US Health Care Reform and the Future of Dentistry

The Patient Protection and Affordable Care Act has grand ambitions: to provide insurance coverage to more than 30 million currently uninsured Americans, to slow increases in health care costs, to reorganize the health care delivery system, and to improve the quality of care provided to all.

Where does the oral health community fit in this initiative? Should dentists ''scope up'' to become a more active part of the primary care workforce? Or should dentists ''scope down'' and delegate parts of the traditional dental tool kit to midlevel practitioners?

Our nation's public health largely depends on whether we can create a more integrated and public health–oriented delivery system. The oral health, physical health, and public health communities should address this challenge together. (*Am J Public Health.* 2011;101:1841–1844. doi:10.2105/AJPH.2011.300358)

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THE US PATIENT PROTECTION

and Affordable Care Act (PPACA)[1] was enacted in March 2010 following a bitter and partisan political debate. The new law has grand ambitions: to reduce the number of uninsured by more than 30 million, to slow the rising cost of the nation's health care bill, to reorganize the health care delivery system, and to improve the quality of care provided to all. Federal and state officials have begun the complicated and controversial process of implementation, while providers, insurers, employers, and consumers work to both understand and influence the process at each step. At the same time, Republicans in Congress are seeking to repeal the law, and federal judges are considering challenges to its constitutionality.

The political, economic, and legal debates over what happens next are sure to be an important part of the 2012 presidential campaign. In addition, the ultimate fate of the health reform legislation is sure to hold a prominent place in any historical review of President Barack Obama's first years in office. Health reform in 2011 continues to be a big story.

Where does the oral health community fit into this ongoing health reform debate? What does the new law say about oral health benefits, oral health providers, and oral health delivery systems? How might the oral health community position itself to be a central player in a reformed health delivery system? And how might the oral health community use the new law to encourage more of a focus on prevention and public health?

THE OBAMA STRATEGY FOR HEALTH CARE REFORM

In early 2009, shortly after taking office, President Barack Obama began to press for comprehensive health care reform. With the nation's economy in the midst of a deep recession, the president was especially focused on rising health care costs. The business community, including both large and small businesses, had long complained about rising private insurance premiums; but policymakers at both the federal and the state levels were equally concerned about the rising Medicare and Medicaid bill. At the same time, increasing costs made it harder and harder for millions of Americans to get access to needed health care services. There were nearly 50 million without any health insurance, and millions more had insurance that was inadequate for their health needs. The cost of private coverage was too high, and the public insurance safety net was too thin. Finally, the president and other reformers hoped to reorganize and improve the health care delivery system itself by encouraging more primary and preventive care, creating fiscal incentives for the provision of higher-quality care, and developing a more integrated health system in which health care providers of all types worked together to provide a true medical home for all Americans.

However, Obama and his allies had inherited a legacy of prior reform failures under presidents as diverse as Harry Truman, Richard Nixon, and Bill Clinton. In addition, the reformers faced 3 significant obstacles to comprehensive health reform. First, any reform initiative would be subject to ruthless interest-group politics, because every dollar of the $2.7 trillion spent on health care is income to some person or organization. Indeed, one of the great ironies of the long-standing health reform debate is that every group agrees that the system has problems and reform is needed, but each group also suggests that the problem rests with others and that their income and their interests need to be preserved. The 2009–2010 debate was no different, as doctors, hospitals, health centers, insurers, employers, pharmaceutical companies, and public officials all scrambled to protect their turf.

Second, the interest-group battles would take place in a cultural context in which Americans strongly disagreed about the proper role of government and the right mix between the public and private sectors. The president rightly anticipated that opponents would call his proposals a "socialistic" government takeover of the health care industry that was inconsistent with values of individualism, capitalism, and personal responsibility. Finally, the interest group and cultural fights would be resolved in an institutional context that was biased against large-scale government action. Reformers would need 60 votes in the US Senate to break a potential filibuster and enact legislation (although there was always the possibility of legislative maneuvering to avoid the 60-vote requirement).

