

Statement of the
American Dental Association's Health Policy Institute

to the

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Finance Committee
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on

An Oral Health Crisis: Identifying and Addressing Health Disparities

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On behalf of the American Dental Association's Health Policy Institute, thank you Chairman Cardin and Ranking Member Daines for the opportunity to testify and share data-driven insights at today's hearing: "An Oral Health Crisis: Identifying and Addressing Health Disparities."

My name is Marko Vujicic. I am the Chief Economist & Vice President of the Health Policy Institute at the American Dental Association. Over the past twelve years, I have led a team of researchers who study the U.S. dental care system, covering topics such as access to dental care, the dental workforce, dental care utilization, dental education, oral health outcomes, and more.

The American Dental Association is pleased to see that the Senate Finance Health Care Subcommittee has selected the topic of oral health as their first hearing of the 118th Congress. This is a testament of not only the important link between oral health and overall health and well-being, but a recognition that there is a need for action. We can and should do better when it comes to our nation's oral health.

My testimony is focused around three main themes: the state of oral health in America; the policy choices we have made along the way; and considerations as we move forward.

The State of Oral Health in America – Key Trends to Highlight from the Data

Among U.S. children, oral health is improving. Over the past two decades, rates of untreated dental disease have been declining; dental care utilization has been increasing, particularly for key preventive services (e.g., dental sealants); and more and more children are covered by some form of dental benefits.¹ These improvements have been most dramatic for low-income children and non-White children. In fact, in several states, including Texas, Hawaii, and Wyoming, dental care utilization rates for Medicaid-insured children are comparable to those of privately-insured children.² New analysis shows that the mix of dental care services being provided to Medicaid-insured children is similar to those being provided to privately-insured children.³ When it comes to children's oral health in America, disparities by income and by race have been narrowing over time.

For working-age adults (age 19-64) and seniors (age 65 and older), the trends are different. For example, rates of untreated disease among working-age adults have not changed significantly over the past two decades, and disparities by income and race are persistent and much wider than for children. The percent of working-age adults who visit a dentist in the course of a year is actually slightly lower today than two decades ago. For seniors, dental care utilization rates have increased over time, but the disparities by income and by race have been stable. In fact, gains in some oral health measures, such as reductions in tooth loss, are concentrated among high-income seniors.⁴ Overall, disparities in oral health are stable for working-age adults and seniors.⁵

In any given year, less than half of the U.S. population visits a dentist.⁶ But oral health in America is a two-part story. We have seen two decades of steady improvements among children, particularly the most vulnerable, in tandem with much less progress among working-age adults and seniors.

The Policy Choices We Have Made Along the Way

The trends in oral health we observe are a result of how dental care is handled in federal and state health policy, particularly the different policy approach for children compared to working-age adults and seniors. Comprehensive dental coverage is a requirement in Medicaid and CHIP programs and is part of the essential health benefit under the Affordable Care Act. As a result, over 90% of U.S. children are covered by dental insurance and this percentage has been increasing steadily the past two decades. Because dental care is an essential service, there are checks and balances in place to ensure a comprehensive basket of dental care services is covered for children with minimal cost-sharing among beneficiaries.

For working-age adults and seniors, the policy approach has been very different. Dental care is not considered an essential health benefit. Medicaid programs are not required to cover dental care services for adults, and traditional Medicare does not cover dental services except in certain circumstances that are linked to medical procedures. The Affordable Care Act did not include adult dental care as an essential health benefit.

As a result, there is considerable variation, for example, in adult dental coverage within state Medicaid programs. As of October 2022, only half of states provide comprehensive dental coverage to adults in their Medicaid programs.⁷ However, more and more states have added dental coverage for adults over the past several years, including all state Medicaid programs now providing dental coverage during pregnancy and for at least 60 days post-partum.⁸

For seniors, dental coverage is an optional benefit within Medicare Advantage, with 94% of enrollees having some form of dental coverage as part of their plan. However, the range of dental care services covered within these plans varies considerably, with some covering only preventive services. Most plans have considerable coinsurance rates (e.g., 50%) for dental care services beyond routine check-ups and cleanings.⁹ There is very little data available on utilization rates for supplemental benefits, including dental care, among Medicare Advantage enrollees.¹⁰ However, a recent study found that dental care utilization rates and certain measures of oral health decline when people reach Medicare eligibility and, more significantly, there were no differences between enrollees in traditional Medicare compared to Medicare Advantage.¹¹ Of all the supplemental benefits, Medicare Advantage enrollees report the most confusion and dissatisfaction about dental coverage.¹⁰

Due to the very different policy approaches taken toward dental care for children compared to working-age adults and seniors, we see vastly different degrees of financial barriers to dental care. A much larger

share of working-age adults and seniors report they cannot access needed dental care services due to affordability issues compared to children.¹² Moreover, 'cost' is the top reason working-age adults and seniors are not able to access dental care, and financial barriers are more severe for dental care than any other health care service (e.g., prescription drugs, mental health, physician services). This is a direct consequence of policy choices.

