An Introduction to Oral Health Care Reform

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Access to dental providers is a critical issue in oral health that was recently catapulted onto the national stage by a single catastrophic event. Federal focus on dental issues has been re-engaged due to the 2007 death of Deamonte Driver. Deamonte, a 12-year old Maryland boy, died when complications from untreated dental problems lead to a fatal brain infection. Deamonte's mother struggled to find a dentist under the Maryland Medicaid system that would accept new patients and treat her two sons. Since this tragedy, Congress has held hearings on dental access issues facing families like the Drivers and others on public programs. States are looking internally and investigating if families have appropriate access to dental care to prevent what occurred in Maryland.

With new attention on oral health there are a number of issues the dental community will need to closely monitor in the near term. The National Association of Dental Plans (NADP) actively tracks these issues for the dental benefits industry and works with partner organizations to help convey the interests of the oral health community to policymakers. Potential issues of interest to our community in the emerging health reform debate include: public program expansion, proposals to increase the dental workforce, and changing the tax preferences for employer-sponsored healthcare coverage.

This chapter will focus on oral health from a political standpoint. It will examine how access to providers and to oral care impacts discussions throughout the dental sector. It is important to understand the variances of oral health care within public programs, as government actions can set the tone for policies, potentially affecting the private dental marketplace. Stakeholders within the dental community are promoting various workforce models addressing the critical need for oral care of the uninsured and underinsured populations. These models are being thoroughly vetted through state pilot programs and tested on the political stage in legislative debates. As 2009 begins, the political direction and discussions on oral health access will be directly influenced by the much larger discussion of health care reform.

Public Programs: Medicaid & SCHIP

There has been a plethora of studies, issue briefs and reports released in 2008 questioning the availability of access to oral care by the uninsured, underinsured and those in public programs. Medicaid is a shared state and federal program covering health care costs for populations with limited income and assets. Although the federal government provides matching funds to finance Medicaid and sets certain coverage and benefit rules, states manage the day-to-day operation of the Medicaid program. A state can run the program directly, contract with a private insurer, or a hybrid of the two. An additional public program is the State Children's Health Insurance Program (SCHIP) passed in 1997 as part of the Balanced Budget Act to assist in covering low-income children in families with incomes too high to qualify for Medicaid but not enough to purchase private insurance. "In general, this program builds on Medicaid by providing federal matching funds that allow states to provide health insurance coverage to certain uninsured low-income children either under Medicaid, under a separate SCHIP program, or a combination of both approaches."[i]

In 2005 one-third of all children living below 200 percent Federal Poverty Level (FPL) did not visit a dental provider.[ii] As reference, a family of four at the FPL would have an income of $21,200 (at 200% is $42,400)[iii]. In recent testimony to the U.S. Congress, Centers for Medicare and Medicaid Services (CMS) explained states with lower utilization of children's dental services frequently require improvements in the following areas:

- Clear information for beneficiaries that is linguistically and culturally appropriate regarding the availability and importance of dental services and how to access the services;
- Process to remind beneficiaries that recommended visits are due;
- Updated dental provider listings;
- Processes to track whether recommended visits occurred;
- Availability of dental providers, particularly in more rural portions of the State;
- Availability of specialists for referrals; and
- Availability and reliability of transportation to dental services.[iv]

As CMS highlights, and states' experience confirms, it is difficult to get dentists to accept Medicaid patients and in some geographic areas it can be very difficult to find any dentists. Dentists cite three primary reasons for their low participation in state Medicaid programs: 1) low reimbursement rates, 2) burdensome administrative requirements, and 3) problematic patient behaviors.[v] The American Dental Association (ADA) has encouraged federal legislation which addresses dental workforce needs by providing grants to dental schools and qualified hospitals to increase the pursuit of pediatric dentistry. ADA also cites the Healthy Kids Dental program in Michigan as an example of a successful public program as it provides Medicaid beneficiaries with the same Delta Dental private sector coverage that is widely accepted by most dentists in the states.[vi] Nonetheless, access to dental services for both children and adults in low income brackets can be difficult to attain.