However, President Obama began the reform effort with 2

significant advantages over his predecessors. The contrast with the Clinton initiative, in 1993–1994, was especially stark. Obama, who was elected with 53% of the popular vote, had much more of a political mandate than did Clinton, who was elected with only 43% of the popular vote. Even more important, the Democrats held 60 seats in the Senate, thereby minimizing the necessity (if not the desirability) of some Republican support.

In this context, President Obama developed a clear political strategy that differed significantly from that adopted by President Clinton, who had created a White House Task Force to lead the reform effort and who had threatened to veto any reform bill that did not include national health insurance. Like Clinton, President Obama declared health care reform to be a top domestic priority, tying it to economic recovery during a deep and long-lasting recession; but there the similarities ended. President Obama delegated to Congress the task of developing the details of a reform plan, thereby engaging the Democratic congressional leadership and encouraging them to feel invested in the outcome. He pressed for fast congressional action, recognizing that delay worked to the benefit of his opponents. He emphasized his willingness to compromise and make deals, thus minimizing interest-group opposition and moving to get the needed votes in both legislative houses. And he argued that any reform should build on the current system, hoping thereby to undercut claims of a government takeover.

Under the guidance of the Democratic leadership in the House and Senate, by late 2009 both houses had enacted versions of health care reform and were preparing to work out the differences in a conference committee. Unexpectedly, however, a Republican Senate candidate from Massachusetts, Scott Brown, won a special election to replace the recently deceased Ted Kennedy, thereby dashing hopes that Senate Democrats could enact the compromise reform bill that would emerge in the conference committee. After some political handwringing, the Democratic leadership in the House decided to enact the Senate version of reform and present it to President Obama for his signature. Democratic leaders in both parties then used the budget reconciliation process (which only requires 51 votes in the Senate) to enact some modifications to the law. By late March 2010, the PPACA was the law of the land.

PATIENT PROTECTION AND AFFORDABLE CARE ACT OVERVIEW

The core of the PPACA comprises 6 provisions designed to provide health insurance to roughly 32 to 34 million Americans, reducing the percentage of the US population without health insurance from 17% to 5%. First, Medicaid, the nation's public health insurance program for the poor, will be made available to all citizens whose incomes are below 133% of the federal poverty level. As a result, beginning in 2014, 16 to 18 million of the currently uninsured are expected to enroll. Second, each state will create insurance exchanges (i.e., purchasing pools) for self-employed people and the small-business community. The federal government will then provide premium subsidies for those exchange participants with income less than 400% of the federal poverty level. It is expected that another 16 to 18 million of the currently uninsured will purchase private coverage through the exchange.

Third, employers with more than 50 employees will be charged a fee if they do not offer health insurance coverage to their workers. Fourth, small businesses with low-wage workers will receive tax credits when they provide coverage. Fifth, a host of new federal regulations will aim to eliminate various insurance industry practices (such as denying coverage to those with preexisting conditions, basing premiums on health status, and imposing lifetime limits on coverage). Sixth, a fiscal penalty will be imposed on nearly all persons who do not have some sort of insurance coverage. The penalty is to be enforced via the federal tax code. To pay for the expanded coverage, the PPACA imposes new taxes, primarily on families with annual income higher than $250 000 and on high-cost health insurance plans, and it significantly cuts Medicare reimbursement to certain providers (especially hospitals) and to managed care plans.

Unlike large-scale, comprehensive efforts to reduce the number of uninsured people, the PPACA makes smaller, more incremental efforts to contain health care costs, restructure the health delivery system, and encourage higher quality of care. For example, whereas other nations generally contain health care costs by either regulating health care prices or limiting the utilization and diffusion of new health technology, neither of these strategies was seriously considered during congressional deliberations. Proposals to regulate private-sector prices not only generate significant interest-group opposition; they also are especially vulnerable to claims of creeping socialism and government takeovers. Similarly, proposals to consider explicit limits on health technology generate claims of health care rationing and so-called "death panels." Neither the Obama administration nor the Democratic leadership in Congress was interested in either approach.

