Insurer Views on Reimbursement of Preventive Services in the Dental Setting: Results From a Qualitative Study

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Objectives. We explored insurers' perceptions regarding barriers to reimbursement for oral rapid HIV testing and other preventive screenings during dental care.

Methods. We conducted semistructured interviews between April and October 2010 with a targeted sample of 13 dental insurance company executives and consultants, whose firms' cumulative market share exceeded 50% of US employer-based dental insurance markets. Participants represented viewpoints from a significant share of the dental insurance industry.

Results. Some preventive screenings, such as for oral cancer, received widespread insurer support and reimbursement. Others, such as population-based HIV screening, appeared to face many barriers to insurance reimbursement. The principal barriers were minimal employer demand, limited evidence of effectiveness and return on investment specific to dental settings, implementation and organizational constraints, lack of provider training, and perceived lack of patient acceptance.

Conclusions. The dental setting is a promising venue for preventive screenings, and addressing barriers to insurance reimbursement for such services is a key challenge for public health policy. (*Am J Public Health.* 2014;104:881–887. doi:10.2105/AJPH.2013.301825)

Health care providers, the public health community, payers, and health services researchers are increasingly recognizing oral health as a crucial component of the medical home, as well as the potential role of dentists as partners to perform public health screening and to engage patients who may not be receiving regular preventive health services.[1–7] Previous research demonstrated high dental care utilization among key populations such as smokers, individuals at elevated risk for HIV, and individuals at risk for diabetes; many at-risk individuals use dental services even when they do not regularly receive primary medical care services.[8–11] Furthermore, rapid advances have been made in salivary diagnostics for early disease detection and routine health monitoring. Emergence of the oral rapid HIV and hepatitis C tests has prompted calls for more aggressive screening in the dental setting.[12,13] Increased attention is also focusing on the use of clinical periodontal markers and self-reported risk factors to detect undiagnosed diabetes.[5,9,14]

The dental venue has been identified as an untapped resource for the provision of oral rapid HIV screening.[8] The Centers for Disease Control and Prevention's revised 2006 guidelines advocated routine opt-out HIV screening and near-universal screening in diverse settings.[15] The oral health component of the *Healthy People 2020* initiative includes the aim to "increase the proportion of adults who receive preventive interventions in dental offices [OH-14]," specifically, smoking cessation services [OH-14.1], oral cancer screenings [OH-14.2], and tests and referrals for glycemic control [OH-14.3].[16] In a survey of dentists, the majority of respondents endorsed the importance of dental screening for specified systemic conditions, such as cardiovascular disease, hypertension, diabetes, and HIV; almost all respondents highly valued chairside medical screening in dental settings.[4]

Despite this broadening view of dentists' professional role, actual provision of preventive screenings, including cardiovascular and HIV screenings, is low.[17] Low provision of routine tobacco cessation service delivery has also been documented, despite high perceived importance as part of the dentist's professional responsibility.[11] Furthermore, research has shown that dentists are not fully assuming the responsibility of conducting thorough oral cancer screenings, although this screening has been characterized as the single most essential service a dentist can offer and is one of the few dental services that can save a patient's life when routinely performed.[18]

Dentists' reluctance to perform medical screenings in their clinical practice is multifactorial; cited barriers to performing HIV oral rapid screening, oral cancer examinations, and tobacco cessation services are lack of training and expertise, time constraints, scope of practice, confidentiality, low perceived disease prevalence, and low index of suspicion.[4,19–23]

Limited insurance reimbursement is another major barrier to broad implementation of comprehensive public health screening in the dental setting.[24] From a payer perspective, the feasibility and cost-effectiveness of broad dental chairside screenings remain unclear.[8] Insurer perspectives regarding such questions are rarely explored. We investigated attitudes of dental insurers toward expanding routine screening, including oral rapid HIV testing, in the dental setting to promote early diagnosis and treatment of prevalent systemic diseases.