Essentially, our health policy approach disconnects the mouth from the body when you become an adult.

Key Considerations for Policy Makers Moving Forward

As policymakers consider ways to address the oral health issues facing the nation, there are some important findings from the data and evidence that I wish to highlight.

The Economic and Fiscal Dividend of Improved Oral Health

Beyond the fact that you cannot be healthy without a healthy mouth,¹³ there is compelling empirical evidence of the economic benefits associated with improved oral health. Oral health issues limit job prospects, hinder workplace productivity, and limit employee earnings. An estimated 29% of low-income adults in the U.S. report that the appearance of their mouth and teeth affects their ability to interview for a job.¹⁴ For low-income adults living in states that do not provide adult dental coverage in their Medicaid program, this figure jumps to 60%. When states provide comprehensive adult dental coverage in their Medicaid program, the job prospects of Medicaid beneficiaries improve and the effect is most significant for Black Medicaid beneficiaries.¹⁵ Investing in oral health improves job prospects and helps narrow economic disparities.

There is new research linking improved oral health with reduced overall health care spending. These links are strongest for certain medical conditions like diabetes, heart disease, and pregnancy. One study shows that newly diagnosed diabetics see reductions in health care spending if they receive certain dental care treatments while those that go without dental care do not.¹⁶ Among pregnant women, when dental care is included as part of routine prenatal care, overall medical care costs associated with the pregnancy are lower.¹⁷

Every 15 seconds in America, someone shows up at a hospital emergency department because of a dental issue. The estimated 2.1 million emergency department visits for dental conditions cost the U.S. health care system \$2.7 billion each year, with Medicaid accounting for the largest share of this spending.¹⁸ This is an example of inefficient spending that could be avoided if more Americans had access to a dental home for routine care and prevention.

The American Dental Association's Health Policy Institute has developed a quantitative model to estimate the fiscal impact of alternative adult dental coverage policies in Medicaid on state budgets. In addition to

estimating additional dental care spending, the model incorporates the fiscal offsets associated with reduced emergency room costs as well as reduced medical care costs. The net cost of adding comprehensive adult dental benefits into all state Medicaid programs that currently do not provide such benefits is estimated at \$836 million per year¹⁹. Detailed analysis has been provided to state legislatures in Maine, Hawaii, Virginia, and Florida.²⁰⁻²³

Investing in oral health also impacts the local economy beyond reduced health care costs, improved job prospects, and overall wellbeing. Each dental practice is estimated to contribute \$2.3 million annually to the local economy when the various direct and indirect effects are taken into consideration.²⁴ Overall productivity losses associated with untreated oral disease were estimated to be \$45.9 billion per year in the U.S., much higher than any other country.²⁵

As a nation, we are paying an economic penalty for how we address dental care within health policy.

A Dental Workforce that is Sufficient, Diverse, Healthy and Located Where it is Needed Most

As in much of health care, the COVID-19 pandemic significantly disrupted the labor market for dental team members. Dental practices are having a tough time finding qualified staff, particularly dental hygienists and dental assistants. As of March 2023, 96% of dentists report it is extremely or very difficult to fill vacant dental hygienist positions and 86% of dentists report the same for dental assistant positions.²⁶ Enrollment in dental hygiene programs has only recently recovered to pre-pandemic levels while enrollment in dental assisting programs has been on a steady decline since before the pandemic.²⁷ As a result, the current staffing shortage for dental hygienists and dental assistants is likely to persist for several years. In the interim, there are strategies for employers to effectively recruit and retain staff²⁸ and for state and federal policymakers to boost training capacity.²⁹

Like many other health care professions, the pandemic took a toll on the mental health and wellbeing of dental team members. Levels of anxiety and depression spiked mid-2020 and then steadily decreased through 2021.³⁰

Beyond the disruptions associated with the COVID-19 pandemic, the supply of dentists per capita is predicted to be steady through 2025 and then to increase significantly after that.³¹ However, between 2011 and 2021, the number of dentists per 100,000 population increased from 60.8 to 62.8 in urban areas while decreasing from 37.3 to 36.5 in rural areas. This is an important issue to highlight, as geographic access to dental care providers in rural areas is much lower than in urban areas.³² There are several policy options to consider to attract and retain more dental care providers in rural areas, including loan forgiveness programs tied to geographic areas, education pathway programs, enhanced mobile clinics, alternative workforce models and scope of practice, and targeted visa programs, to name a few.³³

