REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

Improving Access to Dental Care Study

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 44

COMMONWEALTH OF VIRGINIA
RICHMOND
2001

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Preface

House Joint Resolution (HJR) 198 of the 2000 Session of the General Assembly, as introduced, directed the Joint Commission on Health Care to continue its study of ways to increase access to dental care throughout the Commonwealth. In addition, House Joint Resolution 296, as introduced, requested the Department of Medical Assistance Services (DMAS) to study the feasibility of expanding coverage for dental care, including dentures, to Medicaid recipients.

Neither HJR 198 nor HJR 296 were adopted by the General Assembly. However, both resolutions were communicated to the Joint Commission via letter from the Speaker of the House of Delegates. The Speaker's letter states that:

> "The House Rules Committee believes that the issues addressed by the resolutions merit review. Therefore, the Commission is directed to undertake the study and to submit a written report of its findings and any recommendations to the Governor and the 2001 Session of the General Assembly."

Specifically, the HJR 198 study is to include, but not be limited to, an analysis of:

(i) various ways to increase the number of persons with dental insurance;
(ii) the number of dentists participating in the Medicaid program, the results of recent actions taken to increase the number of participating dentists, and other actions that could be taken to increase further the number of participating dentists;
(iii) potential safety concerns regarding the use of dental amalgam; and
(iv) barriers to access to care and other appropriate issues identified by the Joint Commission on Health Care.

The specific provisions of HJR 296 call for a study of the feasibility of expanding coverage for dental care, including dentures, to Medicaid recipients. The study is to examine eligibility, coverage, and reimbursement policies, and determine appropriate guidelines for providing such services. A copy of the Speaker's letter, HJR 198 and HJR 296 is attached at Appendix A.

Based on our research and analysis during this review, we concluded the following:

- The U.S. Surgeon General released a report on oral health in America and found racial and ethnic minorities experience a disproportionately high level of oral health problems. Oral health problems also are more prevalent in underserved areas. The report also identified clear associations between chronic oral infections and other health problems.

- While the overall ratio of dentists to population in Virginia is adequate, there are 43 underserved areas in the Commonwealth. Approximately 145 dentists are needed to eliminate these underserved areas. Significant progress has been made by the Virginia Department of Health in designating these localities as dental health professional shortage areas (HPSAs). Dental HPSA designations are important because dentists who work in these areas qualify for federal loan repayment assistance which is a significant financial incentive.

- Very few dentists participate in Virginia's scholarship and loan repayment program due to the very limited amount of funding ($25,000) available through the program.

- While the number of dentists participating in Medicaid has increased in recent years (808 in 1997 – 949 in 2000), there still are too few dentists to serve children eligible for services. Reimbursement has been identified as a key reason for limited participation. The 1998 Appropriations Act directed DMAS to increase reimbursement to 85% of UCR; however, current reimbursement is about 65% of UCR.

- There are far more Virginians without dental insurance (41%) than medical insurance (13%). The most recent data on Virginians is 4 years old; more current data on the insurance status of Virginians are needed.

- The number of persons with dental coverage is increasing as more employers offer dental benefits to attract workers. Several alternative dental benefit plans are emerging that are increasing the number of persons with at least some level of dental benefits.

- Currently, 27 states offer dental benefits to Medicaid adults. Virginia does not provide dental benefits to Medicaid adults. The cost to do so would be approximately $8.2 million GF (includes coverage for general dental benefits and dentures).

- Dental amalgam is the most frequently used material to restore decayed teeth. Amalgam contains a small amount of elemental mercury which is a toxic substance. There has been a continuing controversy over whether the level of mercury in amalgam causes health problems. While some research has concluded that persons with amalgam were less healthy than those with no amalgam, several U.S. government studies have concluded it is inappropriate to restrict the use of amalgam. Several anti-amalgam groups continue to argue for restricting or prohibiting the use of dental amalgam. The American Dental Association (ADA) and the Virginia Dental Association (VDA) believe amalgam is safe.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on page 49. Public comments were requested on a draft of this report. A summary of the public comments is attached at Appendix B.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Virginia Department of Health, the Department of Medical Assistance Services, the Virginia Health Care Foundation, the Virginia Dental Association, the Virginia Dental Hygienists Association, Delta Dental Plan of Virginia, and the Old Dominion Dental Society for providing input and information during this study.

Patrick W. Finnerty
Executive Director

December, 2000

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Authority for Study/Organization of Report

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Neither HJR 198 nor HJR 296 were adopted by the General Assembly. However, both resolutions were communicated to the Joint Commission via letter from the Speaker of the House of Delegates. The Speaker's letter, which is attached at Appendix A, states that:

> "The House Rules Committee believes that the issues addressed by the resolutions merit review. Therefore, the Commission is directed to undertake the study and to submit a written report of its findings and any recommendations to the Governor and the 2001 Session of the General Assembly."

The provisions included within HJR 198 direct the Joint Commission to conduct its study in cooperation with the Virginia Department of Health, the Department of Medical Assistance Services, the Virginia Dental Association, the Virginia Dental Hygienists' Association, the Virginia Commonwealth University School of Dentistry, the Virginia Board of Dentistry, the Virginia Association of Free Clinics and the Virginia Health Care Foundation. Specifically, the HJR 198 study is to include, but not be limited to, an analysis of:

(i) various ways to increase the number of persons with dental insurance;
(ii) the number of dentists participating in the Medicaid program, the results of recent actions taken to increase the number of participating dentists, and other actions that could be taken to increase further the number of participating dentists;
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This Report Is Presented In Seven Major Sections

This first section discusses the authority for the study and organization of the report. Section II provides background information on the dental study conducted last year by the Joint Commission, and discusses related dental studies being conducted by other state agencies. Section III summarizes the key findings and recommendations included in the Surgeon General's report on "Oral Health in America," and how these recommendations relate to improving access to dental care in Virginia. Section IV updates information regarding the need to increase the number of dentists practicing in Virginia's underserved areas and participating in the Medicaid program. Section V addresses the issue of increasing the number of persons with dental insurance, and other actions to improve access to dental care. Section VI analyzes the safety of dental amalgam. Lastly, Section VII presents a series of policy options the Joint Commission may wish to consider in improving access to dental care throughout the Commonwealth.

II.
Background

In 1999, The Joint Commission On Health Care Conducted A Comprehensive Study On Improving Access To Dental Care

Last year, in response to HJR 644 of the 1999 Session of the General Assembly, the Joint Commission on Health Care conducted a comprehensive study of actions that could be taken to improve access to dental care throughout the Commonwealth. The specific issues addressed by the Joint Commission in 1999 included the following:

(i) the need for practitioner data for dental workforce planning purposes;
(ii) the financial, structural and other barriers to accessing dental care throughout the Commonwealth;
(iii) dental practitioner shortage areas and ways to increase the number of dentists practicing in these shortage areas;
(iv) the number of dentists participating in the Medicaid program and actions that would increase the number of participating dentists;
(v) the current dental scholarship program, and potential revisions to the program that may increase the number of dentists establishing practices in underserved areas;
(vi) the actions taken in other states to increase access to dental care and to increase the number of dentists participating in Medicaid and practicing in underserved areas; and
(vii) other appropriate issues which will increase access to dental care.

The 1999 Dental Study Identified Potential Actions To Improve Access To Dental Care; A Number Of Legislative Proposals Were Recommended By The Joint Commission On Health Care Of Which Several Were Approved By The 2000 Session Of The General Assembly

Last year's dental study was published as 2000 House Document #86. This report identified 14 potential actions (Policy Options) that could be recommended by the Joint Commission on Health Care to improve access to dental care. From among these potential actions, the Joint Commission introduced a number of legislative proposals to the 2000 Session of the General Assembly, of which several were approved. One of the most significant results of the study was the establishment of a dentist loan repayment program which will provide tuition loan repayment to dentists who agree to practice for a period of time in one of Virginia's underserved areas. Figure 1 identifies the 14 policy

options from the 1999 dental study and the actions taken by the Joint Commission and the 2000 Session of the General Assembly.

The 2000 Dental Study Includes Further Analysis Of Some Issues Contained In Last Year's Report, And Addresses Some Additional Issues; Other Dental-Related Studies Also Are Being Conducted As A Follow-Up To The 1999 JCHC Study

As illustrated in Figure 1, last year's study addressed a wide range of issues related to improving access to dental care throughout the Commonwealth. This follow-up report provides further analysis of certain key issues such as increasing the number of dentists practicing in underserved areas, and monitoring efforts to increase the number of dentists participating in the Medicaid program. While last year's report included an analysis of the costs of providing dental benefits to Medicaid adults, the provisions of HJR 296 of the 2000 Session of the General Assembly call for a review of this issue. The resolution also specifically requests the study to include an analysis of the cost to provide coverage for dentures as part of the dental benefits. This analysis is presented in Section V.

Last year's study did not address directly ways of increasing the number of persons with dental insurance; this report examines this issue in detail. The final major issue addressed in this year's report focuses on the safety of dental amalgam which is used in treating dental caries (tooth decay). There has been a continuing debate regarding whether the mercury content in dental amalgam poses any health or safety risks for patients and providers. Section VI of this report reviews this issue in detail.

