Universal Oral Health Coverage, Changes in Policy

By

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Abstract

There is a pervasive trend within the healthcare industry wherein oral healthcare is isolated and viewed as removed from the medical model that treats the rest of the body. Part and parcel with this trend is the insurance industry and legislative bodies. The Affordable Care Act takes long overdue steps towards providing adequate coverage for those who were previously unable to afford comprehensive medical care. Meanwhile no reforms were made for privatized dental insurance and public dental insurance was changed in a positive yet underwhelming way, increasing Medicaid coverage from 100% of the Federal Poverty (FPL) level to 133% FPL. Limited access to dental insurance remains a significant factor for the underutilization of dental care among those populations that have the greatest prevalence of dental disease. Changes need to be made to the dental insurance system in order to be able to provide the appropriate level of care for those that do carry dental policies. Changes need to be made to the public system to reduce the number of people that currently cannot afford dental care due to its prohibitively expensive price tag. Most importantly changes need to be made to the culture of thinking regarding oral healthcare as an isolated entity that is entirely removed from the comprehensive medical picture.

This paper reviews the current issues surrounding the inadequacy of dental care insurance coverage in the United States and presents a set of proposals and areas for future research to address the underutilization of needed dental care.
Introduction
Since the early rise of the dental profession in the barber chairs of the old west, there has been a disconnect between the public perception of dentistry as a medical profession and the real medical relevance that oral health plays in the comprehensive medical picture. Dental insurance first gained broad acceptance in the early 1970s; nearly fifty years after the advent of medical insurance in the form we recognize it as today. Prior to the 1970s there simply was no dental insurance. As the cost of providing treatment rose throughout the 1960s so did the need for individuals to subsidize their dental payments. Unfortunately, there continues to be a marked divide in what services society deems medically necessary: in the court of public opinion, and despite a considerable amount of reviewed and accepted research, there is still a remarkable disconnect between dental healthcare and overall wellbeing.

The public perception of dentistry and oral health being separate from medicine is most evident in the recent passage of the Affordable Care Act (ACA). The bill is 974 pages long and is a long overdue step in the right direction towards providing all U.S. citizens with appropriate access to health care, but the bill does nearly nothing towards normalizing dental care disparities (H. 111-148, 2010). The ACA does expand Medicaid funding for states to include individuals up to 133% Federal Poverty Level (FPL), which will broaden the population that can use Medicaid’s dental benefits, but a much larger leap is required.
Lack of adequate access to dental care is a serious public health concern. Dental caries (tooth decay) is the most pervasive and prevalent infectious disease in the world; an estimated 5 billion people worldwide suffer from it (Puska, 2003). Fortunately, the morbidity and mortality of dental caries is preventable with proper intervention. Caries has a very manageable behavioral component; with appropriate professional treatment and support most people do not need to suffer through toothaches, dental abscesses or tooth loss. With adequate insurance coverage, more people would have access to what can otherwise be cost-prohibitive treatment.

Dental care also remains the greatest unmet health need of children. According to the Centers for Disease Control and Prevention (CDC), in 2005, fifty-two percent of children will have experienced decay by the age of eight; by the age of seventeen the number jumps to seventy-eight percent. The development of caries can stem from poor oral hygiene practices and poor nutrition: it's particularly important to instill good practices early, reinforce adoption of good habits and correct behavioral issues to reduce the instances of the disease in adulthood. Access to adequate dental insurance is of key importance. For those families that have private or public dental coverage there is a 30% greater incidence of annual preventive dental visits (Sinclair, 2005), and preventive care is the best course for dental treatment. From office fluoride applications to sealants applied to permanent teeth in children, priming teeth for a healthy life is a much better treatment model than using dental offices as emergency rooms once oral health problems turn symptomatic. Any action that increases the number of people that seek routine dental exams and treatment is going to proportionately decrease the number of
people who develop serious oral health problems. Additionally oral cancer rates are on the rise and routine oral exams are the best way to catch these potentially life-threatening conditions.

