



# A Profession in Transition:

## Key Forces Reshaping the Dental Landscape

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**For more information or to request a presentation of these findings,  
please contact the ADA's Health Policy Resources Center at [hprc@ada.org](mailto:hprc@ada.org).**

## Executive Summary

## Background

The American Dental Association (ADA) carried out a comprehensive analysis of the dental care sector to help inform the strategic planning process. The research was carried out by external consultants and the ADA's Health Policy Resources Center. A group of renowned thought leaders reviewed the findings and provided additional insights. This report is a summary of the findings.

## Key Findings

**Several important structural changes have occurred in the dental care sector in recent years.** Utilization of dental care has declined among working age adults, particularly the young and the poor, a trend that is unrelated to the recent economic downturn. Dental benefits coverage for adults has steadily eroded the past decade, again particularly for young and poor adults. Not surprisingly, more and more adults in all income groups are experiencing financial barriers to care. Total dental spending in the U.S. slowed considerably in the early 2000s and has been flat since 2008, with public financing accounting for an increasing share. Trends for children are very different than for adults. Dental care utilization among children has increased steadily the past decade, a trend driven entirely by gains among poor and near-poor children. The percent of children who lack dental benefits has declined, driven by the expansion of public programs. The shifting patterns of dental care utilization and spending have had a major impact on dentists. Average net incomes declined considerably beginning in the mid-2000s. They have held steady since 2009 but have not rebounded. Two out of five dentists indicate they are not busy enough and can see more patients, a significant increase over past years. Most importantly, all of these trends were established well before the recent economic downturn.

**The coming years will bring considerable change to the dental profession, significant challenges, but also some new opportunities.** Modeling results indicate that dental spending will remain flat in the coming decades. This 'new normal' is a stark departure from decades of historically robust growth in the dental economy. For a variety of reasons, dental benefits are likely to continue to erode for adults, which could negatively influence dental care utilization. The Affordable Care Act will expand dental benefits coverage for children, both public and private, but will not address many key access to care issues. It will not reverse the decline in utilization among adults. On the care delivery side, there will be pressure to increase value and reduce costs from all payers – governments, employers, and individuals. This will be driven by a shift toward value-based payments within both public and private plans and a new wave of health care consumerism among the population. Commercial dental plans will increasingly use more selective networks, demanding increased accountability through data and performance measures. The trend towards larger, consolidated multi-site practices will continue, driven by changes in practice patterns of new dentists, a drive for efficiency, and increased competition for patients. The pressure to reduce costs will also drive innovation, including exploring alternative care delivery models. The Affordable Care Act will promote increased coordination of care, providing an opportunity to bridge the gap between oral and general health and to re-examine the role of oral care providers within the health care system. The immediate opportunities will be within the pediatric and Medicaid populations.

## Key Takeaway

**It is a critical moment for dentistry and a time for the profession to define its destiny.** Given the significant environmental changes on the horizon, this is a watershed moment for the profession. It is not a time for complacency. Understanding the key forces at work will assist the profession in defining its own destiny. Ignoring what is happening in the health and consumer environment will mean ceding the future of the profession to others. This first step of scanning the environment through thoughtful, objective, empirical research has provided the ADA with the key facts and information needed to help shape a strategy for navigating the challenges ahead and charting a course for the dental profession.

## The Issue

Routine dental care is an important component of oral health. We examined dental care utilization for various subgroups of the population over the past decade.

## Key Findings

**Dental care utilization for children increased more than 9% over the last decade.** The increase in utilization was driven entirely by low-income children. Children below the poverty line experienced a 38% increase in dental care utilization from 2000 to 2010, while those between 100-200% of poverty saw a 35% increase. Dental utilization by low-income children increased in 47 out of 50 states. By contrast, utilization rates among higher income children were relatively unchanged. While low-income children still lag behind upper-income children in dental care utilization, the gap is narrowing.

**Adult dental care utilization peaked in 2002-2003 before declining 10% over the remaining part of the decade.** The decline in utilization was consistent among all non-elderly adults, but was more pronounced for younger adults. Adults ages 19-34, who are the least likely age group to visit the dentist, experienced the largest decrease in utilization. Among seniors, dental care utilization held steady.

**The decline in adult utilization occurred across all income groups, but was particularly acute for low-income adults.** Adults below the poverty line experienced an almost 14% decline in utilization between 2003 and 2010. By contrast, high-income adults, who were more than twice as likely to have an annual dental visit as low-income adults, experienced a 6% decline during that same period. As a result, the rich-poor gap in utilization is widening for adults.

