

State Health Reform: How Do
Dental Benefits Fit In?
Options for Policy Makers

Andrew Snyder
Shelly Gehshan

April 2008

State Health Reform: How Do Dental Benefits Fit In? Options for Policy Makers

Andrew Snyder
Shelly Gehshan

Copyright © 2008 National Academy for State Health Policy

State Health Reform: How Do Dental Benefits Fit In? Options for Policy Makers

Copyright © 2008 National Academy for State Health Policy.
For reprint permission, please contact NASHP at (207) 874-6524.

About the National Academy for State Health Policy

The National Academy for State Health Policy is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice.

NASHP provides a forum for constructive, nonpartisan work across branches and agencies of state government on critical health issues facing states. We are a non-profit, non-partisan, non-membership organization dedicated to helping states achieve excellence in health policy and practice.

To accomplish our mission we:

- Convene state leaders to solve problems and share solutions.
- Conduct policy analyses and research.
- Disseminate information on state policies and programs.
- Provide technical assistance to states.

The responsibility for health care and health care policy does not reside in a single state agency or department. NASHP provides a unique forum for productive interchange across all lines of authority, including executive offices and the legislative branch.

We work across a broad range of health policy topics including:

- Medicaid.
- Long-term and chronic care.
- Public health issues, including obesity.
- Quality and patient safety.
- Insurance coverage and cost containment.
- Children's health insurance and access to comprehensive services.

NASHP's strengths and capabilities include:

- Active participation by a large number of volunteer state officials.
- Developing consensus reports through active involvement in discussions among people with disparate political views.
- Planning and executing large and small conferences and meetings with substantial user input in defining the agenda.
- Distilling the literature in language useable and useful for practitioners.
- Identifying and describing emerging and promising practices.
- Developing leadership capacity within states by enabling communication within and across states.

For more information about NASHP and its work, visit www.nashp.org

Portland, Maine Office:
10 Free Street, Second Floor
Portland, Maine 04101
Phone: (207) 874-6524
Fax: (207) 874-6527

Washington, D.C. Office:
1233 20th St., N.W., Suite 303
Washington, D.C. 20036
Phone: (202) 903-0101
Fax: (202) 903-2790

TABLE OF CONTENTS

| | |
|--|----|
| Acknowledgements..... | v |
| Executive Summary..... | vi |
| Introduction..... | 1 |
| Oral Health Status..... | 2 |
| Oral Health in Health Care Reform—State Experiences..... | 4 |
| Maine..... | 4 |
| Massachusetts..... | 4 |
| Vermont..... | 5 |
| Dental Insurance in the United States..... | 7 |
| Option 1: Expanding Medicaid..... | 10 |
| Dental Benefits in Medicaid..... | 10 |
| State Models for Improving Medicaid Dental Administration..... | 11 |
| Dental Benefits in SCHIP..... | 13 |
| Providing Dental Coverage through a Medicaid Expansion..... | 14 |
| Option 2: Offering a Private Dental Insurance Product..... | 18 |
| Dental Benefits in Private Insurance Plans..... | 18 |
| Providing Dental Coverage through Private Dental Insurance..... | 19 |
| Benefit Design Questions..... | 21 |
| Option 3: Providing Dental Benefits Through a “Connector”..... | 23 |
| Providing Dental Coverage through a Commonwealth Care Approach..... | 24 |
| Other Options for Improving Oral Health..... | 27 |
| Investing in Prevention..... | 27 |
| Using Medical Providers to Expand the Oral Health Delivery System..... | 27 |
| Expanding the Safety Net..... | 30 |
| Expanding the Dental Workforce Available for Underserved Groups..... | 31 |
| Findings..... | 34 |
| Notes..... | 35 |

ACKNOWLEDGEMENTS

The authors would like to thank our reviewers: Kim Moore with the United Methodist Health Ministry Fund, Teresa Schwab with Oral Health Kansas, Janelle Garrison with the Kansas Health Policy Authority, Dr. Katherine Weno with the Kansas Office of Oral Health, Dr. Burton Edelstein of Columbia University, and Sonya Schwartz, Sara Sills, Alison Borchgrevnik, and Jessica Kronstadt with the National Academy for State Health Policy (NASHP), as well as the other experts who gave us input on the ideas presented here. We sincerely appreciate your assistance and insight.

A version of this report was originally produced at the request of Kansas officials to inform the work of the Kansas Health Policy Authority and Health for All Kansans Steering Committee. This report was produced under a grant from The Robert Wood Johnson Foundation, which supports the work NASHP does to assist states in expanding and improving Medicaid and health coverage.

EXECUTIVE SUMMARY

The United States is once again experiencing a steady wave of state health reforms intended to cover more uninsured people, restrain rising costs, improve health outcomes, and redistribute financial burdens. Maine, Massachusetts, and Vermont were at the forefront in crafting broad, ambitious reforms and are well along in the implementation process. In many other states plans are in motion or legislation is being crafted.

The experiences of the first three states are being watched closely all over the country. Most attention is being focused on the impact of state reforms on the private insurance market and the benefits of increased insurance coverage and access to care. But many other questions have arisen. This paper answers the question: should a state choose to do so, how can it include dental benefits in a health care reform plan? None of the three pioneering states included dental benefits for the majority of their expansion populations, although they were maintained for poor populations in traditional Medicaid. The primary barrier for the states at the outset was cost, although the traditional separation of general health and oral health – with a lesser importance ascribed to oral – was a factor.

Oral health resides, for all intents and purposes, in a different world from general health. Dental care is separate in financing and insurance; provider education, licensing, and regulation; and service delivery. A recent Census Bureau report set the number of people without health insurance in 2006 at 47 million, or 15.8 percent of the population,¹ but the number of people without dental insurance is roughly three times as high. In general, the oral health of Americans has improved markedly in recent decades, but significant disparities remain. Dental caries (the infectious disease that results in cavities) is almost universal. Unlike most physical health ailments that resolve themselves with the healing power of time and self-care, dental caries is not reversible on its own. It is, however, entirely preventable with fluoridated water, sealants (plastic coatings that prevent decay in molars), and proper hygiene. Worse oral health exists in the roughly one-third of the population that is low-income, rural, elderly or disabled, minority or immigrant, or uninsured. Children with poor oral health experience problems eating and sleeping, performing in school, and enjoying normal recreation and growth. Adults with poor oral health have similar problems, coupled with difficulty getting and keeping a job.

There are many causes for oral health disparities. Principally, the great majority of dental care is delivered by private dentists whose practices are filled with patients who use cash or insurance to pay for care. In most states, a small minority of dentists accept patients insured by Medicaid and the State Children's Health Insurance Program (SCHIP) because payment rates are low, administrative burdens are onerous, and provider incomes are high even without the additional business. Most states pay dentists less in Medicaid and SCHIP than it costs them to provide the service, so it doesn't make business sense for them to participate. In addition, many patients aren't well served by the private system, either because they are disabled and can't get to an office, or they need transportation, translation, or flexible hours. Most dentists are white men, so cultural competency gaps exist as well. People from other countries or cultures also have

¹ C. Navas-Watt, B. D. Proctor, J. Smith, "Income, Poverty and Health Insurance Coverage in the United States: 2006," U.S. Bureau of the Census, August, 2007. Washington, DC. p.18.

different care-seeking behavior and attitudes, including assumptions that they will lose all their teeth. These differences amount to a big challenge for states administering the program, and dentists willing to participate.

In considering how to address these disparities and dental insurance gaps during health care reform, it is important to understand the differences between health and dental insurance. Dental insurance is offered much less often than health insurance. While most large employers offer dental insurance, its prevalence is diminishing. In 2006, only 46 percent of private sector full- and part-time workers were offered dental insurance through their employers, and only 36 percent participated in it. Medicare does not offer dental coverage, although some oral surgery is covered if needed for other procedures. States are required to provide full dental benefits through Medicaid for children, but not for adults. As of 2006, eight states and the District of Columbia provide comprehensive dental benefits for adults in Medicaid. Twenty states provide limited benefits, and 22 states provide emergency-only or no benefits for adults. The coverage source puts greatly different burdens on beneficiaries: Medicaid recipients average \$75 out-of-pocket costs, compared to \$220 for people with private dental insurance. Having dental insurance of any sort is positively associated with actual use of dental services, but having private insurance provides superior access to care relative to Medicaid. Medicaid programs traditionally have been unattractive to dentists but a number of states have made great progress in improving participation:

- Michigan – Michigan Healthy Kids Dental program enrolls Medicaid-eligible children in a dental care insurance plan managed by Delta Dental and pays a capitated rate of \$14.61 per member per month. Dentists receive reimbursements that are close to commercial fees, and have the same administrative processes as for privately insured patients. Evaluations have found increased access, decreased travel time for recipients, and higher satisfaction among dentists.
- Tennessee – Tennessee enrolls Medicaid-eligible children through an “administrative services only” contract with Doral Dental, and pays claims on a fee-for-service basis. Fees have been raised to commercial levels (the 75th percentile of a regional survey of dentists’ fees).
- Alabama – The state raised its reimbursement rates in 2000 to 100 percent of the Blue Cross/Blue Shield average regional rates for most procedures. It also has a special unit that conducts outreach to providers, helps them navigate the program, and helps beneficiaries use the services.

SCHIP programs also offer lessons for states seeking an administrative model for expanding dental benefits. In 14 states, SCHIP benefits and administrative structures mirror Medicaid. Most of the remainder provide more limited services that are modeled on private dental insurance. Eleven states require providers to collect some co-payments for services that are not preventative. Seven states have an annual benefit cap, including four with a cap of \$600 or less.

States considering adding dental benefits to their health care reform plans have three approaches they can take. They can use Medicaid as vehicle for providing dental benefits, offer a private dental insurance product for those not enrolled in Medicaid or already covered by dental insurance, or combine Medicaid and private insurance in a “connector” approach similar to the

strategy pursued for health insurance in Massachusetts. Tables A and B offer a quick comparison of these three approaches.

Option 1: States could expand dental benefits under Medicaid. Under authority granted states under the Deficit Reduction Act of 2005 (DRA), states now have the authority to tailor benefits, and use a “benchmark plan” for different groups of enrollees. This plan would involve using general funds and enrollee contributions to allow non-Medicaid eligibles to buy into the program. This approach would require a reform of the administration and financing of the program along the lines of improvements made by states like Michigan, Tennessee, and Alabama.

Advantages: The primary advantage of this approach is that it would allow a state to capture federal funding for services provided to Medicaid enrollees. Medicaid rules also protect low-income enrollees from the higher co-payments and premiums of private dental care.

Disadvantages: In most states, Medicaid’s poor reputation in the dental community would require an intensive effort to revamp administrative processes, and improve reimbursement and communication with providers. Maintaining reimbursement rates that are attractive to dentists would require significant new investment of state funds.

Option 2: States could offer a private dental insurance product that is similar to state or federal employee coverage. The state could opt to pay for part or all of enrollees’ premiums, which, on average, are less than \$30 per member per month.

Advantages: From the viewpoint of providers, participation in the state program would be similar to their private sector business and therefore easier. This approach would allow the state to limit its financial exposure.

Disadvantages: This option places more financial responsibility on the enrollee, which could become burdensome due to the high cost sharing (often 50 to 80 percent of the cost of services) and annual benefit caps (usually between \$1,000 and \$1,200) of most private insurances. This may limit participation.

Option 3: States could offer coverage modeled on the Massachusetts “Connector,” which combines the Medicaid and private-sector approaches in one program that uses a single, freestanding contract with a dental third-party administrator to provide state-funded Medicaid coverage and coverage for the uninsured on a sliding scale of subsidies.

Advantages: This approach narrows the differences between Medicaid and commercial insurance, maintains consistent dental coverage as enrollees move from Medicaid to subsidized coverage through the “Connector,” and permits buy-in by those with employment-based medical coverage, but no dental coverage.

Disadvantages: Massachusetts’ individual coverage mandate is supported by a series of individual and small-group market reforms which not all states currently have in place. The

individual market for dental insurance is not well-developed, and this approach requires the state to organize group coverage.

Expanded dental insurance coverage is a critical step for states seeking to remedy oral health disparities and improve access, but there will continue to be an important role for public oral health efforts and the dental safety net. Community-based water fluoridation has been recognized as a low-cost, extremely effective public health intervention. Regardless of the status of an insurance expansion, the state should consider its investment in this vital population-based strategy. Expanding efforts to provide dental sealants for children would save money in restorative costs down the line. It is also important to examine ways to bolster the oral health workforce to insure there is a source of care for people who need it. Strategies to broaden the pool of providers, whether by increasing the use of medical staff, increasing the reach and productivity of dental hygienists and dental assistants by modifying their duties and supervision requirements, or working to develop a true mid-level dental provider, are worthwhile for the state to pursue.

