



AMA Journal of Ethics®

January 2022, Volume 24, Number 1: E57-63

POLICY FORUM: PEER-REVIEWED ARTICLE

Time for Dental Care to Be Considered Essential in US Health Care Policy

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Abstract

Training, service delivery, and financing are done separately in dentistry and general health care, which has influenced reimbursement structures, access to services, and outcomes. This article considers how medical and dental separation exacerbates health inequity and canvasses data demonstrating that oral health and dental services are the least affordable health services. This article also proposes how dental and general medical care coverage can be meaningfully integrated through better health policy to motivate health equity.

Divided

Dental care services have a long history of being financed and delivered separately from medical care services.^{1,2} In the mid-1800s, dental schools and associations were established independently of medical schools and associations.¹ Several important US health care reform milestones have reinforced this separation—most recently, the Affordable Care Act (ACA) of 2010. Under the ACA, dental care for adults was not included as an essential health benefit, and, while dental care for children was included and lowered total financial outlays,^{3,4} the increase in stand-alone dental plans between 2014 and 2016 reinforced the separation of dental and medical insurance.⁴ In this article, we summarize the implications of financing and delivering dental care separately from medical care, focusing on trends in outcomes and in affordability and utilization of dental care services and highlighting disparities by income, age, and race. We also pose some key questions for policymakers seeking to address these issues.

Oral Health Inequity

Improvements in the oral health of the US population vary by age, income, and racial or ethnic group. Among children, disparities by race and income are narrowing for many oral health indicators. For example, children from low-income families and Black and Hispanic adults are more likely to have untreated tooth decay,^{5,6} but children and adolescents from low-income families and Black and Hispanic children ages 6 and older have seen the biggest improvements in recent years.⁷ Among seniors, untreated cavities are far more common in Black and Hispanic populations.⁷ Another important outcome, retention of natural teeth, highlights the disparities that exist among older adults. While older Americans in general are retaining more teeth than in the past, the improvements

have mainly occurred among high-income seniors.⁸ In other words, income inequity is widening when it comes to retaining your natural teeth. Oral health improvements occur for many reasons, including better access to dental services. Recent data show that working-age adults and seniors are more likely to face financial barriers to obtaining needed dental care than children.^{9,10} Dental care utilization trends have been driven in large part by trends in **dental insurance coverage**. In 2015, 10% to 12% of US children were uninsured for dental care services compared to 28% of working-age adults and 62% of seniors.^{11,12} The share of US children with some form of dental insurance has increased significantly in the past 2 decades, from 73% in 1996 to 88% in 2015,¹¹ with the most significant gains in dental insurance coverage being among children from low-income families.⁹ Among working-age adults and seniors during the same period, dental insurance coverage rates increased modestly, from 67% to 72% for the former and from 35% to 38% for the latter.¹¹

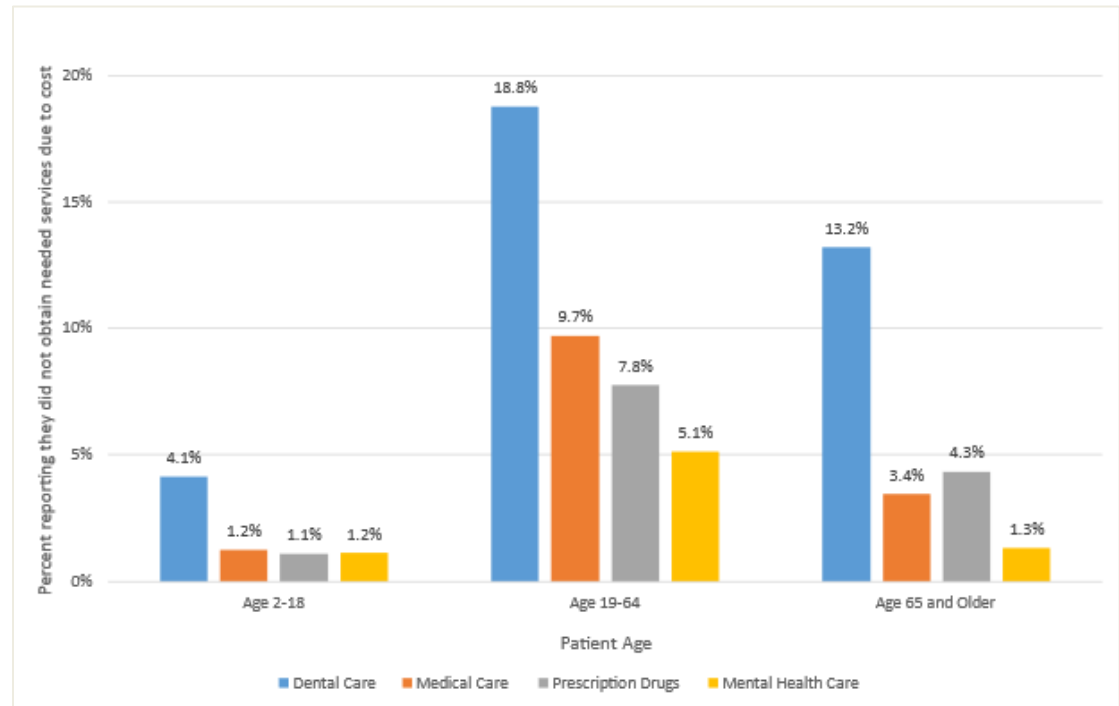
Public Policy

For children from low-income families enrolled in Medicaid, dental insurance coverage is guaranteed by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. This mandatory benefit requires that the Medicaid program and the Children's Health Insurance Program (CHIP) provide comprehensive, medically necessary dental services to all children under age 21.¹³ Roughly 43% of general practice dentists participate in Medicaid or CHIP for child dental services.¹⁴ While dentist participation in Medicaid is much lower than physician participation,¹⁵ the available evidence suggests that financial issues¹⁰ or lack of prioritization of dental care¹⁰ are key barriers to dental care for children as well.