## Key Policy Takeaways

**The reduction in financial barriers has been an important factor in increasing children's dental care utilization.** The enactment of the Children's Health Insurance Program (CHIP), expansion of the dental safety net, and increased participation of dentists in Medicaid programs are key factors not only in increasing utilization, but also in reducing the income disparity in dental care utilization among children.

**Low-income adults and young adults are seeing increased financial barriers to dental care, resulting in decreased utilization.** Adults do not have access to the same dental care safety net as children. The past decade has seen significant reductions and eliminations of adult dental benefits in Medicaid programs. Unlike dental benefits for children in Medicaid, adult dental benefits are optional and often subject to cuts during lean economic times. We are seeing the effect of a steady disinvestment in adult dental benefits within state Medicaid programs, along with a reduction in employer-sponsored dental benefits.

**The Affordable Care Act includes pediatric oral care as an essential health benefit, but does not address adult dental care.** This omission will do little to change the decline in dental utilization among adults and is likely to have long-term consequences. Dental benefits are a major predictor of dental care utilization, and the Affordable Care Act represents a missed opportunity to address the financial barriers issue.

## Additional Materials

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## Critical Issue – Dental Care Expenditures

## The Issue

The dental economy is in transition. After decades of growth, dental expenditures have flattened. We explored recent trends in aggregate dental spending, as well as per-patient spending among those with a dental visit.

## Key Findings

**Dental expenditures are growing, but much more slowly than historical rates.** The growth in dental spending began to slow in the early 2000s, well before the recent economic downturn. From 1990-2002, dental expenditures grew an average of almost 4% per year. Between 2002 and 2008, that average growth rate fell to just under 2%. Between 2008 and 2011, the average annual growth rate declined 0.3%. On a per capita basis, dental expenditures actually declined slightly between 2008 and 2010. Overall, dental spending has experienced a much bigger slowdown than health care spending.

**Among people who had a dental visit, average annual expenditures grew steadily throughout the decade before leveling off in 2008.** Children who had a dental visit had a decline in per-patient expenses over the decade, while adults -- most significantly adults over the age of 65 -- had a significant increase. Per-patient expenses for adults have been largely unchanged since 2008, however. It is too early to tell whether the recession had a permanent effect on per-patient spending.

**Public programs are a small, but growing source of dental financing, while the percentage of out-of-pocket financing has declined.** In 1990, only 2% of dental expenditures were financed by public programs. By 2011, that number grew to 8%. The tradeoff for increased public spending has been reduced out-of-pocket spending. From 1990 to 2011, the rate of dental expenditures financed out-of-pocket declined from 48% to 42%.

## Key Policy Takeaways

**A decline in utilization is an important factor in the slowdown of the dental economy.** The percentage of adults with a dental visit in the past year has declined steadily since the early 2000s. While children have had an increase in annual dental visits over that time, it is not enough to offset the decline among adults. In addition, the growth in utilization is most prevalent among low-income children who are likely to be covered by public programs.

**The decline in utilization has not being offset by an increase in per-patient expenditures.** In order to make up for the decline in utilization, expenses for patients who visit the dentist must increase significantly if total expenditures are to hold steady. Since 2008, per-patient expenditures have been flat, contributing to the slowdown in national dental expenditures. Although there are only two years of post-recession data, a 'new normal' of dental spending may be upon us.

**The small, but growing shift in payer mix has likely contributed to the flattened growth in dental expenditures.** Public programs reimburse at a significantly lower rate than private insurance, although there is evidence private insurers are reducing payment rates as well. Both pay less than private-pay patients. If this trend in payer mix continues, the growth in dental expenditures is unlikely to rebound to earlier levels.

## Additional Materials

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Wall T, Nasseh K, Vujicic M. Per-patient dental expenditures rising, driven by baby boomers. Health Policy Resources Center Research Brief. American Dental Association. March 2013. Available from:  
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## Critical Issue – Population Demographics

### The Issue

The U.S. population is growing and becoming more racially and ethnically diverse than ever before. Baby boomers are retiring at increasing rates, fueling the graying of America. Changing demographics play an important role in dental use as some groups are more likely than others to have dental needs, have dental benefits and visit the dentist. We analyzed trends in dental expenditures over the last two decades combined with population demographic changes to model future dental spending.

### Key Findings

***Per patient expenditures have been relatively flat over the last decade among children and working age adults, but have grown significantly for seniors.*** The growth in expenditures for seniors has leveled off over the last few years. Nevertheless, they have the highest per patient dental expenditures of any age group.