Other Related Dental Studies: In addition to the issues addressed in this report, there are several other studies being conducted as a follow-up to various findings raised in last year's report. Figure 2 summarizes the issues being studied, the agency conducting the study, and the reporting timeframe. As indicated in Figure 2, three of these studies will be presented to the Joint Commission on Health Care at its October 24th meeting. The findings and recommendations from these other studies will be reviewed along with the policy options included in this report when the Joint Commission makes its decisions on which legislative actions to recommend to the 2001 Session of the General Assembly.

Figure 1
Actions Taken By The Joint Commission on Health Care And 2000 General Assembly On Policy Options Included in 1999 Dental Study

Policy Option	JCHC Action	General Assembly Action
Legislation directing Department of Health to designate dental shortage areas	Recommended legislation *(HB 1076/SB 489)*	Approved both bills
Budget amendment to increase the number and amount of dental scholarships	Recommended budget language to increase funding from $25,000 to $200,000, and allow funding to also be used for loan repayment	Approved language; additional funding was not approved
Legislation to revise dental scholarship provision requiring recipient to treat all patients regardless of ability to pay	Not Recommended	N/A
Budget amendment to fund dental hygiene scholarships	Not Recommended	N/A
Legislation to establish dentist loan repayment program	Recommended legislation *(HB 1075/SB 576)*	Approved both bills
Budget amendment to increase salary of public health dentists	Not Recommended	N/A
Budget language directing VDH to review expenditure of dental appropriation and use of dental trailers	Recommended budget language	Approved language *(Item 308D, 2000 Appropriation Act)*
Resolution requesting VDH to study feasibility of establishing public dental health programs in communities without such services	Recommended resolution *(HJR 227)*	Passed by with letter
Resolution requesting VCU/MCV to develop plan for dental student externships	Recommended resolution *(HJR 172)*	Passed by with letter
Legislation to authorize less restrictive supervision of dental hygienists	Not Recommended	N/A
Legislation to authorize licensure by endorsement for dentists	Not Recommended	N/A
Budget amendment to extend dental benefits to Medicaid adults	Recommended Budget Amendment	Not Approved
Resolution to continue dental study	Recommended *(HJR 198)*	Passed by with letter

Source: Joint Commission on Health Care Staff Analysis

Figure 2

Other Dental Studies Being Conducted In 2000

Authority for Study	Focus of Study	Reporting Timeframe
HJR 172	VCU/MCV is requested to prepare and submit a plan for establishing an externship program for dental students to gain experience in practicing in an underserved area	September 15, 2000 (JCHC October 24th meeting)
HJR 227	VDH is requested to examine the feasibility of establishing a public dental health program in those communities without access to public dental health services*	September 30, 2000 (JCHC October 24th meeting)
Item 308D, 2000 Appropriation Act	VDH is directed to identify and explain differences in the amounts appropriated, available and spent on dental health services through cooperative budgets of local health departments. VDH also is directed to study the condition and utilization of the dental trailers and make recommendations regarding their use.	September 15, 2000 (JCHC October 24th meeting)
Item 319L, 2000 Appropriation Act	DMAS is directed to work with dental providers; expand availability and delivery of dental services to pediatric recipients; streamline administrative processes; and remove impediments to efficient delivery of dental services.	Report to money committees on December 15 of each year

* The State Health Commissioner has indicated that while there are currently no resources available to commit to this study, the agency will try to perform as many requirements of the study that are within the scope of its resources.

Source: JCHC Staff Analysis

III.
U.S. Surgeon General's Report On "Oral Health In America"

The 2000 U.S. Surgeon General's Report On "Oral Health In America" Identifies A "Silent Epidemic" Of Dental And Oral Diseases

The first-ever U.S. Surgeon General's report on oral health was released on June 9th. In the report, Surgeon General David Satcher, M.D., Ph.D., identifies a "silent epidemic" of dental and oral diseases that burdens some population groups, and calls for a national effort to improve oral health among all Americans. Despite major advancements in oral health during the past 50 years, Satcher stated that " . . . this report illustrates that profound disparities affect those without the knowledge or resources to achieve good oral care. Those who suffer the worst oral health include poor Americans, especially children and the elderly. Members of racial and ethnic groups also experience a disproportionate level of oral health problems. And, those with disabilities and complex health conditions are at greater risk for diseases that, in turn, further complicate their health."

The Surgeon General's Report Has Four Major Themes

Oral Health Means Much More Than Healthy Teeth: The first theme of the report is that *"oral health means much more than healthy teeth."* It means being free of chronic oral-facial pain conditions, oral and pharyngeal (throat) cancers, oral soft tissue lesions, birth defects such as cleft lip and palate, scores of other diseases, and disorders that affect the oral, dental, and craniofacial tissues. In essence, the report stresses that the traditional view of oral health (i.e., no cavities and or tooth loss) is far too narrow. Instead, other craniofacial tissues provide a useful means of understanding other organs and systems in less accessible parts of the body. Moreover, a thorough oral examination can detect not only tooth decay but also signs of nutritional deficiencies, systemic diseases, immune disorders, injuries, and some cancers.

Oral Health Is Integral To General Health: The second major theme of the report is that *"oral health is integral to general health."* As noted in last year's JCHC dental study, there is a growing body of research that clearly demonstrates persons cannot have good general health without good oral health. Dr. Satcher indicates in the report that oral health and general health should not be interpreted as separate entities, and that oral health must be included in the provision of health care and the design of community programs. Research has

shown clear associations between chronic oral infections and other health problems including diabetes, heart disease, and adverse pregnancy outcomes. For example, there is accumulating evidence that identifies periodontal disease as significantly increasing the risk for heart disease and as a risk factor for cardiovascular disease. All other things being equal, people with periodontal disease are one and a half to two times as likely to suffer a fatal heart attack and nearly three times as likely to suffer a stroke. The association with heart disease is especially strong in people under 50.

Studies also have indicated that chronic oral infections can foster the development of clogged arteries and blood clots. Substances produced by oral bacteria that enter the bloodstream can precipitate reactions that result in a build-up of arterial deposits. Several common oral bacteria can initiate the formation of blood clots and disrupt cardiac function. Scientists have known for some time that diabetes predisposes people to bacterial infections, including infections of oral tissues. However, recently, studies strongly indicate that periodontitis can make diabetes worse. Diabetic patients with severe periodontitis have greater difficulty maintaining normal blood sugar levels. Conversely, treatment of periodontitis often results in a reduced need for insulin. Medical and dental professionals urge that periodontal inflammation be treated and eliminated in all people with diabetes.

Finally, evidence that periodontal disease may be associated with premature births is just developing. Infections of the pelvic organs long have been known to be associated with premature labor. However, recent studies suggest that oral infections also can induce premature labor. While there has not been a substantial amount of research in this area, one small study found that mothers of prematurely born small babies are seven times more likely to have advanced periodontal disease.

Safe and Effective Disease Prevention Measures Exist That Everyone Can Adopt To Improve Oral Health And Prevent Disease: The third major theme of the Surgeon General's report is that continued emphasis on preventive measures is needed and that everyone should adopt these practices to prevent oral disease and disability. These measures include daily oral hygiene procedures and other lifestyle behaviors, community programs such as water fluoridation and tobacco cessation programs, and provider-based interventions such as the placement of dental sealants and examinations for common oral and pharyngeal cancers.

General Health Risk Factors, Such As Tobacco Use And Poor Dietary Practices, Also Affect Oral And Craniofacial Health: The fourth and final major theme of the report is that more needs to be done to ensure that messages of

health promotion and disease prevention are brought home to all Americans. Specifically, the Surgeon General addresses the health risks associated with tobacco use and poor dietary habits that affect many aspects of our health, including our oral health. The report calls for all of the health professions to play a role in reducing the burden of disease by calling attention to these and other risk factors and suggesting appropriate actions.

The Surgeon General's Report Includes Numerous Findings That Have Particular Relevance To Improving Access To Dental Care In The Commonwealth

There are numerous findings included in the Surgeon General's report regarding various aspects of oral health in America. While each of these findings is important, there are a number of findings which have particular relevance to the issues that were addressed in last year's JCHC dental report as well as this report and the other dental-related studies being conducted this year (see Figure 2). Figure 3 identifies some of the more important findings of the Surgeon General's report as they relate to improving access to dental care in Virginia.

The Surgeon General Calls For The Development Of A "National Oral Health Plan" To Improve Quality Of Life And Eliminate Health Disparities

In response to the findings regarding oral health in America, the Surgeon General proposes the development of a "National Oral Health Plan" to improve quality of life and eliminate health disparities. The plan consists of five principal components as outlined below.

Change Perceptions Regarding Oral Health And Disease So That Oral Health Becomes An Accepted Component Of General Health: In this component, the Surgeon General emphasizes that everyone including the general public, policymakers, and health providers must change their perception that oral health is less important than general health. The public needs to understand that avoiding or delaying needed oral health care services can exacerbate their general health. Greater education of the general public is needed to enhance their knowledge of how oral health and the mouth relate to the rest of the body. Policymakers at all levels need to ensure the inclusion of oral health services in health promotion and disease prevention programs, and care delivery programs. More time should be devoted to oral health and disease topics in the education of non-dental health professionals. All health care providers can and should contribute to enhancing oral health (e.g., including oral examination as part of a general medical examination).