In the Medicaid program, a child's EPSDT (Early Periodic Screening, Diagnosis, and Treatment) benefit, requires that state programs pay for regular health items, treatment found to be medically necessary, hearing, vision screening, and comprehensive dental. SCHIP does not include the same requirements of coverage as Medicaid, and states are federally required only to include well-child services, immunizations, and emergency services. "Currently 14 states with separate SCHIP programs offer children the same benefits Medicaid provides; other states provide more limited benefits modeled after private insurance, with seven capping annual dental expenditures or limiting the number of dental services allowed per year. Today, all states except Tennessee cover some dental services under SCHIP."[vii] Experts suggest that "The funding structure for SCHIP is both successful and flawed," noting that, "It has succeeded in meeting its goal of encouraging state expansions while limiting federal liability, with a matching rate sufficient to encourage all states to expand coverage. However, the program's success in enrolling children has come up against its federal funding limits. Congress has acted six times in SCHIP's brief history to modify the program's rules."[viii]

In 2007, the SCHIP program was due to be reauthorized; however, the size and scope of proposals to expand the program generated controversy. Some policymakers viewed reauthorization as an opportunity to grow the program in ways that would better ensure that it reached the millions of children who remain uninsured in America. Others preferred limiting reauthorization to a simple continuation of the existing program with modest financing improvements. Ultimately, the debate centered on several points of disagreement, including how much to spend on reauthorization, how to define the upper income limit for program eligibility and how to address the actions by some states to include parents and other adults in their SCHIP populations.

As debate on these contentious issues continued, bipartisan efforts were underway to include a provision in the reauthorization bill requiring dental coverage for children enrolled in SCHIP. The dental provision enjoyed strong support in the dental community, among children's advocates and with

bipartisan policymakers. It was adopted in the compromise bill approved by the U.S. House of Representatives and the U.S. Senate. However, unhappy with the outcome of several of the other more contentious issues, President Bush vetoed the bill. Congress did not have the votes to override the President's veto, and efforts to pass a full reauthorization bill were abandoned in favor of simply extending current law through early 2009. Congress is set to revisit SCHIP in 2009 with the new Obama Administration.

Amidst the SCHIP federal debate, the Director of CMS sent letters to the lead health officials of each state indicating that for states to expand SCHIP eligibility to children in families with incomes above 250 percent of the federal poverty level, they must guarantee that they have enrolled at least 95 percent of the children in their state below 200 percent of the federal poverty level. Some states, mainly those with higher costs of living, had begun raising their income eligibility levels for the program to 300 percent of poverty. As of May 2007, one state, New Jersey, had set eligibility at 350 percent of the FPL ($74,200).[ix] Many states and children's health advocates argued that the enrollment standards established by the federal government in this directive were unattainable and therefore an attempt to forestall states' efforts to reach children in lower income families without health insurance. States with high-cost metropolitan areas such as New York City and San Francisco were extremely concerned. Others believed that the Administration's move would focus the program on its target population and reduce the threat that public program dollars would be used to replace coverage children may already have through private means, including their parents' employer-sponsored coverage.

'Crowd-out' is defined as an enrollee dropping private insurance to participate in a free or subsidized health program administered by the state. "The crowd-out of private coverage can occur through various avenues. For example, some parents who would have otherwise had family coverage through their employer might decline it for their children – or might decline coverage altogether – if their children are eligible for SCHIP. Estimates vary about the extent to which SCHIP has resulted in the reduction of private coverage. Federal law requires that the states have procedures in place to prevent people from substituting SCHIP for employer-sponsored insurance. However, on the basis of a review of the available studies, CBO concluded that the reduction in private coverage among children is most probably between a quarter and a half of the increase in public coverage resulting from SCHIP. That is, for every 100 children who gain coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children".[x] Although there have been extensive studies and issue briefs regarding public program expansions on employer-sponsored medical insurance, there have been no reports on how crowd-out may affect the dental marketplace. While increasing access to oral health care is necessary, crowd-out is certainly a factor that could impact the overall oral health of the nation if adult coverage is abandoned when shifting children to public programs.

Stakeholders & Workforce Models

There are several key Members of Congress who are actively promoting oral health care legislation, likely prompted by the Driver case and growing concern about the extent of the dental access problem in public programs like Medicaid and SCHIP. The attention of lawmakers has increased as they continue to learn about both the prevalence of dental caries (tooth decay) and the increasing evidence that oral and overall health are correlated. Tooth decay remains the most prevalent chronic disease in both children and adults, even though it is largely preventable.[xi] Federal and state legislators have been investigating additional opportunities to enhance dental care. Legislation has been

introduced in 2007 and 2008 to better coordinate federal efforts to improve oral health by expanding dental services to underserved populations and strengthening the dental workforce.