***Per capita expenditures are expected to grow over the coming decades, but at a very slow rate.*** In 2010 per capita dental expenditures were \$269. Depending on the assumptions made, projections of future per capita dental expenditures range from a conservative \$277 to an optimistic \$325 by 2040. Projected growth rates range from 0.22% to 1.25% over the next decade compared with a growth rate of almost 3.9% between 1996 and 2002. Between 2030 and 2040 the growth rate in dental expenditures is expected to be less than one-quarter of a percent.

***Older Americans are expected to account for a growing share of dental expenditures over the coming decades.*** Seniors ages 60-79 will account for about 32% of all dental expenditures by 2040, followed by children with about 24%. The largest growth will be in adults ages 70-79 whose proportion of total expenditures is expected to double between 2010 and 2040. Children account for such a large proportion of dental expenditures because they have high rates of dental benefits, primarily through a robust safety net system. More surprising is the growth in dental expenditure among seniors, who traditionally have low rates of dental benefits.

***The growing racial and ethnic diversity of the population will likely have an effect on dental utilization trends.*** Racial and ethnic minorities are less likely to use dental care than whites. From 2000 to 2050, the percentage of the white population is projected to drop from 81% to 74%. The percentage of the population identifying themselves as Hispanic is expected to grow from 12.6% in 2000 to just over 30% in 2050. Hispanics are less likely than the general population to visit the dentist regularly and more likely to view regular dental care as unimportant. Hispanics are also more likely to be uninsured for dental benefits than whites. We did not model the effect of racial and ethnic shifts.

### Key Policy Takeaways

***We are unlikely to see a return to the fast growth in dental expenditures of previous decades.*** The growing number of adults without benefits, the growth in public financing at the expense of private insurance, and the increasing diversity of the population all point to very slow growth of expenditures over the coming decades. The near stagnant growth seen in the last few years may be the “new normal.”

***The growing share of dental expenditures from people over the age of 60 represents a bright spot in future projections.*** Overall rates of edentulism have decreased among older adults, and the incidence further decreases with each succeeding age cohort. Seniors are less likely to have dental benefits, primarily because Medicare offers very little dental coverage, and are more likely to pay out-of-pocket for dental care. Seniors have the highest per-patient dental expenditures of any age group.

**Critical Issue – Population Demographics  
(Continued)**

**Additional Materials**

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## Critical Issue – The Affordable Care Act and Dental Care Utilization

### The Issue

The health care system is on the verge of major reform as the Affordable Care Act (ACA) is fully implemented. Dental benefits are included as an essential health benefit for children, but not for adults. We explored the likely impact of the ACA on the utilization of dental care.

### Key Findings

**An estimated 8.7 million children are expected to gain comprehensive dental benefits by 2018 through the ACA.** This increase is split roughly evenly among those gaining access through Medicaid, the new health insurance exchanges, and employer-sponsored insurance. This will reduce the number of children without dental benefits by about 55% relative to 2010 levels. Utilization of dental care is closely tied to the availability of dental benefits. The expansion of dental benefits is expected to generate an additional 13.8 million visits per year, about 20% of which will be financed by Medicaid.

**About 5.3 million adults are expected to gain 'extensive' dental benefits by 2018 through the ACA.** Although almost 17 million adults are expected to gain some level of dental benefits through the Medicaid expansion, only a small share of this will be 'extensive' coverage. Adult dental benefits are optional within Medicaid. Only 800,000 adults are expected to gain private dental benefits through purchases on health insurance exchanges. Taken together, this will reduce the number of adults without dental benefits by about 5% relative to 2010 levels. This expansion is expected to generate 9.2 million dental visits, more than 80% of which will be through Medicaid.

### Key Policy Takeaways

**The increase in children and adults gaining dental benefits through Medicaid will put significant pressure on the safety net delivery system.** Along with other issues, Medicaid reimbursement for dental care in most states is inadequate to entice the majority of dentists to participate. Research shows that reforming Medicaid, including increasing reimbursement rates closer to market levels, is associated with an increase in dental care utilization. The ACA does not address the critical issues of dental care reimbursement and other program inefficiencies within Medicaid. The issue of low Medicaid reimbursement was addressed for primary medical care, but an important opportunity was missed for dentistry.

**The ACA will not help reverse the decline in dental care utilization among young adults and low-income adults.** The exception is in the few states that currently provide extensive Medicaid dental benefits and will continue to do so, or in states that expand adult dental benefits.

**The implementation of the pediatric dental benefit in the essential health benefits regulation lessens its impact.** Because dental benefits are often provided separately from overall health insurance, the regulation allows health insurers in exchanges to comply with the pediatric oral health requirement as long as those benefits are offered as a standalone policy. There is no requirement that health insurers integrate pediatric oral health care or that parents purchase the dental policy on behalf of their children. This may result in children falling through the cracks.

