Access to Oral Health Care for Elders: Mere Words or Action?

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Abstract: For many years, the health care community has used a silo approach to oral health, with little exception, treating the oral cavity as the sole province of the dentist, with no interaction with the medical profession. However, as research shows links between periodontal disease and diabetes, stroke, heart disease, and peripheral arterial disease, it seems clear that the silo approach to oral health should be replaced with a new paradigm—that of including dental care in comprehensive medical benefits. Retirees who have limited or no access to traditional employer-based dental benefits should be among the early beneficiaries of this paradigm shift. The federal government should consider social insurance mechanisms to ensure that retirees have access to oral health care.

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Health professionals are calling for action to improve access to oral care, particularly for the elderly. The attention given to the aging of America is not surprising. In 1900, only 3 percent of the U.S. population, a little more than three million Americans, were sixty-five years of age or older. By 2000, the number of people sixty-five and older had grown to thirty-five million and represented 12.4 percent of the population. The number of centenarians is growing as well. Life expectancy is growing. The baby boom generation currently makes up one-third of the American population, and this group will begin reaching the age of sixty-five in the second decade of the twenty-first century, just five years from now.

It is axiomatic that those with limited financial support encounter difficulty in obtaining access to medical care. But this situation is even more problematic when it comes to dental care. Medicare covers virtually no dental care. The poorest elders, who are dually eligible for Medicaid and Medicare, may fare a little better in some states. States may elect to provide dental benefits to their adult Medicaid-eligible population or elect not to provide dental benefits at all as part of their Medicaid programs. At present, while most states will provide emergency dental services, fewer than half provide a comprehensive dental program for their adult Medicaid-eligible populations.

However, most retirees have relied either on their own financial resources or retiree health insurance offered by their former employers to finance post-retirement dental care, and most retirement insurance does not include dental care. One study showed only 14.5 percent of post-sixty-five-year-old dental patients have dental insurance, and another indicated that fewer than 20 percent of Americans seventy-five and older have any form of private dental insurance. Many are those whose employer-sponsored health benefits included dental coverage and continued into retirement. Some seniors received dental coverage in Medicare Plus Choice Plans, which offered the coverage to attract enrollment in the plan. However, as Medicare Plus Choice Plans have seen their margins erode, these enrollment enticements frequently have been eliminated.

Oral Health America’s 2003 report, “State of Decay,” characterizes limited access to oral health care as posing “one of the greatest crises for the health and well-being of America’s elderly.” It grades America’s commitment to providing oral health access to the elderly “an embarrassing ‘D,’” noting that not one older American receives routine dental care under Medicare, and under Medicaid, available to the poorest and most disabled, dental care is optional and spotty.

Recognizing, as Kaiser Family Foundation President Drew Altman does, that “retiree health care coverage is kind of a slowly vanishing species,” and that social insurance programs like Medicare and Medicaid are not filling the gap, this article argues that the health policy community and the dental profession should focus on providing a dental health benefit for retirees. To put this issue on the agenda, a paradigm shift must occur: that of recognizing the craniofacial connection to the body. As more research is done showing the effects of drugs, edentulism, and periodontal disease on the mouth and general health,
it is more important than ever that primary care physicians should ask their patients, “Have you seen a dentist this year?” as part of a yearly exam. Moreover, it is important that oral health be recognized as integral to general health. Specifically, we should unite dental and medical benefits under Medicare and any other health plans that pay for retiree health benefits, and ultimately all health benefits.

So how do we get there? An American Dental Association witness testifying before a Senate Special Committee on Aging suggested Medical Savings Accounts as an option.11 For some, that may be an option. The Medical Savings Account, and a related concept, the Health Savings Account (HSA), is a tax-advantaged savings mechanism that can be used to pay for routine health care expenses, including dental expenses. It contains funds that the individual enrollee account holder owns and controls. Any money that is saved at the end of the year rolls over for next year’s expenses. These sorts of accounts are portable, so the funds remain with the account holder, without regard to changes in employment. However, tax laws presently restrict participation in these accounts to the uninsured, those with high deductible health plans, and those who do not receive benefits under Medicare.12