Unfortunately, lack of adequate access to care is an almost insurmountable roadblock for certain populations. There is a disparate underutilization of dental health care among lower socioeconomic groups as well as demographics where English is not the first language (Edelstein, 2006). A study by the United States Public Health Service indicates that the incidence of decay increased significantly for two to eleven year olds from 1988-1994 to 1999-2004. The highest incidence was in households below 100% of the Federal Poverty Level (FPL), strongly indicating a causal relationship between poor oral health care and fiscal strength (Dye, 2007). This suggests the oral health care provisions of the existing health care policy are weak; crippling those who cannot afford private insurance.

A comprehensive solution to the problem would be including dental/oral health coverage as a required component of health insurance. It is time to change public and private insurance perception that your overall health stops at your lips. Oral health is as much a factor in systemic health as any other organ system. There is no need to parse out dentistry as different from any other medical specialty. This paper will explore that option, as well as others that would also widely increase access to dental care.
What Drives the Lack of Access to Dental Care?

There are many reasons for the lack of access to dental care: it is no surprise that dental caries is such a pervasive problem. Many employers do not provide dental insurance as part of their benefits package, and the cost of private dental insurance may be out of reach for a good number of individuals and families. Many Americans live in rural communities where there is a shortage of dentists, making dental care harder to access.

In sum, there are many factors contributing towards the poor oral health of the nation, but there are some common threads that can be identified. First, the price of dental care makes it generally inaccessible. Second, the plan coverage and limits (public and private) are insufficient to maintain an adequate level of oral health.

The Price of Dental Care

1. Disparities between varying socioeconomic statuses

Lower-income individuals can sometimes prioritize healthcare spending as a want instead of a need. Unless family members or individuals have an acute medical need, or a chronic medical issue requiring continued medical intervention and medication, it is very easy to deprioritize the importance of maintaining an active health insurance policy. This neglect is multifactorial but the health belief model describes the behavior well: the lower-income population lacks perceived susceptibility to medical crises, under-assessing their risk of getting sick (Siegel, 2007). They also underestimate perceived severity, under-assessing the seriousness of planning for health crises and potential
There are many reasons, but socioeconomic variables like economic status are big drivers in the decision to deprioritize maintaining proper health care. The costs of private dental insurance can be prohibitively expensive for lower income households. The CDC published a study that indicated that as income level increased, the percentage of individuals with dental insurance increased. Those who were college-educated were much more likely to have dental insurance than those with less education (Bloom, 2010). As the level of education increases there is a greater incidence of being employed and greater incidence of employment leads to greater incidence of the individual’s employer providing benefits like dental insurance. The study also found a greater appreciation among college graduates for maintaining their overall health.

Further, in October, 2009 the Children’s Health Insurance Program Reauthorization Act (CHIPRA) set federal guidelines for oral health care that states were required to follow for children of low income families (National Maternal and Child Oral Health Policy Center, 2011). It is now a federal requirement that states provide treatment “…necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions” (H.R. 2, 2009). This is an important distinction because historically there have been various levels of publically funded dental coverage, but this act standardized across all states a set of requirements. It is equally important to note that this required coverage only extends to children up to the age of 19.
That said, Medicaid currently only has federal standards requiring dental coverage for all children from households earning less than 100% of the Federal Poverty Level (FPL), but there are absolutely no federal guidelines for what adults are required to be covered by Medicaid regardless of FPL. This leaves only the option of private sector insurance, which requires that either the individual or his/her employer purchase a plan.

