery system to the degree seen in medicine. However, a greater extent of consolidations will be seen in some segments of the system more than in others.

Figure 1: Percentage of Total Employment by Enterprise Employment Size --Dental, Medicine & All Sectors, 2012



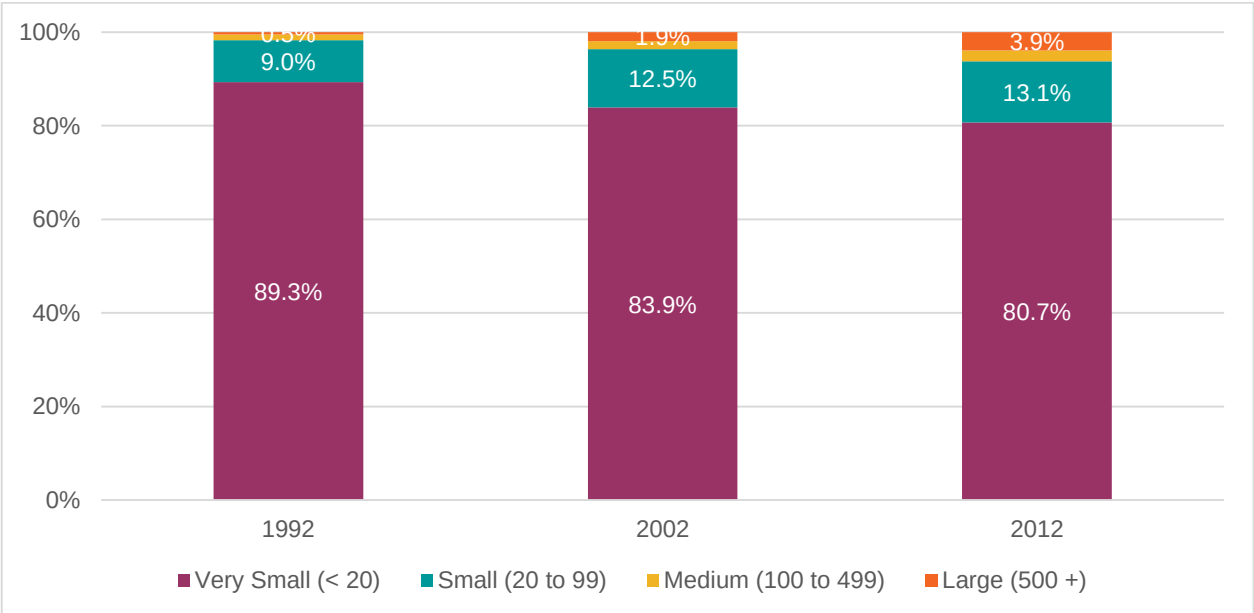
Source: 2012 Statistics of U.S. Businesses.

Figure 2: Percentage of Total Employment by Enterprise Employment Size – Offices of Physicians



Source: 1992, 2002 & 2012 Statistics of U.S. Businesses.

Figure 3: Percentage of Total Employment by Enterprise Employment Size – Offices of Dentists



Source: 1992, 2002 & 2012 Statistics of U.S. Businesses.

Data & Methods

In this study, we used data from the Statistics of U.S. Businesses (SUSB).[21] The SUSB provides annual data on the number of firms, the number of establishments, employment and annual payroll for most U.S. business establishments. The SUSB consists of a compilation of data extracted from the Business Register (BR), which contains the U.S. Census Bureau's most complete, current and consistent data for U.S. business establishments. The BR is updated continuously and incorporates data from the U.S. Census Bureau's economic censuses and current business surveys, quarterly and annual federal tax records, and other departmental and federal statistics.

The SUSB includes business establishments with paid employees.[22] Employment consists of full and part-time employees, including salaried officers and executives of corporations. A business establishment is defined as a single physical location where business is conducted. An enterprise is a business organization consisting of one or more domestic establishments under common ownership or control. Enterprise size in the SUSB is determined by summed employment of all associated establishments. In this report, we use the following employment size categories: very small (less than 20 employees), small (20 to 99 employees), medium (100 to 499 employees), and large (500 employees or more).

Business establishments in the Economic Census are grouped and identified with codes based on the North American Industry Classification System (NAICS).[23] In the SUSB, offices of dentists are identified as NAICS code 621210. According to NAICS, “This industry comprises establishments of health practitioners having the degree of D.M.D. (Doctor of Dental Medicine), D.D.S. (Doctor of Dental Surgery), or D.D.Sc. (Doctor of Dental Science) primarily engaged in the independent practice of general or specialized dentistry or dental surgery. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. They can provide either comprehensive preventive, cosmetic, or emergency care, or specialize in a single field of dentistry.”

The offices of physicians are identified as NAICS code 621111. According to NAICS, “This U.S. industry comprises establishments of health practitioners having the degree of M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) primarily engaged in the independent practice of general or specialized medicine (except psychiatry or psychoanalysis) or surgery. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.”

