Breaking Down Barriers to Oral Health for All Americans: The Role of Finance

A Statement from the American Dental Association

April 2012
Good oral health is essential to promoting and maintaining overall health and well-being, and regular oral care — both self-care and professional care — is essential to attaining and maintaining good oral health. The majority of Americans know how to care for their teeth and gums and receive regular dental care, because they understand their health needs and have the means to address those needs. But a large minority either fails to seek care or cannot afford it. This paper explores the latter subject, how the affordability of care affects people’s oral health, various methods of paying for care, and recommendations for improving oral health care financing and increasing the number of people who receive regular dental care.

When people are able to access oral health care, they are more likely to receive basic preventive services and education on how to attain and maintain good oral health. They are also more likely to have oral diseases detected in the earlier stages. In contrast, lack of access to oral health care can result in delayed diagnosis, untreated oral diseases and conditions, compromised health status, and, occasionally, even death. Unfortunately, access to oral health care eludes many Americans.

This paper examines why people from all walks of life are increasingly facing financial barriers to accessing dental care and offers solutions to reduce these barriers. We realize that the ongoing economic crisis dramatically reduces the likelihood of significant reforms in the short term. But the economy will recover; Americans will return to work, and state and federal governments will be under less pressure to cut or underfund essential services. Economic recovery will present a terrific opportunity to bring tens of millions of dentally underserved — or unserved — Americans into a system of care that is capable of preventing most dental disease and intervening early when disease does occur.

The more than 157,000 members of the American Dental Association (ADA) are committed to seeing that happen, and to working with all interested parties to make the most of available funding now. We believe that part of this involves a fundamental shift away from surgery and toward prevention. Investing in oral health education and prevention in the near term pays off in greatly reduced costs of treating disease over time. Increasing oral health care financing and making better use of existing funds represent major steps toward our common goal of a healthier, more productive nation.
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The utilization of dental services has declined significantly since 2007, eroding several years of gains. After peaking at 40.8 percent in 2007, the percentage of the non-institutionalized U.S. population who visited a general practice dentist declined to 38.6 percent in 2009. This represents a drop from 240.3 million general practice dental visits in 2007 to 226.3 million visits in 2009. The average number of annual dental visits per patient also has been declining over a longer period of time, from 2.07 in 1997 to 1.91 in 2009. (Note that the data in the graph below include specialist in addition to general practice visits, hence the slightly greater percentage.)

Percent with a Dental Visit During the Past Year

Source: Medical Expenditure Panel Survey (MEPS), 1996–2009
One reason behind the decline in utilization is that more Americans increasingly face financial barriers to care, and not just the poor. The percentage of people who couldn’t afford dental services during the past 12 months has increased substantially in recent years. Lack of access to dental care costs the nation dearly. The landmark Surgeon General's report, "Oral Health in America," linked dental needs to 164 million lost work hours and 51 million missed hours of school each year. While this disturbing trend is most pronounced for the poor and near-poor, it is important to note that it holds at higher income levels as well.

During the Past 12 Months Was There Ever a Time When You Needed Dental Care and Didn’t Get It Because You Could Not Afford It? (By Poverty Level – 2003 to 2010)

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<td>17.1%</td>
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Source: National Health Interview Survey, 2003 – 2010

FPL = Federal Poverty Level, set in 2012 at $23,050 for a family of four

Trends in Dental Expenditures

Dental expenditures account for 4.2 percent of total health expenditures in the United States. This share has been declining steadily since 2001 but especially since the start of the recent economic downturn.

In 2009, U.S. dental expenditures totaled $102.2 billion. This was down somewhat from 2008 and represented the first decline in nominal dental expenditures since the government began tracking health expenditures in 1960.

Real (adjusting for inflation) total and per capita dental expenditures have declined recently as well, falling to $340 in 2009 from a peak of $352 in 2004. By way of comparison, real per capita expenditures on overall personal health care were $6,583 in 2004, reached a peak of $6,888 in 2007, and fell to $6,818 in 2009.

The percentage of people who can’t afford dental services has increased substantially in recent years.
Sources of Financing

There are five main sources of financing for dental care. The Centers for Medicare & Medicaid Services (CMS) provides a breakdown of four of these: private insurance, public programs, out-of-pocket payments and other sources. A fifth source, often overlooked, is charitable care provided by dentists.