Figure 3

Key Findings Of The Surgeon General's Report As They Relate To Improving Access To Dental Care In Virginia

(iv) *Despite improvements in oral health status, profound disparities remain in some population groups as classified by sex, income, age, and race/ethnicity. For some diseases and conditions, the magnitude of the differences in oral health status among population groups is striking.*

(v) *Many systemic diseases and conditions have oral manifestations.*

(vi) *Oral health is related to well-being and quality of life as measured along functional, psychosocial, and economic dimensions.*

(vii) *Community-based preventive programs are unavailable to substantial portions of the underserved population.*

(viii) *The public health infrastructure for oral health is insufficient to address the needs of disadvantaged groups, and the integration of oral and general health programs is lacking.*

(ix) *Expansion of community-based disease prevention and lowering of barriers to personal oral health care are needed to meet the needs of the population.*

(x) *Insurance coverage for dental care is increasing but still lags behind medical insurance.*

(xi) *The availability of insurance increases access to dental care.*

(xii) *Eligibility for Medicaid does not ensure enrollment, and enrollment does not ensure that individuals obtain needed care. Barriers include patient and caregiver understanding of the value and importance of oral health to general health, low reimbursement rates, and administrative burdens for both patient and provider.*

(xiii) *The dentist-to-population ratio is declining, creating concern as to the capability of the dental workforce to meet the emerging demands of society and provide required services efficiently.*

(xiv) *Educational debt has increased, affecting both career choices and practice location.*

(xv) *An estimated 25 million individuals reside in areas lacking adequate dental care services, as defined by Health Professional Shortage Area (HPSA) criteria.*

Source: U.S. Surgeon General's Report on "Oral Health in America," Executive Summary, National Institute of Dental & Craniofacial Research, May 25, 2000

Accelerate The Building Of The Science And Evidence Base And Apply Science Effectively To Improve Oral Health: Continued investment in research is critical for the provision of new knowledge about oral and general health and disease for years to come and needs to be accelerated if further improvements are to be made. Here, the Surgeon General states that the challenge is to understand complex diseases and translate research findings into health care practice and healthy lifestyle. There is an overall need for behavioral and clinical research, clinical trials, health services research, community-based demonstration research, development of risk assessment procedures for individuals and

communities, and diagnostic markers to determine whether an individual is more or less susceptible to a given disease.

Build An Effective Health Infrastructure That Meets The Oral Health Needs Of All Americans And Integrates Oral Health Effectively Into Overall Health: The plan calls for an enhanced public health infrastructure that would facilitate the development of strengthened partnerships with private practitioners, other public programs, and voluntary groups. Such an effort also would help address recent reductions in staffing of state dental programs and curtailed oral health promotion and disease prevention efforts. Efforts also are needed to recruit more minority groups to positions in health education, research and practice to not only enrich the talent pool but also create a more equitable geographic distribution of care providers. (The intent of HJR 227, as introduced by the JCHC, was to request the VDH to look into ways of expanding public health dental services as a means of strengthening the public health infrastructure.)

Remove Known Barriers Between People And Oral Health Care: A fourth principal component of the plan is to address known barriers to care such as increasing the number of persons with dental insurance, and providing appropriate levels of reimbursement for providers who participate in Medicaid.

Use Public-Private Partnerships To Improve The Oral Health Of Those Who Still Suffer Disproportionately From Oral Diseases: The final component of the Surgeon General's "National Oral Health Plan" calls for the collective and complementary talents of public health agencies, private industry, social services organizations, educators, health care providers, researchers, the media, community leaders, consumers, and others to be focused on eliminating health disparities. Increased public-private partnerships are needed to educate the public, educate health professionals, conduct research, and provide health care services and programs. In short, a cooperative approach among all is needed to achieve the objective of eliminating oral health disparities.

IV.
Increasing The Number of Dental Providers Practicing In Underserved Areas And Participating In Medicaid

Last Year's Report Reviewed The Training, Licensure And Regulation of Dentists and Dental Hygienists As Well As Programs For Recruiting Dentists To Underserved Areas; This Year's Report Provides Additional Information On The Need To Increase The Number Of Dentists Practicing In Underserved Areas And The Number Of Dentists Participating In The State's Medicaid Program

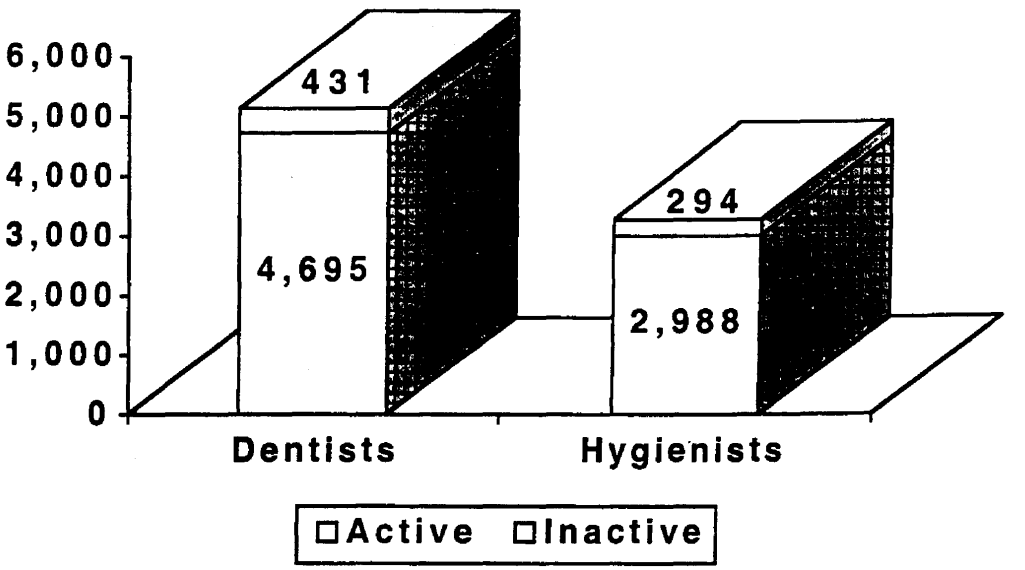
Dental care is provided by dentists and dental hygienists who are licensed according to the *Code of Virginia*. Dental assistants provide important services in the dental office; however, the level of clinical services is limited. Last year's report presented information on the licensure, regulation, and training of dentists and dental hygienists, as well as the ratio of providers to population both on a statewide and locality by locality basis. The focus of this year's report is specifically on actions that could be taken to increase the number of dentists practicing in underserved areas and participating in Medicaid.

There Are Approximately 4,700 Dentists And About 3,000 Dental Hygienists With "Active" Licenses In Virginia

To practice in Virginia, dentists and dental hygienists must hold a current, valid, "active" license. The Board of Dentistry also provides "inactive" licenses to dentists and hygienists who have been fully licensed in the Commonwealth but do not wish to practice in Virginia.

According to statistics maintained by the Board of Dentistry, as of June, 2000, there are 4,695 "active" licensed dentists and 2,988 "active" licensed dental hygienists in Virginia. In addition, there are 431 dentists and 294 dental hygienists with "inactive" licenses. Figure 4 illustrates the number of dentists and dental hygienists who hold active and inactive licenses.

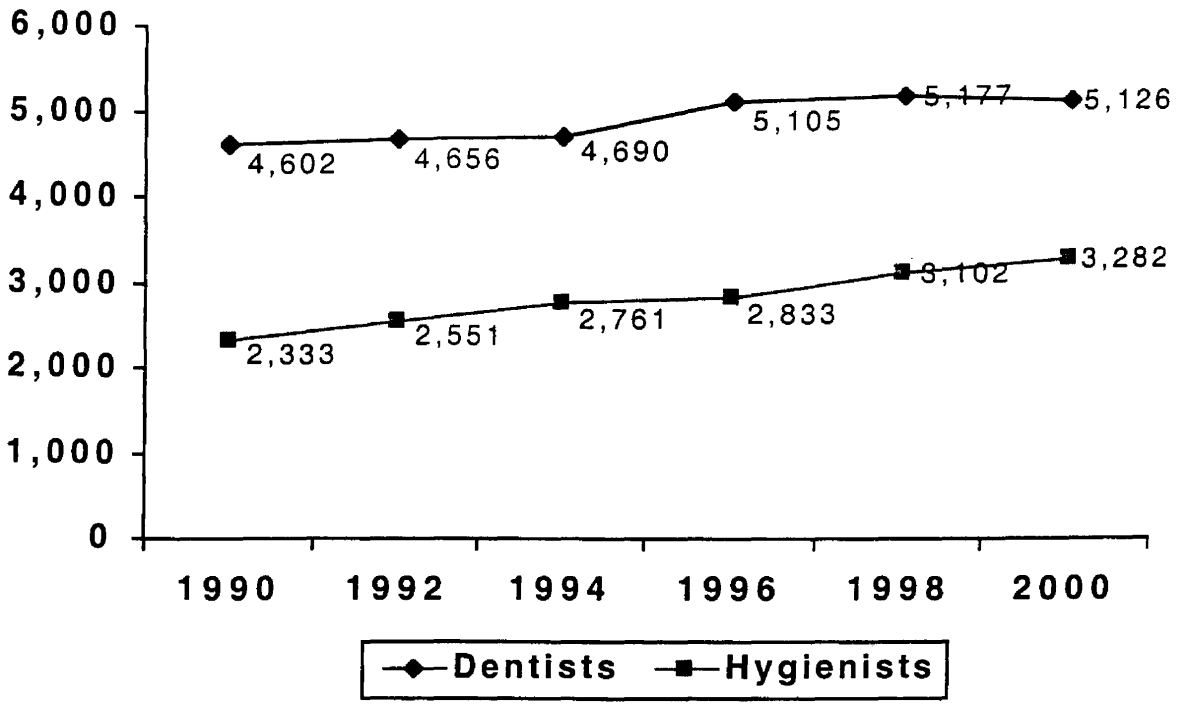
Figure 4
Number of Dentists and Dental Hygienists With "Active" And "Inactive" Licenses In Virginia (June, 2000)