Table A Three options for adding dental benefits: Financing and cost-sharing

| | Medicaid Expansion | Private Insurance Offering | “Connector” Model |
|-------------------------------------|--|--|---|
| Option summary | <ul style="list-style-type: none"> ▪ State expands Medicaid dental coverage to the uninsured ▪ State can use benchmark authority to tailor benefits to certain groups, or introduce coverage incrementally | <ul style="list-style-type: none"> ▪ State contracts for commercial group dental insurance product ▪ Models include state and federal employee dental benefits | <ul style="list-style-type: none"> ▪ Freestanding, single-vendor approach that integrates Medicaid and private-coverage ▪ Modeled on Massachusetts Commonwealth Care program |
| Populations included | <ul style="list-style-type: none"> ▪ Medicaid categorical populations: children, pregnant women, elderly, disabled ▪ Eligibility for parents can be expanded through income disregards ▪ Inclusion of non-categorical populations like childless adults requires federal waiver or buy-in | <ul style="list-style-type: none"> ▪ Persons not covered by Medicaid | <ul style="list-style-type: none"> ▪ Combination of Medicaid and subsidized coverage for all persons under 300% FPL ▪ May be left open for buy-in by higher-income persons without employer-sponsored dental coverage |
| Funding sources | <ul style="list-style-type: none"> ▪ Federal matching funds available for Medicaid enrollees ▪ Combination of state, employer, or enrollee funds for “buy-in” for non-Medicaid-eligibles | <ul style="list-style-type: none"> ▪ Combination of state subsidies, employer contributions, and enrollee payments for premiums | <ul style="list-style-type: none"> ▪ Federal matching funds for Medicaid enrollees ▪ Sliding state subsidy for non-Medicaid persons under 300% FPL ▪ Full-cost buy-in for persons above 300% FPL |
| State financial liability | <ul style="list-style-type: none"> ▪ State share: 30-50% of costs for Medicaid enrollees ▪ All costs for non-Medicaid enrollees (partially offset by buy-in) | <ul style="list-style-type: none"> ▪ State can opt to subsidize premiums | <ul style="list-style-type: none"> ▪ Medicaid expenditures and sliding subsidy for the low-income |
| Enrollee premiums | <ul style="list-style-type: none"> ▪ Limited to 5% of family income for higher-income SCHIP enrollees | <ul style="list-style-type: none"> ▪ Total premium under federal employee plan averages \$29 per member per month ▪ Could be offset by state or employer subsidy | <ul style="list-style-type: none"> ▪ None for Medicaid enrollees ▪ Increasing enrollee contribution to premiums as income increases |
| Enrollee coinsurance / cost-sharing | <ul style="list-style-type: none"> ▪ No cost sharing allowed for children under 19 ▪ Limited cost sharing for adults | <ul style="list-style-type: none"> ▪ Significant cost sharing (20-50%) for services other than preventive or diagnostic | <ul style="list-style-type: none"> ▪ None for Medicaid-enrolled children ▪ Limited cost sharing for Medicaid adults ▪ Private-insurance-style cost sharing for subsidized and buy-in populations |

Table B Three options for adding dental benefits: Benefit design and implementation considerations

| | Medicaid Expansion | “Private Insurance” Offering | “Connector” Model |
|-------------------------|--|---|--|
| Benefits | <ul style="list-style-type: none"> Medicaid-enrolled children under 19 are entitled to all medically-necessary dental services through EPSDT “Benchmark” plans can extend tailored services to different groups of enrollees, impose annual benefit caps on adults, or roll out benefits gradually | <ul style="list-style-type: none"> 100% coverage for preventive benefits, 50-80% coverage for other services Annual benefits typically capped between \$1,000 and \$1,200 Separate lifetime cap (and often a waiting period) for orthodontia | <ul style="list-style-type: none"> EPSDT benefit for Medicaid-enrolled children Tailored benchmark benefit for Medicaid-enrolled adults Private insurance benefits for subsidized and buy-in populations |
| Administration | <ul style="list-style-type: none"> State can opt for in-house administration, dental third party administrator, or dental managed care contract Dentists have longstanding concerns with Medicaid “administrative burden” | <ul style="list-style-type: none"> Standard arrangements are dental HMO, network contract, or indemnity contract Mirrors systems that dental offices currently use | <ul style="list-style-type: none"> Combined, stand-alone dental contract for Medicaid administration and a subsidized private insurance offering Allows for consistent administrative framework as enrollees move from Medicaid to subsidized coverage |
| Provider considerations | <ul style="list-style-type: none"> Slow roll-out of benefit to groups of enrollees creates less of a crunch on participating dentists Several states have promoted integration of oral health care into EPSDT well-child visits to medical providers | <ul style="list-style-type: none"> Dental HMO or network contract gives the state the ability to use an existing commercial network of providers | <ul style="list-style-type: none"> Providers must be made very familiar with any differences in benefits provided to different groups of enrollees |
| Design questions | <ul style="list-style-type: none"> Can the state overcome provider antipathy toward Medicaid? Is the state in a position to implement and maintain adequate provider reimbursement increases? | <ul style="list-style-type: none"> Will the program be open to elderly/Medicare enrollees? Does a private insurance product for low-income people discourage provider participation in Medicaid? Does it crowd out private coverage? | <ul style="list-style-type: none"> Will enrollment in dental insurance be mandatory? Are there adequate protections in the individual market for dental insurance for people without access to group coverage? |
| Biggest challenge | <ul style="list-style-type: none"> Requires significant investment of state funding and effort to make a Medicaid program attractive to dentists | <ul style="list-style-type: none"> Exposes low-income enrollees to high level of liability for cost sharing | <ul style="list-style-type: none"> Requires a variety of insurance-market reforms to support the model |

INTRODUCTION

Oral health occupies an unusual position in health policy. For all intents and purposes it is in a different world: in financing and insurance; provider education, licensing and regulation; and service delivery, oral health is separate from physical health. Although lack of dental care is the single largest unmet need among children,¹ and more than twice as many people lack dental insurance as health insurance, the oral health needs of citizens and the means to address them are seldom front and center in health care reform debates.

A report in 200 by the U.S. Surgeon General highlighted both the immense progress our nation has made in improving oral health over the last 50 years, as well as the gaps and disparities in oral health experienced by the roughly one-third of the population that is low-income, rural, elderly or disabled, minority or immigrants, or uninsured. The report spurred intense discussion and work at the national, state, and local levels about how to close those gaps and make sure that policies and practices recognize the fact that oral health is an integral part of overall health. Good oral health is essential for children so they can perform well in school and develop well both physically and emotionally, and for adults so they can get and keep a job.

Many states are now examining models for health care reform aimed at expanding health coverage by connecting uninsured individuals to public, private, or subsidized insurance products. By doing so, states are seeking to reduce the ranks of the uninsured, assure better health outcomes, bolster the health infrastructure, and contain costs by spreading risk and promoting better health behaviors. There is a growing chorus from the business community that the rising costs and unequal burdens of health insurance are hampering American businesses in the global economy, so health reforms also aim to equalize burdens across employers and promote a better business climate.

Health reform efforts seldom seek to provide broader, richer benefits. Rather, debate more often focuses on tailoring benefit packages to specific groups and adjusting cost sharing. To date, no state reforms have included a comprehensive oral health component. Concerns about cost, as well as the traditional separation between medical and dental care, have forestalled the inclusion of dental benefits, even though oral health needs are widespread and are concentrated among people with lower incomes.

Increasingly, poor oral health is being shown to have an association with chronic and acute systemic diseases, such as cardiovascular disease, diabetes, stroke, and preterm births.² Stronger evidence of links may lead to broader dental benefits. For example, a recent study of Aetna administrative claims data found that privately insured people with advanced gum disease (periodontitis) had higher 2-year costs for diabetes, stroke, and heart disease than people with less severe dental conditions.³ As a result of this study, Aetna is extending enhanced dental coverage to pregnant women and people with heart disease.⁴ Likewise, a private dental insurer in the state of Washington is now paying physicians to provide preventive fluoride treatments to young children as a way to promote this early intervention as a standard of care.⁵

The decision of *whether* to include dental benefits in health care reform or expansion plans is one for policy makers, with the input of stakeholders and citizens. This paper addresses the issue of *how* to include such coverage, should policy makers opt to do so.

There are a few basic approaches that a state could consider if it chooses to add dental coverage to health care reform or expansions. The first is an expansion of Medicaid dental benefits which would augment medical coverage. The second is the development of a stand-alone dental component that state residents could purchase, either on their own or with financial assistance from the state, which would be modeled after the dental insurance products available to federal or state employees. A third option is to combine elements of the public and private approaches, similar to the path that Massachusetts is taking with its “Connector” agency, a new quasi-governmental body charged with making insurance available and affordable. In addition, states may wish to include funding for a number of initiatives to enhance public prevention efforts, particularly among low-income children and other vulnerable groups, and to expand the number and types of providers who can care for these populations. These public health and workforce strategies are important to investigate, even if a state finds that inclusion of dental benefits in health care reform is not feasible financially at this time.

Oral Health Status

National gains

In general, oral health is improving across the life span, although significant disparities exist among minorities and low-income people.⁶ According to a 2004 federal survey, oral health among children is improving across the nation for most age groups across most measures, with a few alarming exceptions. Although the overall presence of dental caries (the infectious disease that results in cavities) among children remained roughly the same since the last survey in 1994, the picture was worse for certain groups of children. The presence of dental caries in primary teeth among children ages 2 to 5 actually increased significantly, from 24 to 28 percent. Also, the prevalence of dental caries in permanent teeth increased significantly from 49 percent to 56 percent among black children ages 6 to 8. For children ages 2 to 11, the average number of decayed, filled, or missing teeth increased as well. Increases were statistically significant for poor children, boys, and whites. Furthermore, the prevalence of untreated dental decay – which causes pain, difficulty eating and sleeping, and can slow healthy development – increased among children ages 2 to 4 from 16 to 19 percent.

Table 1 Oral health needs at a glance (1999-2004)

| |
|--|
| <ul style="list-style-type: none">• 24.5% of children ages 6 to 11 have dental decay• 11.1% of children ages 9 to 11 have untreated dental decay in permanent teeth• 25% of adults ages 20-64 have untreated dental decay• 30% of all youths, and 40.1% of children ages 9 to 11, have dental sealants (up from 22% and 29%, respectively, in 1988-1994)* |
|--|

Source: Dye BA, Tan S, Smith V, Lewis BG, Barker LK, Thornton-Evans G, et al. Trends in oral health status: United States, 1988–1994 and 1999–2004. National Center for Health Statistics. Vital Health Stat 11(248). 2007.

* In an effort to reduce cavities, Healthy People 2010 identifies as an oral health goal increasing the proportion of children who receive sealants for their molars. The program set a national target that 50 percent of children ages 8 and 14 will have sealants.⁷

Why oral health disparities persist

There are many reasons why oral health is worse among those with low incomes and minorities. Principally, the great majority of dental care is delivered by private sector dentists, whose practices are filled with patients who have insurance or cash to pay in full for their care. In most states, only a small minority of dentists accept patients insured by Medicaid or the State Children’s Health Insurance Program (SCHIP) because payment rates are low, administrative burdens are onerous, and provider incomes are high without the additional business. Most states pay less for Medicaid and SCHIP services than it costs for dentists to provide the care, let alone make a profit, so it doesn’t make business sense for them to see these patients. (However, for those private dentists and safety net clinics that do serve publicly insured and uninsured patients, the existence of Medicaid coverage plays an important role by allowing them to capture funding for services that would otherwise be uncompensated.)

In addition, many patients with lower incomes aren’t well served by private sector dentists either because the patients are mentally or physically disabled and can’t go to an office, lack child care or transportation, or need flexible hours that most private offices don’t provide. Since most dentists are white men, there are cultural and language barriers for some patients as well. People with low incomes face many difficulties, and seeking dental care may not rank high if they struggle to pay their bills and put food on the table. There are also people, particularly those from other countries where it is common to lose teeth, who have different cultural attitudes about goals and outcomes of health care. Expanded dental insurance will not be enough to ensure access to care and improve oral health. The roughly one-third of the population that doesn’t have access to dental care also need assistance overcoming these non-financial barriers to care.

For low income people without dental insurance or funds to pay for care, there are few options. Unlike most physical health ailments that resolve by themselves with the healing power of time, rest, and self-care, dental caries is not reversible on its own. If left unchecked, a decaying tooth will progress to the point where people will seek care in hospital emergency rooms (ER). This is a particularly expensive and ineffective use of resources as ERs generally do not have a dentist on staff or even on call, and can only provide palliative treatment – antibiotics and painkillers – that do not resolve the underlying problem. Increasing the ability of people with low incomes to seek timely care in appropriate settings – such as clinics, community health centers that offer free or sliding scale fees, or private dental offices – should reduce this cost.

□ □ □

ORAL HEALTH IN HEALTH CARE REFORM—STATE EXPERIENCES

Despite the great evidence of need for dental benefits, as many states embark on comprehensive health care reforms, so far their plans have only included limited dental benefits. The main obstacles to including dental benefits are cost, the persistent separation of dental care delivery and financing systems from the rest of the health care system, and attitudes which ascribe a lower priority to oral health than physical health.

Maine

The first state to enact a comprehensive reform plan was Maine, whose Governor established a Health Security Board to address access, cost, and quality in 2002. After much planning and consensus-building, the Dirigo Health Reform Act was enacted in 2003, and the state's subsidized insurance plan – DirigoChoice – was implemented in January 2005. Maine's reforms include an ongoing focus on the treatment of chronic diseases; a new entity – the Maine Quality Forum – to promote quality and educate providers and consumers; capital investments; voluntary limits on the growth of premiums; and a move to electronic claims. As of February 2007, more than 24,000 people have health coverage through DirigoChoice, which has a sliding scale for premiums and out-of-pocket expenses based on family income.

The only piece of the reform program that contains dental benefits is the MaineCare program, which provides coverage for all categories and income levels of people who would be eligible for traditional Medicaid, plus some adults without dependent children who ordinarily would not be eligible for Medicaid. MaineCare includes comprehensive dental benefits for eligible people under age 21, as required under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. Adults enrolled in the plan are eligible for emergency dental benefits and, in some cases, dentures, but no ongoing routine dental care.

An oral health improvement plan, developed by the state and other stakeholders through a collaborative process, was released in November 2007. The plan contains 13 goals to improve oral health awareness among policy makers and the public, increase prevention, expand access, improve service delivery, and expand the dental workforce. The group is continuing to work to refine and implement the plan.⁸

Massachusetts

The most talked-about reforms have been in Massachusetts, which enacted legislation in April 2006 that made sweeping changes to its health system.⁹ All major stakeholders – then-Governor Mitt Romney, both chambers of the legislature, businesses, consumers, the insurance industry, and providers – worked together and made compromises to ensure the bill's passage. One key factor spurring the reform was the pending renewal of the federal waiver under which the state operates its Medicaid program, which brought hundreds of millions of federal dollars to the table.

The reform law established a new independent public authority called “the Connector,” which is charged with designing coverage that is affordable and adequate. The Connector works with businesses, insurance companies, providers, and consumers to develop and offer a range of managed care plans, grouped under the names Commonwealth Care and Commonwealth Choice. At present, dental benefits are provided only in Commonwealth Care for all adults with income below 100 percent of federal poverty level (FPL). The oral health benefits available for them are comprehensive, including exams, cleanings, fillings, root canals, and dentures.

Children continue to receive the comprehensive oral health benefit they have received for many years through MassHealth (Medicaid), as required by EPSDT. Eligibility for children in MassHealth was expanded to 300 percent FPL under the 2006 health reform law. Massachusetts also retained the Children’s Medical Security Plan for all non-MassHealth eligible children (because they are above Medicaid’s income limits or do not meet Medicaid’s immigration status requirements) which provides an annual dental benefit of \$750 per child. While this cap is sufficient for ongoing annual dental maintenance care for children, it is insufficient to meet the needs of children who experience problems with tooth decay or have pent-up needs from prior periods without coverage.