Since there is currently no federal dental coverage for adults, only the state coverage is available to indigent adults, but even that is slim. For example, North Carolina Medicaid coverage is primarily for the elderly, children and pregnant women varying between 100% and 200% of the poverty level (North Carolina Department of Health and Human Services, 2012). Beyond the gaps in whom Medicaid covers, there are also significant limitations in what Medicaid covers. In about half the states, Medicaid covers dental care only for pain relief and emergencies, according to a recent report by the Kaiser Commission on Medicaid and the Uninsured, a national health research group (Goodnough, 2012). The report also found other states cover preventive exams and cleanings but not restorative services, like fillings and root canals. Starting in January, Massachusetts Medicaid will pay for fillings — but only for those in the front of the mouth. The reasoning was that healthy front teeth were more important for getting and keeping jobs. The same study details that fewer providers are accepting Medicaid, and that Medicaid dental reimbursement is being cut to dental care providers. It stands to reason that as reimbursements are being reduced, the providers may not want to carry the additional cost during tough economic times.
Compounding the problem of limited access to affordable dental insurance is the disproportionate need for treatment. For example, there is fairly strong evidence for an inverse relationship between socioeconomic status and the prevalence of caries among children less than twelve years of age (Reisine, 2001). In households making <$10,000 annually, children had a 33% incidence of having active untreated caries. In households making >$35,000, the incidence dropped to 10%. The same disparities continued into adulthood. Almost 50% of adults in low income households had active untreated caries versus 17% of higher income families. Poor children were also twelve times more likely to have restricted-activity days (missing school) due to dental problems (General Accounting Office, 2000) (Dye, 2010). It is disappointing that the population that has the greatest incidence of disease is the same population that has the least access to care.

There is a clear disparity in need between the low income population and those in the middle class. The low income population that needs a disproportionate amount of care is the exact population that can least afford it. This trend continues as we look at other risk factors leading to inadequate oral health care.
2. **Disparities between ethnicities**

Various ethnicities have disproportionately unmet oral health needs. “Mexican Americans experienced the highest prevalence of untreated decay among children and adolescents, but non-Hispanic blacks experienced the highest prevalence of untreated decay among adults” (NIDCR/CDC 2002). There are barriers preventing these populations from seeking treatment:

- 27% of adults, or 45 million Americans, have no dental insurance. Only 55% of Hispanic Americans carry some form of private or public dental insurance (The Pew Center on the States, 2012). There are nearly twice as many Hispanic Americans without dental insurance compared to all Americans. There is a clear demarcation with this population as it relates to their access to oral health care.

- “Poor and minority children were less likely to receive preventive dental care, even when insurance status was considered. Rural children were less likely to have dental insurance than urban children. Foreign birth affected insurance status for Hispanic children and use of preventive services for all minority children. African Americans and Latino Americans are more likely than whites to put off seeking medical care” (Liu, 2007). In addition to making dental insurance more available, there needs to be a push to engage minority populations to get them more involved with their health care.
• The Bureau of the Census projects that, by 2025, racial and ethnic minority Americans will more than double as a share of the elderly rising from 14 percent to 35 percent (Moon, 2006). As the amount of untreated dental disease escalates with the aging population, there will be a greater number of adults using emergency rooms and dental clinics to treat acutely symptomatic dental problems. This puts an undue stress on hospital emergency rooms, as well as on the patients that are avoiding routine exams and screening that can detect problems early.

**Inadequate dental coverage of private/public insurance plans**

1. Inadequate coverage of oral health needs by private insurance

Private dental insurance in its current form is staggeringly similar to a dental insurance plan that could be purchased almost 30 years ago, in the mid-1980s. For example, in 1986 the average maximum benefits reimbursed by private dental insurance companies were capped at only $1,000, with very few plans exceeding $1,500. In 2010, roughly 50% of private insurance plans still have annual maximums of less than $1,500 (NADP/DDPA, 2011). Meanwhile premiums in 1986 were less than $5.99 per month. In 2010 monthly premiums were closer to $25-$27. So the average citizen is paying over 400% more than they were over 25 years ago and only some of them are even seeing a slight increase in annual benefits (Jain, 1988). Dentistry as a profession has evolved markedly over the past 30 years. Since 1986, new restorative materials, equipment, lab processes, techniques and treatment modalities have been incorporated into routine dental care. All of this innovation comes at a cost and as such treatment is
more aesthetic, less painful and safer. Keeping dental insurance annual maximums nearly static for 30 years has been a disservice to patients and providers who are more limited in the scope of care that can be provided due to the necessary cost of the treatment provided.