Instead, the PPACA contains a host of pilot programs that are designed to lower costs, integrate delivery systems, and improve quality. For instance, the law calls for a series of Medicare pilot programs designed to test new payment methodologies, such as linking provider pay to performance and paying a single bundled fee for the entire cost of a particular procedure, which presumably will lower costs. The hope is that Medicare will evolve into a policy laboratory and that private insurers will voluntarily adopt strategies that seem to work. Moreover, the law created a new federal administrative entity, the Independent Payment Advisory Board, that will have significant authority to evaluate and expand the various Medicare reform proposals.

The law also includes a series of initiatives designed to encourage the provision of more primary and preventive care, the development of more community health centers, the expansion of chronic care case management, and the evolution of a more interdisciplinary and integrated health system in which health care providers of all types (including dentists and other oral health providers) work together to provide a true medical home for all Americans. The law also authorizes an additional $11 billion for federally qualified community health centers, creates a new Prevention and Public Health Fund, requires chain restaurants and vending machines to disclose

the nutritional content of food sold, and launches a program designed to encourage employers to develop wellness programs for their employees.

HEALTH CARE REFORM AND ORAL HEALTH

This is a time of change within the oral health community, and the PPACA is likely to accelerate trends already under way while prompting new and important conversations about the future of dentistry. A little more than a decade ago, for example, the US surgeon general focused increased attention on the dismal access to oral health care among poor and disadvantaged communities, spurring an ongoing debate over strategies designed to improve access.[2] Nonetheless, Medicaid coverage of dental care continues to vary dramatically across the states: more than half offer no coverage for adults, and Medicaid payment rates to dentists are often so low that access is inadequate even for covered beneficiaries.[3,4]

There also is a greater recognition that oral health has important spillover effects on physical health more generally. Dental caries is the most common infectious disease among children and can have devastating impact if not properly treated. In a particularly tragic case, a 12-year-old Maryland boy died after a tooth infection spread to his brain.[5] Evidence increasingly shows that oral infections are a risk factor for a wide array of physical illnesses, including diabetes, respiratory disease, and cardiovascular conditions.[2]

Finally, the oral health community is engaged in an ongoing debate over who should do what in the dental office. Lamster and Wolf, for example, have documented how oral health providers can conduct needed primary care screenings, such as checking blood pressure, diagnosing sleep apnea, identifying risky skin lesions, and screening for osteoporosis and cardiovascular disease.[6] They also note that oral health providers can deliver needed public health interventions, such as encouraging tobacco-cessation activities. In this context, the dentist might over time become an important component of the primary care and public health workforces, developments that would significantly expand the scope of the dental practice.[6]

At the same time, dental hygienists and dental assistants have long argued that their scope of practice also ought to be expanded, with hygienists authorized to practice independently or to treat basic dental caries, and with assistants authorized to clean teeth and perform other functions generally done by the hygienist. Complicating the story even more are proposals to encourage more states to license dental therapists—a relatively new midlevel oral health provider now practicing in Alaska and Minnesota—who are trained to provide some of the services now delivered by both dentists and hygienists.

Each of these scope-of-practice debates generates ferocious interest-group conflicts as each profession seeks to protect and expand its own turf. In a recent example, the Federal Trade Commission is now suing the North Carolina Dental Board, alleging it is harming competition by blocking nondentists from providing teeth-whitening services. Over the next several years, these turf battles are likely to increase as the focus on oral health grows.