Related to geographic access to dentists, it is important to note that conventional methods of designating ‘shortage areas’ for dental care providers – including the methodology used by HRSA – are significantly flawed. Much has been written about the drawbacks, including a concise two-page summary,³⁴ and the American Dental Association’s Health Policy Institute has developed an alternative, peer-reviewed methodology that addresses these shortcomings. The American Dental Association’s Health Policy Institute has offered, and continue to offer, to assist government agencies in any way to improve the data and methods for assessing provider adequacy. In the meantime, the analysis for every state, including a separate analysis for Medicaid beneficiaries, can be accessed on the American Dental Association’s Health Policy Institute website.³⁵

Among Medicaid beneficiaries, particularly adults, finding a dentist who participates in the Medicaid program is an important barrier to care in many states. One out of three dentists in the U.S. sees at least one Medicaid patient in the course of a year. A mere 18% of dentists see at least 100 Medicaid patients per year. There is significant variation in these kinds of statistics by state and dentist characteristics. At the state level, Vermont, Missouri, and Montana have the highest shares of dentists seeing a high volume of Medicaid patients.³⁶

Policymakers have a considerable body of evidence at their disposal to design effective policies that can boost provider participation in Medicaid. These ‘good practices’ are well documented and include streamlined credentialing and broader administrative practices, sufficient fees, patient navigation assistance to reduce missed appointments, and expanded scope of practice for dental team members. What has been studied less is the role of individual dentist characteristics and practice modalities in the Medicaid participation decision. New research³⁷ indicates that, all else equal, racially and ethnically diverse dentists are far more likely to see a high volume of Medicaid patients. Dentists in large group practices are also more likely than solo practitioners to see a high volume of Medicaid patients. As dental school enrolment diversifies³⁸ and more dentists practice in larger groups,³⁹ this could lead to more dentists, in aggregate, participating in Medicaid.

The dentist workforce does not reflect the U.S. population when it comes to racial and ethnic diversity. The latest data indicate that Black and Hispanic dentists are significantly under-represented in relation to the U.S. population overall.⁴⁰ For example, 3.8% of dentists are Black compared to 12.4% of the U.S. population. Similarly, 5.9% of dentists are Hispanic compared to 18.4% of the U.S. population. Dental school enrollment data indicate a slight increase in diversity. For the 2021-22 school year, 7.3% of first-year dental students were Black and 10.7% were Hispanic, meaning we can expect a more diverse workforce in the future.

The Importance of Addressing Cost Barriers to Dental Care

The evidence is compelling that the most important barriers to dental care for working-age adults and seniors relate to affordability, particularly for those of low income. Lack of dental coverage as well as shortcomings in the status quo model of dental insurance for working-age adults and seniors are key factors driving up financial barriers to dental care. There are a host of policy approaches that could be explored to address affordability. These include improving transparency and accountability within the private dental insurance market through, for example, applying minimal loss ratios to dental insurance plans, setting out-of-pocket payment limits for patients or, even more simply, requiring better data reporting.⁴¹ The private dental insurance model as it currently operates is not true insurance, as it almost universally has an annual maximum benefit and significant coinsurance rates for services beyond prevention. Policymakers could explore broader reforms such as classifying dental care as an essential benefit for all age groups, using the key policy parameters around children's dental care as a framework.

Chairman Cardin and Ranking Member Daines, thank you again for this opportunity to share with you and the subcommittee some key data-driven insights on our nation's oral health. The American Dental Association looks forward to working with the Senate Finance Committee to continue to tackle this important area of health policy.

¹ National Institute of Dental and Craniofacial Research. Oral Health in America: Advances and Challenges. 2021. Bethesda, MD: National Institutes of Health. Available from: <https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Advances-and-Challenges.pdf>. Accessed March 24, 2023.

² American Dental Association. Dental care use among children: 2016. Health Policy Institute. Infographic. July 2018. Available upon request.

³ Nasseh K, Fosse C, Vujicic M. Comparative analysis of dental procedure mix in public and private dental benefits programs. *JADA*. 2022;153(1):P59-66.

⁴ Dye BA, Weatherspoon DJ, Lopez Mitnik G. Tooth loss among older adults by poverty status in the United States from 1999-2004 to 2009-2014. *JADA*. 2019;150(1):9-23.e3.

⁵ Yarbrough C, Vujicic M. Oral health trends for older Americans. *JADA*. 2019;150(8):714-716.