There are a variety of viewpoints on access to dental providers, and while stakeholders agree there currently is a severe maldistribution of dental providers, whether a shortage of dentists currently exists or will occur in the future is being debated. Whichever your viewpoint or stance, government officials are looking for solutions. Approaches to expanding access to oral health care through legislation vary, however they tend to focus on two areas - augmenting the reimbursement of providers of oral care and increasing funding for oral health programs. Beginning in 1998, 14 states have passed legislation in which they can directly reimburse dental hygienists for services under the Medicaid program[xii]. Over half of the states allow dental hygienists to initiate treatment based on the their assessment of patient's needs without the specific authorization of a dentist, and some states go further by allowing the treatment of the patients without the presence of a dentist.[xiii] Several of these statutes were initiated to allow dental hygienists to practice in underserved areas, such as in nursing homes or Indian reservations. While the American Dental Hygienists Association (ADHA) has supported and likely initiated some of these statutes, lawmakers viewed these measures as a step forward in increasing access to areas in need of oral care.

NADP released a position on the access and workforce issue, taking its lead from the U.S. Surgeon General's 2000 report, "Oral Health in America." The Surgeon General's report brought national attention to the issues regarding access to dental care and the importance of dental care to overall health. "The nation's capacity to provide care that is accessible and acceptable to address the oral health needs and wants of Americans in the next century is challenged…." That report also recommended use of "public-private" partnerships to address these important issues. [xiv] NADP supports the principle of public-private partnerships and commits to (and its member organizations) both dialogue and partnership with organized dentistry, dental education, government agencies, and organizations representing allied dental personnel to examine and implement a mix of responses to improve the nation's capacity to provide oral health care. NADP also suggests initial examination of the following mix of responses:

- Expansion of dental school classes;
- Expansion of education and awareness for current and emerging members of the dental profession on ways to increase productivity of the dental workforce, particularly through the use of allied dental personnel;
- Enhanced practice mobility between states, reciprocity between state licensure, and simplification of the licensure process on a national basis;
- Expansion of delegated duties to qualified allied dental personnel where allowed by local laws and supported by education and accountability.
- Incentives for: a) Increased availability of education and training for allied dental personnel, to insure that delegated duties are delivered without diminished quality; b) Allied dental personnel to seek that continuing education, with the goal of increased productivity and enhanced career satisfaction; c) Qualified applicants to enter dental schools, obtain relief of student debt, and assistance in the formation of new practice opportunities; d) Dentists to remain in the workforce as long as they can contribute, rather than opting for full retirement; e) Quality faculty candidates to seek affiliation with dental schools; f) Research for evidence-based dentistry which can identify ways to intervene in the dental disease process before major restoration is required; g) The development of technology that increases the productivity of a dentist in his or her practice.

NADP must play a balanced role in the access debate. Dental plans must prove to their customers (employers and other groups that provide benefits) as well as to state regulators that they provide adequate access in all areas in which the dental plan has enrollees. The plans must also provide enough business to dentists to maintain a positive relationship. While NADP supports the availability of additional allied dental personnel, the organization has not endorsed a one-size-fits-all practitioner approach to expanding the dental workforce.

Both ADHA and ADA have introduced new models for allied dental personnel to lawmakers whom they believe would increase access to oral care. ADHA has proposed the Advanced Dental Hygiene Practitioner (ADHP), a mid-level oral health provider educated and licensed to provide both preventive and limited restorative services to meet identified patient needs. Similar to a nurse practitioner, the ADHP type of provider is utilized in many other countries.[xv] Although both organizations have been careful in their public testimony related to the ADHP, the ADA has been opposed to the new position. Dentists cite the potential for a decrease of quality in patient care, as the yet-to-developed education of the ADHP may not be enough for the duties the position requires. The ADHA posits the ADA is concerned about diminishing of business from the new practitioner, and notes the success of the ADHP position in other countries and similar positions in the medical community.

While ADA states there is not a shortage of dentists, they do agree there is a maldistribution limiting the availability of dentists in certain geographic regions. ADA notes that even with an influx of dentists, providers would not necessarily practice in underserved areas. The ADA proposes the Community Dental Health Coordinator (CDHC) workforce model to remedy the need for oral care in underserved areas. The CDHC, under a dentist's supervision, will provide preventative dental services, such as basic cleanings and sealants, and in addition will collect information to assist the dentist in the triage of patients and address the social, environmental, and health literacy issues facing the community population. Another facet of the CDHC will be educating community members on preventive oral health care and assisting them in developing goals to promote and manage their own personal oral health. Linking patients to avenues of oral health care will also be an important role for the CDHC in working with underserved populations going through the maize of the health and dental care systems.[xvi] The ADA has funded grants in 3 underserved areas to pilot the CDHC program.