Providing managed care has caused certain problems for patients and dentists. The average maximum indemnity provided by most insurance carriers, according to the Dental Wellness Center, remains at $1,500 per year (Erickson, 1999). In sharp contrast, the cost of running a dental practice has increased significantly over time through annual inflation with staff pay, advances in materials, new procedures, equipment maintenance and lab costs. Meanwhile the insurance companies have not budged on the scope of their limited plans.

Preventive services are vital for maintaining adequate oral health. A dental cleaning generally costs anywhere from $100-$300 depending on the area and other services provided during the appointment such as x-rays and exams (CostHelper Inc., 2012). With monthly premiums averaging over twenty five dollars per person, it is very possible that a healthy adult is paying more annually to their insurance provider than their dental office is billing their insurance for. The Social Security Bulletin provided a census on historic benefit expenditures for the 6% of individuals with private plans in 1970 (Mueller, 1972). The total benefit expenditures were $240 million dollars for the 12.2 million individuals enrolled, but the average benefit expenditure per enrollee was only
In summary, the current state of private dental insurance is problematic for two main reasons. First, healthy individuals who only require checkups and wellness exams are overpaying their insurance providers because they never claim those benefits. Secondly, the total coverage is so small it doesn’t provide an adequate safety net for those who need it.

2. Inadequate coverage of oral health needs by public insurance

Medicaid is a wonderful safety net program providing oral health coverage for the nation’s poorest citizens. Unfortunately Medicaid provides meager reimbursement to dental providers. Because of this, most private dental offices choose not to accept Medicaid reimbursement.

Children on Medicaid have a very limited access to care as only about 20% of dentists nationwide participate in Medicaid according to the U.S. Department of Health and Human Services (“Oral health workforce,” n.d.). Unfortunately, the children with the highest risk for dental disease are those on Medicaid. In actuality, less than 25% of Medicaid insured children ages 1-20 had seen a dentist at least one time (Bloom, 2010). The system designed to be the public safety net for children is failing due to poor funding and reimbursement. It can be a challenge for individuals and families to find a
dental practice that accepts their insurance. This is as true for Medicaid as it is for some private insurance plans. With so few providers accepting Medicaid, it puts an additional strain on the family searching for a provider.

The recent economic recession had compounding negative effects on access to dental care. During the 2009 economic recession, emergency rooms reported a 16% increase in dental emergency visits (up from 2006) (Stock & Watson, 2012) (The Pew Center on the States, 2012). The same hard economic times that negate some individuals from being able to afford coverage also leads many families and employers to drop their private dental insurance and depend on the safety of emergency rooms to cover their oral health problems. Again, the problems being treated are preventable or much less expensive and more manageable if they are diagnosed early. Instead of using the network of public and private oral health care providers the unemployed and underinsured are left with the familiar option of palliative antibiotic and analgesic treatment, because then it is covered by their medical insurance. While there is no current comprehensive data regarding nationwide county health department use, there are several sources siting localized health department budget cuts coinciding with an increase in demand from those individuals that lost their private health and/or dental insurance (Christianson, 2011)(Moser, 2012)(Willard, 2012).