The largest component is private, third-party financing (48.2 percent) followed by out-of-pocket (43.5 percent) and public programs (8.2 percent). Other than an increase in the prominence of public programs — up from 4.2 percent in 1996 — the breakdown has been fairly consistent since the late 1990s.

Dental benefit coverage has a profound effect on the likelihood of someone seeking and receiving care. According to the 2004 Medical Expenditure Panel Survey (MEPS), 57 percent of people with private dental insurance had at least one dental visit; 32 percent of those with public coverage saw a dentist; and 27 percent of the population with no dental coverage had a dental visit.
Dental care is financed very differently from medical care in general, with much greater reliance on out-of-pocket financing. As shown in the next section, the current private third-party financing system for dental care is more accurately described as a defined benefit system rather than insurance. It does not provide the same degree of financial protection as private medical coverage. As a result, the cost of dental care is associated with a much lower degree of risk protection for the patient than health care in general.

**Private Third-Party Financing**

**Indemnity Plans**

An insurer pays claims based on the procedures performed, usually as a percentage of the charges.

**Advantages:**
- Freedom to choose a dentist, although some indemnity plans may be paired with preferred provider organizations (PPO), which limit choices to lists of dentists.

**Disadvantages:**
- Insurers usually do not disclose how they determine fee schedules, which often run significantly less than dentists’ fees. This shifts the cost burden to the patient, even as premiums increase.
- Annual maximum limits on benefits have not increased appreciably in 30 years, although costs of care and premiums have. As a result, a $1,000 maximum benefit set in 1980 had only one-quarter of that amount in purchasing power in 2010.

**Preferred Provider Organizations**

A PPO combines a regular indemnity plan with a contracted network of dentists who agree to deliver specified services for discounted fees. Contracted dentists accept the maximum allowable fee as dictated by the plan, and benefit percentages paid are based on that plan allowance.

**Advantages:**
- Patients can maximize plan benefits by seeing contracted dentists.
- Many PPOs allow patients to see dentists who are not contracted with the plan.

**Disadvantages:**
- PPOs can drop dentists who provide care that exceeds what the plan considers necessary. This has the potential to discourage dentists from providing services that the plan doesn’t cover and can therefore interfere with the doctor–patient relationship. It also shifts costs to the patient, who often must pay the difference between what the plan covers and the actual cost of care.
- PPOs often reduce benefits when patients receive treatment from non-contracted dentists, effectively shifting costs to the patients.
- As with indemnity plans, failure to increase annual maximum benefits increasingly shifts costs to the patient.

**Dental HMOs/Capitation Plans**

Under these plans, contracted dentists are pre-paid a certain amount each month for each patient that has been assigned to that dentist. Dentists must then provide certain contracted services at no or reduced cost to covered patients. The model is supposed to be based on the average amount of care provided to plan participants and assumes that patients needing substantial treatment will be balanced out by those who require little treatment or do not seek any treatment. The plan usually does not...
reimburse dentists or patients for individual services and therefore, patients must generally receive treatment at a contracted office in order to receive benefits.

**Advantages:**
- Preventive and diagnostic services generally require no co-payment.
- No need to submit claim forms.

**Disadvantages:**
- Other covered services require co-payments.
- This model is most prevalent among lower-income populations, whose disease rates may be greater. As such, providers can actually lose money in order to get a patient to a state of good oral health. This discourages provider participation and reduces the availability of care.
- This plan has not proven to be an effective means of decreasing the disease burden.

**Direct Reimbursement (DR)**

As the name implies, direct reimbursement plans pay beneficiaries based on the amounts they spend on care, rather than on set amounts for specific procedures. In most cases, a direct reimbursement beneficiary pays the dentist the agreed upon fee and is then reimbursed for a percentage — up to 100 percent — of the cost of care, up to a preset cap.

**Advantages:**
- Patients are free to visit any dentist they choose.
- With some plans there are no claim forms to complete and no administrative processing to be done by the dental office.
- Simple plan administration can be handled by the firm itself or a third-party administrator at low costs.

**Disadvantages:**
- Some patients may have difficulty paying for treatment and waiting for reimbursement. However, some DR plans compensate for this by paying the patient in advance upon receipt of a treatment plan from the dentist.
- Despite its attractiveness to both patients and dentists, employers have been slow to take up the concept, and direct reimbursement plans are not widely available.