In 2008, the Minnesota Legislature proposed a bill allowing for a new type of practitioner, similar to the ADHP. After months of debate between the Minnesota dental hygienists and the Minnesota Dental Association, the final legislation included a compromise that established a new oral health practitioner discipline, licensed by the Board of Dentistry and working under the supervision of a dentist. The legislation created a work group (comprised of all stakeholders of the dental community) to advise the commissioner of health on recommendations and legislation to specify the training and practice details for these new oral health practitioners and report back to the 2009 Legislature.[xvii]

In meetings with certain lawmakers and the various dental stakeholders, ADA has fielded tough questions about how their model would address growing concerns surrounding oral health access issues. The tone of legislators comments and inquires, indicate the CDHC workforce model is not viewed as an adequate solution.

As the access debate continues the education of any new oral health provider will take time to evolve, and the American Dental Education Association (ADEA) has been involved as the voice of dental

educators. As ADEA stated in Congressional testimony, "Some say we have a dental shortage. Others say we have a maldistribution of dentists to meet the nation's oral health needs. No matter how one defines it, there can be no doubt that there is a significant access problem for millions of Americans. We must acknowledge that the current dental workforce is unable to meet present day demand and need for dental care… The math is simple on this equation. There is an increasing need and demand for dental care. There is a current shortage of dental faculty to educate and train the future dental workforce. Several new dental schools are scheduled to open across the country to meet individual state workforce and access needs. We face a crisis if resources are not dedicated to help recruit and retain faculty for the nation's dental schools." [xviii] This statement introduces a new facet to the access issue, a workforce shortage within dental teaching institutions.

ADEA has proposed 18 recommendations to address dental workforce challenges. The proposals range from increasing funding for oral care in Medicaid and SCHIP, including dental, in certain educational block grants, bolstering prevention and education regarding dental caries, and passing federal legislation as explained in the next section.[xix]

Legislative Solutions to the Access Issue

In direct response to the death of Deamonte Driver, several Members of Congress have introduced legislation regarding oral health care.[xx] The programs and funding structures of proposed legislation is important to review, because the momentum to address access to oral care has increased and new legislation has potential for enactment. Dental stakeholders need to be working with their government officials now to shape the future legislation, whether through public programs, grants or other arrangements. Following are the outlines of recent oral health proposals:

The *Deamonte Driver Dental Care Access Improvement Act of 2008* (H.R. 5549, S. 2723) allows for the Secretary of Health and Human Services (HHS) to award grants to:

- Schools of dentistry and hospitals with accredited training programs in pediatric dentistry to increase the number of individuals who pursue academic programs in pediatric dentistry or provide dental services to children;
- Applicants to establish a pilot program for increasing access to dental care for underserved populations through the use of allied dental health professionals;
- Federally qualified health centers (FQHCs) to expand and improve the provision of dental services to medically underserved populations;
- Public or private entities to develop, implement and evaluate public health and clinical strategies to prevent and manage early childhood caries.

The Act also provides a tax credit (up to $5,000) for dentists who treat Medicaid, SCHIP, and uninsured patients, and requires states to report annually information related to children's access to dental services under Medicaid and SCHIP programs. In addition, the Act requests that the Comptroller General study and report to Congress on the adequacy of payment rates for dental services provided to individuals eligible for Medicaid or SCHIP and directs the CDC to conduct a public education and awareness campaign related to pediatric dental health. Lastly, the Act requires HHS to ensure that dental health prevention and promotion activities are included in existing prenatal and maternal child health programs.

The *Essential Oral Health Care Act-2007* (H.R. 2472)

- Provides grants for improving access to dental services in underserved areas, including (a) grants for Community Dental Health Coordinators to work in clinics or private practices; and (b) grants for the purchase of portable dental equipment.
- Provides increased Federal Medical Assistance Percentage (FMAP) up to 90 % for states that ensure Medicaid and SCHIP children have the same access to dental care as other children. States must meet requirements related to provider payments and participation rates, removal of administrative barriers and caregiver education.
- Creates tax credit up to $5,000 for dentists providing charity care to low-income persons.

