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Statement for the Record

American Dental Association

to the

Health, Education, Labor and Pensions (HELP) Committee
United States Senate

on

Examining the Dental Care Crisis in America: How Can We Make Dental Care More Affordable and More Available?

May 16, 2024

On behalf of the American Dental Association, thank you Chairman Sanders and Ranking Member Cassidy for the opportunity to submit a statement for the record and share data-driven insights at the May 16th hearing: "*Examining the Dental Care Crisis in America: How Can We Make Dental Care More Affordable and More Available?*"

The American Dental Association is pleased that the Senate HELP Committee has selected the topic of the dental care crisis in America and see this as a testament of not only the important link between oral health and overall health and well-being, but a recognition that there is a need for action. We can and should do better when it comes to our nation's oral health.

Our statement is focused around three main themes: the state of oral health in America, including dental workforce; the policy choices we have made along the way; and considerations as we move forward.

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

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

For working-age adults (age 19-64) and seniors (age 65 and older), the trends are different. For example, rates of untreated disease among working-age adults have not changed significantly over the past two decades, and disparities by income and race are persistent and much wider than for children. The percent of working-age adults who visit a dentist in the course of a year is actually slightly lower today than two decades ago. Access to dental care for Medicaid beneficiaries continues to be fraught with significant hurdles. Despite sufficient numbers of Medicaid providers located near Medicaid populations, as shown by our geo-analytics, beneficiaries still face considerable difficulties in accessing these providers. The complexity of the system often requires beneficiaries to contact multiple offices before finding an available appointment.

For seniors, dental care utilization rates have increased over time, but the disparities by income and by race have been stable. In fact, gains in some oral health measures, such as reductions in tooth loss, are concentrated among high-income seniors.[4] Overall, disparities in oral health are stable for working-age adults and seniors.[5] In any given year, less than half of the U.S. population visits a dentist.[6] But oral

health in America is a two-part story. We have seen two decades of steady improvements among children, particularly the most vulnerable, in tandem with much less progress among working-age adults and seniors. The ADA has been supportive of the Department of Health and Human Services' recent rules aimed at expanding payment for dental services and appreciates their efforts in resolving operational issues. We continue to believe that maintaining an adequate provider base as well as adequate reimbursement is essential, especially for this vulnerable population.

On the dental workforce, it has shown signs of recovery with first-year enrollment numbers for dental assistants and hygienists returning to pre-pandemic levels. Although this recovery marks a positive development, the effect on the healthcare system will require time to manifest due to the duration needed for training and assimilation into the workforce. Furthermore, our earlier prediction that the workforce shortage would continue for at least five years is proving accurate, highlighting an ongoing challenge that affects service delivery, particularly in rural and underserved areas. Additionally, we face a discrepancy in data quality that impacts our strategic planning, with less accurate and comprehensive information available for dental assistants compared to dental hygienists.

The Policy Choices We Have Made Along the Way

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

For working-age adults and seniors, the policy approach has been very different. Dental care is not considered a mandatory essential health benefit. Medicaid programs do not mandate coverage for adult dental services, and only some Medicare beneficiaries have dental benefits through primarily Medicare Advantage plans. The Affordable Care Act did not include adult dental care as an essential health benefit, but recently the prohibition on states including non-pediatric dental services within their essential health benefit benchmark plans was removed.

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

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

Due to the very different policy approaches taken toward dental care for children compared to working-age adults and seniors, we see vastly different degrees of financial barriers to dental care. A much larger share of working-age adults and seniors report they cannot access needed dental care services due to affordability issues compared to children.[12] Moreover, 'cost' is the top reason working-age adults and seniors are not able to access dental care, and financial barriers are more severe for dental care than any other health care service (e.g., prescription drugs, mental health, physician services). This is a direct consequence of policy choices.

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

Key Considerations for Policy Makers Moving Forward

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

The Economic and Fiscal Dividend of Improved Oral Health

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

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

Every 15 seconds in America, someone shows up at a hospital emergency department because of a dental issue. The estimated 2.1 million emergency department visits for dental conditions cost the U.S. health care system $2.7 billion each year, with Medicaid accounting for the largest share of this spending.[18] This is an example of inefficient spending that could be avoided if more Americans had access to a dental home for routine care and prevention. Ensuring that states provide comprehensive dental services to adult Medicaid beneficiaries is a sound economic investment. The ADA strongly supports S.570, the Medicaid Dental Benefit Act of 2023, to make comprehensive dental care a mandatory component of Medicaid coverage for adults in every state.

The American Dental Association's Health Policy Institute has developed a quantitative model to estimate the fiscal impact of alternative adult dental coverage policies in Medicaid on state budgets. In addition to estimating additional dental care spending, the model incorporates the fiscal offsets associated with reduced emergency room costs as well as reduced medical care costs. The net cost of adding comprehensive adult dental benefits into all state Medicaid programs that currently do not provide such benefits is estimated at $836 million per year[19]. Detailed analysis has been provided to state legislatures in Maine, Hawaii, Virginia, and Florida.[20-23]

The inefficiency in accessing dental services for Medicaid beneficiaries highlights the urgent need for improved scheduling technologies. We suggest an advanced, user-friendly, app-based scheduling tool akin to "OpenTable," which could revolutionize how beneficiaries access care. This app would feature real-time availability viewing, easy appointment booking and management, multilingual support for diverse beneficiaries, and customized provider searches based on specific needs. These features could be designed to reduce the challenges faced by patients, such as lengthy phone calls and scheduling frustrations, thereby enhancing overall patient engagement and adherence to dental health care schedules.