Source: Virginia Board of Dentistry

The number of licensed dentists and dental hygienists in Virginia has increased over the past several years. Statistics maintained by the Board of Dentistry do not track active and inactive licensees as illustrated in Figure 4. Historical data reflect total licensees, which include those who are licensed but not practicing in Virginia. As seen in Figure 5, the total number of licensed dentists increased from 4,602 in1990 to 5,177 in 1998 (a 12.5% increase), but then dipped slightly to 5,126 in 2000. The total number of licensed dental hygienists increased from 2,333 in 1990 to 3,282 in 2000, (a 41% increase).

Figure 5
Total Number of Dentists and Dental Hygienists Licensed in Virginia (1990 – 2000)



Source: Virginia Board of Dentistry

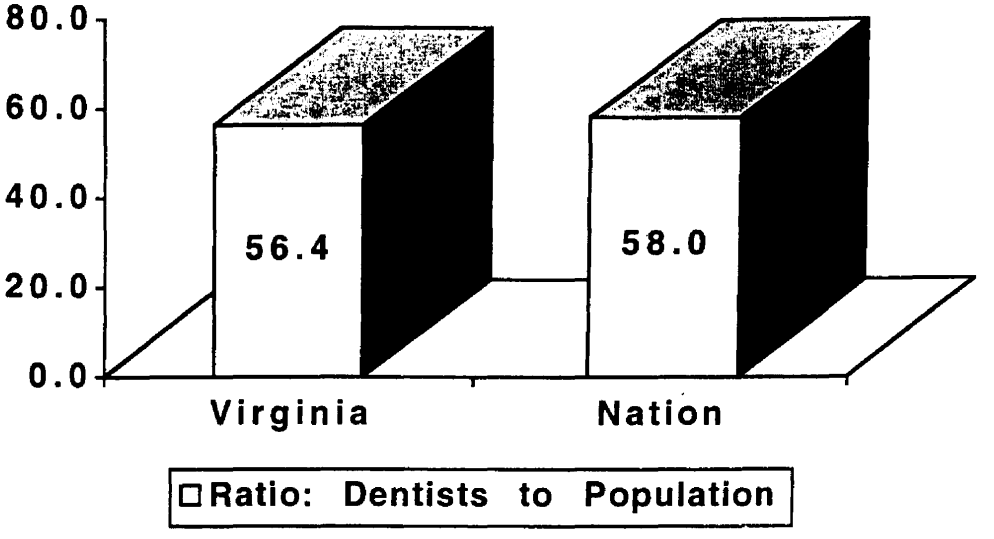
While The Ratio Of Dentists To Population In Virginia Is Comparable To The Nation As A Whole, There Are Many Underserved Communities In The Commonwealth

A number of different statistics have been calculated to measure the number of dentists actively practicing in Virginia. These statistics produce varying results based on how the number of dentists is counted, the year in which the data was collected, and the source of the data.

As stated in last year's report, information regarding the number of actively practicing dentists provided by the Board of Dentistry indicates that Virginia has approximately 56.4 dentists per 100,000 population. Information collected by the American Dental Association (ADA) on the number of active practitioners indicates that there are 58 dentists per 100,000 population in the U.S. Figure 6 compares Virginia's overall ratio of dentists to population compared with the national ratio.

Figure 6

Number Of Dentists Per 100,000 Population: Virginia And The Nation



Source: Virginia Board of Dentistry, American Dental Association

The Virginia Department of Health Concluded In 1996 That While The Overall Dentist To Population Ratio In Virginia Is Favorable, There Are A Number Of Underserved Areas

The Virginia Department of Health (VDH) conducted a study on the availability of dental services in 1996 in response to Item 311 of the 1996 Appropriation Act. VDH found that while the overall ratio of dentists to population (1 dentist per 2,002 persons) in Virginia is favorable, there are significant disparities in communities across the Commonwealth.

VDH identified "underserved" areas to be those communities which have a ratio of 1 dentist to 5,000 persons or higher. This ratio is the same as one of the main indicators used by the National Health Services Corps Loan Repayment program to designate a dental health professional shortage area (HPSA). VDH identified 43 communities with dentist to population ratios higher than 1 to 5,000. In addition to these communities, VDH identified 15 communities as the most underserved areas of the state based on high dentist to population ratios,

limited public health dentists, and few Medicaid providers. The 43 underserved areas and the 15 "most underserved" areas are identified in Figure 7. The 1996 VDH report identified four localities with no general or specialist dentists, and a number of localities with extremely high dentist to population ratios (e.g., Halifax County 1 : 30,317)

Figure 7

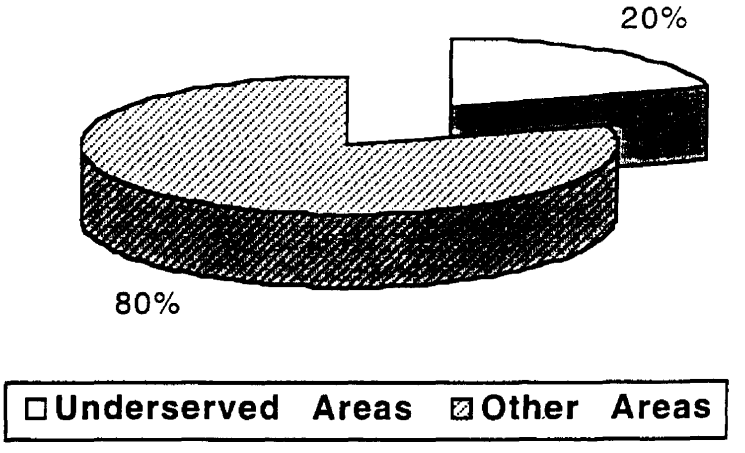
Virginia's Dental Underserved Areas

Source: Virginia Department of Health, Item 311 Final Report

Based on 2000 population projections maintained by the Virginia Employment Commission, approximately 20% of Virginians, or 1 of every 5 citizens live in a dental underserved area (Figure 8).

Figure 8

Percent of Virginia Population Living In Dental Underserved Areas



Source: Virginia Department of Health, Item 311 Final Report, VEC 2000 Population Projections, JCHC Staff Analysis

A Total Of 40 Dentists Would Be Needed To Eliminate The Most Underserved Areas In The Commonwealth; An Additional 105 Dentists Would Be Needed To Eliminate The Other Underserved Areas

The 1996 VDH report included information on the number of general and specialist dentists practicing in each locality throughout the Commonwealth. While the data are five years old, given the small increase in the number of licensed dentists since 1996 (Figure 5) and the difficulty in getting dentists to locate in underserved areas, the 1996 VDH report represents at least a reasonable estimate of the number of dentists practicing in these underserved localities.

An estimate of the number of additional dentists that would be needed to eliminate the Commonwealth's underserved areas was determined by developing an estimate of the total number of dentists needed to have a dentist to population ratio no greater than 1:5,000. The number of practicing dentists reported for the locality in the 1996 VDH report was then subtracted from this figure to arrive at an estimate of the number of additional dentists that would be needed to get the locality to the 1:5,000 threshold. While this method does not take into account certain other issues such as proximity of providers in other

adjacent communities, dentists practicing in more than one location, productivity variations by type of provider, and other manpower type considerations, it does provide a rough estimate of the need for additional dentists in Virginia's underserved communities.

The results of this analysis indicate that approximately 40 dentists are needed in the 15 most underserved communities to reduce the dentist to population ratio down to 1:5,000. An additional 105 dentists are needed in the other underserved areas for a total of 145 total dentists (see Figure 9).