How does the PPACA affect the ongoing debates over the future of oral health? Several provisions in the new law specifically address some of these issues. For instance, children's dental coverage is part of the essential benefit package to be offered in the insurance exchanges; the new Medicaid and CHIP Payment and Access Commission (MACPAC) is required to review the adequacy of payments to dentists by Medicaid and the Children's Health Insurance Programs (CHIPs); and the law has created scholarship and loan programs that have the goal of expanding all components of the oral health workforce (especially midlevel and alternative dental providers). Perhaps more important than any specific oral health provision, however, is the PPACA's strong encouragement of the ongoing effort to integrate the different components of the health care delivery system into a more seamless and interdisciplinary medical home.

At the heart of this effort is the same issue now challenging the oral health community: who does what in the health care system? What is the right scope of practice for the physician, the nurse, the public health practitioner, the social worker, the physical therapist, and the host of other health care providers, certainly including the oral health providers? To what extent should the dentist "scope up" to become a more active part of the primary care workforce? And to what extent should the dentist "scope down" and delegate parts of the traditional dental tool kit to midlevel providers to encourage greater access to dental services (and perhaps lower-cost services as well)? Who does what in the medical home or the Chronic Care Case Management Program? How do the different members of these integrated delivery systems work together? How is the money divided among the different members of the team?

These scope-of-practice issues are relevant to every aspect of the health care debate, from access to cost to quality. Importantly, however, the PPACA does not offer any particular road map other than a general preference for care integration and comprehensive health systems. Instead, the debate over how best to achieve care integration and systemic reform is only just beginning. Scope of practice will be at the heart of that debate.

Similarly, although the new law acknowledges the disparities in access to oral health care and makes incremental improvements (e.g., including children's dental coverage as part of the essential benefit package), the law itself is unlikely to significantly improve access, especially for adults. Having the new MACPAC review the adequacy of Medicaid payments to dentists is hardly a major effort to improve access, especially because MACPAC itself has no power to change rates.

WHAT HAPPENS NEXT?

In the months following the enactment of the PPACA, the debate over its merits grew even sharper. More than half the states brought litigation in federal court challenging the constitutionality of the new law, and federal judges who have reviewed the issue so far are relatively evenly split. Meanwhile, the Republicans took over the House of Representatives in the 2010 elections, and they promptly passed a bill that would repeal the PPACA. Although the Senate unsurprisingly defeated the bill, the political debate will surely continue at least through the 2012 presidential campaign, if not beyond. And as the politicians wrangle and the judges deliberate, the massive effort by federal and

state policymakers to implement the new law continues, just as providers, insurers, employers, and consumers all work to understand the law's impact—and to have an influence on it.

It is of course impossible to predict the ultimate impact of the PPACA. Most Americans still do not understand the substance of the law; it is a large, complicated piece of legislation, and the political rhetoric surrounding it is partisan and exaggerated. Moreover, most of the PPACA's provisions do not take effect until 2014, which makes the situation even more confusing. Assuming that the law survives constitutional challenge (which is likely but hardly certain), there is still likely to be significant variation in how the states implement key provisions, such as the insurance exchanges and the Medicaid expansions. The substance of the medical-home model and the impact of the new pay-for-performance initiatives are also quite uncertain.

Regardless of what happens with the PPACA, however, the nation's oral health system is changing in fundamentally important ways. At the heart of this change are 2 scope-of-practice issues. Should the dentist play a larger role in the primary care delivery system, working with primary care physicians, nurse practitioners, and physician assistants? This would seem to make sense, especially because more than 80% of all dentists are generalists, almost a mirror image of the more specialty-oriented physician community; and also because more than 70% of adults see a dentist at least annually. But where does the dentist fit in the emerging primary care system?

Alternatively, should the midlevel dental provider—the dental hygienist, the dental therapist, and the dental assistant—play a larger role in providing basic oral health care? And if so, could midlevel providers significantly improve access to oral care for the poor and for other disadvantaged communities?

The public health of our community depends, in large part, on how we answer these questions. There is no single answer, but the goal needs to be the creation of a more integrated, more interdisciplinary, public health–oriented care delivery system. With or without the PPACA, this is a challenge that the oral health, physical health, and public health communities should work on together. ■

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