Beyond the introduction of scheduling technologies, there is need for a comprehensive overhaul of state Medicaid programs to include modern digital tools that enhance both accessibility and efficiency. Integrating these technologies can significantly reduce administrative burdens, lower the costs associated with missed appointments, and improve overall patient and provider satisfaction. These proposed

innovations are not merely enhancements but are essential steps towards modernizing our healthcare infrastructure to better serve all stakeholders involved, particularly our most vulnerable populations.

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

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

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

As in much of health care, the COVID-19 pandemic significantly disrupted the labor market for dental team members. Dental practices are having a tough time finding qualified staff, particularly dental hygienists and dental assistants. As of March 2023, 96% of dentists report it is extremely or very difficult to fill vacant dental hygienist positions and 86% of dentists report the same for dental assistant positions.[26] Enrollment in dental hygiene programs has only recently recovered to pre-pandemic levels while enrollment in dental assisting programs has been on a steady decline since before the pandemic.[27] As a result, the current staffing shortage for dental hygienists and dental assistants is likely to persist for several years. In the interim, there are strategies for employers to effectively recruit and retain staff[28] and for state and federal policymakers to boost training capacity.[29]

Like many other health care professions, the pandemic took a toll on the mental health and wellbeing of dental team members. Levels of anxiety and depression spiked mid-2020 and then steadily decreased through 2021.[30]

Beyond the disruptions associated with the COVID-19 pandemic, the supply of dentists per capita is predicted to be steady through 2025 and then to increase significantly after that.[31] However, between 2011 and 2021, the number of dentists per 100,000 population increased from 60.8 to 62.8 in urban areas while decreasing from 37.3 to 36.5 in rural areas. This is an important issue to highlight, as geographic access to dental care providers in rural areas is much lower than in urban areas.[32] There are several policy options to consider to attract and retain more dental care providers in rural areas, including loan forgiveness programs tied to geographic areas, education pathway programs, enhanced mobile clinics, alternative workforce models and scope of practice, and targeted visa programs, to name a few.[33] Reauthorizing the Action for Dental Health Act (S. 2891) aims to mitigate workforce challenges and enhance access to care in rural areas.

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

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

Policymakers have a considerable body of evidence at their disposal to design effective policies that can boost provider participation in Medicaid. These 'good practices' are well documented and include streamlined credentialing and broader administrative practices, sufficient fees, patient navigation assistance to reduce missed appointments, and expanded scope of practice for dental team members. What has been studied less is the role of individual dentist characteristics and practice modalities in the Medicaid participation decision. New research[37] indicates that, all else equal, racially and ethnically diverse dentists are far more likely to see a high volume of Medicaid patients. Dentists in large group practices are also more likely than solo practitioners to see a high volume of Medicaid patients. As dental school enrolment diversifies[38] and more dentists practice in larger groups,[39] this could lead to more dentists, in aggregate, participating in Medicaid.

The dentist workforce does not reflect the U.S. population when it comes to racial and ethnic diversity. The latest data indicate that Black and Hispanic dentists are significantly under-represented in relation to the U.S. population overall.[40] For example, 3.8% of dentists are Black compared to 12.4% of the U.S. population. Similarly, 5.9% of dentists are Hispanic compared to 18.4% of the U.S. population. Dental school enrollment data indicate a slight increase in diversity. For the 2021-22 school year, 7.3% of first-year dental students were Black and 10.7% were Hispanic, meaning we can expect a more diverse workforce in the future. Increased funding for training and recruitment programs like the Health Careers Opportunity Program, HRSA's Title VII Primary Care Training Program, National Health Service Corps and Teaching Health Centers are crucial to the supply, distribution and diversity of the dental workforce.

The Importance of Addressing Cost Barriers to Dental Care

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

Currently, patients are being adversely impacted by provisions in dental and vision plans that dictate how much a doctor may charge a plan enrollee, even though the services provided to the enrollee are not "covered" (i.e., paid for) by the plan. The ADA supports S. 1424, the Dental and Optometric Care (DOC) Access Act, to prohibit dental and vision plans from setting the fees network doctors may charge for services not covered by the insurers. Even though 42 state governments have taken action, many dental plans are federally regulated, so insurers claim they are exempt from having to follow state laws. This insurer loophole means some enrollees and doctors face undue confusion in how their plans work.

Furthermore, we propose the introduction of measures that would simplify the administrative aspects of dental care provision. This includes the implementation of uniform credentialing processes, attachment standardization, and standardized Explanation of Benefits. These changes would significantly reduce the administrative burden on dental care providers, making it easier for them to participate in various insurance programs without the hassle of navigating through disparate requirements from different insurers.

Chairman Sanders and Ranking Member Cassidy, thank you again for bringing attention to oral health care in America. The American Dental Association looks forward to working with the Senate HELP Committee to continue to address how to make dental care more affordable and more available.

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