These oral health improvements were made with the momentum gained from restoring adult dental benefits, which had been cut from MassHealth in 2002. In 2005, oral health benefits were restored for 600,000 lower-income adults, including MassHealth-enrolled parents under 133 percent FPL, and for certain other groups of adults with higher incomes. Massachusetts also made changes sought by providers: they loosened restrictions that required providers who accepted one Medicaid dental patient to accept any and all Medicaid patients, raised reimbursement rates, and contracted with a third party administrator to ease paperwork burdens.

Although funding remains an obstacle, the Massachusetts oral health coalition’s future goals include expanding dental coverage to higher-income adults in Commonwealth Care, as well as Commonwealth Choice – the unsubsidized commercial insurance offered to individuals and small businesses through the Connector.

Vermont

Vermont, like Massachusetts, had been working on health reform in stages for many years before comprehensive reform succeeded. The state:

- Negotiated a controversial Medicaid waiver (“the global commitment to health”) in 2005 that allowed it to receive federal matching funds for certain adults who would not ordinarily qualify for Medicaid.
- Implemented the “Blueprint for Health,” which sets forth a plan for improving prevention and treatment of chronic conditions.

In May 2006, a law was enacted that created Catamount Health – a program that provides comprehensive, state-subsidized coverage through private insurers for families with incomes up to 300 percent FPL. Families above that income level pay the full cost of coverage. Dental

benefits offered by the state's two vendors are limited. Blue Cross Blue Shield has no routine dental benefit,¹⁰ but MVP Vermont covers dental exams and x-rays for children under age 19.¹¹ Oral health also will be addressed as part of the reforms being planned for chronic care management and care coordination programs.¹²

In the same legislation, reimbursement rates for dental care were raised in Vermont's Medicaid program (VHAP – Vermont Health Access Program), which covers childless adults with incomes up to 150 percent FPL and parents with incomes up to 185 percent FPL. Premiums for VHAP were cut in half to make the program more affordable.

The state's FY 2008 Medicaid Budget introduced “the dental dozen,” which consists of 12 targeted initiatives, based on the Vermont Oral Health Plan, to improve oral health for all Vermonters, including enhancements to Medicaid (including raising dental reimbursement rates and improving outreach), public health efforts, and dentist loan repayment, among others. Work began on these objectives in 2008, and the state's 2009 Medicaid Budget seeks further funding for their expansion over the next two years.¹³

Following the lead set by Maine, Massachusetts, and Vermont, many states are now examining models for health care reform that seek to expand health coverage by connecting uninsured individuals to public, private, or subsidized insurance products. In considering dental benefits during health care reform, it is important to highlight the differences between dental and medical insurance, as well as public and private dental insurance as they operate in the United States.

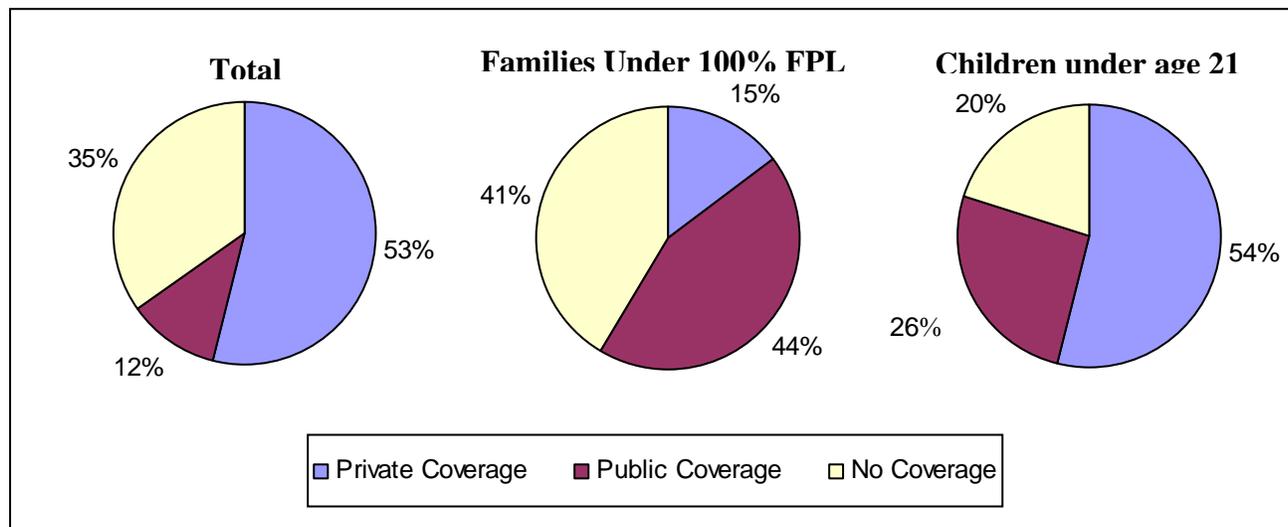
□ □ □

DENTAL INSURANCE IN THE UNITED STATES

There are two major types of dental insurance coverage in the United States: private insurance plans, usually received through employment, but occasionally purchased in the individual market, and public programs, including Medicaid and SCHIP. Medicare is not a source of public dental insurance; it covers only extremely limited hospital-based oral surgery needed in conjunction with other treatment (although a few Medicare Advantage plans include modest dental benefits).

Overall, dental insurance coverage is much less prevalent than medical insurance. In 1999, 64 percent of dental office patients were covered by private insurance, 6 percent were publicly insured, and 30 percent were uninsured.¹⁴ While more than 15 percent of Americans ages 18 or older in 2000 had no form of medical insurance, more than three times as many had no form of dental insurance.¹⁵ A more recent study conducted in 2003-2004 showed that, among children, 77 percent had insurance coverage that paid for dental care, and 29 percent received this coverage through public programs. The number of children without dental insurance was more than two and a half times greater than the number without medical insurance.¹⁶

Figure 1 Dental coverage, 2004



Source: E. Brown, and R. Manski, *Dental Services: Use, Expenses, and Sources of Payment* (Rockville, MD: Agency for Healthcare Research and Quality, 2004) MEPS Research Findings No. 20. AHRQ Pub. No. 04-0018. pp. 10-11.

While most large employers still offer private dental insurance, its prevalence is diminishing. Through the early 1970s, most dental care was paid for out-of-pocket. Employer-sponsored dental insurance grew over the next decade and peaked in 1984, when 77 percent of full-time private employees of medium and large firms had private dental coverage. However, dental benefits are the most vulnerable to loss in times of economic retraction. Due to rising health insurance costs and a tough economy, by 1995, dental insurance penetration had receded to 57 percent.¹⁷ A 2006 Bureau of Labor Statistics survey of private-sector full- and part-time workers showed that overall, only 46 percent have access to dental insurance through work, and only 36 percent participate in it.¹⁸

Private dental insurance is more often available to employees of larger businesses than those of smaller businesses. About 90 percent of employers with more than 500 employees offer a comprehensive dental plan, but among employers with 10-499 employees, this figure drops to 64 percent. Only 21 percent of employers provide dental coverage through their medical insurance plans; the rest provide dental benefits through a freestanding contract.¹⁹

In the private market, dental insurance differs from medical insurance in the size of premiums, cost sharing by plan enrollees, and maximum annual benefits. Although premiums for dental plans are much smaller than for medical ones, participants are often required to pay a larger share of the cost of services. Additionally, many plans cap the amount they will pay out in a year at around \$1,500.

The differences between medical and dental coverage are attributable to the differing assumptions about risk underlying each type of plan, and how that risk is shared among plan enrollees. Traditional group medical coverage is a risk-sharing proposition; it anticipates that premiums paid by those in the group who remain healthy will fund those who, by chance, become ill. In contrast, dental disease is widespread and dental treatment needs are often able to be anticipated. Dental coverage presumes that all covered individuals will need dental services. Thus, annual benefit limits and significant coinsurance limit the insurer's risk, and transfer significant liability back to the enrollee.

These assumptions also mean that the individual market for dental insurance is underdeveloped in comparison to the individual medical insurance market. Because those seeking individual insurance are almost certainly doing so with the intent of utilizing dental services, offering such voluntary products is seen as not being a good "bet" for insurers to make. The introduction of a voluntary dental benefit under the federal employees' health plan in 2006 is testing this assumption, and it remains to be seen what will happen to utilization, premiums, and cost sharing in that program in coming years.

As a result of this low level of insurance and the structure of dental benefits, out-of-pocket expenditures account for a much larger percentage of total dental care spending than they do for medical care. Data from 2005 show that, of \$86.6 billion spent on dental care in 2005, 44 percent of dental expenditures (\$38.3 billion) were out-of-pocket, 50 percent (\$43.1 billion) were paid by private dental insurance, and 6 percent (\$5.2 billion) were paid by public programs.²⁰

Public insurance programs have limits on cost sharing that help to shield enrollees from out-of-pocket expenses. A study of 2000 Medical Expenditure Panel Survey data showed that people under age 65 with public insurance paid an average of \$75 out-of-pocket. Almost 80 percent of these people had no out-of-pocket expenses, and about seven percent paid more than \$200 out-of-pocket. This compares to people with any private insurance, who paid an average of \$220 out-of-pocket. Thirty-one percent of the privately insured had no out-of-pocket liability, and 23 percent paid \$200 or more out-of-pocket.²¹

**Table 2 Out-of-pocket expenditures by insurance status
(for people under age 65) 2000**

| Population characteristic | Population with a visit, in thousands | Mean out-of-pocket expense per person with a visit | Percent of users with out-of-pocket expense | | | |
|---------------------------|---------------------------------------|--|---|----------|-------------|---------------|
| | | | None | \$1-\$99 | \$100-\$199 | \$200 or more |
| Total | 115,819 | \$237 | 31.6% | 31.8% | 13.6% | 23.0% |
| Any private insurance | 87,258 | \$220 | 31.2% | 34.7% | 12.5% | 21.6% |
| Public insurance only | 8,207 | \$75 | 79.5% | 10.7% | 2.5% | 7.3% |
| Uninsured | 6,208 | \$322 | 20.4% | 31.6% | 20.7% | 27.2% |

Source: MEPS data, 2000. "Any private insurance" includes persons with both public and private insurance.

Research has found that having medical or dental insurance of any sort is positively related with actual use of dental services, but that private insurance provides superior access to services compared to public coverage. While people under age 65 with Medicaid coverage are more likely than the uninsured to receive preventive dental services, patients with private insurance are more likely than either the uninsured or publicly insured to receive care and have better oral health status.²² Medicaid programs have been unattractive to dentists due to a perception of low reimbursement and burdensome administrative requirements; however, states like Michigan, Alabama, and Tennessee have made improvements that have succeeded in overcoming these barriers, and these will be discussed in more detail below.

Inclusion of dental benefits in health care reform can be accomplished through the private or public financing and delivery systems. The key factors to success are attracting providers and assuring an adequate financing structure. The next sections outline the options available to states through a Medicaid expansion that incorporates the lessons learned from other states' experiences, or through designing a private-insurance product. A third option for states is to blend the two approaches through use of an insurance "Connector."

□ □ □

OPTION 1: EXPANDING MEDICAID

Option summary:

The state can deliver dental care through an expansion of Medicaid benefits. For populations that are typically not Medicaid-eligible, such as childless adults, the state could use general funds (or a combination of state funds and contributions by enrollees and/or their employers) to provide subsidized dental coverage through Medicaid. This approach would provide greater financial protection for people with low incomes, but it would require an extensive effort to make the program attractive to dentists.

Financing considerations:

- Federal funds are available to match state expenditures for Medicaid-eligible enrollees.
- Greater financial responsibility lies with the state than with the enrollee.
- Enrollees would have increased protection from financial liability.
- The financial commitment required from the state may increase significantly.
 - Designing a successful Medicaid expansion may require rate increases, contracting with an outside administrator, and enhanced customer service for both participating dentists and newly insured patients.
 - Pent-up demand among people newly able to access services may spur higher expenditures at the outset.

Capacity considerations:

- Medicaid has a reputation among providers as reimbursing far under commercial rates and being administratively difficult to work with. It will take significant work to overcome this image, and attract providers to the program.
- Medicaid offers a promising vehicle for states to better integrate oral health care with medical care.

Design considerations:

- Because of new flexibility given to states in the Deficit Reduction Act of 2005, Medicaid does not necessarily have to be a “one-size-fits-all” program.
 - States now have the authority to design “benchmark” benefit packages that provide different benefits to different groups of enrollees.
 - States could consider adding dental benefits for priority populations only, such as pregnant women or the chronically ill, or phase in coverage one group at a time, as funding and capacity allow.

Dental Benefits in Medicaid

Medicaid provides health care to certain categories of people with low income – children, pregnant women, caretaker relatives, the elderly, and the disabled, among others. It is financed jointly by state and federal governments. In fiscal year 2007, the federal matching rate ranged from 50 percent in states like California and New York to nearly 76 percent in Mississippi.²³

That means that every dollar the state spends on a Medicaid service is matched by between \$1.00 and \$3.15 in federal spending. This federal financing stream is an important consideration in weighing the benefits of Medicaid expansion as an approach to including dental care in health care reform.

Under Medicaid, children under age 21 are entitled to dental services, but states may choose whether to offer dental benefits to adults. Children's services are mandated through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, which requires that state programs pay for treatment found to be medically necessary, whether or not it is included in the state's regular set of covered services.²⁴ This means that states are required to provide a comprehensive dental benefit to Medicaid-enrolled children. Another important note is that Medicaid-enrolled children under the age of 19 are exempt from cost-sharing.