The *Children's Dental Health Improvement Act-2007* (H.R. 1781, S. 739) is similar to the previous legislation in that it provides grants to states, in this case (a) through the Department of Health and Human Services (HHS) to improve dental services for SCHIP and Medicaid, (b) through the Centers for Disease Control and Prevention, to improve oral health for children and their families, and produce public statistical reporting of the types of dental care services received (c) through HHS to improve primary dental services in underserved areas, including retention bonuses for dental officers in IHS. In addition, states will have the option to provide wrap-around coverage of dental services for kids with private coverage, and revise the Graduate Medical Education (GME) payments for dental residency programs. The bill requires HHS create initiatives to (a) reduce disparities in oral health and (b) identify populations at risk for early childhood caries and develop prevention programs. Additionally the legislation establishes Chief Dental Officers for Medicaid, SCHIP**,** Health Resources and Services Administration (HRSA) and CDC, and requires CDC to collect data on oral health.

The *Oral Health Initiative Act of 2008* (S.3064) establishes a working group to review the effectiveness of and recommend improvements to existing Federal oral health programs and to develop programs to improve the oral health of and prevent dental disease in children, Medicaid-eligible adults, medically-compromised adults, and other high-risk vulnerable populations.

The *Dental Health Improvement Act of 2007* (S.3067) reauthorizes a program that awards grants to states to help the states develop and implement programs to address the dental workforce needs of designated dental health professional shortage areas.

While federal bills are prolific and receive national attention within the dental community, state legislatures also have been taking action. Vermont and Maine passed voluntary health reform programs, and Massachusetts was the first state to mandate all individuals be covered by health insurance. Included in the MA regulations was a dental component for low-income children and adults. California tried to tackle health reform, but political issues kept the legislation from passing. Many states are waiting for a clear cost benefit analysis to emerge in MA as early results indicate costs are much higher than budgeted. The economic crisis is also straining state budgets, leaving less room for health initiatives. However, states are examining incremental steps in medical and in dental systems. As mentioned previously, expansion of duties for dental hygienists has been a prevalent policy discussion, and many states are reimbursing dental hygienists directly through Medicaid for basic dental services to the underserved population. The trend of expanding a hygienist's duties and areas they can serve is a trend likely to continue into 2009.

The Dental Community and Health Reform

As President-elect Barack Obama formulates his administration, some might suggest that health care reform could take a backseat to the increasing concern over the economy. However, Bob Blendon, who studies public opinion at the Harvard School of Public Health, states "Even if the new president was tempted by the sagging economy to put off his promise to address the health care mess, he would do so at his peril, says. Not only did voters who cited health care as their top issue flock to Obama in huge proportions, but 60 percent of his voters expect that if he became president, something big would be done about this problem… Of course, a big problem is that voters still disagree about what "something big" in health reform would look like."[xxi] Most of the stakeholders within the dental community have released principles on oral health care reform, with many organizations framing their statements around the larger discussion of health care reform.

The NADP released a *Position Statement on Health Care Reform* in 2008. The statement outlines NADP's five principles for expanding access to dental health benefits: 1) oral health is vital to overall health; 2) cost is a key barrier to dental care; 3) dental benefits are key to expanding access to affordable, quality dental care; 4) employers play a critical role in providing access to dental benefits; and 5) dental plans help government programs work for beneficiaries. Reports from the both the Surgeon General Office and the National Center for Health Statistics of the CDC provide evidence that enrollees covered by private or public dental coverage will visit the dentist more frequently.[xxii]

In 2008, ADA adopted a resolution on Improving *Oral Health In America*. The resolution is in three parts: 1) oral health is essential for a healthy America; 2) access is a key to good oral health; and 3) we must build on current successes. The ADA stresses educating the population about oral care, making reimbursement rates and funding for public programs and dental education a priority, and supports the NADP position that private dental benefits currently work, and should be utilized when expansion of coverage is considered.[xxiii]

ADHA has made public their *Statement on Health Reform*, highlighting that oral health must not be neglected, disease can be avoided with preventive care, and costs should be less expensive. The statement adds that workforce must be expanded and offered in a variety of settings, and federal funding should test the ADHP model. ADEA has supported two *Main Principles for Health Care Reform* - (1) The availability of health care, including oral health, fulfills a fundamental human need and is necessary for the attainment of general health, and (2) The needs of vulnerable populations have a unique priority. ADEA has also released a policy statement, adding that any comprehensive reform of the U.S. health care system must include coverage and access to affordable oral health services.[xxiv]