METHODS

Approximately 166 million Americans were covered by some kind of dental benefit in 2009.[25,26] The National Association of Dental Plans (NADP) is the industry's predominant trade association, representing more than 70 dental insurance carriers who provide employer-based dental benefits and public insurance plans. Through the NADP's clinical work group, we identified executives who were knowledgeable about reimbursement policies and firms' decision-making strategies regarding

wellness screening during dental care. These individuals represented plans that provided employer-based coverage and that participated in Medicaid.[27]

We conducted pilot interviews with 2 dental insurance executives and consultants from NADP's clinical work group to develop the study instrument; we did not include these interviews in the final empirical analysis.

Sample

Because of industry concentration and the sensitive nature of requested data, we employed a targeted sampling strategy to reach firms with a large cumulative market share across the industry. This procedure yielded a total sample size of 13 informants. We approached 8 dental insurance executives and consultants who were participants in the NADP clinical work group, and they consented to qualitative interviews. Consultants were members of the NADP work group. They were either employees of health care consulting firms or university-based dentists who also served as industry consultants on public health and wellness issues. These interviewees identified an additional 5 respondents with specific expertise in dental preventive health services.

NADP market data indicated that our analysis sample of insurers provided dental coverage for roughly 90 million people. NADP calculations (derived from proprietary data) indicated that our analysis sample reached a cumulative 54% market share among American dental insurance plans.

Interviews and Analysis

R. T. F.-W. conducted and digitally recorded all 13 semistructured interviews by telephone between April and October 2010. A professional transcription company transcribed the recordings, and R. T. F.-W. then reviewed and de-identified them for analysis. The interviews followed a 31-item questionnaire (the box on this page), which captured information about

Questionnaire for Qualitative Study of Insurer Views on Reimbursement of Preventive Services in the Dental Setting

1. Could you provide an annual report or other material with basic information regarding the number of covered lives in your portfolio of plans?
2. Some have suggested that the dental profession should offer wellness services such as hypertension and diabetes screening that lay outside the traditional realm of dental care. Would you support more aggressive efforts to offer such services in dental settings?
3. Does your plan now reimburse dentists for any of the following: oral cancer screening, hypertension/cholesterol screening, diabetes screening, and any others?
4. Has your plan discussed reimbursing any of these services? If so, which ones?
5. What are the most important potential benefits to your plan of covering such services?
6. What are the most important potential costs or barriers?
7. What information or resources would influence your coverage decisions regarding these services?
8. Some have suggested that dentists and dental hygienists should offer tobacco cessation services as a routine part of the dental visit. What do you think?
9. Has your plan considered providing reimbursement for tobacco cessation assistance in dental settings? If so, which services do you cover?
10. Do you believe that dentists and/or hygienists can be effective in helping patients halt or reduce their tobacco use?
11. Can you think of any benefits to your plan of covering tobacco cessation services?
12. What are the most important barriers or costs to your plan's covering these services?
13. Has your organization explicitly analyzed the costs and benefits or ROI of offering these services?
14. If reimbursed, how enthusiastic do you think dentists would be about offering smoking cessation interventions? What percentage do you think would offer it?
15. Have you ever been asked by purchasers (employers or public payers) to reimburse these services? Do you believe that providing these services would make your plan more attractive to them?
16. Has a state or local public health department ever contacted you and asked you to cover this service? How, if at all, do such contacts influence your decisions?
17. Suppose that smoking cessation services required, on average, 20 minutes of dentists' time for every tested patient. What would you regard as a reasonable reimbursement rate for this service?
18. Some people have suggested that dentists should offer rapid oral HIV testing to all patients as a routine aspect of dental care. Do you agree with this suggestion?
19. Do you believe that dentists and/or hygienists can be effective in performing such testing
20. Does your plan now reimburse HIV testing in the dental setting? If so, under what circumstances?
21. Can you think of any benefits to your plan of covering HIV testing?
22. What are the most important barriers or costs to your plan's covering these services?
23. Has your organization explicitly analyzed the costs and benefits or ROI (return on investment) of offering these services?
24. Have you ever been asked by purchasers (employers or public payers) to reimburse these services? Do you believe that providing HIV testing would make your plan more attractive to these payers?
25. Has a state or local public health department ever asked you to cover this service? How, if at all, do such contacts influence your decisions?
26. Suppose that HIV tests required, on average, 20 minutes of dentists' time for each tested patient. What would you regard as a reasonable reimbursement rate for this service?
27. If reimbursed, how enthusiastic do you think dentists would be about offering HIV testing? What percentage do you think would offer it?
28. Are you aware of clinical or public health practice guidelines that include HIV testing in the dental setting? How, if at all, would such guidelines influence your decisions?
29. What information or resources would lead you to change your reimbursement policies regarding HIV testing?
30. If state or local health departments were willing to provide free testing kits, would this influence your willingness to reimburse dentists for the time required to administer these tests?
31. Do you have any other thoughts about the issue of dentists offering HIV testing in their offices that you would like to add before we finish?