This benefit, however, is not a guarantee of access to dental care. Only 30 percent of children received any dental service in Medicaid in 2004 – a Medicaid card by no means ensures access for enrolled children.²⁵

Dental coverage for adults under Medicaid is much more limited. Dental services are considered an “optional” service, and states often choose to offer a more limited set of covered services to adults, or offer no coverage at all. As of 2006, eight states and the District of Columbia offer adults in Medicaid a comprehensive set of dental benefits that include dentures, root canals, fillings, and preventive care. Twenty more provide a more limited dental benefit, often with a yearly cap on benefits and a service set that excludes complicated services. Another 15 only cover emergency services, and seven cover no adult dental services at all.²⁶

The problems that state Medicaid programs face in delivering dental services are long-standing and well-documented. In most states, dentist participation in the program is low and utilization rates lag far behind those of the privately insured, even though the program's enrollees are more likely to have unmet dental needs.²⁷ A large proportion of dental care for Medicaid beneficiaries is delivered by a very small number of providers. For example, of the 42 states that responded to a 2000 study, 16 reported that 15 percent or fewer of the state's dentists billed Medicaid more than \$10,000 a year—which would represent about 23 children.²⁸ Dentists cite three main reasons for non-participation in the program: reimbursements that are often well below their commercial fees; difficulties in navigating the program's administrative requirements that can overwhelm small offices; and a Medicaid clientele that is harder to schedule and work with than private-pay patients.²⁹

State Models for Improving Medicaid Dental Administration

Several states have made changes to the administration and financing of their Medicaid dental programs to increase access to care and dentists' participation. Alabama, Michigan, and Tennessee all moved in the late 1990s and early 2000s to increase their state's investment in Medicaid dental benefits and implemented rate increases that brought payments into closer alignment with dentists' commercial rates. Michigan and Tennessee use “dental carve-outs,” where the state contracts with a specialized dental benefits administrator to oversee the dental

program. This is an approach often advocated by organized dentistry, because administering dental benefits is seen as being sufficiently different from medical benefits to require specialized expertise which states and medical managed care organizations by and large do not possess. Alabama retains full control of the dental benefit, but has dedicated resources to improve outreach to dentists and dental patients, as well as the processing of dental claims.

Michigan

Michigan's Healthy Kids Dental program enrolls Medicaid children in a Delta Dental insurance product. Starting in 2000, enrollment in this insurance product began in a few counties, and was gradually rolled out to other areas of the state. Currently, 200,000 children in 59 of the state's 83 counties (mainly rural counties) have dental coverage through the Delta Preferred Option product, and are able to seek care from any dentist who accepts Delta insurance. A 2001 evaluation of the project indicated that Healthy Kids Dental enrollees experienced an increase in utilization of services, and a decrease in the distance traveled to dental appointments.³⁰ The state pays a capitated payment of approximately \$14.61 per member per month to Delta Dental, which administers the program. Dentists receive reimbursement close to their commercial fees and experience administration processes that mirror their privately-insured patients. Enrollees retain their EPSDT right to medically necessary services and benefits from the relatively large pool of Delta-affiliated providers.

Tennessee

Tennessee's TennCare dental program (which is currently available only to Medicaid-enrolled children under age 21) has an "administrative services only" contract with Doral, a Wisconsin-based dental benefits administrator. The services provided by Doral – enrolling providers, answering recipient and provider inquiries, processing claims, and determining whether a treatment plan meets coverage standards – are substantially similar to those provided by Delta Dental. The main difference is that the state itself pays claims on a fee-for-service basis, rather than in monthly capitated payments. At the program's inception in 1999, these fees were raised to commercial levels (the 75th percentile of a regional survey of dentists' fees). In 2005, Tennessee awarded a new contract to Doral worth approximately \$4.5 million per year (\$13.47 million over 3 years).³¹

Alabama

In the Smile Alabama! program, responsibility for all dental services is carried out by the state's fee-for-service fiscal agent. In October 2000, Alabama raised its reimbursement rates to 100 percent of the Blue Cross/Blue Shield average regional rates for all but nine dental procedure codes, and dedicated funding to a special unit to conduct outreach to providers, assist them with navigating the program, encourage them to use electronic billing, and help them promote responsible behaviors among enrollees.³²

Other state approaches

Each of the initiatives described above was accompanied by a sizable rate increase, moving Medicaid reimbursements from roughly 50 percent of dentists' billed charges to close parity with commercial fees.³³ However, when states' fiscal situations do not allow for rate increases of this magnitude, they need more modest and creative ways to address financing. In 2005, Virginia embarked on an administrative services contract with Doral, similar to Tennessee's, called Smiles for Children.³⁴ At the same time, the state legislature approved a two-part budget increase of 30 percent – the first part being dedicated to a general rate increase, and the second being targeted to specific procedures that an advisory panel identified as being particularly critical in a dentist's decision to participate in the program.³⁵ Rhode Island has pioneered a financing mechanism that funds enhanced reimbursement for services provided to children under 6 years of age, using anticipated savings from averted disease and orthodontic problems later in childhood.³⁶ Minnesota is working to develop a system of "contact capitation," which will provide incentives for managed care contractors to deliver dental services by withholding capitated payments until an individual has actually been seen by a dentist.³⁷

Dental Benefits in SCHIP

The State Children's Health Insurance Program allows states to receive enhanced federal funding to provide coverage to higher-income children who do not qualify for Medicaid. About one-third of states administer this program through a Medicaid expansion, one-third through a separate state-designed program, and one-third through some combination of these approaches. Although Medicaid expansion programs must meet the EPSDT requirement, there is no such requirement for state-designed SCHIP programs. Yet, every state, with the current exception of Tennessee, offers dental coverage to children through SCHIP. This lack of a dental requirement has given rise to extensive discussion during the current reauthorization of the federal SCHIP legislation.

Fourteen states with separate SCHIP plans provide benefits that mirror the state's Medicaid program. Most of the remainder provide basic services that are modeled after private insurance benefits, meaning that they provide a range of services that is more limited in scope – 13 states do not cover braces for SCHIP children – and limit the number of services that are allowed per year. Often, these benefits are administered by third party administrators through managed care contracts.

Eleven states require providers to collect co-payments for dental services that are not preventive, typically \$5 or less per service.³⁸ Seven states have gone further and instituted an annual benefit cap on dental claims payments – three states have an annual cap of \$1,000, and four have a cap of \$600 or less.

While these restrictions help control the costs of the program, and make it more similar to private insurance, there is no EPSDT guarantee of coverage, and cost-sharing requirements and benefit caps may impede some children from seeking medically necessary care.

Providing Dental Coverage through a Medicaid Expansion

Using Medicaid as a delivery vehicle for expanding dental coverage has some distinct advantages – among them, federal funding and greater protection for enrollees from liability for high health costs – but also carries some long-standing difficulties in regard to attracting and retaining providers.

Benefit design – Adult expansions and benchmark plans

There are several choices that a state pursuing an expansion of Medicaid dental benefits must make. First is the question of what to do about parents. Many states only provide Medicaid coverage to parents with very low incomes. Thirty-five states set the threshold below 100 percent FPL, and Alabama—the state with the most stringent eligibility requirements—only provides Medicaid to non-working parents whose incomes are at or below 12 percent FPL.³⁹ If the state takes the approach that Massachusetts did, where coverage is extended to the lowest-income uninsured by enrolling them in Medicaid, then expanding eligibility and offering dental benefits to caretaker relatives would be a high priority.

Parental coverage has a documented positive impact on the utilization of care by covered children, and an expansion of coverage in this category can be achieved without any special waiver authority.⁴⁰ States can use “income disregards” to raise the effective income threshold for this group – for example, to disregard all family income between 29 and 100 percent FPL, so that parents at the poverty line would be eligible for Medicaid along with their children.

On the other hand, it is important to note that if states wish to use Medicaid as a vehicle for extending dental benefits to groups of adults who are not categorically eligible for Medicaid, such as childless adults under age 65, they would need to seek a waiver from the federal Department of Health and Human Services. Massachusetts has received such a waiver for its childless adults under 100 percent FPL.

A second decision is the nature of the benefit offered to adults. States have a wide degree of latitude in the services offered under optional benefits such as adult dental. These benefits can be limited, or be broader in scope than simply emergency coverage. For example, Iowa limits adult care to exams, x-rays, fillings, dentures, bridges, and oral surgery, and Indiana caps yearly adult benefits at \$600.

New authority allowed under recent federal legislation grants states even more flexibility in targeting benefits. Prior to the passage of the Deficit Reduction Act of 2005 (DRA), any limitations imposed by the state would have needed to meet a “comparability” requirement – that is, the benefit package offered to one category of recipients (e.g., pregnant women), would have needed to be the same as the package offered to all other categories (e.g., the elderly and disabled). However, under new authority granted in the DRA, the state can instead craft a “benchmark” benefit package modeled after federal employee standard coverage (a Blue Cross/Blue Shield PPO), the state employees’ health plan, or the largest commercial plan in the state. The state can also seek the approval of the Secretary of the federal Department of Health and Human Services to implement “benchmark-equivalent” benefit plans that offer different

benefits to specific categories of enrollees. Recently, states like Virginia and Washington have begun to use the “benchmark-equivalent” mechanism to offer groups of beneficiaries coverage that maintains traditional Medicaid coverage for most services, and provides services like disease management that are targeted to diabetics or asthmatics. No state has yet used a “benchmark-equivalent” plan to extend dental benefits, but it is a possibility that merits exploration.

A dental benchmark plan could be crafted in a variety of ways to achieve state objectives. West Virginia’s controversial benchmark plan for medical services allows enrollees to access enhanced benefits if they sign a member agreement to pursue healthier activities. Enrollment in a dental benchmark module might be conditioned on the enrollee agreeing to keep scheduled appointments, and participate in oral health education. Benefits could also be varied among categories of enrollees. For example, the state could offer a fuller benefit to children and pregnant women (which could include a screening and preventive services component delivered in medical practices), and a more limited benefit to caretaker relatives.

Further, if the state wished to limit its financial exposure at the outset, it could decide to implement this benchmark gradually by extending it initially to populations of special interest. An initial extension of the benchmark to groups like the chronically ill or pregnant women would be supported by the research that links dental care to lower costs from systemic infections in these groups. The state could follow later with expansions to categories of enrollees such as caretaker relatives. Tailoring benefits in this fashion would help the state contain costs for the expansion, but it would entail some additional administrative complexity for the dentists participating in the program.

Financing and capacity considerations

The biggest advantage to expanding Medicaid coverage from the state’s perspective is that it allows the state to capture federal matching funds for services delivered to all Medicaid-enrolled individuals. This can help mitigate a significant portion of the state’s cost. From the enrollee’s perspective, an expansion through Medicaid helps them to receive services at minimal personal cost. Medicaid has limits on enrollee cost sharing that protect recipients from financial burdens that serve as a barrier to seeking appropriate regular care. Co-payments are prohibited for Medicaid-enrolled children under age 19, and co-payments for adults are limited to “nominal” levels – usually \$.50-\$3.00 per service. Coinsurance is limited to five percent of the state’s payment for a given service. Medicaid providers are also required to accept Medicaid payment as payment in full – they may not “balance bill” enrollees for the difference between Medicaid payment rates and their commercial fees.⁴¹ This is important in regard to dental services because of the high level of unmet need among the Medicaid-enrolled population and the high cost of dental services. Private dental insurance frequently involves high levels of enrollee cost sharing, often up to 50 percent coinsurance for extensive procedures like crowns and dentures, which might lie beyond the means of people eligible for Medicaid.

The major drawback to a Medicaid expansion is low dentist participation in the program, and the notion that exists in the dental community of Medicaid as a wasteful, inefficient, and cumbersome program. Choosing Medicaid as the vehicle for expanding dental coverage does not limit the state’s options in choosing a delivery system. Like Michigan, states could bid out a

managed care contract for the benefit. Alternatively, states might embark on an effort similar to Alabama's to keep a state-administered fee-for-service program, and seek to improve the image of the program through an intensive public relations and customer service effort with dental offices.

Regardless of the delivery system, the importance of reimbursement that approaches dentists' commercial rates cannot be understated. Indiana's experience in the mid-1990s with substantial rate increases found that raising reimbursement rates to commercial levels roughly quadrupled Medicaid dental expenditures, while doubling the percentage of children with a visit and increasing the number of participating dentists by more than 40 percent.⁴² While states could mitigate this somewhat by tailoring dental benefits to different groups of beneficiaries through the use of benchmark plans, an expansion would represent a significant new investment, albeit one matched with funds from the federal government. Table 3 summarizes what states have spent on the expansions discussed in this section, and the results they have experienced.

While the investments have been large compared to the initial levels of spending, dental spending is a small part of overall Medicaid spending – under two percent of total program expenditures⁴³ – so, even with large growth in expenditures, it will still be a tiny piece of the Medicaid pie, relative to other Medicaid services such as prescription drugs or nursing home care. Increasing Medicaid dental expenditures would also bring them closer in line to overall national health expenditures, in which dental expenditures represent five percent of total spending.⁴⁴ Investments in dental reimbursement rates have helped these states improve beyond the typical poor performance of Medicaid, where nationally, only one in three Medicaid-enrolled children received any dental service in 2006.⁴⁵

Table 3 State Medicaid dental reforms have significant costs, produce significant gains

| State | Expenditure | Effect |
|---------------|--|--|
| Alabama | Dental expenditures more than tripled in the first two years of Smile Alabama! from \$11.6 million in 1999 to \$38.8 million in 2002 | The percentage of children with visits rose from 26 to 31%, and the number of providers increased by 16% |
| Indiana | Fee increase to commercial rates raised total dental Medicaid expenditures for children from \$7.8 million in 1997 to \$37.7 million in 2000 | The percentage of children with visits rose from 18 to 32%, the number of dentists submitting Medicaid claims increased by 42% |
| Michigan | Transition from Medicaid to Healthy Kids Dental increased payments per member per month approximately 2.5 times | The percentage of children with visits rose by one-third, 183 more dentists saw HKD kids, and the average distance traveled to appointments shrank to a level identical to the privately-insured |
| Tennessee | Moved reimbursement from 40% of retail fees to rates comparable to retail fees; administrative contract with Doral recently re-bid for \$13.5 million over 3 years | Percentage of children with visits rose from 24 to 47%, and the number of participating dentists doubled from 385 to more than 700 in the first two years of the program |
| Virginia | Rate increase of 30% over 2 years (2005-2006), plus cost of administrative services contract | Percentage of children with visits rose from 24 to 32%, and the number of participating dentists increased by 57% from 2005 to 2006 |
| United States | Dental benefits constitute less than 5% of Medicaid expenditures nationally, compared to 20% of private insurance expenditures | Only 19.4% of Medicaid-enrolled children received any dental service in 2004 |

Sources: (Alabama) M. Greene-McIntyre, M. Finch, and J. Searcy, "Smile Alabama! Initiative: Interim results from a program to increase children's access to dental care," *Journal of Rural Health*, 19 Supplement, (2003): 407-15. S. (Michigan) Eklund, J. Pittman, and S. Clark, "Michigan Medicaid's Healthy Kids Dental program: An assessment of the first 12 months," *Journal of the American Dental Association* 134 (November 2003): 1509-15. (Indiana) R. Hughes, P. Damiano, M. Kanellis, R. Kuthy, and R. Slayton, "Dentists' participation and children's use of services in the Indiana dental Medicaid program and SCHIP: Assessing the impact of increased fees and administrative changes," *Journal of the American Dental Association*, 136 (April 2005): 517-23. (Tennessee) American Dental Association, *State and Community Models for Improving Access to Dental Care for the Underserved – A White Paper*. Chicago: American Dental Association, 2004. State of Tennessee, Bureau of TennCare media release, "TennCare announces dental contract winner," August 31, 2005. Internet; available at http://www.tennessee.gov/tenncare/news/2005_Releases/DBM_RFP_Awarded083105.pdf. (Virginia) Presentation by Patrick Finnerty, Virginia Department of Medical Assistance Services. National Academy for State Health Policy webcast, August 1, 2007. Internet; available at <http://www.ian.ibeam.com/events/nash001/23139/> (registration required). (United States) S. Gehshan and M. Wyatt, *Improving Oral Health Care for Young Children*. Portland, ME: National Academy for State Health Policy, 2007.