### Additional Materials

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## Critical Issue – Consumer Dental Care-Seeking Behavior

### The Issue

Consumers are changing their attitudes on their role in managing their health and how they interact with the health care system. This trend has been called “consumerism.” Patients are no longer passive participants, but active members of a team helping making health care decisions. Less is known about the consumerism trend in dental care. We reviewed the available evidence to better understand consumer behaviors and attitudes on oral health.

### Key Findings

***The degree of consumerism corresponds with income, education, age, and health status.*** Active consumers are more likely to have college diplomas and higher income than passive consumers. Age and health status are important factors, but in different ways. Millennials are more likely to have a casual attitude toward health care, but are also more likely to use health information technology and shop around for better prices than their older counterparts. Baby boomers and seniors, on the other hand, are more likely to be compliant with their providers' treatment decisions, but will take an active role if they have one or more chronic conditions.

***Dental care-seeking behavior is strongly associated with having dental benefits.*** Individuals with dental benefits are more likely to have visited the dentist in the last year and go to the dentist for preventive care than those without benefits. More than three-quarters of individuals without dental benefits report having gone to the dentist only once or not at all in the last 10 years. Individuals who lack dental coverage are three times as likely to go to the dentist only when they have a problem rather than for preventive care. Financial barriers and not knowing how much treatments cost are the two most common reasons for delaying dental care.

***Hispanics are less likely to visit the dentist regularly than the general population despite being more likely to experience oral health problems.*** Hispanics are less likely than the general population to see regular dental visits as important. About half of Hispanics do not feel dental visits are necessary as long as they take good care of their teeth. Knowledge gaps, cost, and language or cultural differences are the top barriers to Hispanics seeking regular dental care.

### Key Policy Takeaways

***Dentists will increasingly encounter patients who proactively shop for value and quality.*** Compared with health care, more patients pay out-of-pocket for dental care, increasing the importance of savvy shopping. Young adults are the least likely to have dental insurance and most likely to use information technology to gather information, find providers, and compare prices. This will intensify as advances in health information technology make it easier for patients to access information on specific providers.

***Baby boomers are less likely to shop around for value than younger consumers, but this may change.*** Many experts believe the next generation of seniors will be less wealthy than the current generation and may be more cost conscious as a result. It is unclear how these two forces will interact going forward in the dental market.

***Dental practices can prepare for the growing consumerism trend by making information available online on treatments and prices.*** The heaviest users of health information technology also have the highest income, making them more able to pay out-of-pocket for their dental needs. Young adults, who have low rates of dental coverage, are also high users of technology and most likely to shop for a good bargain.

### Additional Materials

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Keckley P, Coughlin S. The U.S. Health Care Market: A Strategic View of Consumer Segmentation. Deloitte Center for Health Solutions. Available from: [http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us\\_chs\\_InfoBrief\\_2012HealthCareConsumerSegments\\_011813.pdf](http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_InfoBrief_2012HealthCareConsumerSegments_011813.pdf)

**Critical Issue – Consumer Dental Care-  
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Consumer Survey: Dental Health & Health Care Reform. National Association of Dental Plans. May 2012.

## Critical Issue – Increased Dental School Capacity

### The Issue

Significant increases in dental school enrollment are planned or underway, in part due to a perceived shortage of dentists, but also due to the presence of a significant excess demand for dental education. We analyzed how the supply of dentists could evolve in the coming years and how this compares to expected demand for dental care under different scenarios.

### Key Findings

***The supply of dentists, on a per capita basis, has been fairly stable the past few decades.*** According to the most comprehensive data, the number of professionally active dentists in the United States was between 59 and 60 per 100,000 population since 1990. During this time, the profile of dentists has changed, with female and older dentists accounting for a larger share of supply.

***Over the past two years, however, the supply of dentists has increased.*** The most recent data from the ADA's Health Policy Resources Center indicate that the number of professionally active dentists in the United States increased from 60 per 100,000 population in 2008 to 62 in 2011. Further research is needed, but this is a result of an increase in average retirement age (which was 68.3 in 2011) and increased dental school enrolment.

***The demand for dental care, measured as dental spending per capita, has slowed considerably in recent years and a 'new normal' could be emerging.*** Modeling of dental spending per capita under various scenarios suggests that, if anything, a very slight increase is expected through 2030. This is very different than the steady growth – about 4% per year in inflation adjusted, per capita terms – of previous decades.

***Dentist earnings appear to be influenced by the growth of dental spending relative to the supply of dentists, as economic theory would predict.*** The period leading up to the mid-2000s saw robust growth in dental spending among the population and a relatively stable supply of dentists. Through 2010, however, demand for dental care has declined, resulting in decreased spending. At the same time, the supply of dentists has increased. This period corresponds with a significant decrease in dentist net incomes.