The Virginia Dentist Scholarship And Loan Repayment Program Is The Primary Tool For Recruiting Dentists To Underserved Areas; However, Only $25,000 Per Year Is Appropriated For The Program

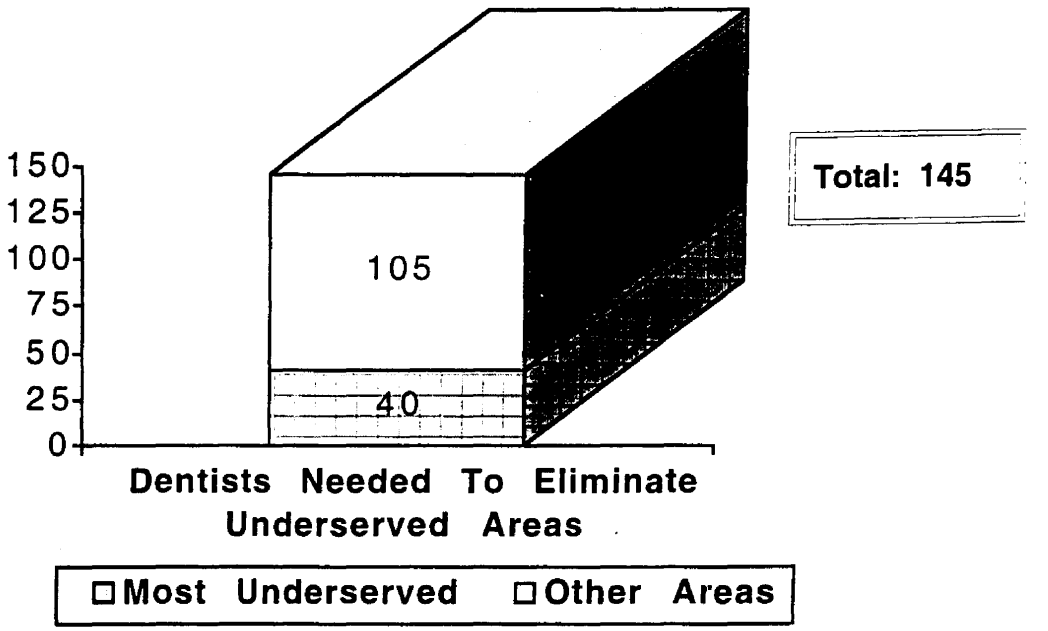
The Virginia Dental Scholarship Program is administered by VDH and provides scholarship money to students who agree to practice in underserved areas. Prior to 1999, ten scholarships of $2,500 each were available each year for Virginia dental students who agreed to provide one year of service in a Virginia underserved dental area for each year of scholarship award. The 1999 Appropriation Act increased the amount of the scholarships to $5,000 each, but reduced the number of scholarships to five.

Dentist Loan Repayment Program: As a result of last year's JCHC dental study, the 2000 Session of the General Assembly passed Senate Bill 489 and House Bill 1076 to establish the Virginia Dentist Loan Repayment Program. The program will provide loan repayment in return for the dentist agreeing to practice in an underserved area for a given period of time.

While the bills were passed to establish the program, no additional funds were appropriated. However, language was included in the Appropriation Act allowing VDH to use the $25,000 appropriated for the scholarship program for loan repayment as well. While this language is very helpful and is necessary to give VDH the flexibility of utilizing the funds in the manner that best meets the needs of prospective dentists, the total amount is very limited. While $25,000 is appropriated for the dental scholarship and loan repayment program, these amounts are far less than the $1.0 million that is appropriated for medical scholarships, loan repayment and other financial incentives to recruit physicians to underserved areas.

Figure 9

Estimate Of The Number Of Dentists Needed To Eliminate Virginia's Underserved Areas



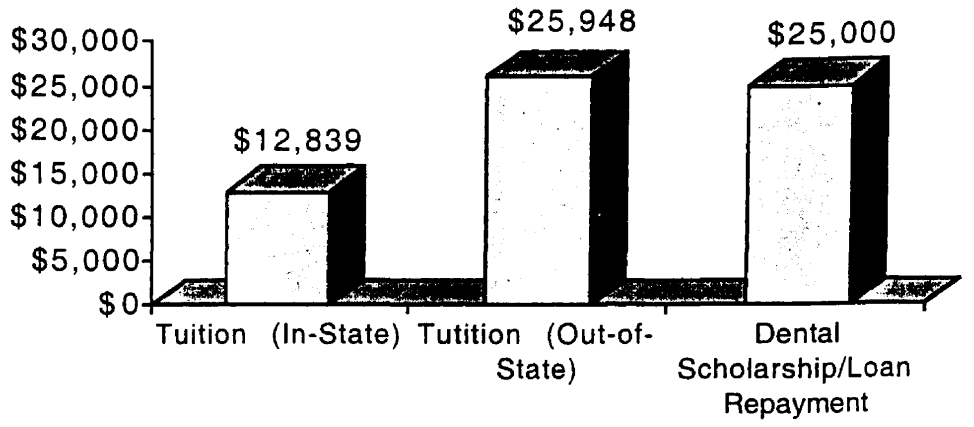
Source: Virginia Department of Health, Item 311 Final Report, VEC 2000 Population Projections, JCHC Staff Analysis

Whereas 40 Dentists Are Needed To Eliminate The Most Underserved Areas In Virginia, The Current Scholarship/Loan Repayment Funding Is The Equivalent Of Only Two Students' In-State Tuition Costs For One Year

As previously noted, it is estimated that roughly 40 dentists are needed to eliminate the most underserved areas in the Commonwealth. However, as illustrated in Figure 10, the funding available for scholarships and loan repayment equates to the in-state annual tuition costs for only two students each year, or one out-of-state student. The current funding for this program is significantly below the amount needed to make any appreciable progress in reducing the number of underserved areas.

Figure 10

Current Appropriation For Dental Scholarship/Loan Repayment Compared To Annual Tuition Costs (2000)



Source: VCU/MCV School of Dentistry, JCHC Staff Analysis

In Addition To Virginia's Scholarship And Loan Repayment Programs, The National Health Services Corps (NHSC) Also Provides Loan Repayment For Dentists Who Practice In A Community Designated As A Dental HPSA

The NHSC loan repayment program is sponsored by the U.S. Department of Health & Human Services and provides significant loan repayment amounts to physicians, dentists and mental health workers and other health professionals in return for agreeing to practice in a health professional shortage area (HPSA). Health providers who agree to locate in a HPSA are eligible for up to $50,000 for a 2-year commitment, up to $85,000 for a 3-year commitment, and up to $120,000 for a 4-year commitment.

VDH Is Making Progress In Designating Dental HPSAs: The NHSC loan repayment amounts provide a significant incentive for a dentist to locate in an underserved area. However, to obtain the loan repayment, the dentist must locate in an underserved area that is designated as a dental HPSA. As reported in the Joint Commission on Health Care's 1999 dental report, despite the fact that 43 areas in Virginia meet at least one criterion (1 dentist per 5,000 population) for

HPSA designation, as of last year, only 10 communities in Virginia had been designated as dental HPSAs.

The importance of designating underserved communities as dental, medical and mental health HPSAs was a key reason why the Joint Commission on Health Care introduced legislation (SB 489/HB 1076) during the 2000 Session of the General Assembly designating VDH as the state agency responsible for obtaining and maintaining HPSA designations. The passage of this legislation should ensure that all eligible communities are appropriately designated. More importantly, as more and more communities receive the HPSA designation, Virginia will be in a far better position to attract NHSC loan recipients to address the provider needs in our underserved areas.

VDH staff report that an additional 10 communities have submitted applications for HPSA designation. Should these communities be designated as HPSAs, the total number of Virginia dental HPSAs would double to 20 which will increase the number of choices available to NHSC loan recipients, and attract more dentists to Virginia's underserved communities.

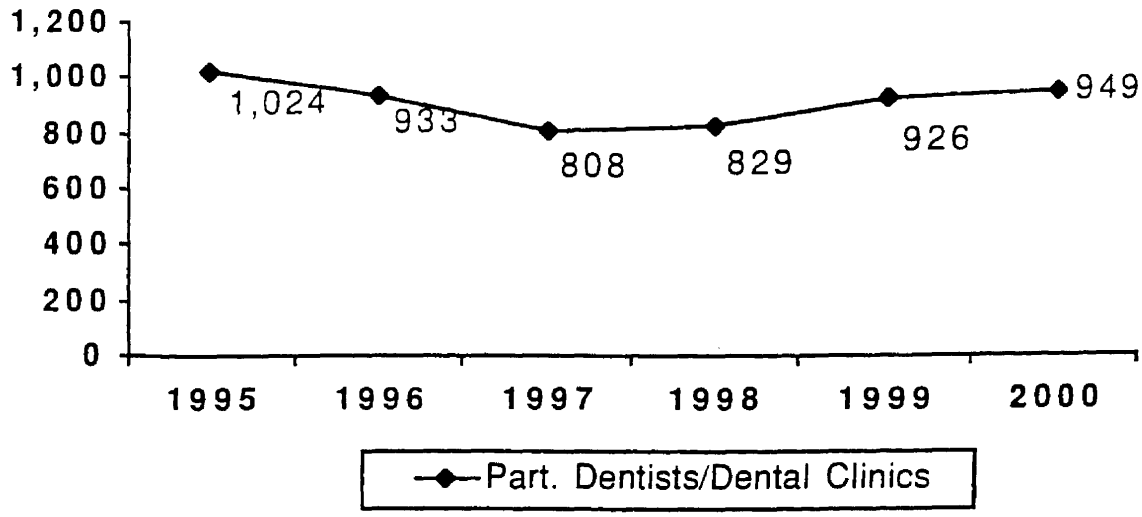
The Number Of Dentists Participating In Medicaid Has Been A Major Problem In Virginia And Throughout The Nation

As noted in the Joint Commission on Health Care's 1999 dental report, there has been a significant shortage of dentists participating in the Virginia Medicaid program. Based on 1998 data from the Department of Medical Assistance Services (DMAS), a total of 370,249 children under age 21 were eligible for dental benefits. However, only 95,145 or 26% of eligible children actually received dental services through Medicaid. The limited number of dentists participating in Medicaid is a key reason why so many children eligible for dental services have not actually received services. As seen in Figure 11, during the period 1995 - 2000, the number of dentists and dental clinics participating in Medicaid declined from 1,024 in 1995 to 808 in 1997. Since 1997, the number has increased gradually to 949 in 2000.