Another instrument, the Health Reimbursement Arrangement (HRA), offers high deductible plans to participants. It sets benefit parameters for the administrator, wherein the plan generally offers first dollar coverage for usual low cost services and provides coverage for high cost, infrequent health expenses. That leaves a gap in the middle, for the participant to fund. As with HSAs, any money left at the end of the year can be carried over to the next year, providing participants with an incentive not to spend all of the money and to make better medical and financial choices, thereby reducing health care utilization and inflation.13 The next generation of retirees, now known as the baby boomers, is in line to inherit as much as twelve to eighteen trillion dollars from their parents.14 So the gap may not present such a problem for them. But not all will inherit. And for these families, already stretched by the burdens of taxes, their mortgage, credit card debt, and the expense of financing their children’s college tuition, not to mention saving for retirement, it is likely that they will not have the wherewithal to put away money now to pay for their future medical or dental expenses. And what about the older of the aging baby boomers, who may not have that opportunity before the expenses overtake their savings? A recent survey of people filing for bankruptcy found that 75.7 percent of the people interviewed had health insurance at the onset of the illness that began their spiral towards insolvency. Even middle class insured families were found to fall into bankruptcy when a catastrophic medical event befell a member of the family, threatening the earning power of a member of the family.15

At least one commentator has suggested that the dental profession should join with senior citizen groups when the time is right to ask Congress to expand Medicare to cover oral health.16 Another suggests that older people should have access to dental care as part of primary care as a matter of justice and that financing should not stand as an impediment.17

Following on the 2000 surgeon general’s report on oral health by Dr. David Satcher, current Surgeon General Richard Carmona has issued a national call to action to promote oral health, which acknowledges the perception that oral health “is in some way less important than and separate from general health has been deeply engrained in American consciousness,” and recognizes that the perception must be challenged and changed.18 Although Dr. Carmona’s call to action does not endorse universal Medicare coverage of oral health expenditures, its acknowledgment of oral health as part and parcel of general health primary care begs the question, “Why should Medicare not include oral health as part of primary care and treat oral health expenditures differently?”

An appreciation of the political history of Medicare should teach us that an expansion of Medicare to cover oral health will not occur simply because it is just, right, necessary to fill the gaps left by the impending demise of retiree health insurance benefits, scientifically meritorious, or solely because there is broad public demand. The recent expansion of Medicare to cover prescription drugs after decades of attempts teaches us that Medicare benefits will not be provided unless and until the public demands it and it is demonstrated to be scientifically meritorious and cost effective. Calls for action are mere words unless accompanied by efforts to build a popular consensus for benefits expansion. Health policy professionals and the dental profession must assist in building the popular consensus if we are to change the paradigm and unite dental and medical benefits under Medicare and any other health plans that pay for retiree health benefits.
The Rise and Fall of Retiree Health Benefits

The move toward generous employee benefits, pensions, and health benefits took off in the boom years following World War II, when the competition for talent was keen. While a competitor may have offered higher salaries, companies like IBM competed for the loyalty of employees with the inducement that the company would take care of them when they could no longer work. Labor unions demanded the same for their members. Once one company in an industry relented on generous retiree benefits, the same was demanded of other companies in the industry.

That world has changed. In 1999, IBM did a study of its competitors and found that 75 percent of them did not offer a defined benefit pension plan and fewer still paid for retiree health care. Companies like IBM, US Airways, and General Motors must contend with rivals who don’t bear the cost of those old-style retiree benefits. Business Week noted, “For every lumbering US Airways there’s an agile Southwest [Airlines] or JetBlue Airways Corp., newer rivals with cheaper benefits.”

Since the 1980s, there has been a serious decline in the number of large firms, defined as firms with 200 or more workers, offering retiree health benefits. In 1988, 66 percent of large employers provided retiree health benefits; this number dropped to 46 percent three years later; and in 2003, only 38 percent of large employers were reported as providing health coverage for their retirees.

Premiums for retiree health insurance rose in 2001, both for pre-sixty-five and for Medicare-age retirees, and, due to a change in accounting standards that took place in the early 1990s requiring firms to include the unfunded value of future retiree health benefits as a liability on their balance sheets, these health care costs began to appear more daunting. One response was for employers to place caps on the contributions they would make in the future toward these retirees’ health benefits. Once retirees’ medical costs rose above this predetermined level, retirees would have to assume the costs above that amount.

By 2003, 46 percent of large firms offering retiree health benefits had caps on their future liability for that benefit for retirees younger than age sixty-five. As for Medicare-age retirees, the story is largely the same: 46 percent of large firms offering retiree health benefits had caps on their firm’s contributions to their current retirees’ health benefits. Other strategies used by employers have included not providing retiree health benefits to newly hired employees or increasing cost sharing for current retirees.

Recent data suggests that this trend is continuing. The recently issued Kaiser Family Foundation/Hewitt Associates 2004 Survey on Retiree Health Benefits, which included 333 large, private sector firms, indicated only 16 percent of respondents estimated that all of their firm’s active employees will be eligible for subsidized health benefits when they retire, although about half believe that 26 percent to 99 percent of their employees will continue to receive some form of subsidized coverage. That coverage may be more expensive to the employee.