Medicaid reimbursement to providers was cut below the cost of delivering care; this resulted in a spike in dental-related hospital emergency room visits (The Pew Center on the States, 2012). When the reimbursement for dental treatment was cut to less than
what it costs providers to deliver the care, many private dental clinics stopped taking Medicaid because the amount of money they lose in accepting it. Unfortunately, emergency room visits for dental disease are costing states millions of dollars annually (The Pew Center on the States, 2012). When patients use the emergency room without health insurance, the hospital is obligated to see them and stabilize their condition to the best of their ability. More often than not, this means prescribing pain medication and antibiotics. The majority of the time the hospitals have to absorb the cost of diagnostics and treatment when a patient is unable to pay. Some patients use the ER because they have health insurance including Medicaid. This leads to a misappropriation of Medicaid funds being used to pay a hospital to treat the symptoms of an oral health problem versus paying less money to a dental clinic to treat the problem and cure the symptoms. In 2009, there were 62,000 emergency room visits by Medicaid enrollees in North Carolina that could have been avoided if these patients had received preventative care from a dentist (The Pew Center on the States, 2012). Most dental caries take months to years to become symptomatic. These North Carolinians, if they had been seeing a dentist regularly (annually or semi-annually), would have likely had these problems diagnosed early. They could have received treatment before the problem escalated or, at worst, they would have at least known where to go for their acute dental problems. Keeping dental emergencies out of hospital emergency rooms saves money for the hospitals and tax payers.

Solutions
After discussing the barriers to adequate oral health coverage and dental care for the uninsured, we need to resolve the uninsured issue of plans being inaccessible. We must also resolve the insured issue of plans being inadequate in their coverage. Ideally, a solution would increase access to preventative care, as well as enhance insurance coverage levels and broaden the types of treatments covered (or at the very least, offer full coverage of prevention services).

**Require that dental insurance be part and parcel of owning medical insurance**

Within the federal and state governments, oral health care needs to be recognized and prioritized as analogous with general medical care in terms of need. There is a multitude of current medical research touting the connections between oral health and serious systemic medical problems like diabetes, heart disease, HIV/AIDS and various cancers (Takahashi, 2006) (Moore, 2002) (Petersen, 2003). Inflammatory mediators associated with gingivitis and periodontitis have also been linked to other systemic inflammatory diseases including complications with pregnancy and other neonatal outcomes (Dasanayake, 2008). While neglecting oral hygiene is not likely to lead directly to a heart attack, neither is eating a cheeseburger. There is a large body of biomedical research knowledge identifying the majority of systemic diseases as multifactorial. There are few systemic diseases that are identified as having one cause that initiated and furthers the disease process. There should be no daylight between providing adequate systemic health care and providing adequate oral health care.
This would require a policy level change to the effect of creating legislation mirroring the Affordable Care Act as it pertains to dental plans. The publicly controversial yet aptly titled Affordable Care Act, once fully implemented, will allow all Americans access to affordable health insurance. This is a remarkable and long overdue step towards helping to insure and ensure care to the “working poor,” a population that is making too much money (over 100% of the Federal Poverty Level (FPL)) to qualify for public assistance yet not making enough money to afford private insurance. The best time to address a change to this legislation is now, during the implementation of this landmark public health policy. A policy change needs to be made requiring a change in the language. “Comprehensive medical insurance” must include dental insurance. Addressing systemic needs but omitting oral health must not continue.

There is currently a spectrum of health insurance choices and with the Affordable Care Act the cost of the plans will be more manageable for low-income households due to subsidies. There are also requirements for most employers to provide health insurance to their employees. Prior to these provisions it was an easy decision for many low-income families to choose between groceries for their family and health insurance.

Further, currently the Children’s Health Insurance Program (CHIP) provides coverage to children until the age of 19 (Dolatshahi, 2011). With amendments to the Affordable Care Act policy this coverage could easily be expanded out until the individuals are 26. The age extension would be equally effective for private insurance.
The ACA removes lifetime maximums from health insurance policies. With an analogous change to dental insurance policies it would encourage people to use their insurance without fear their costs will go outside of their annual maximums leaving them with inexorable out-of-pocket costs. Insurance caps were put in place to reign in medical industry overspending. Accreditation boards review hospitals and medical clinics to ensure that they follow best practices. A similar system will need to be set up to provide oversight for the oral health professions.