Dental insurance for adults at all income levels, on the other hand, is not guaranteed. Adult dental benefits under state Medicaid programs are optional, and there is significant **state-to-state variation** in terms of what dental services are covered. According to the most recent analysis, 3 states provide no adult dental benefits, 10 states provide emergency-only benefits, 16 states provide limited benefits, and 20 states cover a more comprehensive mix of dental services.¹⁶ Medicare, the medical insurance program for adults ages 65 and older, does not cover routine dental services. However, roughly 94% of Medicare Advantage (Part C) enrollees in individual plans had some dental services included as a part of their benefits package in 2021.¹⁷

Between 2000 and 2015, dental benefits utilization and insurance coverage of dental services for children increased,^{18,19} reducing oral health inequity among children from families with low-income and among Black and Hispanic children.⁷ But inequity has not decreased for working-age adults and seniors. Why does age alone dictate whether society deems oral health essential? Different policy approaches to dental insurance for children, working-age adults, and seniors affect affordability. For all age groups, data suggest that financial barriers to dental care are more significant than for any other health service,²⁰ yet children face dramatically lower financial barriers to dental care than working-age adults and seniors (see Figure).²⁰

Figure. Financial Barriers to Dental Care and Other Types of Health Care Services in 2019^a



Even when dental coverage is offered, it is almost always as a stand-alone dental plan (SADP) and not embedded as part of a medical plan. Among the privately insured prior to the passage of the ACA, 99% of those with dental insurance obtained that coverage through SADPs.²² (As of 2017, the take-up rate of SADPs in federally facilitated marketplaces was only 16% for adults and 17% for children.²³) Moreover, Medicaid dental programs are administered separately from medical programs, with different provider network arrangements, different patient record systems, and different care coordination challenges for clinicians.^{23,24} Thus, affordability challenges for working-age adults and seniors aside, dental care delivery is not effectively linked with medical care delivery in the true sense of a health care “system.”

System fragmentation undermines medical-dental care coordination. Physicians’ referrals to dentists are compromised by separate insurance systems and lack of service delivery integration.^{24,25} Moreover, **accountable care organizations** tend not to offer dental services due to coverage gaps in their patient base and practical challenges posed by differences in information technology platforms used by medical and dental clinicians.²⁶

What Now?

In our view, the income, age, and race inequity in oral health outcomes, dental care use, and affordability stem from major dental insurance coverage gaps for vulnerable populations and lack of medical-dental integration that would facilitate interprofessional referrals and care. Current dental care financing and delivery streams leave vulnerable groups behind.²⁷ We urge policymakers and stakeholders to consider 2 key policy questions.

Should dental care be considered an essential health care service for people of all ages within public and private insurance programs? Medicaid's EPSDT benefit has proven effective in improving oral health outcomes and reducing inequity among children.⁹ This policy approach can be used to design and implement similar mandatory dental benefits for adults. In January 2021, Congress introduced the Medicare Dental Benefit Act of 2021,²⁸ which calls for inclusion of oral health benefits in Medicare Part B for the two-thirds of Medicare beneficiaries who currently have no dental coverage.²⁹ Expanding dental coverage to adults and seniors would likely reduce costs for those with chronic health conditions (eg, diabetes),³⁰ improve oral health and well-being, and promote economic productivity among working-age adults.³¹

What is needed to improve care coordination between medical and dental practitioners? There are 27 million people who visit a dentist but not a physician and 108 million who visit a physician but not a dentist in any given year.²⁵ There are undoubtedly medical and dental conditions going undetected in these respective populations that, if addressed, would improve overall health and potentially reduce long-term health care costs.

Current dental service delivery streams do not enable effective care coordination between dental practitioners and other clinicians.³² Foundational changes in education and training programs are needed to facilitate interprofessional patient care. Diagnostic data is not collected routinely in dental insurance data. Dental insurers must recognize the importance of coding procedures and diagnoses to track outcomes and contribute to evidence-based practice. Integrated health information technology and enhanced understanding of the day-to-day care offered by medical colleagues would facilitate referral processes and increase access to care.

Act Now

Former US Surgeon General David Satcher said more than 20 years ago that “you cannot be healthy without oral health.”³³ Certainly, we have made progress in improving oral health for children since then, especially for vulnerable children. But for working-age adults and seniors, disparities in oral health outcomes and in access to dental care have widened by income and race. Treating dental care as essential in US health policy—for all ages, not just children—is the only way to address these challenges.

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Citation

AMA J Ethics. 2022;24(1):E57-63.

DOI

10.1001/amajethics.2022.57.

Acknowledgements

The authors thank Brittany Harrison of the American Dental Association's Health Policy Institute for research and editorial assistance.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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ISSN 2376-6980