### Key Policy Takeaways

***Looking forward, despite expanded dental school capacity, the future labor supply of dentists is subject to uncertainty.*** Dental school enrolment is increasing. At the same time, even with increased career spans and average age of retirement, the expected number of retiring dentists will increase in the coming years. The changing demographic profile of the dentist workforce could also influence aggregate labor supply, although more research is needed.

***But various factors could result in fewer dentists being needed to deliver a fixed amount of dental care.*** The modeling does not take into account major increases in efficiency and changes in the dental care delivery system that could emerge in the coming years. If things like technological advancement, the emergence of new dental providers to take on some of the work dentists currently do, the growth of larger dental care organizations, and the incorporation of dental care within accountable care organizations, fewer dentists may be required to deliver the same amount of dental care to the population.

***Given the dental economy is expected to remain sluggish, any further major ramping up of the supply of dentists could potentially have negative effects on dentist earnings.*** As a result, policy makers need to give careful consideration to any further expansion of dental school capacity or increase in foreign dentists in the face of what appears to be decades of very modest growth in dental spending and demand for dental care. Moreover, for various reasons, and pure economic reality is one of them, dentists could consider expanding their scope of practice beyond traditional dentistry.

## Critical Issue – Changing Dental Care Delivery Models

### The Issue

New models of dental practice are emerging and there is considerable interest in understanding their implications for the public and practicing dentists. We provide an update on the ADA research program on large group practice. Only very preliminary findings are available at this stage.

### Key Findings

**Multi-site practices are a small but growing segment of dentistry.** In 2011, approximately 6.4 percent of dentists across the nation report that their practice is part of a larger entity that delivers dental care at more than one location, up from 5.4 percent in 2008. This is a small, but growing portion of practicing dentists in the United States. The youngest cohort, below thirty-five years of age, is most likely to be in this model, followed by those 65 and older. It would appear that multi-office firms seem to be a common method for entry into the dental care system for new and younger dentists, but also can be a viable option for a dental career for about 4 to 8 percent of dentists over 65.

**The dental market has seen gradual consolidation in recent years.** In the period 1992 through 2007, the number of firms decreased somewhat, while the number of establishments within these firms increased. The delivery system has concentrated through acquisitions, and the development of de novo practices in a manner similarly seen in medicine. It would appear that the expansion of group practices occurs at the large, multi-office organizations level, where economies of scale emerge and can be significant.

**About 8,000 dentists are currently working in very large/corporate/DMSO-affiliated practices.** Across the 25 Dental Group Practice Association (DGPA) practices in the United States, the average number of dentists affiliated with the typical practice was 326. However, smaller practices are the norm, so the median number of 154 dentists is a better description of the size of the typical DGPA practice. An estimated 7,827 dentists are affiliated with the 25 DGPA practices.

### Key Policy Takeaways

**The care delivery model is changing.** But it is unclear how fast and how prevalent the non-solo model will be or how prevalent non-ownership will be. The evolution of group practice to date has been gradual. Most dentists and dental students still intend to own their own dental practice one day. But this does not mean they do not want to affiliate with dental service management companies to 'outsource' significant functions.

**We do not know much about the implications of alternative care delivery models for patients and dentists.** The ADA's research agenda on group practice exactly tries to fill this knowledge gap. Results, however, are not yet available. The evidence that does exist suggests that there are no significant differences in treatment patterns between DGPA-type dental practices and traditional dental practices.

### Additional Materials

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**Critical Issue – Changing Dental Care  
Delivery Models (Continued)**

**Additional Materials (Continued)**

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## Critical Issue – The Rising Cost of Dental Education

### The Issue

Educational debt can affect career choices, discouraging graduates from taking jobs in the public sector in favor of obtaining higher salaries in the private sector. We examined the trends in dental student debt, how they compare to other fields, and what effect educational debt has on career choices.

### Key Findings

**State financial support for public dental schools declined dramatically over the last decade and schools offset this loss with increases in revenue from tuition and fees.** Public dental schools have seen overall revenue increase of only 1% from 2004 to 2012. The low increase in revenue is primarily a result of a 17% reduction in public financing. The main reason overall revenue did increase slightly even as public support decreased is because of tuition revenue. In addition to increasing tuition, dental schools have also increased enrollment.