A 1997 study of Medicaid dentists conducted by the Williamson Institute at Virginia Commonwealth University in response to Item 322(U) of the 1997 Appropriation Act found that 20 localities had no Medicaid participating dentists. A number of other localities were found to have too few dentists to provide appropriate access to dental care. Similar problems exist in other states. The Williamson Institute study found that the three main reasons dentists do not participate in Medicaid are: (i) inadequate reimbursement, (ii) broken appointments, and (iii) complex or excessive paperwork.

Figure 11

Number of Dentists/Dental Clinics Participating In Virginia Medicaid Program 1995 - 2000



Source: Statistical Record of the Virginia Medicaid Program, 1999; Department of Medical Assistance Services

The General Assembly Has Included Language In The Appropriations Acts Since 1998 To Raise Medicaid Reimbursement For Dentists, And Increase The Number Of Participating Dentists

1998 Appropriation Act: In response to the findings of the 1997 study conducted by the Williamson Institute, the 1998 General Assembly included language in the 1998 Appropriation Act (Item 335R) directing DMAS to work with the Department of Health and the dental community to increase the number of dentists participating in Medicaid and to improve the administrative efficiency of the program. The 1998 language also directed DMAS to streamline administrative requirements and remove impediments to the delivery of dental services.

The 1998 budget submitted by Governor Allen included additional funding to increase the level of reimbursement for dental services. The General Assembly included language in the Appropriations Act directing DMAS to increase reimbursement rates to 85% of usual, customary, and reasonable (UCR) charges. However, the rates proposed by DMAS were based on fees originally adopted in 1991 by the Virginia Department of Health (VDH) and used by VDH in 1995, as opposed to 85% of UCR charges. DMAS also included an inflation

in 1995, as opposed to 85% of UCR charges. DMAS also included an inflation factor in arriving at the new rates. The DMAS proposed schedule would have set the rates closer to 65% of UCR.

1999 Appropriation Act: In response to DMAS' proposed increase in dental fees, the 1999 General Assembly included language in the Appropriation Act to develop a methodology that would increase dental fees to the 85th percentile of UCR charges based on commercial insurers' data. The 1999 language also prohibited DMAS from requiring dentists who agree to participate in the delivery of Medicaid services to pediatric dental patients to also deliver services to subscribers enrolled in the commercial plan of the managed care vendor.

2000 Appropriation Act: The 2001-2002 biennial budget proposed by the Governor did not include any additional funding for increasing dental reimbursement rates. The General Assembly appropriated an additional $1.0 million (GF) and $1.1 million (NGF) in each year of the 2001-2002 biennium to increase dental fees by 10 percent. Item 319 L of the 2000 Appropriation Act also directs DMAS to: (i) expand the availability and delivery of dental services to pediatric Medicaid recipients; (ii) streamline administrative processes; and (iii) remove impediments to the efficient delivery of dental services and reimbursement thereof. DMAS is required to report to the Senate Finance and House Appropriations Committees on its efforts by December 15 of each year. The 2000 Appropriations Act also continued the language prohibiting DMAS from requiring dentists who agree to participate in the delivery of Medicaid services to pediatric dental patients to also deliver services to subscribers enrolled in the commercial plan of the managed care vendor.

DMAS Has Taken Steps To Respond To Some Concerns Of The Dental Community

In response to the concerns voiced by the dental community regarding the Medicaid program, DMAS: (i) accepts the American Dental Association's (ADA) claim form for processing dental claims (although some additional data are still required); (ii) sends a letter to recipients after a second missed appointment to remind them of the importance of keeping dental appointments; (iii) has changed its HMO contracts in accordance with the 1999 Appropriation Act language regarding Medicaid dentists not having to accept other managed care patients from the commercial vendor; (iv) has changed the manner in which it reimburses for orthodontia services to pay over a shorter period of time; and (v) has offered to attend regional VDA meetings to provide information to dentists about Medicaid.

Most recently, DMAS has: (i) continued to meet with the Virginia Dental Association (VDA) to address provider concerns; (ii) reduced the number of procedures requiring preauthorization; and (iii) made changes in its claims submission and billing systems to accommodate the most current ADA procedure codes. DMAS also indicates it plans to explore ways of improving access to care in underserved areas with VCU/MCV School of Dentistry and VDH.

The VDA Has Taken Steps To Encourage Dentists To Participate In Medicaid

The VDA has actively participated in the work group established by DMAS to address the shortage of dentists participating in Medicaid. VDA also has communicated with its member dentists on several occasions encouraging them to participate in the program. Various newsletters have been sent to VDA members urging them to reconsider their past decisions not to participate in Medicaid, and to sign up for the program in response to the increased fees and other program improvements.

While There Has Been An Increase In The Number Of Dentists Participating In Medicaid, Further Increases Are Needed

While Figure 11 illustrates an increase in the number of participating dentists since 1997, the number of dentists continues to be a problem. Limited availability of dentists contributes to the low percentage of Medicaid children who actually receive dental services. Further increases in the number of dentists participating in Medicaid are needed to ensure recipients have appropriate access to care.

As previously noted, the 2000 Appropriation Act requires DMAS to report to the Senate Finance and House Appropriation Committees each December on its progress in improving administrative processes and removing impediments to receiving care. The Joint Commission on Health Care may wish to continue to monitor this issue by reviewing the annual progress reports and taking any appropriate follow-up action it deems necessary. The Joint Commission may also wish to consider increasing the level of Medicaid reimbursement to increase the number of participating dentists.

V.
Increasing The Number Of Persons With Dental Insurance And Improving Access To Care

The U.S. Surgeon General's Report On "Oral Health In America" And Other Research Indicate That Persons With Dental Insurance Have Greater Access To Care And Have Fewer Health Problems

As noted in Section III of this report, the U.S. Surgeon General's report on "Oral Health in America" concludes that the lack of dental insurance is a major barrier to oral health care. The report includes the following statistics regarding the importance of having dental insurance:

- *Medical insurance is a strong predictor of access to dental care. Uninsured children are 2.5 times less likely to receive dental care than insured children*

- *Children from families without dental insurance are 3 times as likely to have dental needs as compared to their insured peers.*

Other research also has concluded that persons with insurance have greater access to care, have better overall health, and have lower mortality and morbidity rates. The 1996 Health Access Survey sponsored by the Virginia Health Care Foundation confirmed the adverse impact of not having health insurance. Specifically, the survey results indicate that, when compared to persons with coverage, uninsured persons:

(v) *Visit clinics, hospitals, and doctors' offices less frequently;*

(vi) *Have longer periods of time between medical care visits;*

(vii) *Are one-half as likely to regularly go to a dentist;*

(viii) *Are three times more likely to not get a prescription filled because it costs too much; and*

(ix) *Are four times more likely to take a smaller than prescribed dose of a prescription drug.*

More recently, a report issued in March, 2000 by the Kaiser Commission concluded the following regarding the importance of health insurance:

(x) *Uninsured adults are at least four times as likely as the insured to report delaying or foregoing needed health care services;*

(xi) *Uninsured persons enter the health system with more advanced stages of serious diseases (e.g., breast and prostate cancer) than insured persons;*

(xii) *The uninsured are at least twice as likely as those with private insurance to be hospitalized for avoidable complications of conditions such as diabetes and hypertension; and*

(xiii) *Uninsured women are 40-50% more likely to die from breast cancer than insured women, depending on their age.*

The Average Cost Of Dental Coverage Ranges From $11 To $26 Per Month For A Single Person And From $31 To $60 Per Month For A Family Depending On The Type Of Insurance Plan