Note. ROI = return on investment.

the level of organizational and financial support of public health and wellness screening in the dental setting. We also asked insurers open-ended questions regarding the role of dental providers in delivering such preventive services, their current reimbursement policies for screening and prevention, and factors that influenced reimbursement policies. Interviews lasted approximately 30 minutes. We offered respondents no monetary compensation for study participation.

We used multilevel, thematic coding to analyze the qualitative data. We manually coded the interview transcripts and examined them through multiple-matrix analyses. First, 2 authors (R. T. F.-W. and H. A. P.) created a list of generalized thematic codes from the main domains of the questionnaire. As additional themes emerged from the data, particularly through the open-ended responses, we included corresponding subcodes in the analysis. Finally, we conducted a systematic review, involving reanalysis of all transcripts to ensure that they were systematically coded for all codes and emerging themes.

RESULTS

Four of the 13 respondents represented traditional large, nationwide dental insurers; 7 represented smaller, statewide firms; and 2 were dental consultants working closely with multiple dental insurance companies. Eight of the represented companies offered traditional fee-for-service, preferred-provider benefits, and 4 offered some type of managed dental benefits (1 firm offered both). Seven firms provided both dental and medical benefits. All but 1 of the dental insurers participated in Medicaid.

All respondents supported incorporation of preventive screening into dental practice as an ideal model for integrated delivery of health care. An executive of a nationwide, fee-for-service and managed care dental insurer said,

> We obviously advocate for an integrated model of delivering care. Not only integrated care delivery but integrated data analysis, integrated programs. So we certainly believe that practitioners should be screening the whole patient. We want to be able to offer integrated patient-centered care. . . . [W]e know this is not quite a reality yet, but that a dentist should be part of the larger health care team. . . . It is not for us. It is for members to be able to identify those at risk and refer them for appropriate follow-up.

Yet insurers were hesitant and skeptical in translating such generalized support into actual reimbursement for specific screenings. A respondent employed by a statewide, managed care dental insurer said, "There is a lot of chatter about the link between oral health and systemic health, and it seems like most of the public chatter has overstated it and used it as a marketing ploy."

Reimbursement and Models for Screening

Respondents described 2 main reimbursement models for preventive screenings (Table 1). The first integrated screening into the comprehensive oral examination (defined by the American Dental Association as "a thorough evaluation and the recording of the extra-oral and intraoral hard and soft tissues"[28[p4]]) or intermittent periodic oral examination (defined as "an evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation"[28[p3]]). The second model used traditional pay-for-service codes for any additional screenings beyond the typical dental examination. A few firms also collaborated with academic researchers and state-based prevention projects to provide such services.

Hypertension and oral cancer screening were the most widely implemented wellness initiatives, viewed by respondents as already within the dental professional's traditional role or directly related to oral health. The majority of respondents said their companies reimbursed for both of these screenings. In regard to hypertension screening, an executive from a statewide, fee-for-service dental insurer stated that "dentists should be doing that already." However, we did not find universal agreement that taking a blood pressure reading was standard practice during dental visits.

Similarly, a respondent from a statewide managed care company also emphasized oral cancer screening as an expected and necessary component of the dentists' professional responsibility: "Whenever we do an exam of a patient, we try to capture their risk for disease in three categories—oral disease: oral cancer, periodontal disease, and dental decay."