**The average debt for dental school graduates has increased over time, primarily due to increases in the cost of attending dental school.** Students graduating from private dental schools had an average debt of \$213,000 in 2011, while the average for public school graduates was \$161,000. Between 1994 and 2011, the 4-year cost of attending dental school increased at an average annual rate of 7.8% for public schools and 5.6% for private schools. Similarly, between 1990 and 2011, cumulative educational debt grew at an average annual rate of 7.0% for public and 5.9% for private dental schools. This indicates students are borrowing more to offset increasing tuition rates. Dental graduates are not unique in their increasing educational debt, however. The growth rate in debt for dental students is similar to that of graduates in other professions such as medicine, law, and pharmacy.

**The ratio of debt-to-income started increasing fairly rapidly in 2003, driven by a slow growth in dental salaries.** The debt-to-income ratio is a good measure of the feasibility of paying off educational debt. In 1990, the debt-to-income ratio was 76% for graduates from private dental schools and 46% from public schools. By 2011, those ratios had grown to 119% and 90%, respectively.

**Educational debt has an effect on some career decisions, but the effect is small, and not as large as gender or race.** When modeling the effect of an additional \$35,000 in educational debt (the actual increase for dental education between 2004 and 2011), graduates were more likely to enter private practice, less likely to pursue an advanced education and less likely to accept a faculty or government position. Graduates' choice in practice setting, however, is more heavily influenced by gender, race, ethnicity, and having a parent who is a dentist than by educational debt. Debt was not found to have an influence on owning a practice, going into public health, practicing in an underserved area, the percentage of poor patients seen or the number of hours worked.

### Key Policy Takeaways

**Dental schools are now more dependent financially on tuition and fees than in the past.** Schools have been able to pass increases in operating costs onto students in the form of higher tuition and fees, because of a large, well-qualified applicant pool. Now that growth in dentists' incomes is slowing, and student debt is at an all-time high, this financing strategy may come to an end. We could be seeing a dental education "bubble."

**Educational debt is not the main driver of career choices.** The analysis has shown clearly that while some career choices are influenced by debt, many are not. Other individual characteristics have a far greater impact on career choices.

**The steady increase in dental education costs and educational debt, combined with the slow growth in dental salaries, could make dental education less attractive to some students.** This may have a dampening effect on the applicant pool. Although two-thirds of dentists who graduated in 1996 are now debt free, they started with a much lower debt burden than today's graduates. Ninety percent of younger dentists are experiencing stress over educational debt and more than 60% describe their stress as "a lot" or "extreme." The growing educational debt is a problem for graduates in all professional fields, but the debt-to-income ratio for dentists is among the highest. Time will tell whether debt begins to play a larger role in graduates' career choices.

**Critical Issue – The Rising Cost of Dental Education (Continued)**

**Additional Materials**

Bailit H, Beasoglou T, Paturzo D, Robinette A, Tomlinson K. Trends in Dental School Finances: Report to the American Dental Association. May 2013. Unpublished. Draft available upon request.

## Critical Issue – The Affordable Care Act and Dental Care Delivery and Financing

### The Issue

Most dental care is financed through out-of-pocket payments and standalone dental plans. Historically, dentists have provided care primarily in small, independent, provider-owned practices, although this is changing somewhat with the recent growth of large group practices. We analyzed how dental care financing and delivery may change with the implementation of the Affordable Care Act (ACA).

### Key Findings

***The ACA changes the health care delivery system in important ways, primarily through Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs).*** An ACO is the integration of primary care clinicians, specialists, and hospitals providing coordinated care for patients. The ACO shares responsibility for treating a group of patients and its reimbursement is tied to performance measurement. The ACA provides incentives for ACOs to grow and expand through Medicare. PCMH is a practice model guided by a primary care clinician in which a team of health care providers deliver coordinated care to patients. Unlike ACOs, PCMHs do not have to move towards a financial risk sharing arrangement, and their role in the ACA is limited to Medicare. In fact, PCMHs more commonly serve Medicaid patients.

***Dental care does not have an important role in today's ACOs.*** Existing ACOs under the ACA primarily serve Medicare patients, and Medicare does not provide significant coverage for dental services. ACOs are focused on integrating their core medical services, particularly high-cost, high-risk procedures that have potential cost savings. Dental care is usually not viewed as a core service.

***PCMHs are more likely than ACOs to incorporate dental care, especially when serving a Medicaid population.*** Dental benefits for children are a mandatory benefit under Medicaid, creating a payment stream for at least some PCMH patients to receive dental services. PCMHs created by non-profit community health centers, which are likely to serve a predominantly low-income, Medicaid population, are particularly apt to include dental services. There are several ACOs in operation that include dental services for adults and children as part of their core basket of services. They tend to focus on Medicaid populations in states where Medicaid covers adult dental.