□ □ □

OPTION 2: OFFERING A PRIVATE DENTAL INSURANCE PRODUCT

Option summary:

The state could design and offer a private dental plan, similar to the state employee health plan, or the new Federal Employee Dental and Vision Insurance Plan. This approach involves higher cost sharing and yearly maximum benefits, which increases the financial responsibility of enrollees but limits the state's financial exposure. It would be more attractive immediately to dentists than a Medicaid expansion, but it may be less feasible for low-income people, unless the state modified the approach to mitigate some of the cost concerns.

Financing considerations:

- Greater financial responsibility lies with the enrollee under this model, through deductibles, coinsurance, and annual benefit maximums.
- Some enrollees with advanced dental needs may exhaust a capped yearly benefit quickly, and be exposed to liability for the full cost of further treatment.
- Affordability of the premium is a large concern, and if the state opened the product to higher-cost populations, such as the elderly, that may drive the premium upward.
- The state could choose to contribute part or all of the enrollee's monthly premium.

Capacity considerations:

- This would be a more attractive program for private dentists, but there are still overall concerns about the adequacy and willingness of the private dental workforce to provide services to a new population of people with low incomes.
- Dentists are sometimes wary of participating in a plan with a capped benefit, as they then face the ethical dilemma of whether to provide needed care without an identified source of funding.
- Integration with medical care is currently very limited in private dental insurance. Promoting it as a strategy would require specialized attention from the state.
- There may be unintended effects of this product on Medicaid. Dentists may feel an incentive to move away from seeing Medicaid enrollees toward seeing this new group of low-income people whose coverage more closely resembles their other patients.

Dental Benefits in Private Insurance Plans

Dental benefit plans are structured in one of three ways: indemnity plans, network plans, or dental health maintenance organizations (DHMO). In a traditional indemnity plan, any provider may submit claims to the administrator for payment. Network plans use a panel of dentists who agree to accept contractually-negotiated rates for services. Enrollees may use out-of-network providers, but they will incur higher out-of-pocket costs. Under a DHMO, enrollees are required to use contracted providers in order to receive any benefit.⁴⁶

As discussed above, the cost of dental insurance differs from medical insurance and the private dental insurance market is relatively underdeveloped. Dental insurance costs much less on a

monthly basis – the entire premium of the six plans that are available nationwide under the new Federal Employee Dental and Vision Insurance Program (FEDVIP) dental benefit range from an average of about \$24 per person per month for single coverage in the least expensive region of the country to about \$34 in the most expensive region.⁴⁷ This is summarized in Table 4. However, there is significant cost sharing – while preventive and diagnostic services are usually paid entirely by the insurer, the insurer typically pays only 80 percent of fillings and periodontal services, and 50 percent of extensive services like crowns and bridges.⁴⁸

Table 4 Monthly premium for federal employees’ dental plans available nationwide

| Plan | Self | Self + 1 | Self + Family |
|--|---------|----------|---------------|
| Least expensive plan (Met Life Standard PPO, region 1) | \$15.80 | \$31.59 | \$47.41 |
| Average of all 6 plans in all 5 regions | \$28.72 | \$57.44 | \$84.16 |
| Most expensive plan (GEHA PPO, region 5) | \$40.99 | \$82.01 | \$123.00 |

Source: Federal Employees’ Dental and Vision Insurance Program (FEDVIP) benefits tables, available at <http://www.opm.gov/insure/07/guides/fedvipTables.asp>.

For example, the dental plan that is available to Kansas state employees reflects typical benefits of private dental insurance programs. This product has an annual maximum benefit of \$1,700 per person per plan year, which is somewhat higher than typical maximum benefits which tend to fall between \$1,000 and \$1,200. The benefits are summarized in Table 5.⁴⁹

Table 5 Features of the Kansas state employee dental plan

| Service type | Delta pays (PPO/Premier) | Enrollee pays (PPO/Premier) | Limitations |
|---|--------------------------|-----------------------------|---|
| Diagnostic/Preventive | 100% | 0% | No deductible. |
| Amalgam and Composite Fillings | 80%/60% | 20%/40% | |
| Oral Surgery, Root Canals, Periodontics | 80%/60% | 20%/40% | \$45 deductible per person per year |
| Crowns, Dentures, TMJ | 50% | 50% | |
| Orthodontics | 50% | 50% | \$1,000 lifetime maximum benefit (separate from the yearly maximum benefit) |

Source: State of Kansas, *Benefit Description of Dental Care Coverage* (revised 5/23/06). Available at <http://www.khpa.ks.gov/OpenEnrollment07/2007BenDescriptions/2007DeltaFinal.pdf>.

Providing Dental Coverage through Private Dental Insurance

There are several arguments to support the use of a freestanding private dental insurance product as the vehicle for providing dental coverage. First, because dental insurance is usually administered separately from medical insurance, it is not clear that medical insurers would be able to provide new dental benefits. Second, private dental coverage would likely not have the negative connotation among the dental community as would a Medicaid expansion. It would mirror systems with which dentists already interact and find easy to use.

Third, the state would have more control over its expenditures for these services. Premiums under FEDVIP are paid entirely by the enrollee. The employer only arranges the contract with the vendor. The state could choose to follow this model, which would place financial responsibility wholly on the enrollees. Alternatively, the state could use a premium-assistance strategy where the state contributes a portion or all of the premium. The level of premium assistance could be on a sliding scale based on ability to pay, much as Massachusetts does for medical insurance in its Commonwealth Care program. This type of plan might be attractive politically because it would build on employer-based insurance.

The central question regarding inclusion of a dental benefit in a health care reform package is affordability for the enrollee. In general, most people can plan the time that they seek dental care, and the costs are not usually catastrophic – average costs per person receiving dental care in 2004 were \$575; median costs were \$213.⁵⁰ There is a risk that for low-income people, a private insurance model, even with a premium that is under \$30 per month, may be unaffordable. A subsidized premium may help, but the high cost of coinsurance may be prohibitive for people with low incomes who may have delayed care during their period of dental uninsurance. Those who become newly able to access care may have a backlog of need that could quickly exhaust an annual benefit. For example, the median national charge in 2005 for a root canal and a basic crown on a bicuspid tooth was \$1,326.⁵¹ Under a plan like the Kansas state employee dental benefit, the patient’s coinsurance liability for the procedure would be about \$485. This level of coinsurance would be 4.8 percent of the total yearly income of someone living at the federal poverty level (\$10,210 for a one-person household in 2007).⁵²

While the extension of a new dental benefit might allow some adults covered by a new dental benefit to seek care earlier, there is likely to be a backlog of unmet need which will require restorative interventions. A 2005 study in the *Journal of the American Dental Association* found that privately-insured adults in Iowa were three times as likely to access dental care in a given year than Medicaid enrollees with similar covered benefits (69.3 percent of Delta Dental enrollees versus 27.2 percent of Medicaid enrollees), but Medicaid adults were twice as likely to have a root canal (9.9 percent versus 5 percent) and four times as likely to have an extracted tooth (27.4 percent versus 7.1 percent). People in Medicaid had lower oral health status and high levels of unmet need at the time they sought care.⁵³

The state could calculate the effect on premiums of raising the maximum annual benefit, lowering the coinsurance requirements, or providing reinsurance for catastrophic care needed by people who exhaust their annual benefit. The state might also choose to address the backlog of costs by phasing in benefit caps over the first several years of a person’s enrollment so that annual limits are more generous than commercial insurance in the initial years of enrollment, and then, as the person’s active treatment needs are addressed, and they settle into a “maintenance” state, benefits more closely resemble private insurance.

A 1999 actuarial study by the Milbank Memorial Fund provides a guideline for the costs of such changes. That study, which designed a capitated dental benefit under SCHIP, determined that a \$17 to \$18 per member per month payment (\$21 to \$23 in 2007 dollars) would meet the needs of

most children, although five percent of children could have catastrophic needs – defined as costs in excess of \$1,000 (\$1,250 in 2007 dollars).⁵⁴

In 2006, Mercer Oliver Wyman performed an actuarial estimate for George Mason University. Virginia was proposing to offer insurance to small businesses so they could provide a dental rider for people with incomes of 100 to 300 percent FPL. This dental rider included coverage for preventive care, but with restrictions on restorative care including: 50 percent coinsurance, a \$100 deductible, and a 6- to 18- month waiting period. The package was subject to a combined \$250,000 annual limit on medical and dental benefits. The monthly premium was estimated at \$26 per month for employee dental coverage, \$49 per month for employee plus spouse, and \$74 for family coverage.⁵⁵

Benefit Design Questions

There are a variety of other policy decisions that the state must make, and these may affect enrollment levels and pricing of a private insurance dental product.

Optional vs. mandatory enrollment

A major consideration is whether to require that people eligible for subsidized premiums buy coverage. Mandating dental coverage for these people would allow the dental product to function more like medical insurance, by spreading risk and helping to control the size of premiums for the dental product. A dental insurance mandate, however, would be the first of its kind, so it is useful to examine the dynamics of making the benefit optional.

The main variables in determining the level of take-up for an optional benefit are likely to be affordability and the perceived value of the benefit. A recent study in the journal *Health Affairs* defined an “affordable” health care package as one where the cost, as a percentage of income, to an enrollee below 300 percent of the poverty line was the same as that currently paid by privately insured people with incomes above that level – roughly between 2 and 8 percent of income.⁵⁶ If the total cost to the enrollee of the dental and medical coverage components rises above this level, then enrollees may need to decline optional dental coverage.

In regard to perceived benefit, newly-covered enrollees must be successful when seeking needed care. In crafting its contract requirements, the state must pay particular attention to the capacity of the contractor’s network to absorb new patients, and of the willingness of network dentists to accommodate the needs of the low-income population. Otherwise, the state runs the risk of state and enrollee premium contributions being paid to the carrier for services that may not be available, thus incurring significant inefficiency, excess cost, and frustration among enrollees.

There is also the issue of adverse selection – that is, if enrollment is optional, coverage will only be sought by those with the greatest intention of utilizing the service. Several pieces of evidence suggest that adverse selection may be less of an issue for dental insurance than for medical insurance overall. The first is the high take-up rate of dental coverage among privately employed people. According to the 2006 National Compensation Survey of employees in private industry,

78 percent of those who were offered dental coverage through work enrolled in the benefit. Even among those with hourly wages below \$15, take-up was 69 percent.⁵⁷ The second is the experience of the federal employees, who were first offered dental coverage in 2006. Demand for dental insurance among this group was much greater than forecast. The Office of Personnel Management had estimated that approximately 200,000 people would enroll in the first year, but roughly double that number did. Third is the structure of commercial dental benefits. The relatively low annual benefit maximums limit the possible liability of the insurer, and should mitigate the upward pressure on premiums from any adverse selection that does occur.

Enrolling the elderly

A major policy question for states is whether to offer enrollment in the dental plan to the elderly. Adults aged 65 and older have the lowest level of dental insurance of any age group, and their average out-of-pocket expenditures for dental care are much higher than for the general population – \$400 in 2000. For those with health coverage only through Medicare, this figure rises to \$550.⁵⁸ At the same time, members of the Baby Boom generation are retaining more of their natural teeth into their retirement years than ever before. This, combined with an expectation of a high level of oral health will lead to a higher demand for dental services among older adults, even as they lose employment-based dental coverage.⁵⁹ The inclusion of people over 65 in a state-designed dental offering would provide these people an avenue to seek care at lower personal cost, but it would change the makeup of the pool being insured, and would likely raise premiums due to their higher average cost.

Impact of stand-alone dental program on other types of coverage

Another consideration is the impact that a stand-alone dental offering would have on the Medicaid program and on employer-sponsored dental insurance. In regard to Medicaid, the availability of a state-designed product that mirrors private dental insurance raises the question of whether dentists would shift their business practices to accept enrollees of the new program, and become less willing to serve Medicaid-enrolled children. In regard to private coverage, the existence of a state-subsidized dental product may encourage employers to reduce or eliminate their dental offerings (known as “crowd-out”). Massachusetts’ health care reform plan addresses this concern in regard to medical care by requiring that employers either provide a “creditable” level of coverage, or contribute a percentage of their payroll to the programs that are administered by the Connector Authority.

□ □ □

OPTION 3: PROVIDING DENTAL BENEFITS THROUGH A “CONNECTOR”

Option summary:

A third option is to combine the Medicaid and private insurance approaches using a mechanism similar to Massachusetts’ new quasi-governmental “Connector.” In such an approach, the poorest enrollees would be covered through a Medicaid expansion, and the state would provide a sliding scale of subsidized premiums for higher-income enrollees. The state would organize group coverage for these two populations, and potentially leave the contract open to buy-in by higher-income, unsubsidized people.

Financing considerations:

- To follow the Massachusetts model, the state would expand Medicaid eligibility to all persons with incomes under 100 percent FPL and receive federal matching funds for this population.
- The state would need to develop a funding mechanism to subsidize premiums for people with incomes between 100 and 300 percent FPL.
- The affordability of high coinsurance would remain a concern for subsidized enrollees.

Capacity considerations:

- The state will likely have to formulate a new group contract to enroll the subsidized population. It must determine whether this contract will be bid to a single vendor or multiple vendors.
- The state must also determine whether it will require people to enroll in dental coverage.