⁶ Manski R, Rohde F, Ricks T. Trends in the number and percentage of the population with any dental or medical visits, 2003–2018. Agency for Healthcare Research and Quality. Statistic brief #537. October 2021. Available from: https://meps.ahrq.gov/data_files/publications/st537/stat537.pdf. Accessed March 24, 2023.

⁷ National Academy for State Health Policy. State Medicaid coverage of dental services for general adult and pregnant populations. Updated October 22, 2022. Available from: <https://nashp.org/state-medicaid-coverage-of-dental-services-for-general-adult-and-pregnant-populations/>. Accessed March 24, 2023.

⁸ U.S. Department of Health and Human Services. HHS approves 12-month extension of postpartum Medicaid and CHIP coverage in North Carolina. September 22, 2022. Available from: <https://www.hhs.gov/about/news/2022/09/22/hhs-approves-12-month-extension-of-postpartum-medicaid-and-chip-coverage-in-north-carolina.html>. Accessed March 24, 2023.

⁹ Freed M, Ochieng N, Sroczynski N, Damico A, Amin K. Medicare and dental coverage: a closer look. Kaiser Family Foundation. Issue brief. July 28, 2021. Available from: <https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/>. Accessed March 24, 2023.

-
- ¹⁰ Government Accountability Office. Medicare Advantage: plans generally offered some supplemental benefits, but CMS has limited data on utilization. Report to Congressional Committees. GAO-23-105527. January 2023. Available from: <https://www.gao.gov/assets/gao-23-105527.pdf>. Accessed March 26, 2023.
- ¹¹ Simon L, Song Z, Barnett ML. Dental services use: Medicare beneficiaries experience immediate and long-term reductions after enrollment. *Health Affairs*. 2023; 42(2):286-295.
- ¹² Vujicic M, Fosse C. Time for dental care to be considered essential in US health care policy. *JAMA Ethics*. 2022; 24(1):E57-63.
- ¹³ U.S. Department of Health and Human Services. Oral health in America: a report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health. 2000. Available from: <https://www.nidcr.nih.gov/sites/default/files/2017-10/hck1ocv.%40www.surgeon.fullrpt.pdf>. Accessed March 24, 2023.
- ¹⁴ American Dental Association. Oral health and well-being in the United States. Health Policy Institute. Infographic. 2015. Available from: <https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/us-oral-health-well-being.pdf>. Accessed March 26, 2023.
- ¹⁵ Vujicic M, Fosse C, Reusch C, Burroughs M. Making the case for dental coverage for adults in all state Medicaid programs. American Dental Association. Health Policy Institute White Paper. July 2021. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/whitepaper_0721.pdf. Accessed March 24, 2023.
- ¹⁶ Nasseh K, Vujicic M, Glick M. The relationship between periodontal interventions and healthcare costs and utilization. Evidence from an integrated dental, medical, and pharmacy commercial claims database. *Health Economics*. 2017;26:516-527.
- ¹⁷ Jeffcoat MK, Jeffcoat RL, Gladowski PA, Bramson JB, Blum JJ. Impact of periodontal therapy on general health: evidence from insurance data for five systemic conditions. *Am J Prev Med*. 2014;47(2): 166-174.
- ¹⁸ American Dental Association. Emergency department visits for dental conditions – a snapshot. Health Policy Institute. Infographic. April 2020. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0420_1.pdf. Accessed March 24, 2023.
- ¹⁹ Vujicic M, Fosse C, Reusch C, Burroughs M. Making the case for dental coverage for adults in all state Medicaid programs. American Dental Association. Health Policy Institute White Paper. July 2021. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/whitepaper_0721.pdf. Accessed March 24, 2023.
- ²⁰ Vujicic M, Fosse C. Estimating the cost of introducing comprehensive Medicaid adult dental benefits in Florida. American Dental Association. Health Policy Institute. Research brief. May 2021. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_0621_1.pdf. Accessed March 24, 2023.
- ²¹ Vujicic M, Fosse C. Estimating the cost of introducing a Medicaid adult dental benefit in Maine. American Dental Association. Health Policy Institute. Research brief. March 2021. Available from: https://www.maineohn.org/assets/docs/ADA_HPI_Estimating_the_Cost_of_MADB_in_Maine_FINAL.pdf. Accessed March 24, 2023.
- ²² Vujicic M, Starr RR, Fujii DF, Starkel Weninger R, Harrison B. Estimating the cost of introducing comprehensive Medicaid adult dental benefits in Hawaii. Association. Health Policy Institute. Research brief. February 2020. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_0220_1.pdf. Accessed March 24, 2023.
- ²³ Vujicic M, Starkel R, Harrison B. Estimating the cost of introducing comprehensive Medicaid adult dental benefits in Virginia. Association. Health Policy Institute. Research brief. January 2020. Available from: https://vahealthcatalyst.org/wp-content/uploads/2020/02/HPI-Report-with-Intro-Letter_Update.pdf. Accessed March 24, 2023.
- ²⁴ American Dental Association. Total economic impact of dentists: over \$350 billion. December 2022. Available upon request.
- ²⁵ Righolt AJ, Jevdjevic M, Marcenes W, Listl S. Global-, regional-, and country-level economic impacts of dental diseases in 2015. *J Dent Res*. 2018;22034517750572.