There have been several non-profit policy think tanks and consumer advocate groups that have released reports and issue briefs on oral health care, however currently there is only one advocate group that focuses exclusively on dental – the Children's Dental Health Project (CDHP). CHDP's mission is to "forge research-driven policies and innovative solutions by engaging a broad base of partners committed to children and oral health", and has released their key principles as the *Foundation for Health Reform in Oral Health*, including: (1) affordable, comprehensive, and high-quality health coverage that includes coverage to achieve oral health for all children; (2) prevention as the most efficient strategy for avoiding costly and lifelong health and developmental consequences; (3) effective care management and professional coordination for all children and their families to achieve optimal health, including oral health; and (4) efficient systems of care that integrate emerging technologies and health professionals to improve health status and eliminate disparities.[xxv]

The significance of these various position statements is that these associations share very similar philosophies on oral health. The connection between oral health and overall health is the key. Many of the reform statements go into more detail citing studies which connect dental health with heart disease and diabetes, or noting a correlation between poor periodontal health and premature birth, and detecting the presence of oral cancer. Access to dental care can not only identify overall health conditions but trigger their treatment, thus reducing physical and financial impacts for adults and children. Paying for dental care can reduce costs for medical care, and yet, as NADP statistics show, there are currently 173 million Americans with dental benefits, leaving two out of five Americans without dental coverage. The dentally uninsured outnumber the medically uninsured by two and half times.[xxvi]

While there are more similarities than differences among the dental community, each organization has various priorities on how health reform should take shape and where government funding should be spent. The focus spent on advocacy and lobbying within these associations varies greatly on their scope and size, but each one has a presence in Washington D.C. And while discussions among the dental community takes place often, how and when these groups will advance their priorities will depend on how health reform takes shape in the Obama Administration.

Health Reform Scenarios[xxvii]

If major health reform is to occur, it may move quickly in the new congressional session, set to begin in January 2009. President-elect Obama has created a health care transition working group, which has already begun planning and engaging the public and interest groups on health reform. Major reform could take many different shapes. It might include an expansion of public programs such as Medicaid and SCHIP. It also could include the expansion of dental coverage to Medicare, funding for dental workforce models or other targeted components that impact dental. New political discussions also have taken place regarding the use of the tax code to support health insurance. For example, Senator Baucus (D), Chair of the U.S. Senate Finance Committee has suggested capping the amount of the health care premiums that can be excluded from employee wages for income and payroll tax purposes. There is also discussion regarding provider payments and changes to insurance regulations. All of these reforms are likely to directly impact the dental sector.

If comprehensive reform proves unachievable, incremental reform may be possible. This might include, for example, more targeted expansions of public programs such as a sizable expansion of the SCHIP program. Small does not mean insignificant; consider that both the Health Insurance Portability and Accountability Act (HIPAA) and SCHIP were 'incremental' reforms following the failure of Clinton health care reform. Of course, it remains possible that health reform will not occur for several years due to various factors such as the economy and the war in Iraq, or the lack of political consensus.

The majority of analysts believe there will be some sort of health reform because the consequences are too great if health care reform is not addressed. However, action on reform will require overcoming political and fiscal challenges. Without action, employers, specifically small business will continue to struggle with affordability of health insurance, health care costs will continue to escalate, and the uninsured population will likely expand.

The dental sector will be watching health reform very closely. While all the dental stakeholders would applaud federal and state funding in public programs for oral care for children and low-income

adults, concerns and priorities about the specific of implementation of these and other policy options may differ.

Dental insurance is very different from medical insurance, and though oral health is systemic to overall health, care and coverage is handled very differently. In its current form, dental insurance works – it is cost effective, employers are pleased, and enrollees with coverage see their dentist regularly, satisfying plan providers[xxviii]. Proposals regarding tax benefits will be heavily scrutinized as virtually all dental coverage is provided through employers or other groups. Any proposal that has the potential to make employers reevaluate their benefit packages and potentially drop their dental benefit or turn it into a voluntary benefit[xxix] could reduce access to health care. Other proposals such as the various workforce models will certainly be reviewed by the dental sector as well.

In Conclusion

Oral health care reform is made up of several components, but access to care is central. Health care reform will occur in some fashion at some point, and how it will impact the entire dental sector is unclear. In the short term, there is likely to be a dental component during the reauthorization of SCHIP in early 2009, and several federal oral health bills are expected to be introduced again. Additional public funding for new programs and program expansions remains questionable as federal funding will be tight. Fiscal conservancy will be occurring in the states as well, however, various proposals to expand dental hygienists duties are likely, as are proposals related to student grants for dental schools. Regardless of one's political stance, the profile of oral health care has been elevated, offering countless opportunities for improvement in the oral health of the nation.

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