Another facet of the proposed legislation would enhance/create adult Medicaid coverage, as very little Medicaid funding is actually used for adult’s oral health care needs. Adult dental needs will be covered under their health insurance that is provided by their employer or purchased through the health insurance exchanges. Also, up until the age of 26, individuals can be covered on their parent’s insurance. The savings to the Medicaid budget could be added to the additional subsidies to cover low income households purchasing insurance through exchanges. The health insurance exchanges are still in the process of being set up on a state-by-state basis. They will provide a single location where an individual or employer can compare health insurance plans between all the different health insurance providers. This head to head purchasing ability will lead to insurance companies keeping their rates competitive as opposed to increasing faster than inflation. States will save $110 million annually with eliminating the use of emergency rooms for preventable dental disease (World Health Organization, 2003). While there are a myriad of financial obligations to consider regarding a new overhaul to oral health insurance, this paper is not being written as a financial solution.
The example above merely illustrates that with restructuring and providing comprehensive oral health care, certain aspects of the change in direction will save the government and private sector money.

**Eliminate barriers to dental plan enrollment**

Eliminating barriers to enrollment is another reason to modify the Affordable Care Act to include dental care. When people pay for a service, like dental insurance, they are more likely to utilize it. For example, persons with private dental insurance have more dental visits in the previous year than persons without private dental insurance (Bloom, 2010). Those individuals who are paying for the plan clearly see the value in what they are paying for and appreciate the service that they receive.

In the recent economic downturn, dental insurance was cut by many employers as a way to save money. When an individual or family comes upon difficult financial times, routine dental check-ups quickly get deprioritized and frequently neglected altogether. Many individuals and families rely heavily on employer-provided plans for coverage and cannot handle the financial burden on their own. By taking the burden of enrollment off of the individual and putting it on the employer, individuals will be less likely to interrupt their routine active or preventive treatment. This will result in fewer acute oral health problems for the individual and lower cost paid out by the insurance provider.

A large barrier for many Americans is the costly nature of private dental insurance plans. In order to overcome this problem with private medical insurance the Affordable
Care Act is establishing health insurance exchanges that allow individuals to purchase plans at a lower cost. The newly established health insurance exchanges can have private dental insurance plans added to the plans thus making the dental plans more competitive and lowering the cost of premiums to the patient.

Provider level change

While there are a handful of insurance companies that provide health insurance plans and dental insurance plans, a great majority of private insurance companies specialize in either dental or health insurance e.g. Dental Dental, United Concordia. This is just part of the continued narrative of keeping systemic health and oral health segregated. Steps can be made to integrate the two into a commensal relationship. Currently only 3% of medical insurance plans are comprehensive, in that they also provide dental insurance coverage. Individuals who purchase their own medical insurance (not provided through their employer) only have a 30% likelihood of also buying dental insurance (Delta Dental Plans Association, 2012). There is a clear prioritization taking place regarding the importance that is placed on oral health.

Maintain reasonable Medicaid policies/provide adequate Medicaid reimbursement

The Affordable Care Act (ACA) makes many large and productive steps forward in the expansion of health insurance coverage. The optional expanded State Medicaid funding, as a part of the ACA, is the only aspect of it that pertains to oral health. The immediate restrictions of health reform do not apply to stand-alone dental plans, including the elimination of annual and lifetime maximums and the expansion of the
dependent child definition to age 26. The restrictions apply to group health plans as defined by the Health Insurance Portability and Accountability Act (HIPAA). Dental benefits are considered “excepted benefits” under current law; therefore, the restrictions do not apply. At least for the immediate future, it appears it will be business as usual for stand-alone dental plans (Miller, 2010). These same sweeping changes that are slated to make great progress in providing adequate access to care should be the public health benchmark for the entire medical system. It is unfortunate that the great public health measures in the ACA do not extend to oral health care.

