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Reconnecting Mouth and Body Requires Rethinking Dental Care Financing

The mouth is incontestably linked to the body. Unsurprisingly, oral health plays a critical role in whole-body health. Although the relationships are not fully understood, oral health is linked to several chronic conditions. For example, periodontal health is associated with a lower risk of heart disease and diabetes. These links are increasingly important given that 1 in 12 Americans (and 1 in 4 seniors) has some form of diabetes, and almost half of U.S. adults suffer from periodontal disease. Dental caries is the most prevalent chronic disease among children and could lead to significant development problems and cause physical disabilities.

The benefits of oral health extend beyond just whole-body health. For every 100 children ages 5 through 17, it is estimated that three days of school are missed each year because of dental symptoms and treatment. For every 100 employees, two days of work are lost each year due to poor oral health. Diminished oral health, including the loss of teeth, has also recently been linked with lower cognitive function throughout adult life and even lower career earnings. There are also potential medical cost savings associated with increased dental care use and improved mouth health. For example, treatment of periodontal disease has been associated with lower overall medical costs among patients with diabetes, heart disease, and stroke.

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But when one looks at how dental care is financed in the U.S. healthcare system, the status of the mouth is not that clear. Take Medicaid, for example, which is the second largest source of health insurance coverage for Americans. Dental care coverage is mandatory for children, but optional for adults. Most states have chosen to provide only limited dental benefits to Medicaid adults. This dual approach within this critical safety net program has had important implications. (1) Among low-income children dental care use

has increased significantly in recent years, while among low-income adults, it has decreased. Low-income adults have experienced the sharpest increases in financial barriers to dental care and emergency room use for dental conditions. It is not surprising, then, that dental care is financed very differently from medical care. According to the most recent data, about 8 percent of dental care spending comes from public sources, mainly Medicaid, compared to 36 percent of general health-care spending. About 42 percent of dental spending is out of pocket, compared to 11 percent of healthcare spending. (2)

Going forward, the Affordable Care Act (ACA) in many ways reinforces this disconnect of the mouth and body among adults. Dental coverage for children is part of the essential benefits package, although for a variety of reasons the pediatric dental benefit mandate will actually not be enforced. But adult dental care is not considered ‘essential’ under the ACA. Recognizing



the importance of attracting providers in Medicaid programs, the ACA mandates significant reimbursement rate increases for many primary care services. In this provision, too, dental care is excluded. However, other aspects of the ACA provide an opportunity to rethink how dental care is delivered and financed as well as to reexamine the role of dentists within the healthcare system. (3)

As care delivery slowly shifts to Accountable Care Organizations (ACOs) and provider reimbursement shifts away from fee-for-service to value- or outcome-based payment, there will be unprecedented opportunities to raise the profile of oral health within the primary care system. The immediate opportunities will be within the pediatric population, where dental benefits coverage will expand significantly, and within the Medicaid population, including adults who live in states that provide an extensive adult Medicaid benefit. This is because these groups carry with them a source of financing for dental care, which is a major factor that will drive ACOs to incorporate dental care into the basket of services they provide to their clients.

The speed at which tomorrow's ACOs proceed down this path of expanding their provision of dental care services will depend on many factors. First, if oral health or dental care measures are directly included within the outcome measures the ACOs are evaluated against, this will provide a strong incentive to expand dental care services.

Second, if financing for dental care services is included in the calculation of per-population payment the ACO receives for each client, this ensures that ACOs are de facto expected to provide dental care services. But even if dental care financing remains siloed, this does not mean that ACOs will not expand into dental care services. If the ACOs of tomorrow find themselves with a client base with extensive commercial dental coverage through stand-alone dental plans, or a Medicaid client base with dental benefits paid for through a separate Medicaid dental program, there will still be interest in expanding dental care services.

Third, if ACOs can find (or build) a robust network of dental care providers relatively easily, this makes it much easier to incorporate dental care services. If it becomes operationally challenging to find dental care providers interested in participating in an outcomes-driven, mixed fee-for-service and bundled payment contracting arrangement, then dental care services are less likely to be incorporated into the ACO's basket of services.

For all three of these factors, there is a high degree of uncertainty on how things will evolve moving forward. While most ACOs today do not provide dental care, the few that do demonstrate the benefit this brings in terms of more satisfied clients and lower healthcare costs, for example, due to avoided emer-

gency room use. (4) In terms of dental care financing, a new analysis shows that over one-quarter of medical plans being offered in the newly established health insurance marketplaces include an embedded pediatric dental benefit. (5) If there is significant take-up of such plans by consumers, then this could shift the way dental care is financed in a post-ACA world, with less stand-alone dental fi-

naning and more integrated medical-dental care financing.

In essence, at the highest level, a central question for the policy community going forward is: Can we truly reconnect the mouth and the body without rethinking how we finance and deliver dental care? The coming years will bring incredible change to the U.S. healthcare system with much more integration and interprofessional collaboration. (6) It is important for the oral health community to take advantage of these opportunities to ensure continued progress in improving America's oral health.

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