***The ACA includes pediatric dental benefits as an essential health benefit, but does little to integrate it with medical benefits in the private market.*** All health plans sold on the individual and small employer market, both inside and outside the exchange, are required to include the essential health benefits. Currently, dental benefits are almost always sold as standalone products in both the employer and individual markets. The ACA does not change this structure. In fact, the ACA allows health plans on the exchange to satisfy the pediatric oral health requirement as long as a standalone dental plan providing pediatric benefits is available. Health plans in the exchange are not required to integrate dental benefits for children, and parents are not required to purchase the standalone plan for their kids. Health plans outside the exchange can be compliant with the pediatric oral health requirement if they can be "reasonably assured" that an individual has obtained that coverage through a standalone dental plan.

### Key Policy Takeaways

***The ACA, both as written in law and in its implementation, continues the bifurcation of dental care and medical care.*** ACOs, because of their primary focus on Medicare, have little incentive today to include dental care, despite the research showing the link between poor oral health and some chronic diseases. In terms of financing, the implementation of the pediatric dental benefit mandate weakens considerably its status as a true essential health benefit and encourages the siloing of dental care financing from medical plans.

***ACOs outside the Medicare program present more opportunities to integrate medical and dental care.*** ACOs existed prior to the ACA, perhaps under a different name. ACOs in some states serve Medicaid beneficiaries and are more likely to include dental care than Medicare ACOs. This is especially true where Medicaid covers adult dental care. An additional opportunity that should be explored is ACOs that serve dual Medicare and Medicaid eligible beneficiaries in states that provide adult dental benefits through Medicaid.



**Critical Issue – The Affordable Care Act  
and Dental Care Delivery and Financing**

***Primary Care Medical Homes offer the most promising delivery reform opportunity for dental care.***

Especially in PCMHs that serve Medicaid beneficiaries or dual eligible Medicare and Medicaid beneficiaries, including dental care makes sense. The states with the biggest opportunities for integrating dental care in PCMHs are those that provide adult dental benefits in their Medicaid program.

**Additional Materials**

Vujicic M, Nasseh K. Accountable care organizations present key opportunities for the dental profession. Health Policy Resources Center Research Brief. American Dental Association. April 2013. Available from:

[http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief\\_0413\\_2.pdf](http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0413_2.pdf)

Vujicic M, Goodell S, Nasseh K. Dental benefits to expand for children, likely decrease for adults in coming years. Health Policy Resources Center Research Brief. American Dental Association. April 2013. Available from:

[http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief\\_0413\\_1.pdf](http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0413_1.pdf).

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## CRITICAL TRENDS AFFECTING THE FUTURE OF DENTISTRY: Assessing the Shifting Landscape

Prepared for American Dental Association

### Executive Summary

Dentistry in the United States is in a period of transformation. The population is aging and becoming more diverse. The health care delivery system is changing rapidly with the implementation of the Affordable Care Act. Consumer habits are shifting with Americans increasingly relying on technology and seeking greater value from their spending. The nature of oral disease and the financing of dental care are in a state of flux.

To assist the American Dental Association in its strategic planning, Diring and Associates was retained in March 2013 to conduct an environmental scan of emerging trends that affect the future of dentistry. Consisting of a comprehensive literature review and key informant interviews, the scan found that:

### People

1. The population is getting older and more diverse, leading to different disease patterns, care-seeking behavior and ability to pay.
2. Consumers are becoming more astute purchasers of health care and seeking value for their spending.

### Providers

3. An increasing number of dentists are being trained, but mounting debt load and changing demographics are altering the practice choices for new dentists.
4. Pressures are growing for an expanded dental team to provide preventive and restorative services.
5. Care is being integrated within "patient centered medical homes" in medicine but there has been slow take up of dental care services.

### Payments

6. Payment for dental services is shifting from commercial dental insurance to public coverage and personal out of pocket payments.
7. Commercial dental plans are increasingly using more selective networks, demanding increased accountability through data and performance measures, and pressuring providers to reduce costs.

Research Commissioned from Diring and Associates (Continued)

**Policies**

8. The Affordable Care Act pediatric dental benefit will provide millions of additional children with dental coverage through the small group and individual markets and optional Medicaid expansions.
9. Public programs, with a growing number of participants, will demand increased accountability from dental providers.

**Practice Implications**

10. With the increased demand for value in dental care spending, practices will need to become more efficient.
11. The trend towards larger, multi-site practices will continue driven by dental plan pressures for smaller provider networks, practice patterns of new dentists and increased competition for patients.
12. Health care reform and Medicaid expansions with an increasing emphasis on outcomes and cost-effectiveness will encourage alternative models of dental care.