This Research Brief was published by the American Dental Association's Health Policy Institute.

211 E. Chicago Avenue
Chicago, Illinois 60611
312.440.2928
hpi@ada.org

For more information on products and services, please visit our website, www.ada.org/hpi.

References

[1] Byrns RT, Stone GW. *Microeconomics*. 4th ed. Glenview, IL: Scott Foreman and Co., 1989.

[2] Cottage industry. Wiktionary. Available at: https://en.wiktionary.org/wiki/cottage_industry. Accessed March 2, 2016.

[3] Cottage industry. Investopedia. Available at: http://www.investopedia.com/terms/c/cottage-industry.asp. Accessed March 2, 2016.

[4] Guay AH, Wall TP, Peterson BC, Lazar VF. Evolving trends in size and structure of group dental practices in the United States. *J Dental Education*. 2012;76(8):1036-1044.

[5] Wall T, Guay AH. Very large dental practices seeing significant growth in market share. Health Policy Institute Research Brief. American Dental Association. August 2015. Available at: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_0815_2.pdf. Accessed March 2, 2016.

[6] Caruso A. Statistics of U.S. Businesses Employment and Payroll Summary: 2012. U.S. Department of Commerce, Economics and Statistics Administration. U.S. Census Bureau.

[7] Cutler DM, Morton FS. Hospitals, market share and consolidations. *JAMA*. 2013;310(18):1964-1970.

[8] *Mosby's Medical Dictionary*. 8th ed. St. Louis, MO: Mosby/Elsevier, 2009.

[9] Anderson GD, Grey EB. The MSO's prognosis after the ACA: a viable integration tool? Economy-Wide Statistics Brief. Physician and Physician Organizations Law Institute. February 2013. Available at: https://www.healthlawyers.org/Events/Programs/Materials/Documents/PHY13/B_anderson_grey.pdf. Accessed March 2, 2016.

[10] Burns LR, Pauly MV. Accountable care organizations may have difficulty avoiding the failure of integrated delivery networks of the 1990s. *Health Affairs*. 2012;31(11):2407-2416.

[11] Kocher R, Sahni NR. Hospitals' race to employ physicians—the logic behind a money-losing proposition. *N Engl J Med*. 2011;364(19):1790-1793.

[12] Medical Economics. Physicians feeling over-worked, abandoning independent practice. September, 2014. Available at: http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/hospital-employment/physicians-feeling-over-worked-abandoning-indepen
Accessed March 23, 2016.

[13] Marbury D. Reimbursement, operational costs threaten independent physicians to sell practices. *Medical Economics*. November 21, 2014. Available at: http://medicaleconomics.modernmedicine.com/medical-economics/news/reimbursement-operational-costs-threaten-independent-physicians-sell-practice?page=full. Accessed March 2, 2016.

[14] Ritchie A. Physicians feeling over-worked, abandoning independent practice. *Medical Economics*. September 19, 2014. Available at: http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/hospital-employment/physicians-feeling-over-worked-abandoning-indepen. Accessed March 2, 2016.

[15] Guay AH. The differences between dental and medical care: implications for dental benefit plan design. *JADA*. 2006;137(6):801-06.

[16] Centers for Medicare & Medicaid Services. National Health Expenditure Data. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Accessed March 2, 2016.

[17] Deloitte. The great consolidation: the potential for rapid consolidation of health systems. Available at: http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/great-consolidation-health-systems.html. Accessed March 2, 2016.

[18] Budryk Z. Consolidation will continue in 2015. *Fierce Health Finance*. January 14, 2015. Available at: http://www.fiercehealthfinance.com/story/consolidation-healthcare-will-continue-2015/2015-01-14. Accessed March 2, 2016.

[19] Munson M, Vujicic M. Dentist earnings not recovering with economic growth. Health Policy Institute Research Brief. American Dental Association. December 2014. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1214_1.pdf?la=en. Accessed March 2, 2016.

[20] Wall T, Nasseh K, Vujicic M. Fewer Americans forgoing dental care due to cost. Health Policy Institute Research Brief. American Dental Association. October 2014. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_6.pdf?la=en. Accessed March 2, 2016.

[21] U.S. Census Bureau. Statistics of U.S. Businesses. Available from: http://www.census.gov/econ/susb/index.html. Accessed March 2, 2016.

[22] Not included are businesses that have no paid employees and are subject to federal income taxes. These non-employer businesses are generally small, such as real estate agents and independent contractors. These firms average less than 4 percent of all sales and receipts nationally and are excluded from most other U.S. Census Bureau business statistics.

[23] U.S. Census Bureau. North American Industry Classification System. Available from: http://www.census.gov/eos/www/naics/. Accessed March 2, 2016.

Suggested Citation

Guay A, Wall T. Considering large group practices as a vehicle for consolidation in dentistry. Health Policy Institute Research Brief. American Dental Association. April 2016. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_0416_1.pdf.