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Kansas Health Reform: Options for Adding Dental Benefits

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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, including Kansas, 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 a question posed by policy makers in Kansas: how can the state include dental benefits in a health care reform plan, should the state choose to do so? Unfortunately, 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 them 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 is 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 immigrants, 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 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 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 it, 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, including Kansas, 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. 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, 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 Kansas does not 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 considerations

	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 contribution, 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"> ▪ 40% 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 averages \$24 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, effort to make 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