Participants reported that many dentists participating in their plans provided smoking cessation services and diabetes screening, reimbursed either as part of the comprehensive periodic oral examination or through special funding programs (e.g., state initiatives or pilot studies). Many respondents were generally supportive of providing smoking cessation services in the dental office; an executive of a nationwide fee-for-service dental insurer commented on the appropriateness of this practice as part of the dentist's professional role:

> [Tobacco cessation counseling] is probably the easiest for dentists to do because we're taught about the effects of tobacco in the oral cavity. I think dentists feel very comfortable with doing that. I think it's another great avenue to help people to quit using tobacco products. So it's just a question of . . . the bottom line.

Although respondents embraced strong public health and professional arguments for providing smoking cessation services in the dental setting, it was less clear that such support readily translated into actual reimbursement, because only a few respondents said their companies provided some type of reimbursable risk assessment and referral service. One reported that although the American Dental Association provides a Current Dental Terminology code for smoking cessation, it was not covered as a reimbursable service.

Diabetes screening had lower levels of support, with minimal financial coverage. As described by a respondent employed by a statewide fee-for-service dental insurer,

> The diabetes testing is just a matter of how comfortable dentists are with the different types of tests they can do in the office, having them trained to do it and getting them to do it. There's a big question about the reimbursement on it because we wouldn't cover that.

Respondents' concerns about tobacco cessation services and diabetes screening encompassed both the comfort of the dental provider and reimbursement costs.

No respondent reported reimbursing for either cholesterol or HIV screening, and these were viewed as low priority. Although respondents offered no encouragement for cholesterol screening, they generally supported the idea of HIV screening, although not its reimbursement. An executive of a statewide fee-for-service company said,

> I think it's a great idea because people go to the dentist regularly. Whether or not a lot of people

TABLE 1—Support for Reimbursement for Prevention Services in the Dental Setting Among Insurers: United States, 2010

Type of Chairside Service	Respondents' Definitions of Screening	Supportive	Not Supportive	Reimbursement as Part of Comprehensive Oral Examination	Reimbursement at Extra Cost for Each Added Service
Hypertension screening	Doing or taking blood pressure (n = 2)	10[a]	3	8	5
	Testing (n = 2)				
	Blood pressure screening (n = 2)				
	Blood pressure/hypertension monitoring (n = 1)				
Oral cancer screening	Brush test (n = 2)	9[b]	4	7	1
	Brush biopsy (n = 5)				
	Risk assessment (n = 1)				
	Risk reduction (n = 1)				
	Oral examination (n = 1)				
	Physical examination (n = 2)				
	Oral cancer protection (n = 1)				
	Head/neck examination (n = 1)				
Smoking cessation services	Counseling (n = 2)	6	7	4	0
	Cessation activity (n = 1)				
	Risk assessment for smoking status (n = 1)				
	Quit smoking (n = 4)				
	Reducing smoking/tobacco use (n = 2)				
	Smoking consultation(n = 1)				
Diabetes screening	Diabetes status (n = 1)	4	9	3	0
	Diabetes testing (n = 4)				
	Diabetes monitoring (n = 1)				
	Testing for glucose level (n = 1)				
	Glucose monitoring (n = 1)				
Cholesterol screening	Diagnostic testing (n = 1)	0	13	0	0
HIV screening	Oral fluid testing (n = 1)	6[c]	7	0	0
	Simple salivary test (n = 1)				
	Saliva testing (n = 5)				
	Saliva diagnostics (n = 2)				

Note. Respondents were dental insurance company executives or consultants (n = 13).
[a]Two from companies that did not reimburse for this service.
[b]Three from companies that did not reimburse for this service.
[c]Support expressed for idea of HIV screening in the dental setting but not for reimbursement.

> would be open to having it [HIV screening] done in a dental office is a totally different question.

Whether they were supportive or not, most respondents reported that our interview was the first in-depth discussion about HIV screening that they had ever had.

Open-ended questions regarding wellness services elicited information about innovative programs and pilots. Three respondents reported participating in academic research initiatives and pilot programs related to public health wellness. Another 3 respondents reported participating in state public health prevention programs. Two discussed specific participation in diabetes prevention pilot programs in conjunction with university researchers. One respondent described the assessment and referral process for smoking cessation that her firm used in collaboration with the state quit line and information clearinghouse. Another discussed how the firm's contract with the state Medicaid program has influenced its reimbursement plans, particularly for tobacco cessation.