**Discount or Referral Plans**

Discount or referral plans are technically not benefit plans. They generally are used by patients who have no dental coverage. The company selling the plan contracts with a network of dentists who agree to discount their dental fees. Patients pay all the costs of treatment at the contracted rate determined by the plan.

**Advantages:**
- There are no dental claim forms to file.
- Advertised fees for services are less than the patient would pay outside the plan.

**Disadvantages:**
- The viability of these plans depends on a sufficient number of providers who are willing to discount fees. This could make it difficult for patients to find a dentist who participates in the plan in some markets.

**Alternative Financing**

In recent years, as coverage for dental services has failed to keep up with inflation, a variety of tax exempt or tax deferred mechanisms have increased the amounts that families can devote to dental expenses. They include:

**Flexible Spending Accounts and Cafeteria Plans**, through which employees can set aside predetermined amounts of pre-tax dollars to pay for a wide variety of health-related expenses, including dental.

**Health Reimbursement Arrangements**, employer-funded accounts set up for employees to spend on qualified health expenses not covered by a health care plan.

**Health Savings Accounts (HSA)**, which provide tax-advantaged alternatives to traditional health plans. In essence, health savings accounts permit employees to pay for necessary medical, dental and other health expenses with tax-free dollars. Employees own and are responsible for the funds in their HSAs.
Trends in Private Third-Party Financing

Three economic forces are creating a perfect storm that is reducing the number of U.S. families with any dental coverage. The first is unemployment. Despite recent signs of economic recovery, unemployment remains rampant, and millions of Americans will continue to suffer the consequences of a down economy for the foreseeable future. As people lose their jobs, they lose private insurance coverage, including dental benefits.

The second force is a steady reduction in the percentage of firms providing dental benefits. Approximately half of companies offering health benefits also offer dental benefits, a percentage that has remained level for several years. However, fewer and fewer employers are offering health benefits. The Census Bureau reports that the percentage of employers offering health benefits fell from 69.2 percent in 2000 to 58.6 percent in 2010. And dental benefits are falling at the same rate.

The third force is cost-shifting. A 2010 survey by the Kaiser Family Foundation and the Health Research and Educational Trust found that firms are increasing cost sharing, reducing the scope of coverage, or increasing the amount workers pay for third-party private benefits as a result of the economic downturn.

Out-of-Pocket Dental Expenditures

Real per-patient, out-of-pocket dental expenditures have increased in recent years, from $270 in 1996 to $332 in 2008. The figure for 2009 drops somewhat — to $323 — but this likely reflects the state of the economy, rather than any improvement in dental benefits. This contrasts with recent trends in per-patient, out-of-pocket expenditures for all health services, which were $709 in 2009, down from a peak of $843 in 2005. Dental care accounts for more than 22 percent of total consumer out-of-pocket spending on health care services. For a family of four living at the Federal Poverty Level ($23,050), this could mean $1,328 in out-of-pocket dental expenses, clearly out of reach for many such families.

The increase in per-patient, out-of-pocket dental expenditures likely stems from the reductions in private third-party coverage and limitations on dental care coverage within public programs. The end result is clear though — more and more of the cost of dental services is being shifted to the patient. And more people are reporting that their families are postponing or even forgoing dental care because they cannot afford it.

The retirement of tens of millions of Baby Boomers, at a rate of 10,000 per day, will add substantially to the existing group who have retired out of employer-sponsored dental plans and who will either have to purchase individual
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coverage or pay entirely out-of-pocket for dental care. Presently, 77 percent of over-65 Americans pays out-of-pocket for dental care.

States are responsible for providing funding for the program and the federal government provides a match, known as the Federal Medicaid Assistance Percentage (FMAP). There is no limit on the amount of funding the federal government will provide as long as a state contributes its share. FMAP provides greater matching assistance to states with higher proportions of low-income residents. The minimum FMAP is 50 percent and the maximum is 83 percent.

States design their Medicaid benefits packages within broad federal guidelines, which include federally required medical and dental benefits as well as coverage for certain vulnerable populations. Dental services are required as part of the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) program for qualifying Medicaid beneficiaries up to age 21. EPSDT is designed to provide comprehensive dental care for children at appropriate intervals, with an emphasis on prevention. State programs are required to develop a schedule that outlines the frequency of dental services. While specific services are not defined, they must include relief of pain and infection, restoration of teeth and maintenance of dental health. EPSDT requires state Medicaid programs to provide medically necessary services, such as hospitalization or anesthesia. But each state program determines what constitutes medical necessity. Dental services are not required for Medicaid beneficiaries over age 21, and few states provide anything beyond minimal coverage to adults.