A note about “The Connector”

The Massachusetts Connector Authority governs two distinct programs, and the distinctions between these programs are important to highlight in regard to actions that states might take to add dental benefits into this model for health care reform. The two Connector programs are:

- Commonwealth Care, a state-subsidized set of managed care products for people with incomes between 100 and 300 percent FPL, and
- Commonwealth Choice, a set of unsubsidized products for individuals with incomes over 300 percent FPL and small employers.

A key part of the Massachusetts reform is the individual mandate that requires almost everyone to be enrolled in health insurance coverage.

In Commonwealth Care, the Connector holds contracts with four managed care organizations that are also contractors to MassHealth (the state’s Medicaid program), to provide benefits substantially similar to Medicaid. Coverage for Commonwealth Care enrollees is subsidized on a sliding scale, funded through a safety net pool that combines federal disproportionate share hospital payments and state assessments on hospitals and insurers.

Commonwealth Choice is a very different sort of program, wherein the state helps insurers to develop three tiers of products for individuals and small groups (plus an additional set of

products for young adults) which provide similar health benefits, but which vary in the level of premiums and cost sharing required. The Connector also helps uninsured people to locate, compare, and purchase these products, but it does not provide any subsidy, nor require them to enroll in any particular plan. It works on the principle that, in the context of an individual mandate, the health insurance marketplace will develop a variety of products to meet demand.

The Connector reform, especially in regard to its Commonwealth Choice function, is supported by a health insurance context in Massachusetts that may differ significantly from the situation in other states. Massachusetts has a large set of benefits that it requires insurers to provide, coupled with the individual mandate's requirement that every person be enrolled in "creditable" coverage – that is, an insurance policy that the state determines meets a minimum standard of coverage. The reform law combined the individual and small group markets, which provided extra protections to people seeking coverage in the individual market. These protections include:

- Modified community rating – a requirement that premiums in these plans can only vary based on age, and not on health status or preexisting condition
- Guaranteed issue – a requirement that health plans must offer coverage to those seeking it
- Affordability provisions – the Connector's Board is required to establish guidelines as to acceptable levels of cost for enrollee premiums and cost sharing.

Not all states' individual markets contain these safeguards. Additionally, in some states a segment of this market is filled by "dental discount plans," where enrollees pay a monthly fee, usually under \$15, for discounts at participating dental offices. Since these discount plans are not technically insurance products, they are not subject to the same state regulation. If states do not have a well-regulated individual market, it may be best to form a group contract, similar to Commonwealth Care, for those with incomes under 300 percent of poverty, and possibly for those over 300 percent of poverty as well.

Providing Dental Coverage through a Commonwealth Care Approach

In this approach, Medicaid would be expanded to all possible enrollees with incomes under 100 percent FPL. (Note that if the state wishes to enroll non-categorical populations like childless adults in Medicaid, it will need a federal waiver to do so.) Those with incomes between 100 and 300 percent FPL would be enrolled in a private insurance product offered through the same vendor or vendors, and the state would subsidize their premiums on a sliding scale.

This method has the advantage of maintaining consistent coverage through a single administrator as enrollees move from Medicaid coverage to subsidized private coverage under the Connector.

- Medicaid-enrolled children would receive a dental insurance product fully paid for by the state – Medicaid would pay the monthly premiums, and the children would be exempt from cost sharing. There would be very few service limitations, and an EPSDT guarantee of coverage for medically necessary dental services.

- Medicaid-enrolled adults would also have premiums paid by the state; however, the benefit package might look considerably more like private insurance, with an annual maximum benefit of \$1,000 to \$1,200. Because of Medicaid regulations, cost sharing for these enrollees would be limited until the annual maximums were met. The benefit could be tailored to specific populations using benchmark authority, and rolled out gradually, beginning with groups of particular interest.
- Higher-income or non-Medicaid eligible families would share the cost of premiums, based on a sliding scale of subsidies. The benefit and cost-sharing structure would very closely mirror private insurance. This product could also be made available for buy-in by small employers who wish to offer dental insurance to their employees, with an employer contribution substituting for or augmenting the state subsidy. It could also be made available to retirees who do not have a dental benefit through Medicare.

The state would have several decisions to make about the dimensions of the program:

- Will medical insurers participating in the Connector be required to offer dental benefits in addition to medical benefits, or will the state negotiate freestanding dental contracts?
- If the freestanding dental contract route is chosen, will the state select one vendor or multiple vendors?
- Will enrollment in the dental benefit be mandatory for beneficiaries or optional?

Type of contract and number of vendors

The state must determine how the dental offering will be delivered to the enrollees – through medical contracts or through a stand-alone dental contract or contracts. The experience of state efforts to reform Medicaid dental programs and evidence from the introduction of the federal employees’ dental benefit indicate that a freestanding contract with a single dental vendor may be the option that is easiest for the state and most attractive to dentists.

An integrated contract offers the promise of greater ease in coordinating medical and dental care – potentially through contract provisions requiring that medical providers be reimbursed for oral health screening, counseling, and delivery of preventive services like oral health education and fluoride varnish – but typically, “integrated” medical and dental insurance products are administered by separate branches of the agency, and little coordination occurs. Additionally, integrated contracts are less common than freestanding dental contracts. As mentioned above, only 21 percent of large employers offering dental coverage do so through an integrated medical-dental contract. The rest offer a stand-alone dental product. Likewise, the federal employee health plan provides dental coverage through stand-alone contracts.

Regarding the number of contractors, while multiple vendors may allow for competition in price and benefits, most of the FEDVIP offerings are very similar in the amount and scope of benefits that they offer, differing mainly in the level of monthly premium (although most center around \$25 per member per month for single coverage). Of the 400,000 federal employees opting to take up this coverage, more than sixty percent (250,000) of them chose one vendor – MetLife.⁶⁰

Dental associations have long expressed a preference for Medicaid program reforms that select a single, specialized vendor that is separated from other managed care contracts.⁶¹ Dentists often express frustration at Medicaid managed care plans that have different administrative processes and coverage standards; if an enrollee moves between plans, this may disrupt the dentist's treatment plan, or require the treatment to be re-authorized by the new insurer. A single vendor provides a consistent administrative framework for dentists navigating the system. It also provides a path for the state to integrate a Medicaid and private insurance approach that can help lessen the distinctions between those covered by Medicaid and those covered by the Connector.

Optional vs. mandatory enrollment

As discussed under the private insurance option, a major decision is whether to mandate enrollment in dental coverage. The concerns under the Connector model for subsidized people between 100 and 300 percent of poverty are the same as those under the "private insurance" option above, but there is an added consideration for unsubsidized people with incomes above 300 percent FPL. In Massachusetts, people with higher incomes are directed to Commonwealth Choice individual and small-group products. Mandating dental coverage for those higher income people might help to develop the individual dental insurance market, but it bears reiterating that Massachusetts' individual mandate operates in a framework where individual and small-group markets have been merged, and are subject to a variety of regulations, and that the individual market for dental insurance is very small. If the state seeks to rely on the individual market to deliver mandated dental benefits, the status of the insurance market will require special attention. Another option would be to open up enrollment in the state-designed dental insurance product to dentally uninsured higher-income workers. These people could pay the full, unsubsidized premium, and this would likely bring healthier people into the pool and help to keep premium costs stable.

The goal of this public-private construction is to engage the dental provider community in providing services to both Medicaid enrollees and the people who would become newly dentally insured. In order for this coverage to be useful to these new enrollees, coverage must translate to an ability for an insured person seeking care to be able to find it. This is especially important if the state chooses to require people to enroll in coverage.

Because of the nature of dental disease and also the structural limitations of the current dental workforce, the state has to examine ways to insure that there is adequate provider capacity and to attack the problem of dental disease through population-based prevention. Even in a context of "universal" coverage, there will continue to be a role for public oral health measures and the dental safety net. We next turn to a consideration of these public health and workforce factors.

□ □ □

OTHER OPTIONS FOR IMPROVING ORAL HEALTH

There are a number of other approaches states may take, in addition to or instead of expanding dental insurance coverage, that could improve the oral health status of residents. States pursuing health reforms often take the opportunity presented by the reform process to address underlying issues, such as the cost and quality of care, in addition to coverage. Such issues with respect to oral health are integrating oral and physical health to enhance prevention and reduce restorative costs, expanding the safety net to provide a source of services for underserved people, addressing workforce shortages, and beefing up prevention to reduce the incidence of dental caries.

Investing in Prevention

According to the Centers for Disease Control and Prevention, as of 2002 only two-thirds of Americans who use public water supplies were receiving fluoridated water and half the states were below the Healthy People 2010 goal of providing fluoridated water to 75 percent of their population.⁶² Even with the widespread availability of fluoride in over-the-counter products, fluoridated water reduces the amount of decay in children's teeth by 18 to 49 percent and among adults by 35 percent.⁶³ For states that have not already fluoridated their entire water supply, doing so might be the most cost-effective investment in oral health that policy makers could make.

Dental sealants for children are another very cost-effective way to improve oral health and reduce future restorative costs. Sealants are plastic coatings that prevent cavities when applied to the chewing surfaces of permanent molars, where 90 percent of cavities are found.⁶⁴ Although they are applied to an individual's teeth, they are considered a public health intervention because they are targeted generally at low income, high risk children who are most likely to lack access to care. Medicaid and SCHIP do reimburse dentists for sealants, but since only a minority of enrolled children see a dentist every year, many do not receive them.

Using Medical Providers to Expand the Oral Health Delivery System

State Medicaid programs – as payors – have the ability to expand alternative models of service delivery that can promote prevention and reduce the high cost of restorative care. Given limited access to private dentists for publicly funded patients, and shortages of dentists and dental auxiliaries in parts of every state, many states are moving to integrate oral health screening and early intervention into the medical delivery system.

One of the strategies that states have adopted is reimbursing non-dental Medicaid providers for the application of fluoride varnish on young children. Approximately 16 states now allow medical providers to bill Medicaid for oral health risk assessment and application of fluoride varnish, and more are considering it.⁶⁵ One advantage to this approach is that it allows state Medicaid programs to draw on medical care funds to enhance limited dental care budgets. States vary in how they reimburse for these services. For example, North Carolina, which pioneered the approach, pays \$53 for fluoride varnish and patient education. Kansas pays \$17 for varnish

alone; education is considered a routine part of a well-child visit under EPSDT. Wisconsin pays only \$12.76 for a varnish.

Using pediatric providers makes perfect sense since they see infants, young children, and their caregivers many times in the first two years of life for well-child care and immunizations, whereas most families don't take young children to the dentist until they are three or older. It is not uncommon for at-risk young children to have advanced tooth decay by age three. Experts in pediatric dentistry have identified seven strategies for preventing dental caries in preschool children:

- oral health education,
- instruction about proper, age-appropriate diet,
- tooth brushing,
- fluoridated water or supplements in rural or un-fluoridated areas,
- topical fluorides,
- antimicrobials (such as xylitol and chlorhexidine), and
- sealants.

Medical providers can make an important contribution to oral health with each of these strategies except sealants (see Table 6). State dental practice acts restrict sealant application to dentists, dental hygienists, and in nine states, expanded function dental assistants.⁶⁶ The American Academy of Pediatrics (AAP) now has two formal policies on oral health risk assessment and preventive oral health interventions, which are intended to influence the everyday practice of pediatricians for all well-child visits. The AAP has mounted an extensive effort to educate and involve pediatricians in providing preventive oral health education and services, although the idea is still relatively new. The more prevalent information and reimbursement for such services become, the wider their adoption is likely to be.

Table 6 Provider capacity for working with children

| Level of Care | Procedures | Expanded Function Dental Assistants | Dental Therapists | Registered Dental Hygienist | Dentist | Nurse Practitioner or Physician Assistant | Physician |
|------------------------------|--|-------------------------------------|-------------------|-----------------------------|---------|---|-----------|
| Risk Assessment | Parent interview, visual screening | | x | x | x | x | x |
| Anticipatory Guidance | Patient and caregiver education and counseling geared to level of risk | | x | x | x | x | x |
| Primary Prevention | Oral hygiene instruction | | x | x | x | x | x |
| | Dietary counseling | | | x | x | x | x |
| | Topical fluorides | x | | x | x | x | x |
| | Dental sealants | x ⁽¹⁾ | | x | x | | |
| Prophylaxis | Mechanical cleaning of teeth | x ⁽²⁾ | x ⁽⁴⁾ | x | x | | |
| Disease Suppression | Fluoride regimens, antimicrobials, plaque management | | x ⁽⁵⁾ | x | x | x ⁽⁶⁾ | x |
| Cavity treatment | Atraumatic Restorative Technique (ART) | | x | | x | | |
| | Restorations | x ⁽³⁾ | x | | x | | |
| | Extractions | | x | | x | | |
| | Stainless steel crowns | | x | | x | | |

Source: Compiled by the National Academy for State Health Policy, 2008. Reprinted and updated from S. Gehshan, M. Wyatt, "Improving Oral Health for Young Children," NASHP, April 2007.

Notes: Permitted functions and supervision level vary by state dental and medical practice acts.

(1) Expanded Function Dental Assistants (EFDAs) can receive training and certificates to apply fluoride varnish and sealants in nine states: California, Illinois, Minnesota, North Dakota, New Mexico, Oklahoma, Tennessee, Texas, and Washington.

(2) In most states, EFDAs can perform parts of a prophylaxis: "toothbrush" cleanings using a rubber cup or brush.

(3) In most states, EFDAs place temporary restorations, and place and finish amalgam and composite resin restorations. They may not diagnose or prescribe, or cut hard or soft tissue.

(4) Dental Therapists currently practice at Indian Health Service sites in Alaska (called Dental Health Aid Therapists). Currently, no state licenses or trains dental therapists.

(5) Dental Therapists in Alaska practice under general supervision, and can dispense disease suppression agents prescribed by a dentist under standing orders.

(6) Nurse practitioners and physician assistants have limited prescriptive authority that varies by state. They often prescribe under standing orders from a physician, which could be expanded to include disease suppression treatments.

There may be other Medicaid populations that would benefit from a similar approach. Some studies have indicated an association between untreated dental infections among pregnant women and a higher risk of low birth weight or preterm birth. States might consider reimbursing obstetrical providers for a visual oral health screening, hygiene education, and referral to dentists.