Private dental insurance is primarily employment based and offered as an add-on to an employer’s health insurance benefit. The surgeon general’s 2000 report observed that private dental insurance is a benefit available to about 59 percent of full-time employees in medium and large businesses. Dental coverage is a sought-after product in the employee benefits marketplace. Since the 1960s, dental coverage has been offered to large employers by insurers already providing their health coverage, and by 1990, “approximately one hundred fifty million Americans received some form of dental coverage.”

As companies eliminate retiree health insurance, it is reasonable to assume that retiree dental benefits will similarly be lost. The employee benefits consulting firm Towers Perrin’s 2003 Health Care Cost Survey noted that, while dental premium increases were not as dramatic as health care insurance premiums, they continue to outpace the rate of inflation and commonly represent 8 percent to 10 percent of a company’s active health care costs.

Retiree dental insurance programs may continue to be an option in particular sectors of the economy, particularly in the government sector and in sectors where labor unions continue to exercise substantial bargaining power. In addition, 100 percent retiree-paid group plans can be an asset to individuals, as they may be less expensive than individual plans and less expensive than paying for care without insurance. Along the same lines of voluntary plans, the AARP-Delta Dental plans offer retirees a choice of dental programs. The problem that this paradigm raises is that it continues to treat the craniofacial cavity as separate from the body, as opposed to an integral part of the body.
Do Dental Benefits Matter?

The term “insurance” is technically a misnomer in the dental arena. Unlike dental insurance, medical insurance provides coverage for preventive and acute care, services deemed medically necessary to prevent a catastrophic event or financial risk associated with a serious health issue. In many major medical policies, there is a deductible, after which the individual will be covered up to a lifetime maximum of a large dollar sum, insuring that the individual will be covered in case of any catastrophic event. Dental policies, however, cover routine treatments, offer discounts on more complex requirements, and carry a small yearly cap ($1500 is typical) on total expenditures. As Manski points out, “If car insurance were designed like a dental plan, an oil change and tune up would be covered at 100 percent; shocks, tires, and batteries would be reimbursed at 80 percent; and accidents would be reimbursed at 50 percent, with an annual maximum limit of $1000.”16 However, the industry continues to refer to the product as dental insurance, even though Manski more appropriately recognizes the product to be “part insurance, part prepayment, and part large volume discount.”16

Nevertheless, numerous commentators observe that the people with health and dental insurance are more likely to use dental services. Dental insurance coverage is a strong correlate of dental service use, particularly among older adults.26 Even so, according to a 1984 HCFA study, the out-of-pocket share for dental services for the elderly was 94 percent.27

Will the Paradigm Be Changed?

The surgeon general’s 2000 report on oral health in America presented information suggesting a relationship between oral and systemic health.4 Several studies have found associations between periodontal disease and systemic diseases such as rheumatoid arthritis,28 glucose intolerance (diabetes),29-30 cardiovascular disease,31-33 pneumonia and pulmonary infection,34 ischemic stroke,35 and peripheral arterial disease.36 Periodontal infections are more prevalent in the elderly. In those aged sixty-five to seventy-four years, approximately 23 percent have periodontal disease (measured as six millime-
ters of periodontal attachment loss).3 As more epidemiological evidence links dental infections and systemic complications, it should be clear that dental and health benefits should not be compartmentalized, but instead, should be part of the same package of benefits in order to improve health and reduce costs.

Writing in 2001, Manski suggested that as soon as the debate over Medicare prescription drug coverage ends, the debate to provide dental care coverage for the elderly may soon begin. Although this prophecy has yet to come true, Manski accurately predicted that the debate, once it begins, could attract a powerful constituency. “The elderly constitute a vocal and powerful force capable of influencing Congress,” he says. “In addition, the American Association of Retired Persons, a significant lobbying force on Capitol Hill, relentlessly attempts to initiate, block, or change proposed legislation on behalf of its members.”16

There are several factors favoring expanding Medicare’s benefits, not the least of which is the supposed political power of seniors. They vote in American elections in higher rates than do younger citizens and write to their elected officials.29 And, while the elderly do not vote as a block, “the perception of the elderly as a block vote carries political weight among policymakers regardless of its validity.”37 Beyond this, Medicare is a popular program, with public opinion data showing strong support for increasing program benefits for such things as nursing home care.37

However, the position of seniors in society has changed. While the elderly once were seen as a deserving group of people for whom benefits should be provided, beginning in the 1980s, this “sympathetic stereotype” was revised.37 Seniors became tagged as “greedy geezers” who were receiving too much aid. Thus emerged a politics of inter-generational equity, with seniors on the losing end. And while this epithet has largely disappeared from the political landscape, the view of seniors as frail and deserving has not fully returned, either. This is a tribute to the success of Medicare, which has, since its enactment, facilitated the rise from poverty of most female seniors, who were the largest poverty group when Medicare was enacted.