Public Financing

Medicaid currently covers more than 57 million Americans. Though all states participate, it is a voluntary program that is jointly financed by the states and the federal government.

Real Per-Patient Out-of-Pocket Dental Expenditures, 1997–2009 (in 2009 Dollars)

Source: National Health Expenditures (NHE) Data by Type of Expenditure and Source of Funds: Calendar Years 1997–2009
The Children’s Health Insurance Program (CHIP) was created in 1997 to provide health coverage to children whose families don’t qualify for Medicaid but cannot afford private health insurance. Similar to Medicaid, states design and administer the program benefits within broad federal guidelines. The Children’s Health Insurance Program Reauthorization Act of 2009 included dental services as a federally required benefit. Prior to this time, states provided dental services, but benefits varied and were vulnerable to elimination in economic downturns.

State funding for public dental programs seesaws with the economy. Unfortunately, program enrollment mirrors this. As unemployment rises, enrollment increases, which places additional burdens on state programs already facing cuts caused by revenue shortfalls. Congress has provided temporary FMAP increases during economic downturns, most recently through the American Recovery and Reinvestment Act of 2009. But even with temporary FMAP increases, Medicaid programs frequently reduce reimbursement rates and non-mandated services, eliminating any benefit not required by federal law, such as adult dental coverage. Prior to the current recession, many states had implemented reimbursement rate increases for dentists in successful efforts to expand access. But fiscal pressures resulted in 20 states cutting rates in FY 2010 and FY 2011.

Despite the fact that tooth decay is the most common, chronic childhood disease and is preventable, dental services constitute, on average, less than 2 percent of state Medicaid expenditures. By comparison, dental care accounts for 9 percent of private sector health expenses.

Well over half the states report that revenues will not cover planned expenses for the next few years, and spending cuts cannot be avoided. Medicaid, as one of the largest parts of state budgets, is a logical target for reductions. Federal Medicaid regulations require states to reimburse providers at rates adequate to ensure that services for Medicaid enrollees are available to an extent equivalent to similar services available to the general population. This Equal Access provision of Medicaid is an obstacle when states

Enrollment in Medicaid and CHIP increases by roughly one million people for every one percent increase in the unemployment rate.

Percent of Medicaid Expenditures by Category of Service — 2009

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Source: National Health Expenditures Data (NHE), 2009
Dentists’ reimbursement for providing care under Medicaid is often less than their operating costs and almost always far less than market rates.

Propose to reduce payments to health care providers as a means of cutting state spending. Recently, the Department of Health and Human Services proposed more robust enforcement of the Medicaid Equal Access law, which will squeeze the states even further, with downward pressure from the federal government and upward pressure from increasing numbers of people whose economic circumstances make them eligible for Medicaid.

The Kaiser Family Foundation estimates that from December 2007 through June 2010, Medicaid enrollment nationwide increased by about 18 percent. In 2010, monthly Medicaid enrollment averaged 57.7 million, according to the Congressional Budget Office.

Dental care under Medicaid going forward will be subject to recently adopted structural changes. Under the maintenance of effort provisions in the Patient Protection and Affordable Care Act (PPACA), states are not allowed to reduce Medicaid eligibility requirements beyond those that were in place when the president signed the law, March 23, 2010. (At this writing, the U.S. Supreme Court is deliberating the possibility of striking down key provisions of the PPACA, which could potentially affect all of the law’s provisions). Additionally, enhanced federal funding for Medicaid that has been in place over the past few years has expired, which places a greater burden on states to cover health care costs for the poor.

These realities make fiscal planning for health care extremely difficult for state governments. Oral health advocates are likewise challenged to protect funding for publicly funded programs, particularly Medicaid, as the economy and federal requirements continue to shift.

Of course, these challenges trickle down to the providing dentists and, most important, to the patients they serve. Dentists’ reimbursement for providing care under Medicaid is often less than their operating costs and almost always far less than market rates. In addition to inadequate reimbursement, the well-documented impediments to private practitioners who want to participate in Medicaid include unduly burdensome administrative requirements and lack of case management, which results in poor patient adherence to treatment plans and high rates of missed appointments. Addressing these issues has been proven to increase the number of dentists able to provide comprehensive dental care to those who need it most.