Expanding the Safety Net

States are likely to need to strengthen the safety net system so that low income and uninsured citizens, and those left out of health care reform, have a place to go for dental services. Even if policy makers opt to expand financing for dental coverage, access may not improve without attention to service delivery options. For example, a 1999 survey of 39 states found that in 23 states, fewer than half the dentists saw a single Medicaid patient in the course of the year; and 26 states said that fewer than a quarter of the states' dentists saw more than 100 Medicaid patients a year.⁶⁷ While reforms to the Medicaid program may attract greater provider participation, it is unlikely that all the state's dentists will opt to participate. In addition, while dentists are known for the volumes of charity care they provide, charity is not a system of care that can be accessed by beneficiaries, nor is it responsive to planning by policy makers, nonprofit providers, or communities. There will continue to be a need for a safety net of community-based dental clinics.

All across the country, community health centers are a lifeline for the uninsured and people with low income who need primary medical and dental care. Many people who are insured by Medicaid, or whose children are insured by Medicaid or SCHIP, seek care at health centers because they are more comfortable with the clinic model than private sector physicians or dentists. Clinics or health centers often make accommodations needed by low-income patients, such as Saturday or evening hours, translation and transportation assistance, and case management. By bolstering the safety net's ability to provide dental services, states can help to provide services to people whose oral health needs are not addressed by the private marketplace.

Health centers are providing a growing number of dental services; in 2005 they provided dental care to more than 2.3 million patients, up from 1.3 million in 2000.⁶⁸ Yet shortages in dentist supply may limit these centers' capacity to provide needed care. According to a 2004 survey, 48 percent of health centers said they had a vacancy in a dentist position and 12 percent reported multiple vacancies.⁶⁹ Almost a fifth (18 percent) of these vacancies had lasted for over a year. Dentist supply is particularly troublesome in rural health centers.

Even if they are fully staffed, health centers may not be able to reach all individuals who need them. Less than half of the 2,000 counties or partial counties that are considered dental Health Professions Shortage Areas have federally qualified health centers, their look-alikes, or rural health clinics.⁷⁰ Additionally, only 73 percent of federally funded health centers provided oral health services onsite in 2003.

States are using a number of approaches to expand their ability to provide safety net care, particularly in rural areas. Many states fund loan repayment programs and scholarships for dentists and hygienists who agree to practice in safety net clinics and underserved areas. Repayment programs that offer around \$25,000 per year, tax-free, can be effective in attracting or helping retain dentists and hygienists for a few years in rural settings, but are generally limited in the funding and number of slots per year. State funds could supplement the federal program.

Some states such as California have programs that allow foreign-trained dentists to receive a license to practice in underserved areas or clinics, although few take the opportunity. Maryland allows foreign-trained dentists to complete a residency in Maryland and receive a license once they pass their exams. Dental schools in several states allow foreign-trained dentists to enter directly into the second or third year of their programs, or offer a certificate program that allows foreign-trained dentists to stand for licensure exams.⁷¹ These approaches allow a state to recruit dentists interested in a particular specialty, such as pediatric dentistry.

Many states are now developing programs to do rotations for third- or fourth-year dental students in community settings. This accomplishes two goals: it increases the supply of dental professionals in those settings, and exposes the students to patients with low income and the experience of practicing in rural or underserved areas. This increases the comfort level of the students in accepting and treating these patients once they graduate, and may increase the number who locate in rural and underserved areas. Another option for filling positions for dentists at community health centers is contracting with private dentists. The Children's Dental Health Project has a manual to guide states and clinics with the process, which is available at http://www.cdhp.org/Advocacy/Safety-Net.asp?zoom_highlight=contracting.

Expanding the Dental Workforce Available for Underserved Groups

Planning for an adequate workforce to meet increased demand is another essential component of health care reform. The dental workforce is aging, the training of new dentists has not kept pace with population growth, and there are recognized problems with the geographic distribution of practicing dentists. Using its Dental Workforce Model, the ADA projects that the ratio of active private practitioners per 1,000 U.S. residents, which has held steady at 0.55 through most of the 1990s, will drop to 0.50 by 2025.^{72, 73} In 2000, 224 counties across the country did not have any private practice dentists.⁷⁴ The shortage of dentists is particularly acute in rural areas. Among the 430 most rural counties (those with fewer than 2,500 people, not adjacent to a metropolitan area), 134 counties (with a total population of 426,000 people) had no private practice dentist, and 133 counties (containing 700,000 people) had only one.

States are facing the question of whether to train more dentists, develop new mid-level dental providers, or expand scope of practice and loosen supervision requirements for dental hygienists and dental assistants. Since dentists are at the top of the pyramid of dental providers, take the longest to educate, and are the most expensive to produce, there will be increasing pressure to consider less expensive options for expanding the dental workforce. The economics of dental practice require that new options be considered for their impact on private practices, particularly in rural or underserved areas. Since the great majority of dental care is delivered by private

practices, new models that would allow them to treat more patients more efficiently could be beneficial.

Dentistry, unlike medicine, has no mid-level providers. There are currently three new workforce models being developed that could increase dentists' productivity, increase the profitability of serving publicly-funded clients, and increase access to prevention and a limited range of restorative services in remote, rural, or underserved sites. These models would all be a welcome addition to dental teams in clinics and many dental offices. First is the dental therapist, a model in use in the United Kingdom, Canada, New Zealand, and 50 other countries, where graduates of a two- or three-year program can provide preventive and basic restorative care, under the general supervision of a dentist. This model, using the moniker "Dental Health Aide Therapists" (DHAT), is being used by the Indian Health Service in certain sites in Alaska. DHATs in Alaska practice in remote locations, and use specialized carts with internet access to transmit information to their supervising dentist. The second model is the Advanced Dental Hygiene Practitioner (ADHP) being developed by the American Dental Hygienists' Association. ADHPs are envisioned as being able to function in much the same way as DHATs, but they would have a broader range of non-clinical capabilities as well. The third is the Community Dental Health Coordinator (CDHC), which was developed by a task force established by the American Dental Association. CDHCs have a much more limited range of clinical skills proposed, which would be performed under direct supervision. If implemented in this way, CDHCs would be most valuable as public health educators in schools and community settings, rather than clinicians. Table 7 contrasts the planned scope of practice and features of the three. All offer promise for expanded functions and are worth examining by state policy communities.

Other changes that could be considered are expanding the scope of duties that hygienists can provide and integrating expanded function dental assistants (EFDAs) to the state's mix of providers. States often adopt two standards for scope of practice and supervision requirements: one for private dental offices and an alternative for safety net, public health, or community settings. In nearly half of all states, hygienists can work in a dental office – with or without the physical presence of a dentist – on a variety of restorative procedures, such as removing, placing, carving, or finishing restorations.⁷⁵ Other states license hygienists for a much more limited set of procedures. Permitting hygienists to practice to the full extent of their training is cost-effective for dentists and third party payors, and would make sense to consider.

Similarly, EFDAs (who are called registered dental assistants in expanded function in some states) are licensed and practice in 23 states, although in most states there aren't yet many and most dentists aren't trained to use.⁷⁶ Across the country, EFDAs work under direct supervision and can be trained to prepare or finish up restorations, take x-rays, apply sealants and fluoride varnish, and polish teeth. They can perform limited cleanings, but not full hygiene services. Establishing a new category of EFDAs who can assist dentists with more procedures could greatly expand the productivity of a dental office and increase the financial feasibility of accepting publicly-funded patients.

Table 7. Proposed and current dental providers

| | Community Dental Health Coordinator ⁽¹⁾ | Advanced Dental Hygiene Practitioner | Dental Therapist |
|--------------------------------|--|--|--|
| Developed by | American Dental Association | American Dental Hygienists' Association | Dental therapist model developed in New Zealand, in use in 53 countries. The Indian Health Service, Alaska Tribal Health Consortium, employs Dental Health Aide Therapists |
| Stage of development | The ADA is seeking to develop pilot projects. | A curriculum has been developed. Several states and colleges are considering developing training programs. | 11 are trained and practicing in IHS Alaska sites. |
| Education/training | 12-18 months | 2-year Masters program after a 4-year dental hygiene degree | Formerly trained in New Zealand; training is now being conducted in Anchorage, Alaska through the Medex Program at the University of Washington. |
| Certification/licensure | Certification | Licensure | Certified by IHS board (similar to licensure) |
| Proposed settings | Community-based and public health roles; private offices | Hospitals, nursing homes, clinics, public health settings, or private offices | IHS clinics |
| Proposed supervision | Dual; education under general supervision; patient care under direct or indirect supervision | Unsupervised or general supervision; in collaborative practice with dentist, physician, or clinic manager | General supervision; operates under standing orders; dentists review x-rays and treatment plans electronically |
| Preventive capacity | Prevention education Fluorides Sealants | Comprehensive prevention services | Fluoride treatments Sealants |
| Treatment capacity | Gingival scaling (only for Type I patients) Coronal polishing | Manage care for referred periodontal patients Prophylaxis | x-rays Gingival scaling Prophylaxis |
| Restorative capacity | Atraumatic restorative technique | Simple restorations Simple extractions | Simple restorations Stainless steel crowns Simple extractions |

Source: American Dental Association Workforce Task Force Report, May, 2006; American Dental Hygienists Association Draft Curriculum, January, 2006; Alaska Department of Health and Social Services, Division of Public Health, January, 2005. Reprinted and updated from S. Gehshan, M. Wyatt, "Improving Oral Health for Young Children," NASHP, April, 2007.

(1) Community Dental Health Coordinators have a proposed skill set that is very similar to the Primary Dental Health Aides (PDHA) who are practicing in Alaska for the Indian Health Service.

□ □ □

FINDINGS

States working on reforming their health systems have a unique opportunity to bring dental coverage into the conversation. This brief describes three options states can consider:

- a benefit package based on a public insurance model, like Medicaid,
- a private insurance model, like the federal employee health plan, or
- a combination of the two approaches, much as Massachusetts is doing with its Commonwealth Care model.

The two major considerations in each approach are: (1) the ability to recruit and retain providers, or strengthen the delivery system, so that coverage actually translates into access to care, and (2) the costs, and the allocation of them across government, employers, and citizens. Each model has advantages and disadvantages.

Medicaid coverage would require the development and extension of a new benefit to people with low income, but it would shield enrollees from potentially unaffordable out-of-pocket costs. A product that is more similar to private insurance would make participation easier for private dentists, but it exposes enrollees to a higher level of financial risk. A Massachusetts-style insurance “Connector” would allow for a single administrative framework, but the state must recognize that Massachusetts’ individual mandate is built upon a framework of insurance market regulations that not all states currently have.

All three of these models are feasible, and the state has a great deal of flexibility in how it could implement any of them. Medicaid benefits can be tailored for specific enrollee groups through the use of a benchmark plan. Coverage can be phased in gradually to spread out costs. Premiums, coverage, and coinsurance in a private insurance offering can be adjusted to mitigate the financial burden on enrollees. The state can share financial burdens across government, employers, and enrollees to achieve its desired balance.

Even beyond determining the design of dental benefits in a health reform package, the state has the ability to take action on structural issues that underpin dental service delivery. Investment in proven, evidence-based public oral health measures such as community water fluoridation and sealant programs helps to reduce the prevalence of oral disease and ease the strain on the dental infrastructure at low cost. Beyond that, the state should investigate ways that it can expand the dental workforce through integration with the medical care delivery system, increasing the reach and productivity of dental hygienists and dental assistants, or working to develop a true mid-level dental provider.

Poor oral health has long been recognized as a persistent unmet need, particularly among our most vulnerable citizens. The current wave of health care reform efforts offer states an excellent opportunity to address dental care systematically.

□ □ □

Notes

¹ P.W. Newacheck et al., “The Unmet Health Needs of America’s Children,” *Pediatrics* 105 no. 4 pt 2 (April 2000): 989-997.

² For more on the current status of the oral-systemic disease link, see the special supplement to the October 1, 2006 *Journal of the American Dental Association* available at http://jada.ada.org/content/vol137/suppl_2/index.dtl.

³ D. Albert, D. Sadowsky, P. Papapanou, M. Conicella, and A. Ward, “An Examination of Periodontal Treatment and per Member per Month (PMPM) Medical Costs in an Insured Population,” *BMC Health Services Research* 6 (August 16, 2006): 103. Internet; available at <http://www.biomedcentral.com/1472-6963/6/103>. Accessed August 6, 2007.

⁴ Aetna press release, “Aetna Launches Dental/Medical Integration Program that Includes Specialized Pregnancy Benefits” (October 30, 2006). Internet; available at http://www.aetna.com/news/2006/pr_20061030a.htm. Accessed August 3, 2007.

⁵ See http://www.deltadentalwa.com/WDSFoundation/WDSFoundation.aspx?DView=WDSFoundation_PrimaryCarePhysicians. Accessed August 3, 2007.

⁶ B.A. Dye, S. Tan, V. Smith, B.G. Lewis, L.K. Barker, G. Thornton-Evans, et al., “Trends in Oral Health Status: United States, 1988–1994 and 1999–2004,” National Center for Health Statistics, *Vital and Health Statistics* 11 no. 248 (April 2007): 2-6.

⁷ U.S. Department of Health and Human Services, *Healthy People 2010*, 2nd ed, vol. 2 (Washington, DC: U.S. Government Printing Office, 2000). Internet; available at <http://www.healthypeople.gov/Document/HTML/Volume2/21Oral.htm>. Accessed October 24, 2007. See Objective 21-8.

⁸ Maine Dental Access Coalition. *Maine Oral Health Improvement Plan* (Augusta, ME: Maine Dental Access Coalition, November 2007).

⁹ Based on conversations with Brian Rosman and Stacey Auger, Health Care For All. Also, see Neva Kaye and Andrew Snyder, *Health Reform in Maine, Massachusetts and Vermont: An Examination of State Strategies to Improve Access to Affordable, Quality Care* (Augusta, ME: Maine Health Access Foundation, 2007).

¹⁰ See Catamount Blue Certificate of Coverage, pages 14-15. Available at <http://www.bcbsvt.com/pages/PDFs/catamount/Catamount%20Health%20Plan%20Certificate.pdf>. Retrieved March 27, 2008.

¹¹ See MVP Catamount Choice Subscriber Contract, pages C-42 – C-43, and C-50 – C-51. Available at http://www.mvpvermont.com/pdf/VT_Catamount_Subscriber_Contract_PPO_200801.pdf. Retrieved March 27, 2008.