Institutional Barriers to Reimbursement

Respondents described how aspects of the current commercial environment of health care were not designed to operationalize efforts to increase diagnostic and preventive health services in the dental setting. Discussion of HIV screening, in particular, underscored the constrained role that respondents viewed dentistry as filling within overall medical care and highlighted many financial, organizational, and professional obstacles to providing such screening.

Financial constraints. Compared with standard medical coverage, dental insurance has a low annual maximum benefit—usually $1000 to $1500 per person per year. Respondents emphasized that any funds spent on preventive

screening would be deducted from a patient's maximum dental benefit and therefore limit the amount available for other services, including expensive procedures such as root canal therapy or crown and bridge prosthesis. A dental insurance consultant said,

> So while the company or the purchaser may want tobacco cessation offered and oral cancer screening offered . . . [i]t comes down to what the plan actually can provide and at what cost. So again it comes down to that bottom line.

Seven of our 13 respondents cited financial barriers, or the bottom line, as the final, deciding factor in providing any service beyond the annual dental benefit.

Dental plans are also subject to market demands and employer preferences. An additional service will be offered when employers highly value it or when it becomes standard industry practice. Employer requests for preventive screenings, even for costly smoking cessation services, are thus frequently honored. A respondent from a statewide managed care company told us,

> So it gives us a market advantage, being a large group, that we can implement those sorts of things much easier than in a competitor who might have a network of fee-per-service dentists, private-practice dentists.

However, as explained by an executive of a nationwide fee-for-service dental insurer, provision of preventive screenings that employers do not value will raise costs while bringing little competitive advantage. These are unlikely to be covered, despite arguable medical or public health benefits.

Organizational constraints. Respondents described other barriers to the provision of screening and to the proper integration of dental services with other medical care. Even insurance companies that provide both medical and dental coverage under 1 commercial umbrella typically segregate medical and dental reimbursement systems, staff, procedures, medical records, and reimbursement codes. Six respondents expressed concerned about how to handle test results and how a referral would be made back to a primary care provider if a patient were screened and received a positive test result. A respondent employed by a statewide managed care company said,

> [D]ental offices, dentists, dental plans are separate from medical, so the coordination and the integration is difficult. The communication of results back to the primary care physician is not very smooth.

Six respondents also detailed specific concerns about information flow between medical and dental providers and insurers—both the communication of medical information for the coordination of care and the possible integration of billing systems (such as Current Dental Terminology codes) that might allow a medical insurer to cover billable services in a dental setting. An executive from a nationwide fee-for-service company explained this dilemma:

> They're sort of in a dividing line between, well, what's covered under your medical benefit and what's covered under your dental benefit. . . . I would say that a lot of these screening things—hypertension and diabetes and whatever, even HIV—if they've been on the medical side, it's unlikely that a payer or a purchaser is going to say, "Well, I want it on both sides," right? I don't want to pay for it twice. . . . It could potentially be a turf war.

Provider and Patient Barriers

Most respondents supported prevention and early detection efforts, particularly when such efforts had an obvious link with disease of the oral cavity, such as oral cancer screenings and smoking cessation services. Yet, 3 insurance company respondents noted specific discomforts with the more delicate concept of HIV screening, especially regarding social stigma and the complex treatment referral process.

An executive of a statewide fee-for-service insurer said, "It's an amazing concept and I think it should be done actually from a personal point of view. . . . I think there's still such a stigma about what it is." An insurance consultant was skeptical:

> Early detection is key in treatment, in cost savings on the medical side, preventing a patient from having a poor outcome and possibly dying. I mean early intervention is where it is at. But . . . suppose that the HIV test required on average 20 minutes. I mean maybe for all of the negatives, but what about the positives? There is no way it is going to be a 20 minute—I just can't envision that.