How Medicaid Funding Affects Access to Care

- A 2009 increase in Medicaid reimbursement in Connecticut increased the number of participating dentists from 150 to 1,359.
- In contrast, a sharp decrease in Medicaid reimbursement in Georgia in 2006 precipitated a corresponding decrease in dentists able to participate substantially in the program, from nearly 1,900 to 400.
Charity Care

The ADA estimates that dentists in private practice provided $2.16 billion in free or discounted care in 2007 alone. More than 70 percent of dentists provide charity care, with the typical dentist donating more than $13,000 in free or discounted care annually. The words of one dentist, now retired from private practice, offer a personal perspective:

“When in practice, once someone was a patient of record, they remained such regardless of the tricks life can play on an individual or family. If someone lost their job, I simply did not abandon them, or say, ‘Sorry Mr. Smith, now that you’re unemployed we’ve cancelled your next recall appoint. Please call us back when you have a job.’ I couldn’t do that. The same would apply if someone became ill, disabled, widowed or divorced. You were part of the practice, I was responsible to care for you and your family, and I continued to do so, regardless of the ability to pay. I remain confident that this is the moral and ethical thing that one must do when one is in practice.”

People living in communities with large, economically disadvantaged populations (primarily the working poor, the elderly, the disabled, and the uninsured) often have no easily obtainable dental care. As a consequence, many live with extreme pain and disfigurement, which is often accompanied by a sense of shame. Responding to these profound access disparities, many state dental societies organize Missions of Mercy (MOMs), temporary dental field hospitals set up in such underserved locations as remote rural areas, inner cities and Native American communities. MOM events since 2000 have provided some $50 million in care to more than 100,000 people who otherwise might never receive it. In addition, MOMs and other charitable events seek to make visible what Surgeon General David Satcher, M.D., famously called a “silent epidemic” of untreated oral disease. Hundreds of people — dentists, allied dental professionals and lay people — volunteer for each MOM project. Private foundations and corporations provide support. At this writing, 29 state dental societies have conducted or are planning MOM events in 2012.

Some dental MOM projects operate in conjunction with Remote Area Medical Volunteer Corps (RAM), a non-profit, volunteer, airborne relief corps dedicated to serving the public by providing free health care, including dental care, eye care, veterinary services, and technical and educational assistance worldwide, including the United States. Founded in 1985, RAM is a publicly supported all-volunteer charitable organization. Volunteer physicians, nurses, pilots, dentists, veterinarians and support workers participate in expeditions at their own expense.

Give Kids A Smile® (GKAS) began as an annual one-day volunteer initiative to provide education, preventive and restorative services to children from low-income families. Thousands of dentists and their staff across the country take time from their practices to help underserved children who aren’t getting the oral health care they need. It is an annual centerpiece to National Children’s Dental Health Month and is observed every year on the first Friday in February, though GKAS events are held throughout the year. The ADA is expanding GKAS to ensure dental homes and continuity of care to as many of these needy children as possible.

In addition to providing free care to needy children, GKAS seeks to grow awareness of the need to extend good oral health to all American children. One example of this awareness-building component was a dental health screening event at the Charlotte Motor Speedway’s “Kid Zone” during the NASCAR Charlotte Race Weekend, where 85 volunteer dentists and other dental team members
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provided free dental evaluations, fluoride treatments and dental sealants to 175 children. February 2012 marked the 10th anniversary for GKAS. To date, GKAS has provided educational, preventive and restorative services to approximately 4.5 million children.

Since its inception in 1993, Special Olympics Special Smiles® has demonstrated remarkable success in its mission: increasing access to dental care for Special Olympics athletes and other people with intellectual disabilities. Dental screenings at Special Olympics events increase awareness of the oral health needs of the athletes themselves, as well as their parents and/or caregivers. Providing solutions to chronic dental problems, or providing an athlete with a mouth guard, can enhance the athlete’s performance. One of the primary objectives of Special Smiles is to increase the number of dental professionals who will serve people with intellectual disabilities in their practices and clinics. This is accomplished by encouraging dental students, as well as practicing dentists, to participate in Special Smiles events.