-
- ²⁶ American Dental Association. Economic outlook and emerging issues in dentistry. Insights from data from March 2023. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/mar2023_hpi_economic_outlook_dentistry_slides_2023.pdf. Accessed March 24, 2023.
- ²⁷ American Dental Association. Survey of Allied Dental Education Programs, 2021-22. Report 1, Table 1. Health Policy Institute, Commission on Dental Accreditation. Available from: <https://www.ada.org/resources/research/health-policy-institute/dental-education>. Accessed March 26, 2023.
- ²⁸ ADA Health Policy Institute in collaboration with American Dental Assistants Association, American Dental Hygienists' Association, Dental Assisting National Board, and IgniteDA. Dental workforce shortages: Data to navigate today's labor market. October 2022. Available from: https://www.ada.org/-/media/project/adaorganization/ada/ada-org/files/resources/research/hpi/dental_workforce_shortages_labor_market.pdf. Accessed March 24, 2023.
- ²⁹ Garvin J. Oregon Dental Association supports bill to increase recruitment, retention of dental support staff. *ADA News*. March 2, 2023. Available from: <https://www.ada.org/publications/ada-news/2023/march/oregon-dental-association-supports-bill-to-increase-recruitment-of-dental-support-staff>. Accessed March 24, 2023.
- ³⁰ Eldridge LA, Estrich CG, Gurenlian JR, et al. US dental health care workers' mental health during the COVID-19 pandemic. *JADA*. 2022;153(8):P740-749.
- ³¹ Munson B, Vujicic M. Projected supply of dentists in the United States, 2020-2040. American Dental Association. Health Policy Institute. Research brief. May 2021. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_0521_1.pdf. Accessed March 24, 2023.
- ³² Nasseh K, Eisenberg Y, Vujicic M. Geographic access to dental care varies in Missouri and Wisconsin. *Public Health Dent*. 2017;77(3):197-206.
- ³³ Oral Health Workforce Research Center. How evidence-based is US dental workforce policy for rural communities? Center for Health Workforce Studies. School of Public Health. University at Albany. September 2020. Available from: https://oralhealthworkforce.org/wp-content/uploads/2020/10/OHWRC_Dental_Workforce_Policy_for_Rural_Communities_2020.pdf. Accessed March 24, 2023.
- ³⁴ Vujicic M. A new way to measure geographic access to dentists in North Carolina. *North Carolina Medical Journal*. 2017. 78(6):391-392.
- ³⁵ American Dental Association. Geographic access to dental care. Health Policy Institute. Available from: <https://www.ada.org/resources/research/health-policy-institute/coverage-access-outcomes/geographic-access-to-dental-care>. Accessed March 24, 2023.
- ³⁶ Vujicic M, Nasseh K, Fosse C. Dentist participation in Medicaid: how should it be measured? Does it matter? American Dental Association. Health Policy Institute Research Brief. October 2021. Available from: https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1021_1.pdf. Accessed March 24, 2023.
- ³⁷ Nasseh K, Fosse C, Vujicic M. Dentists who participate in Medicaid: who they are, where they locate, how they practice. *Med Care Res and Rev*. 2022;80(2):245-252.
- ³⁸ American Dental Association. Dental education program enrollment and graduates report: 2021-22. Health Policy Institute. Updated June 2022. Available from: <https://www.ada.org/resources/research/health-policy-institute/dental-education>. Accessed March 24, 2023.
- ³⁹ American Dental Association. How big are dental service organizations? Health Policy Institute. Infographic. July 2020. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0720_1.pdf. Accessed March 24, 2023.
- ⁴⁰ American Dental Association. Racial and ethnic mix of the dentist workforce in the U.S. Health Policy Institute. April 2021. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0421_1.pdf. Accessed March 24, 2023.
- ⁴¹ Vujicic M, Gupta N, Nasseh K. Why we need more data on the dental insurance market. *JADA*. 2018;149(1):75-77.