¹² Based on conversation with Russell Frank, Office of Vermont Health Reform, and Glenn McRae, Health Care Reform in Vermont, *Hard Choices for Transformative Change* (Burlington, VT: Snelling Center for Government: 2007).

¹³ Office of Vermont Health Access. *Medicaid Budget: State Fiscal Year 2009* (Williston, VT: Office of Vermont Health Access, February 2008), 73-80.

¹⁴ The American Dental Association’s *1999 Survey of Dental Practice*, as cited in E. Mertz and E. O’Neil, “The Growing Challenge of Providing Oral Health Care to All Americans,” *Health Affairs* 21 no. 5 (September/October 2002): 70.

¹⁵ U.S. Department of Health and Human Service, *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, p. 231).

-
- ¹⁶ C. Lewis, W. Mouradian, R. Slayton, and A. Williams, “Dental Insurance and Its Impact on Preventive Dental Care Visits for U.S. Children,” *Journal of the American Dental Association* 138 (March 2007): 369-380.
- ¹⁷ T. Wall and L. Jackson Brown, “Recent Trends in Dental Visits and Private Dental Insurance, 1989 and 1999,” *Journal of the American Dental Association* 134 (May 2003): 621.
- ¹⁸ U.S. Department of Labor, Bureau of Labor Statistics, *National Compensation Survey, Employee Benefits in Private Industry in the United States, March 2006* (Washington, DC: U.S. Bureau of Labor Statistics, 2006, 6-7). Internet; available at <http://www.bls.gov/ncs/ebs/sp/ebsm0004.pdf>. Accessed July 31, 2007.
- ¹⁹ Employee Benefit Research Institute (EBRI), *Fundamentals of Employee Benefit Programs* (Washington, DC: Employee Benefits Research Institute, 2005, pp. 35-39).
- ²⁰ Center for Medicare and Medicaid Services, National Health Expenditures data, Table 10, Personal Health Care Expenditures, by Type of Expenditure and Source of Funds, Calendar years 1998-2005. Internet; available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>
- ²¹ E. Brown, and R. Manski, *Dental Services: Use, Expenses, and Sources of Payment* (Rockville, MD: Agency for Healthcare Research and Quality, 2004) MEPS Research Findings No. 20. AHRQ Pub. No. 04-0018. Table 12, p. 34. Internet; available at www.meps.ahrq.gov/mepsweb/data_files/publications/rf20/rf20.pdf. Accessed August 28, 2007.
- ²² J. Liu, J. Probst, A. Martin, J. Wang, and C. Salinas, “Disparities in Dental Insurance Coverage and Dental Care among US Children: The National Survey of Children’s Health,” *Pediatrics* 119, Supplement 1 (February 2007): S12-S21.
- ²³ Department of Health and Human Services, “Federal Financial Participation in State Assistance Expenditures, FY 2007,” *Federal Register* 70: 229 (November 30, 2005). Internet; available at <http://aspe.os.dhhs.gov/health/fmap07.htm>. Accessed August 15, 2007.
- ²⁴ A service that the EPSDT requirement often impacts is orthodontics. States may choose not to cover orthodontic services, except if evidence is presented through an EPSDT screening that an enrolled child’s orthodontic problems cause impairment to his or her ability to eat, sleep, or breathe. It is important to note that the EPSDT entitlement is effective from the first day of coverage. This stands in contrast to most private dental insurance, where enrollees have a waiting period – sometimes up to 24 months – before being covered for expensive services like orthodontics.
- ²⁵ S. Gehshan and M. Wyatt, op. cit. p. 3.
- ²⁶ American Dental Association, *Adult Dental Benefits in Medicaid: Decade Review*, available from the Government Affairs Division. Accessed June 11, 2007.
- ²⁷ S. Gehshan, P. Hauck, and J. Scales, *Increasing Dentists’ Participation in Medicaid and SCHIP* (Washington, DC: National Conference of State Legislatures, 2001). Available at <http://www.ncsl.org/programs/health/forum/oralhealth.htm>.
- ²⁸ Ibid.
- ²⁹ General Accounting Office, “Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations” (Washington: DC, 2000, pp. 10-11). Internet; available at <http://www.gao.gov/new.items/he00149.pdf>.
- ³⁰ S. Eklund, J. Pittman, and S. Clark, “Michigan Medicaid’s Healthy Kids Dental Program: An Assessment of the First 12 Months,” *Journal of the American Dental Association* 134 (November 2003): 1509-1515.
- ³¹ State of Tennessee, Bureau of TennCare media release, *TennCare Announces Dental Contract Winner*, August 31, 2005. Internet; available at http://www.tennessee.gov/tenncare/news/2005_Releases/DBM_RFP_Awarded083105.pdf. Accessed July 27, 2007.

-
- ³² M. Greene-McIntyre, M. Finch, and J. Searcy, "Smile Alabama! Initiative: Interim Results from a Program to Increase Children's Access to Dental Care," *Journal of Rural Health*, 19 Supplement, (2003): 407-415.
- ³³ American Dental Association, *State and Community Models for Improving Access to Dental Care for the Underserved – A White Paper*. (Chicago: American Dental Association, 2004). Internet; available at http://www.ada.org/prof/resources/topics/topics_access_whitepaper.pdf. Accessed August 6, 2007.
- ³⁴ See <http://www.dmas.virginia.gov/dental-home.htm>.
- ³⁵ Presentation by Patrick Finnerty, Virginia Department of Medical Assistance Services. National Academy for State Health Policy webcast, August 1, 2007. Internet; available at <http://www.ian.ibeam.com/events/nash001/23139/> (registration required). Accessed August 6, 2007.
- ³⁶ Presentation by Martha Dellapenna, Rhode Island Department of Human Services. National Academy for State Health Policy, October 17, 2006. Internet; available at <http://www.nashp.org/loadedfiles/Martha%20Dellapenna%20session%205.pdf>. Accessed August 6, 2007.
- ³⁷ Presentation by Kathleen Cota, Minnesota Department of Human Services. National Oral Health Conference, April 30, 2006. Internet; available at <http://www.nationaloralhealthconference.com/docs/presentations/2006/0430/Kathleen%20Cota%20-%20nohc-2006..pdf>. Accessed August 6, 2007.
- ³⁸ By contrast, Medicaid-enrolled children under age 19 are exempt from cost-sharing, including copayments.
- ³⁹ Statehealthfacts.org, "Income Eligibility for Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level (FPL), 2006." Internet; available at <http://www.statehealthfacts.org/comparatable.jsp?ind=205&cat=4>. Accessed October 1, 2007.
- ⁴⁰ See, for example, Committee on the Consequences of Uninsurance, Institute of Medicine, *Health Insurance Is a Family Matter* (Washington, DC: National Academy Press, 2002).
- ⁴¹ A. Schneider, et al., *The Medicaid Resource Book* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2002, pp. 63-64).
- ⁴² R. Hughes, P. Damiano, M. Kanellis, R. Kuthy, and R. Slayton, "Dentists' Participation and Children's Use of Services in the Indiana Dental Medicaid Program and SCHIP: Assessing the Impact of Increased Fees and Administrative Changes," *Journal of the American Dental Association* 136 (April 2005): 517-523.
- ⁴³ Centers for Medicare and Medicaid Services, *MSIS State Summary, FY 2004: Table 17, FY 2004 Medicaid Medical Vendor Payments by Service Category* (Baltimore, MD: U.S. Department of Health and Human Services, June 2007). Retrieved November 6, 2007. <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/msistables2004.pdf>.
- ⁴⁴ Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. *National Health Expenditure Accounts: Total Personal Health Care Spending, By Age Group, Calendar Years 1987, 1996, 1999, 2002, 2004* (Baltimore, MD: U.S. Department of Health and Human Services, 2004). Retrieved March 3, 2008. <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/2004-age-tables.pdf>.
- ⁴⁵ Centers for Medicare and Medicaid Services, *Annual EPSDT Participation Report: Form CMS-416 (National), 2006*. (Baltimore, MD: U.S. Department of Health and Human Services, 2008). Retrieved March 3, 2008. http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp.
- ⁴⁶ Ibid.
- ⁴⁷ See the Federal Employees' Dental and Vision Insurance Program (FEDVIP) page at <http://www.opm.gov/insure/07/guides/fedvipTables.asp>. Internet; accessed October 1, 2007.
- ⁴⁸ EBRI, op cit., 35-36.

⁴⁹ State of Kansas, *Benefit Description of Dental Care Coverage* (revised 5/23/06). Internet; available at <http://www.khpa.ks.gov/OpenEnrollment07/2007BenDescriptions/2007DeltaFinal.pdf>. Accessed August 2, 2007.

⁵⁰ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, and National Center for Health Statistics. *Medical Expenditure Panel Survey (MEPS): Table 3: Dental Services – Median and Mean Expenses per Person with Expense and Distribution of Expenses by Source of Payment: United States, 2004*. Internet; available at http://www.meps.ahrq.gov/mepsweb/data_stats/MEPS_topics.jsp?topicid=10Z-1. Accessed August 2, 2007.

⁵¹ American Dental Association, Survey Center, *2005 Survey of Dental Fees*. (Chicago: American Dental Association, 2005). The particular codes are D3320 – Bicuspid root canal (\$596) and D2751 – Crown – porcelain fused to predominantly base metal (\$730).

⁵² 2007 HHS Poverty Guidelines available at <http://aspe.hhs.gov/poverty/07poverty.shtml>. Accessed August 24, 2007.

⁵³ M. Sweet and P. Damiano, et al., “A Comparison of Dental Services Received by Medicaid and Privately Insured Dental Populations,” *Journal of the American Dental Association* 136 (January 2005): 93-100.

⁵⁴ Milbank Memorial Fund and the Reforming States Group. *Pediatric Dental Care in CHIP and Medicaid: Paying for What Kids Need, Getting Value for State Payments* (New York: Milbank Memorial Fund, 1999). Internet; available at <http://www.milbank.org/99071mrpd.html>. Accessed May 30, 2007.

⁵⁵ George Mason University, Center for Health Policy Research and Ethics. *Actuarial Findings: Mercer Oliver Wyman, for the Virginia State Planning Grant Proposed Model Insurance Product*. (Fairfax, VA: George Mason University, January 2006, p. 5). Internet; available at <http://tfede.u24.mangohost.com/spg-ii-files/020806-UpdatedActuarialInfoFeb3.doc>. Accessed August 6, 2007.

⁵⁶ L. Blumberg, J. Holahan, J. Hadley, and K. Nordahl, “Setting a Standard of Affordability for Health Insurance Coverage,” *Health Affairs* 26 (June 4, 2007): w463-w473. Internet (web-exclusive, subscription required); available at <http://content.healthaffairs.org/cgi/content/full/hlthaff.26.4.w463>. Accessed August 20, 2007.

⁵⁷ Bureau of Labor Statistics, op cit., 11.

⁵⁸ R. Compton, “Expansion of Dental Benefits under the Medicare Advantage Program,” *Journal of Dental Education* 69 (September 2005): 1034-1044.

⁵⁹ R. Manski, S. Goodman, B. Reid, and M. Macek, “Dental Insurance Visits and Expenditures among Older Adults,” *American Journal of Public Health* 94 (May 2004): 759-764.

⁶⁰ B. Ballenstedt, “OPM Seeks to Leverage Success of Dental, Vision Program,” *Government Executive* (February 23, 2007). Internet; available at http://www.govexec.com/story_page.cfm?articleid=36193&ref=relink. Accessed August 20, 2007.

⁶¹ See for example American Dental Association, *Medicaid Program Administration*, (Chicago, IL: American Dental Association, March 2004). Internet; available at http://www.ada.org/prof/advocacy/issues/medicaid_administration.pdf. Accessed August 21, 2007.

⁶² Center for Disease Control and Prevention, Community Water Fluoridation Statistics. Internet; available at <http://www.cdc.gov/fluoridation/statistics.htm>.

⁶³ Centers for Disease Control and Prevention, Preventing Chronic Diseases: Investing Wisely in Health—Preventing Dental Caries. Internet; available at http://www.cdc.gov/Oralhealth/factsheets/dental_caries.htm.

⁶⁴ National Center for Health Statistics, Centers for Disease Control and Prevention. *National Health and Nutrition Examination Surveys 1999-2004*, cited in J. Beauchamp et. al., “Evidence-Based Clinical Recommendations for the Use of Pit-and-Fissure Sealants,” *Journal of the American Dental Association* 139 (March 2008) : 257-268. <http://www.danb.org/PDFs/JobTitles.pdf>

⁶⁵ National Academy for State Health Policy, unpublished survey of state Medicaid dental program managers, March 2008.

⁶⁶ National Roadmap of Job Titles, Dental Assisting National Board, accessed at <http://www.danb.org/PDFs/JobTitles.pdf>, March 29, 2008.

⁶⁷ General Accounting Office, *op. cit.*

⁶⁸ Ginger Ruddy, “Health Centers’ Role in Addressing the Oral Health Needs of the Medically Underserved” (Bethesda, MD: National Association of Community Health Centers, August 2007, p. 6). Internet; available at <http://www.nachc.com/research/Files/Oral%20Health%20Report%20FINAL.pdf>.

⁶⁹ *Ibid*, p. 11.

⁷⁰ *Ibid*, p. 3.

⁷¹ See, for example, the ADA’s list of “Accredited Dental Education Programs That May Accept International Graduates with Advanced Standing,” at http://ada.org/prof/prac/licensure/licensure_advanced_standing.doc, and “International Dentists Programs” at http://ada.org/prof/prac/licensure/licensure_intl_dentist_programs.pdf. (Last updated July 2007.)

⁷² L Jackson Brown, *Adequacy of Current and Future Dental Workforce: Theory and Analysis* (Chicago, IL: American Dental Association, 2005, p. 77).

⁷³ The ADA notes that advances in the productivity of dentists may compensate for the declining ratio of dentists-to-residents.

⁷⁴ Thomas P. Wall, and L. Jackson Brown, “The Urban and Rural Distribution of Dentists, 2000,” *Journal of the American Dental Association* 138 (July 2007): 1003-1011.

⁷⁵ ADHA Practice Act Overview Chart of Permitted Functions and Supervision Levels by State, downloaded August 10, 2007 at http://www.adha.org/governmental_affairs/downloads/fiftyone.pdf.

⁷⁶ Dental Assisting National Board. Accessed August 13, 2007 at <http://www.danb.org/main/statespecificinfo.asp>.