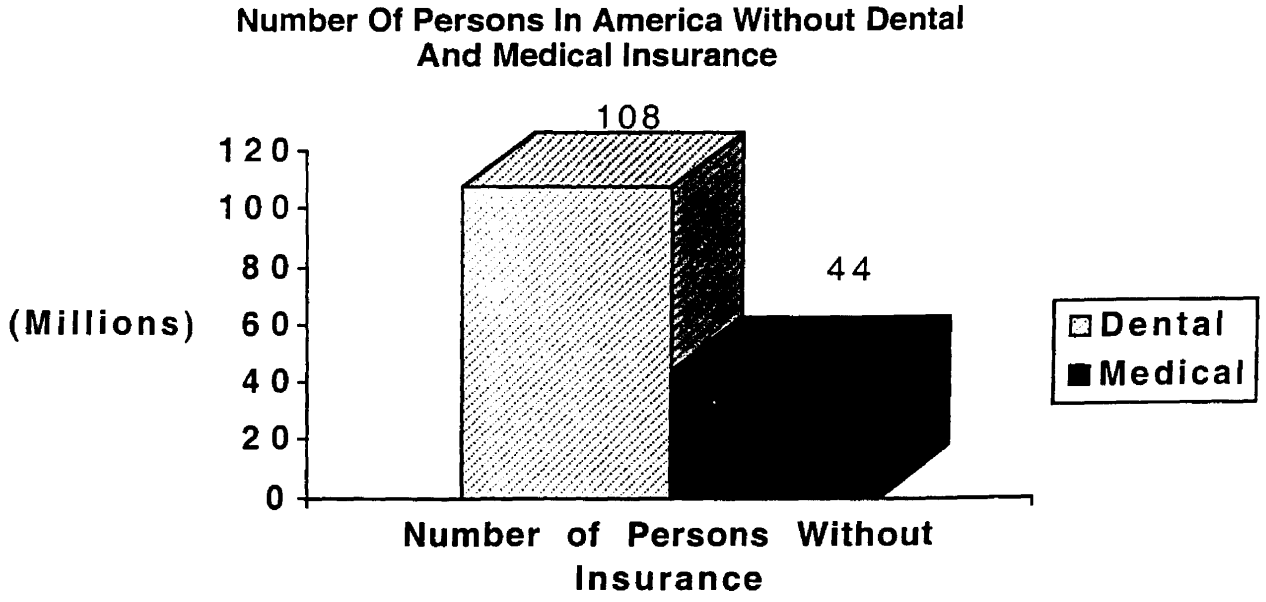
The cost of dental coverage depends on the type of insurance plan (i.e., indemnity, PPO or HMO). Data reported by the National Association of Dental Plans indicate that the average monthly cost for dental insurance in 1998 ranged from $11 to $26 for a single person and from $31 to $60 per month for family coverage. The range of costs is a function of the type of insurance plan; indemnity dental plans are the most expensive and dental HMO plans are the least expensive.

More recent data reported by Ceridian Benefits Services (an employee benefits administration firm) estimate the average monthly single premium (irrespective of insurance type) to be $21.50 and the average family premium to be $62.00.

There Are Far More Persons Without Dental Insurance Than Persons Without Medical Insurance

As seen in Figure 12, the U.S. Surgeon General's report on "Oral Health In America" estimates that while 44 million Americans do not have medical insurance, approximately 108 million Americans lack dental insurance. The report also notes that for every child without medical insurance, there are 2.6 children without dental insurance. Similar estimates of the number of persons without dental insurance nationally are reported by other researchers and organizations (The Kaiser Foundation, Delta Dental).

Figure 12



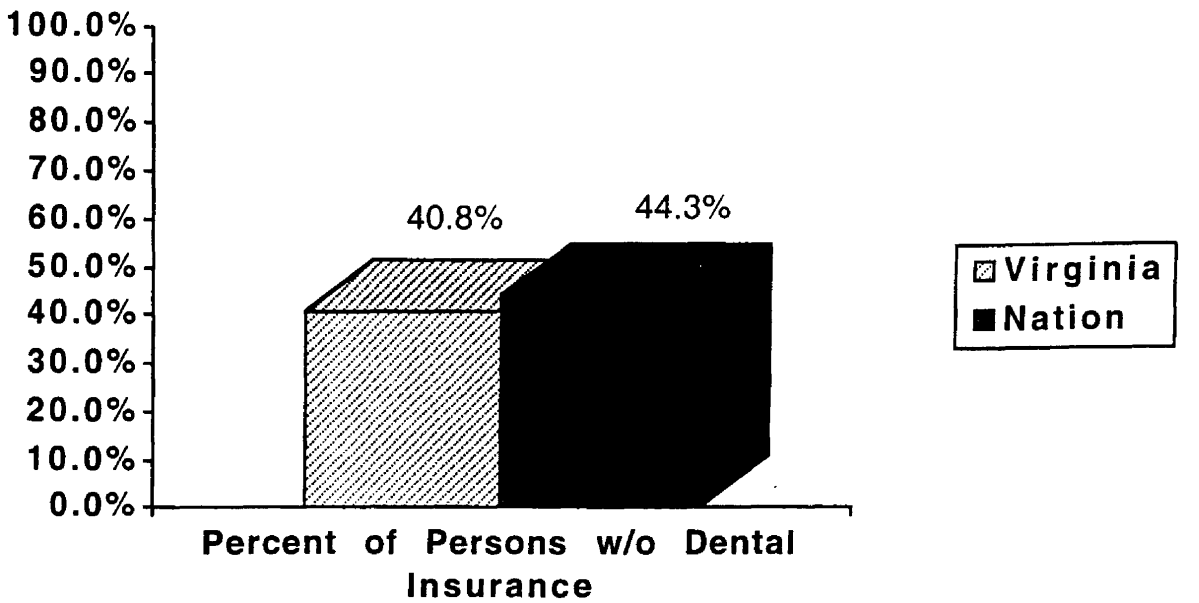
Source: U.S. Surgeon General's Report "Oral Health In America," May, 2000

While 13% Of Virginians Have No Medical Insurance, It Is Estimated That 41% Of Virginians Have No Dental Insurance

The 1996 Health Access Survey found that approximately 13% of Virginians have no medical insurance. The 1995 Behavioral Risk Factor Surveillance System (BRFSS), which develops estimates of the number of uninsured persons based on a national survey of persons residing in all 50 states, estimates that approximately 41% of Virginians have no dental insurance. As illustrated in Figure 13, while the percentage of Virginians without dental insurance is high, the BRFSS estimate of Virginia's dental uninsured population (40.8%) is somewhat less than the national percentage (44.3%).

Figure 13

Percent of Persons Without Dental Insurance: Virginia and the Nation



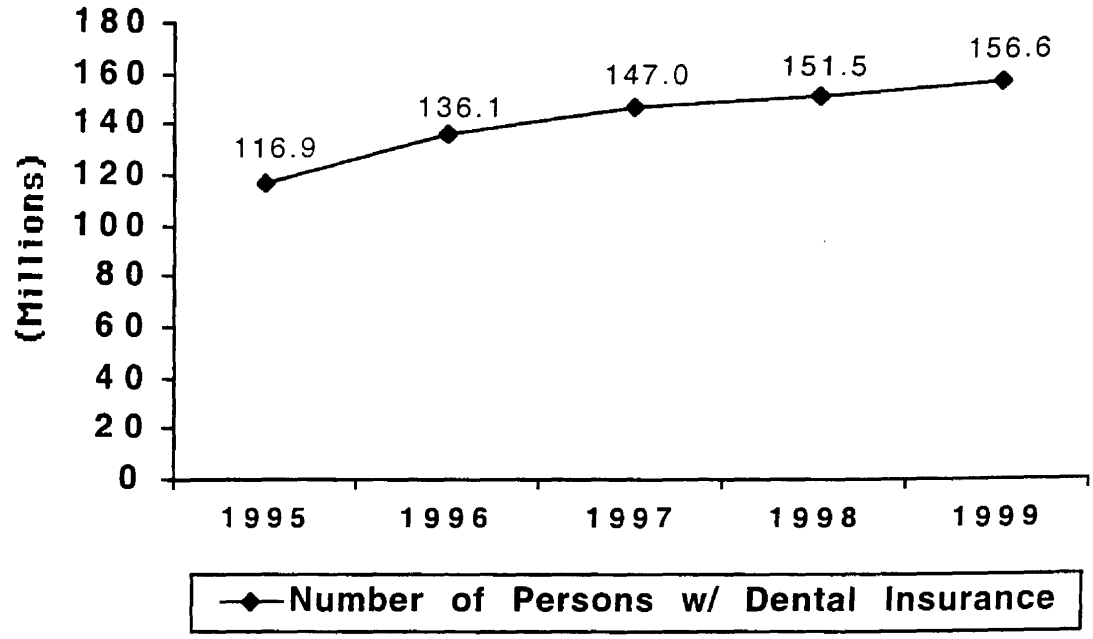
Source: Behavioral Risk Factor Surveillance System, Morbidity and Mortality Weekly Reports, December, 1997

While The Percentage Of Persons Without Dental Insurance Is High, Recent National Data Indicate The Number Of Persons With Dental Insurance Is Increasing

National data indicate the number of persons with dental coverage is increasing. Figure 14 illustrates that, nationally, the number of persons with dental insurance has increased nearly 34% in just four years. JCHC staff were not able to obtain information regarding a specific number of persons in Virginia with coverage; however, the two major insurers marketing dental coverage in Virginia, Trigon, Blue Cross Blue Shield and Delta Dental, both indicate significant growth in the number of covered lives in recent years.