Other Factors to consider and areas for future research

Alternative options for universal health care and oral health care

It may also be prudent to evaluate alternative methods of providing universal healthcare. The military oral health care system could be used as a model for universal healthcare, eliminating disparities in oral health (Hyman, 2006). A universal access-to-care system that incorporated an aspect of compulsory treatment displayed little to no racial disparity in relevant oral health outcomes. The study showed no disparities between black and white adults in untreated caries and recent dental visit rates in the military population. Disparities in missing teeth were much lower among military personnel than among civilians. This demonstrates that it is possible for large, diverse populations to have much lower levels of disparities in oral health even when universal access to care is not provided until the patient is 18 or 19 years of age.

Population public health awareness
An important start to any public health campaign lies in creating public awareness. Future research needs to be completed to properly identify a strong and multilevel marketing campaign that can make individuals aware of the importance of their oral health as it relates to their systemic health. There also needs to be education and promotion of information at the level of oral health providers. There is currently resistance to even discussing systemic disease in the dental office because many providers feel it is out of their scope of practice. Oral healthcare providers need to feel empowered to give their patients more information even if it means the patient then has to go ask their physician some relevant health questions.

As with most public health movements there will be some societal pushback. The manipulation of law to allow medical/health insurance to comprehensively cover the spectrum of oral health conditions will certainly draw significant attention from health insurance companies, dental insurance companies, health service providers, oral health service providers and likely a significant fraction of the general public. The union of dental insurance and health insurance in their current forms will require a delicate touch.

Inadequate access to care in rural areas

In rural areas there is an increasing shortage of available dentists. For every 30 dentists (per 100,000 people) in urban settings, there are only 22 dentists available to address the needs of rural communities (Doescher, 2009). This problem is compounded by the distance individuals in rural areas are required to travel in order to reach a clinic. Additionally, in 2008, 44% of rural dentists were over the age of 56. The
average age of retirement for a general dentist is 62 years old. This means that nearly half of rural dentists will be retiring within the next few years (Lee, 2007). A 2006 study found that 26 percent of rural clinics had open dentist positions, and as of 2010, research showed that figure had risen to 39 percent (Doctors, 2012). Improvements need to be made in order to provide greater access of care to remote rural locations: specifically, measures need to be taken to ensure young dentists have incentives to practice in rural areas.

**Narrow the focus to urgent needs (prioritize low income/rural areas)**

Cooper and Manski found that large corporations were more likely than small firms to offer dental insurance to employees. These are the same small firms that, if dental insurance is consolidated into the Affordable Care Act, will be taking advantage of the health insurance exchanges for their employees. Grouping dental insurance together with health insurance would allow these employers to provide comprehensive health coverage to their employees.

The same study found that about 56 percent of all employers offered health insurance and 63 percent of those (the original 56%) also offered dental insurance” (Manski, 2010). That works out to only 35% of insurers. The language of the Affordable Care Act requires all employers to provide health insurance options for their employees. Including dental insurance as a part of the big health insurance picture, helps to reduce the cost of care to the individual; requiring employers also provide adequate dental insurance also helps to break down that barrier to oral health.
Another important limitation to access to care is geographic limitations. There are rural populations that do not have convenient access to dental care due to their burdensome distance from their closest dental clinic. Increasing the availability of dental insurance does very little to address this need. Particularly as the average rural dentist is nearing retirement age, there needs to be increased incentives to new dental school graduates to seek out employment in rural health centers or simply maintain a private dental clinic in a rural area of need. Student loan repayment and compensation supplements are techniques that have historically been used with some success. Though there is clearly still a marked gap between the needs of the rural population and the providers that are available. More research needs to be done to evaluate the best way to manage comprehensive medical and dental care to isolated and rural populations.