Indeed, 7 respondents expressed concern about dentists obtaining appropriate training and practice guidelines to confidently provide health screening and to appropriately convey a positive test result with proper treatment referral. A respondent who worked for a statewide managed care insurer said,

> I don't think the public nor purchasers of benefits are ready for that without more of a public education campaign as to the value of having it done in all primary care settings to include dental settings. . . . I think they could be, but I don't think they're ready for it yet.

Patient acceptance posed yet another perceived potential barrier to the successful implementation of preventive screening. Because HIV screening is not traditionally identified with the dentist's professional role, insurers expressed concerns regarding patients' reactions to the offer of such screening services. Perhaps if patients received more education about the benefits of screening, they would be more likely to accept it in the dental setting and would be more confident that their dentist could help them with any possible result. These concerns were illustrated by an executive of a statewide fee-for-service dental insurer:

> I think that if the patient would accept it [HIV screening], if they would—if we could reassure them that there won't be any false positives—we don't want to upset the patient. Routinely, I just don't know—routinely, that is how you get into the habit of doing it, but I am not sure that you would do it for every patient. . . . I would have to have total acceptance.

An executive with a nationwide fee-for-service company described another aspect of patient acceptance:

> Patients might wonder where dentistry fits into all of this. . . . If the concept of dentists started to get more involved and screening in general starts to become more of an accepted norm and dentists are more frequently doing some of these other less "controversial" types of tests such as BMI [body mass index], high blood pressure, diabetes, then making the leap to HIV might be a little bit easier. I think it is a little early yet.

Another identified barrier was the lack of definitive evidence for the efficacy and cost-effectiveness of particular forms of screening in the dental setting, expressed by a respondent from a statewide managed care insurer: "We're trying to build that body of evidence that provides that analytical value. We have a lot of process measures, but we need outcome measures. And that's the challenge."

DISCUSSION

We conducted one of the few public health studies to specifically interview dental insurers on chairside preventive screening. As found

in other dental populations and settings, officials who operate dental health plans recognize and value the potential public health benefits of screening efforts in the dental setting.[2,4,29] Yet our interviews underscored many barriers to the delivery and financing of such screenings in the existing commercial environment.

Some barriers could be addressed through targeted comparative-effectiveness research. Respondents noted the dearth of specific data to support the cost-effectiveness of medical preventive screening in dental settings. Randomized controlled trials could play an important role in addressing such questions by, for example, calculating the number of undetected cases of HIV that could be identified in pertinent patient populations. Respondents emphasized that return on investment strongly influences firms' decisions about financing additional services beyond the typical dental visit. Cost-effectiveness and feasibility data will be particularly important in persuading companies to make early detection and preventive services reimbursable for entire dental patient populations.

Market demand—particularly as expressed in employer preferences—also plays a critical role. Employer interest likely accelerates the proliferation of some services, such as smoking cessation. Other services of clear medical or public health import attract more limited employer interest and are thus less likely to be reimbursed.

Dentists' preferences and practice norms also play an important role. Even if preventive screenings are proven feasible and cost-effective, dentists' willingness to offer such services also influences firms' coverage policies. In some cases, this poses a chicken-and-egg set of obstacles: insurers cite dentists' unwillingness to provide a certain service, and dentists point to uncertain reimbursement as a significant factor in their unwillingness to offer such services.[4,22,30] Until key insurance stakeholders and public policies change, it is difficult to gauge dentists' true willingness to conduct medical chairside screenings. Meanwhile, firms may be less likely to push for change until dentists' preferences or employer demand motivates them to do so. Because such screenings remain outside the experience of routine dental care, patients themselves may respond ambivalently to dentists' offers to provide such screening.

The Affordable Care Act may provide a useful model to address such difficulties. It requires public and private payers to provide first-dollar coverage of clinical preventive services granted an A or B rating from the US Preventive Services Task Force.[31] Some services currently provided an A or B rating could be provided in the dental setting. Especially prominent examples include screening for HIV infection in all adolescents and adults aged 15 to 65 years, screening for type 2 diabetes in asymptomatic adults with sustained hypertension, and tobacco cessation counseling and interventions for adults who use tobacco products.