This is a critical moment in dentistry and not a time for complacency. Understanding the key forces at work will assist the profession in defining its own destiny. Ignoring what is happening in the health and consumer environments will mean ceding the future of the profession to others.

By commissioning this report and convening key thought leaders, the ADA has taken on the challenge of facing the new reality and charting a course for the dental profession and the oral health of America.

*Diring and Associates is a California based health policy consulting firm founded in 2001. It has significant experience in oral health, public policy, evaluation and organizational development. This report was authored by Joel Diring, JD, MPH, Kathy Phipps, MPH, DrPH, and Becca Carsel, MA.*

The full report is available on [www.ada.org/escan](http://www.ada.org/escan).

Description of Strategic Planning  
Environmental Scan Process

**Objective**

The goal of environmental scanning is to alert decision makers to potentially significant external changes before they crystallize, so that decision makers have sufficient lead time to react and incorporate these factors into the strategic planning process. An environmental scan focuses on the external environment and should:

- detect scientific, demographic, technical, economic, social, and political trends and events important to the institution
- identify the potential threats, opportunities, or changes for the institution implied by those trends and events
- promote a futuristic orientation in the thinking of leadership
- alert leadership to trends that are converging, diverging, speeding up, slowing down, or interacting

The Strategic Planning Steering Committee requested that the ADA’s Health Policy Resources Center lead the environmental scan.

**Scope of Work**

Two categories of research were needed: (i) a broad macro view of the changing landscape in dentistry (ii) deeper analysis on specific topics including:

Topic	Description
<b>Dental Care Utilization</b>	Analysis of recent trends in utilization of dental care by different segments of the population and factors driving trends.
<b>Dental Care Expenditure</b>	Analysis of recent trends in dental expenditure by different segments of the population and factors driving trends.
<b>Population Demographics</b>	Analysis of how population demographic shifts, mainly aging, will influence demand for dental care going forward.
<b>Increased Dental School Capacity</b>	Analysis of workforce projections based on current trajectory of increased enrolment and alternative scenarios.
<b>The Affordable Care Act and Dental Care Utilization</b>	Analysis of how the ACA could influence dental benefits patterns, dental care utilization and expenditure.
<b>The Affordable Care Act and Dental Care Delivery and Financing</b>	Analysis of how the ACA could influence dental care financing and delivery.
<b>Consumer Dental-Care-Seeking Behavior</b>	Analysis of changing attitudes toward oral health and dental care.
<b>The Rising Cost of Dental Education</b>	Analysis of cost of dental education, student debt, and implications for career choices of graduates.
<b>Changing Dental Care Delivery Models</b>	Analysis of group and corporate dentistry models and their potential implications on patients and dentists.
<b>Key Factors in Membership Participation</b>	Analysis of member satisfaction and factors influencing whether dentists join the ADA.

For the macro analysis, a request for proposals was sent out to over 15 consulting firms with experience in doing environmental scans in the health care field. The consulting firm of Diringer and Associates was selected.

For the specific issues research, the Health Policy Resources Center used a combination of external consultants and internal researchers to complete the analyses. On certain topics, research had already been commissioned through separate ADA efforts (e.g. education debts, the Affordable Care Act) and was available to incorporate into the environmental scan. The Health Policy Resources Center was already carrying out some of the research on the specific topics as part of its strategic research agenda.

Description of Strategic Planning  
Environmental Scan Process (Continued)

**The Intelligence Fair**

The broad macro analysis and the deeper specific issues research were presented at a 2-day Intelligence Fair held in Chicago in May 2013. The objective of the Intelligence Fair was to distill, synthesize and interpret all of the research findings in order to identify the most pressing environmental factors that need to guide the strategic plan. This meeting was a chance to discuss “what does this all mean for the ADA” in an open, strategic setting.

To assist the Strategic Planning Committee, a group of external thought leaders from outside of the ADA with diverse background and perspectives were selected to lend their insights, contribute their expertise, and assist in interpreting the findings. The thought leaders were:

**Dr. Howard Bailit**

Professor Emeritus  
University of Connecticut Health Center  
Farmington CT

**Dr. Ira Lamster**

Dean & Professor of Dentistry  
Columbia University  
New York, NY

**Dr. Roger Levin**

Chairman & CEO  
Levin Group, Inc.  
Owings Mills, MD

**Dr. Anthony LoSasso**

Professor and Senior Research Scientist  
Division of Health Policy and Administration  
University of Illinois at Chicago  
Chicago, IL

**Dr. Matthew Messina**

Founder, Dentist  
Matthew Messina DDS., Inc.  
Fairview Park, OH

**Mr. Steve Thorne**

Founder, President  
Pacific Dental Services  
Irvine, CA