The Dental Lifeline Network (DLN) coordinates the Donated Dental Services (DDS) program nationally. Over the past 25 years, the DDS network has spread to 40 states, and has engaged 15,000 volunteer dentists and 3,200 dental laboratories in donating comprehensive treatment services to people with disabilities or who are elderly or medically at-risk, and who cannot afford care. The DLN national safety net program provides limited services in the remaining 10 states and the District of Columbia. Collectively, these programs have generated $200 million in services for 103,000 vulnerable people. Historically, state governments have provided most of the funding for DDS administrative and technical support services. But over the past few years, these programs have suffered significant cuts, ultimately causing their complete elimination in Illinois, Kansas, Louisiana, Oregon, Pennsylvania and Minnesota. In the current fiscal environment, more states may follow. One result of these cutbacks is a corresponding decline in case management services, without which many dentists who would participate in DDS are reluctant to do so.

In addition to the programs detailed above, a network of free clinics has gradually developed in the United States to provide care for the uninsured. Structured as private, non-profit organizations, free clinics offer basic health care services to uninsured patients by licensed volunteer clinicians at little or no cost. A recent study identified 1,000 such clinics and reported that 35 percent provide on-site dental services. Collectively, these clinics were estimated to provide nearly 300,000 dental visits annually.

Ohio’s Dental OPTIONS program, (Ohio Partnership to Improve Oral health through access to Needed Services) primarily serves adults, the majority of whom are the working poor or senior citizens on fixed incomes. These patients have no private dental insurance and are not Medicaid-eligible. The program has delivered more than $16 million in free dental services to thousands of Ohioans since its inception in 1997. In the first six months of the 2011-12 fiscal year, 416 patients have received treatment valued in excess of $1 million. An additional 579 people have been matched with dentists who will treat them. Nine hundred seventy-one dentists currently serve as Dental OPTIONS volunteers.

Certainly, charity care provided by private practice dentists represents a significant contribution to meeting the oral health care needs of the underserved. However, charity is not a health care system, and dentists alone can never successfully bear the burden of providing continuous care to these populations without better support from state and federal governments.

Looking Forward

Although overall U.S. expenditures on dental care are dwarfed by those for medical care, the financial barriers to dental care are potentially more significant, given the reliance on out-of-pocket payments and increased cost shifting from benefit plans to patients. According to the Economic Policy Institute, the declining number of Americans with employer-sponsored health insurance and the associated increase in the total uninsured over the past decade are likely to continue. Although the implementation of the PPACA may slow or even reverse that trend for overall health insurance, its main dental provisions apply only to children.

The PPACA requires states to create insurance “exchanges,” through which individuals and small businesses will be able to purchase coverage that contains a set of essential health
benefits, beginning in 2014. A pediatric dental benefit must be included as part of the essential benefits package offered through the exchanges. While adult dental benefits will not be a requirement, plans will be allowed to offer coverage for individual adults and small businesses that choose to purchase them.

The PPACA is estimated to result in 5.3 million more children gaining dental coverage by 2014. Many of them will enter Medicaid or CHIP programs. However, it is not clear where additional funding for these programs will come from. According to a recent survey of state governors, most states plan on cutting funding to Medicaid programs. State Medicaid programs hope to reduce costs by contracting with large managed care providers. These trends may allow states to cover more people while reducing expenditures, but a likely result will be pressure to reduce already low reimbursements to health care providers, which will in turn reduce beneficiaries’ access to care. One potential benefit from the exchanges is that they will allow interstate competition among health plans, which could result in better coverage for plan participants.

According to a recent survey of state Medicaid budgets for Fiscal Years 2010 and 2011, benefit restrictions are also likely. In FY 2010, 20 states implemented benefit restrictions and 14 states planned benefit restrictions in FY 2011. These benefit restrictions include eliminating covered benefits and applying utilization controls or limits for existing benefits. For example, several states, including Arizona, California, Hawaii and Massachusetts, have eliminated all or some adult dental services.

These trends suggest that both public and private third-party financing for dental care will continue to decline in the short term. This is expected to increase the financial burden on privately covered patients through higher out-of-pocket costs, further restricting access to care. For those with no means to pay, receiving care through Medicaid and other assistance may prove even more difficult than it is now.