**Increase social marketing to encourage people to change behavior/use their insurance benefits**

There are also nonfinancial barriers that are currently limiting individuals and families from seeking access to available dental care. Some of these barriers include an inaccurate perceived susceptibility, severity or benefits. “[Public] health practitioners must concentrate on effecting social change by helping to modify individual behaviors and lifestyles, improve social and economic conditions, and reform social policies (Siegel, 2007).” Social marketing techniques address public health concerns, like untreated dental disease, by improving unhealthy lifestyles and behaviors,
disseminating vital health information to at risk populations and establishing a means for community change.

In addition to the proposed policy level change, behavior modification and understanding is required at the individual, interpersonal, community and population level (McLeroy, 1988). For a truly successful adoption of change there must be a culture of acceptance to the health improvements being recommended.

As an example, low-income Hispanic individuals stated their limited use of dental services was due to their low prioritization of dental health (World Health Organization, 2003). The limited perceived susceptibility and perceived severity of dental disease within this population is an ideal avenue to use the health belief model in order to gain greater utilization of dental services. A social marketing campaign focused on low-income Hispanic populations could raise utilization of dental care. The use of lay health advisors could be used to enroll key members of the population to take a stake in the oral health of the community. There could also be a campaign incentivizing minority enrollment in dental professions. It would familiarize the community with the professions, as well as supplement a much-needed work force. More research should be done to evaluate which techniques will work best to engage this low-income Hispanic population as well as other populations where underutilization of dental care is not directly related to the absence of dental insurance.

Expand the dental workforce (dental therapists)
With all the potentially new clientele, there would be an overwhelming demand on the oral healthcare system. The workforce needs to be expanded. There is currently work being done at the state level to introduce a mid-level oral health provider, a dental therapist. They would be part of the dental care team as an allied provider along similar lines to an expanded duty dental assistant or dental hygienist (Doctors, 2012). Further research needs to be done to evaluate the extent of the potential increased demand and the breadth of utilization that the expanded duty mid-level providers can safely and responsibly cover.

**Financial/ what is covered, what is not in terms of treatment**

When oral health care is finally acknowledged as an unalienable right there will need to be evaluation of what contexts need to be applied when identifying necessary treatment. Analogous to the health care sector where cosmetic and elective procedures are not covered under health insurance similar standards need to be laid out for comprehensive dental insurance. The brief argument needs to be made that esthetics and dentistry are tightly intertwined even in medically/dentally necessary treatment. This paper was not created with the intent of being a financial guidebook towards providing universal oral healthcare. The scope of covered treatment will directly affect the bottom line of any policy amendment that is passed. More research needs to be considered in establishing a set of comprehensive guidelines for what treatment is to be covered and what treatment is elective.

**Summary**
Untreated dental disease is a pervasive and growing public health concern. Though there are a multitude of reasons why individuals may not have adequate professional oral healthcare, significant portions of individuals who ignore seeking treatment do so knowingly due to financial concerns. The important takeaway message is that there are ways that policy change can significantly increase public access to dental care. Increasing the number of insured Americans will go great lengths towards reducing oral health problems at the population level.

A simplified solution will be redefining the language of the Affordable Care Act to make “health care” cover an individual’s comprehensive health including all organ systems, vision and dental included. With the ACA extending plans for children until the age of 26 and removing lifetime insurance caps a significant increase in preventive care visits would be seen, particularly during the impressionable formative years of young adulthood.

There will be broad change involving public and private insurance and all health care providers (dental and medical). The alteration to insurance plans is not insurmountable. Alterations to policies happen on a continuum and applying guidelines that the new policies must adhere to should be done on a timeline appropriate for insurance companies to make the necessary changes. Similarly, most dental offices have staff trained in dealing with the ever-changing world of dental insurance plans. These staff would require time to become acquainted with any changes that directly affect their work, their reimbursement or their patient’s treatment options. As
with all change, there will be some bumps in the road and some line items that work better on paper than in practice.
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