Provision of such medical screenings during dental care has not been the subject of specific policy discussion. Policies focused on the dental setting would be beneficial in bringing these recommended widespread screenings to fruition, in light of the many individuals, including those at high risk for these chronic illnesses, who secure dental treatment but not preventive medical care.[7,8]

Perhaps the most serious obstacle remains the segregation of financing and records of oral health from other health services. Even when a single firm provides both medical and dental insurance, these 2 forms of coverage and health records are typically operated separately, in accordance with existing business and system practice models for the respective programs, resulting in lost opportunities for identifying cases.

One emerging concept being promoted by the National Network for Oral Health Access and the National Association of Community Health Centers is the electronic health record option that integrates medical and dental records and systems, known as the Electronic Medical/Dental Record.[32] This computerized record of patients' health information will be contained in a single health care organization, such as a community health center, and is being implemented to provide more efficient provision of integrated health care services and communication, maintain 1 central billing and collections system, and improve overall management of health plans. Medicaid programs offering integrated adult dental benefits may provide another opportunity to bridge this gap by providing medical plan reimbursement for services conducted in the dental setting.

Our respondents expressed particular concerns about HIV screening during dental care. Insurers might be influenced by evaluations of pilot programs that provide formal training to dentists on performing HIV screening, delivering results, and referring patients for any needed follow-up care within integrated, medical–dental systems such as those emerging in federally qualified health centers. Moreover, such pilot programs enable the development and proliferation of formalized practice guidelines that could influence both providers and dental insurance plans, in part to shift practice norms toward embracing population screening.

More specific data regarding provider and patient acceptance of particular screening tests are essential. Dental plan executives expressed particular concerns about providers' willingness and self-efficacy in performing rapid HIV testing. Existing data suggest that such perceptions may be unduly pessimistic. One study found that a majority of patients were willing to have a dentist conduct a screening for heart disease, high blood pressure, diabetes, hepatitis, and HIV.[33] As one of our respondents emphasized, "total [patient] acceptance" is vital for broad implementation of such services. Securing such total acceptance requires health education campaigns that do more than underscore the value of HIV screening. These campaigns should also articulate the specific value of HIV screening in the dental setting, to prepare both patients and providers for this practice to promote overall health.

Limitations

We employed a nonrandom, targeted convenience sampling strategy for our respondent population. Although our sample achieved a cumulative market share of 54%, it might still have been limited in breadth, and the views, attitudes, and policies described might have been specific to the large plans in the NADP. Future studies surveying randomized samples may provide more generalizable policies and practices from this industry.

We found that respondents' definitions and understanding of each preventive screening discussed varied unexpectedly. For example, 5 respondents understood the term "oral cancer screening" to mean a brush biopsy, 1 to mean a risk assessment for oral cancer, and another to mean a head and neck examination.

In future studies, more consideration should be given to standardizing the operational definitions of these screenings.

Further clarification should also be given when eliciting professional versus personal views of such screening services. Most respondents spoke in accordance with their professional opinion or on behalf of their company, but 2 respondents responded more personally. One respondent stated that he was advised by senior direction to speak about his own personal perspective and not as a representative of his company. Going forward, it would be advantageous to specifically ask respondents about the perspectives of their responses to determine whether their responses represent their own individual perspectives or those of policymakers in their company or industry.

Conclusions

The modest expenditures typically associated with dental coverage pose real constraints on the use of this care setting to achieve broader clinical or public health goals. Our data help us to understand why medical screening efforts, especially those directed at HIV prevention, often stop at the dental insurer's doorstep. Furthermore, they suggest ways policymakers might collaborate with insurers to implement well-designed, evidence-based public health screening in dental settings. ■

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Contributors

R. T. Feinstein-Winitzer conducted the interviews and analyzed the data. H. A. Pollack conceptualized the study methods and analyzed the data. M. R. Pereyra assisted with the analyses and interpretation of findings. L. R. Metsch was the study's co-originator and lead investigator and oversaw its implementation. R. T. Feinstein-Winitzer, H. A. Pollack, C. L. Parish, and S. N. Abel wrote the article. All authors edited the article and approved the final version.

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Human Participant Protection

The University of Chicago, Columbia University, and the University of Miami institutional review boards approved the study protocol.

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