Generally speaking, older Americans are retaining their teeth more than before.1 The surgeon general’s report, “Oral Health in America,” issued in 2000, points out that while members of the baby boom generation can look forward to good oral and
general health, the challenge will be in providing oral health care for those who are not in good health, especially the oldest old, and those with limited financial support.4

More importantly, the challenge in adding a benefit to Medicare is the fact that money is involved. If the benefit is structured as an “enrollee-pay-all” plan, the concern is that only those with a dental problem will sign up, creating problems of adverse selection. However, this problem can be reduced by placing such design features as waiting periods prior to an enrollee’s access to more intensive services. More importantly, if an enrollee leaves the program, the individual could be permanently barred from re-enrollment. If the program is structured as a plan in which the government will pay a share and the enrollees will pay a share, then adverse selection may be avoided, but fiscal issues arise. Given that Medicare policymakers see their primary goal as one of fiscal responsibility,37 and given that Congress just implemented a prescription drug plan, it may be that Medicare policymakers and Congress lack the appetite for further benefit expansion at this point. However, the first step is to get the need for dental benefits on the national agenda.

To do this, the dental community must convince Americans, and particularly aging boomers, that oral health is integral to all health, and for that reason, retiree dental benefits are an important issue. For many years, Americans have been speaking about various health issues: we had a debate about the merits of national health insurance; we enacted and rescinded a Medicare Catastrophic Coverage Act; and we implemented a Medicare Prescription Drug Program. At no time, however, have we discussed, on a national level, dental insurance for retirees, or for any other group of underserved Americans.

To start this dialogue requires getting on the national agenda. Things do not get on the agenda because they deserve to be there; they get on the agenda because influential people put them there and mobilize grassroots support to keep them there. The American attention cycle is measured in seconds. A story captures the attention of Americans and then Americans move on to the next big news event.38 Thus, to avoid having the issue forgotten in the Washington, DC policy arena, getting on the agenda means educating members of the House of Representatives and the Senate about the importance of the issue of retiree dental benefits. This has been started, as in 2003, when the Senate Special Committee on Aging heard testimony on whether the nation’s seniors were receiving proper oral care. But more has to be done.

The dental community should continue to educate policymakers in Congress about the linkages between periodontal disease and systemic disease. Further, articles should be written for the senior market and placed in magazines such as *AARP Magazine* and *Modern Maturity*. Making elders aware of the importance of dental care to overall health care may be the first step in activating this powerful constituency. Increasing access to dental care will not only help seniors lead healthier and more comfortable lives, but also the case should be made that prompt attention to dental issues prevents more costly medical treatment. The dental community must assist dental students, dental educators, and policymakers to eradicate the silo thinking that has oral health care separated from general health care; rather, they must understand that oral health is integral to all health. As Jones et al. have suggested, “Dentistry should develop lobbying efforts to promote the inclusion of dental care among comprehensive health benefits.”27 The dental community should be prepared to advance legislative proposals, sometimes floating trial balloons. Most important, the dental community should be prepared when a policy window opens unpredictably and creates an opportunity to join its project with some other policy stream.39 Such an opportunity may be coming sooner than we think. Congress may be ready to refine the Medicare Prescription Drug bill. If Medicare returns to the Congressional agenda, the dental community should be prepared to respond and ask to add language about retiree dental benefits in the prescription drug fix. Perhaps the proposal would not be enacted, but the discussion that would ensue would put the question on the agenda. In this way, the greater policy debate would begin.

The dental community must also begin to build support in the general community to promote the new paradigm: including dental care among comprehensive health benefits. In the case of seniors, it means an expansion of Medicare to make this a reality. Just as seniors expressed a desire for prescription drug benefits because they knew they needed costly prescription drugs, seniors who know the value of dental benefits will make their voices heard to their representatives in Congress. As members of the Senate and House hear the same thing from their constituents as they are hearing from health care lobbyists, it will begin to register that something should be done.
At the same time, proponents of Medicare dental coverage should be prepared to demonstrate that the cost incurred by the Medicare trust fund to address oral health problems will save money in the long run.

Manski argued that dentistry should be prepared to join this debate if and when it begins. However, without strong support from the dental community, the debate may never begin. While polls reported by the Kaiser Family Foundation suggest that Americans are concerned about access to health care and the cost of health care and prescription drugs, Americans’ interest in increased access to dental care for seniors never registers. Unless this changes, efforts to gain parity for oral health in Medicare may never leave the starting gate.

REFERENCES


40. Health policy information, including healthcare polling by the Kaiser Family Foundation, can be found at www.kaisernetwork.org.