The ADA believes that adequate funding should be made available through both public and private financing mechanisms. Financial barriers to care must be removed or lessened to increase the utilization of dental services. Policies should be adopted to increase the treatment capacity of dental offices. Expanded function dental assistants, working under the supervision of dentists, have been shown to increase efficiency. Dental hygienists are invaluable dental team members and should be employed in as many practices as is feasible. Graduates of the ADA’s Community Dental Health Coordinator pilot project are working in underserved areas, providing oral health education, preventive services and helping patients navigate an often daunting system and receive care from dentists.

Although some states are exploring the use of so-called “midlevel” providers to perform surgical procedures as a cost-saving solution, there is no evidence that these providers will lower the cost of care or improve access to dental services among the underserved. The ADA believes every person deserves a dentist. Only dentists are adequately trained to provide such crucial aspects of care as proper diagnosis, treatment planning and surgery. As the leader of the team, only a dentist possesses the breadth and depth of knowledge and training needed to coordinate all of the elements that go into comprehensive patient care, detect conditions in the mouth that could indicate systemic health problems, and deal with dental and nondental emergencies that could occur during or after treatment.

The current fiscal reality may preclude immediate, major strides in the recommendations that follow. But it does not preclude those who care about the health and productivity of all Americans from aiming high and agreeing to work toward the day when unnecessary, costly, preventable dental disease is a thing of the past. It is with that in mind that we set these goals, which we believe the nation can meet and which will reap great and worthwhile benefits over time.

• **The government can use tax policy** to encourage small employers and individuals to purchase dental benefit plans in the private sector or develop cooperative purchasing alliances, such as the state exchanges created by the PPACA. Cost sharing (copayments) should be eliminated for diagnostic, preventive, and direct restorative procedures. Necessary care should not be subject to unreasonably low yearly maximums on coverage.

• **Maximum plan benefits should be set** in an open and transparent manner, with appropriate scrutiny from attorneys general, insurance commissioners and providers.
• **Medicaid and CHIP should reimburse** for dental care minimally at rates that are acceptable to sufficient numbers of dentists practicing in the covered area to provide care to those eligible patients who seek it, as consistent with federal law. State programs should base these rates on the ADA Survey of Dental Fees or an equivalent database.

• **Preventive care reduces the disease burden**, thereby reducing the need for restorative care and yielding improved health and cost savings. Dentistry has always been on the forefront of prevention. But to show even greater results, dental plans should cover 100 percent of the cost for preventive services.

• **State health exchanges should offer** reasonably priced dental coverage to adults, especially the vulnerable elderly.

• **States should implement administrative reforms** to cut red tape that impedes dentists from delivering care and patients from receiving it. In many cases, this may involve “carving out” the dental portion of Medicaid and dedicating health department staff exclusively to running the dental portions of their Medicaid and CHIP programs.

• **State Medicaid programs should be broadened** gradually to include adults, beginning with coverage for urgent care that otherwise drives them to hospital emergency departments.

• **Federal and state governments should expand** programs that provide incentives for dentists to establish practices in underserved areas. Such programs are proven to work, and are especially attractive to new dental school graduates, who carry an average debt load of $200,000, and who increasingly are interested in loan forgiveness arrangements.

Certainly, increased funding alone cannot “fix” a dental financing system that is rife with inefficiencies and shifting policies, and overly tilted toward costly surgical intervention in disease that could have been prevented. Healthy people of means would be better off self-funding their dental treatment than paying for insurance that has inadequate annual maximums and co-pays for major procedures. People of lesser means would be better off going to get their teeth checked periodically, even though the costs come out of pocket, rather than waiting until something hurts, which increases costs dramatically and can lead to lost teeth and cause or aggravate other health problems.

Funding alone will not guarantee other needed improvements in the system — a greater emphasis on oral health education and disease prevention, case management and improved public health programs. These goals can and must be pursued by expanding, not reinventing the existing system of care. Increased funding and better use of currently available funds will enable great strides toward breaking down the barriers that continue to impede too many Americans from achieving optimal oral health.
About the American Dental Association
The not-for-profit ADA is the nation’s largest dental association, representing more than 157,000 dentist members. The premier source of oral health information, the ADA has advocated for the public’s health and promoted the art and science of dentistry since 1859. The ADA’s state-of-the-art research facilities develop and test dental products and materials that have advanced the practice of dentistry and made the patient experience more positive. The ADA Seal of Acceptance long has been a valuable and respected guide to consumer dental care products. The monthly *The Journal of the American Dental Association (JADA)* is the ADA’s flagship publication and the best-read scientific journal in dentistry.

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