Figure 14

National Estimates Of The Number of Persons With Dental Insurance: 1995-1999



Note: 1998 figure is an estimate extrapolated from 1997 and 1999 data

Source: National Association of Dental Plans, 1998; Mercer/Foster Higgins, 1999

Recent Increases In The Number Of Persons With Dental Insurance Are Attributed To The Strong Economy And Employers' Need To Offer Dental Coverage To Attract And Retain Employees

A 1999 study conducted by William M. Mercer, Inc. found that the number of employers offering dental benefits to their employees increased from 49% of employers in 1998 to 54% of employers in 1999. Mercer notes that this trend is reflective of a strong economy in which employers are having to offer additional benefits to attract or hold onto workers. The 1999 U.S. Benefits Survey conducted by the Bureau of Labor Statistics also reports increases in the number of employers offering dental coverage, and estimates the number of large and medium firms offering coverage in 1997 to be 59%. The U.S. Chamber of Commerce 1999 Employee Benefits Study reports that 74% of all companies offered dental benefits. While the percentage of companies offering dental insurance vary somewhat, all estimates indicate a trend of increasing availability of coverage through employers.

Dental Coverage Appears To Be Widely Available From Insurers Operating In Virginia

In order to assess whether the availability of dental insurance poses a problem in Virginia or is part of the reason why 41% of Virginians do not have dental coverage, JCHC staff reviewed the benefits offered by members of the Virginia Association of Health Plans (VAHP). The "1999-2000 Directory of the Virginia Association of Health Plans" indicates that all 14 member plans offer dental coverage. While the VAHP members do not represent all insurers that sell insurance in Virginia, the association members provided coverage to nearly three million Virginians in 1999, and, therefore, represent a significant portion of the Virginia marketplace.

Bureau of Insurance: Although there are no specific data available from the Bureau of Insurance to identify the exact number of carriers that offer dental coverage, Bureau staff indicated that dental coverage is generally available in the marketplace.

Insurance Agents: JCHC staff also interviewed representatives of two of the larger insurance agent associations/organizations in Virginia about the availability of dental coverage. The insurance agent representatives also indicated that availability of dental coverage is not a problem in Virginia, and that groups, as well as individuals can find coverage in the marketplace.

Despite Increases In The Number Of Persons With Dental Insurance And The Availability Of Coverage, The Overall Cost Of Medical Insurance Is Believed To Be The Main Reason Why More Persons Do Not Have Dental Coverage

While the number of persons with dental coverage has increased substantially in recent years, the rising cost of medical insurance benefits is viewed by many as a key reason why more persons do not have dental coverage. JCHC staff interviews with insurance industry representatives and insurance agents, as well as articles appearing in various periodicals, note that a key controlling factor in the ability of employers to offer coverage and for individuals to purchase the coverage, is the cost of medical benefits.

For employers, even though the current economy is pushing some to offer dental coverage to attract and retain employees, there nonetheless is a finite amount of money available for employee benefits. While dental insurance is important, few would argue against the notion that medical insurance represents a more critical employee benefit than dental coverage. As such, as the cost of medical benefits increases, the financial ability of an employer to offer dental or other benefits (e.g., vision) decreases. Similarly, for persons purchasing coverage

in the individual market, as the cost of medical insurance increases, their ability to purchase dental coverage is lessened.

Recent Trends In Insurance Premium Rates Show A Return To Double-Digit Annual Increases

During the mid to late 1990s, medical inflation and its impact on health insurance premiums had diminished from the record double-digit annual increases seen in the early 1990s. However, 1999 data reflect increases between 7 and 8 percent over 1998 rates, and market analysts and benefits consultants are predicting a return to double-digit inflation for health insurance premiums in 2000. William M. Mercer's recent *National Survey of Employer-sponsored Health Plans* estimates that premiums will increase at an annual rate of 9% for large employers (over 20,000 employees) and up to 14% for small employers (10-49 employees). A survey by Towers Perrin found that the cost of large employers' health insurance will increase about 12 % on average in 2000, with more than 90% of employers predicting double-digit increases to continue over the next few years. Both the Mercer and Towers Perrin surveys point to rising prescription drug costs as a key factor in the premium increases.

Insurers Argue That Controlling The Cost Of Medical Insurance Will Help Increase The Number Of Persons And Employers Purchasing Dental Coverage

Representatives of the insurance industry believe that one means of increasing the number of persons with dental insurance is to control the cost of medical benefits. Among the actions suggested by insurers is to refrain from additional mandated insurance benefits which add to the cost of health insurance. The number of mandated benefits has increased substantially in recent years. The State Corporation Commission (SCC) is required by §38.2-3419.1 of the *Code of Virginia* to report on the financial impact of mandated health insurance benefits. In 2000 House Document 12, the SCC estimated that mandated benefits and providers accounted for approximately 15-21% of single coverage premiums, and 21-23% of family coverage premiums. (This analysis includes the additional cost attributed to benefits that carriers are "mandated to offer.")

Insurers argue that if fewer benefits were mandated, medical insurance premiums would be lower and there would be more benefit dollars available for dental coverage. While it is true that if medical benefits were less expensive there would be additional available dollars, there is no guarantee that the additional money would be spent by employers on providing dental benefits, or that individuals purchasing coverage on their own would use the available funds to purchase dental insurance rather than spend it in other ways.

Direct Reimbursement Legislation: Insurers also point to recent legislation that requires carriers to provide direct reimbursement to dentists who do not participate in the insurer's network, and allows the dentist to "balance bill" the patient for charges in excess of the carrier's reimbursement amount as a policy decision which makes insurance coverage less attractive to patients. Insurers contend that this legislation makes network participation less attractive to dentists resulting in fewer participating dentists, which ultimately leads to dental insurance being less attractive to prospective purchasers (i.e., employers and individuals). Dentists, however, counter that the level of reimbursement paid by managed care companies does not adequately cover their expenses and overhead, and that to make a reasonable profit, they must be able to balance bill patients.

In Addition To Traditional Dental Insurance Coverage, Other Alternative Dental Care Products Are Available In The Market

Traditional insurance coverage, such as indemnity plans, preferred provider organization (PPO) plans and HMOs provide the vast majority of dental insurance coverage in Virginia and the nation. However, there are other dental products that some employers offer to employees as an alternative to traditional dental insurance.

Direct Reimbursement Plan: One such alternative dental plan is the Direct Reimbursement Plan. The Direct Reimbursement Plan is promoted by the American Dental Association nationally and the Virginia Dental Association here in the Commonwealth. Rather than an *insurance* plan, the Direct Reimbursement Plan is a self-funded benefit plan in which an employer pays for dental care with its own funds, rather than paying premiums to an insurance company or third-party administrator. In this arrangement, the patient receives dental care from the provider of his choice, pays the full cost to the dentist, and submits the receipt to the employer. The employer then pays all or a portion of the cost of care, depending on the specific benefit level offered by the employer. The ADA contends that the program can keep corporate costs as much as 40% lower than standard plans because it pays only for employees who actually use the service. Thus far, this program has not garnered a significant part of the market; ADA estimates that about 2,500 companies have such plans and that another 300 or so adopt the program each year. The ADA and VDA are planning a major marketing effort to promote the plan in the coming months.

Discount Referral Plans: Another alternative dental benefit plan currently being marketed is called a "discount referral plan." Like the direct reimbursement plan, in this arrangement, there is no contract of insurance. Instead the discount referral plan is a network-based product that provides

access to dental care at guaranteed costs. Typically, a small monthly fee is paid by either the employee or employer on behalf of the employee for a list of dentists who have agreed to accept certain negotiated rates for services. The patient may go to any dentist in the network, but pays the full amount out-of-pocket, albeit at negotiated rates. In essence, the monthly fee is paid in return for access to dentists who have agreed to provide services at a somewhat lower cost. The National Association of Dental Plans (NADP) reports that this type of dental plan is growing rapidly as employers look for ways to provide dental benefits without having to assume financial risk of traditional insurance coverage. NADP estimates that approximately 5.4 million Americans were enrolled in a dental discount referral plan in 1997.

Flexible Spending Accounts: A third alternative means of providing some level of benefits for dental services is a flexible spending account (FSA) authorized by the Internal Revenue Service. An FSA allows an employee to set aside an amount of his salary in an account that can be used to pay for health-related expenses not covered under the employer's health insurance benefits plan. The amounts deposited into the FSA are not taxed which provides a significant tax benefit to the employee. Rather than purchasing a traditional dental insurance plan, some employees are choosing instead to use their FSA to pay for their dental expenses.

Mandating That Insurance Policies Include Dental Benefits Does Not Appear To Be A Necessary Strategy For Increasing The Number Of Persons With Dental Insurance; Current Market Trends Indicate The Insured Population Is Increasing

While mandating that insurance policies include coverage for dental benefits may increase the number of policies that are sold which include dental coverage, this does not appear to be needed given the current market trends and availability of coverage in Virginia. Despite the fact that nearly 41% of Virginians do not have dental insurance, recent market trends indicate that the number of persons with dental coverage is increasing appreciably each year. Moreover, as previously noted, availability of dental insurance is not a problem in Virginia; the problem is the affordability of coverage for both medical and dental insurance. Mandating that insurance policies include dental benefits would increase the cost of the policy and may result in fewer groups/individuals purchasing any coverage at all. Given the availability of the benefits in the market for those who wish to purchase it, there does not appear to be an appreciable advantage to mandating dental benefits, especially given the potential adverse consequence of some not being able to purchase coverage at all.

One Means Of Increasing The Number Of Persons With Dental Insurance Would Be To Provide Dental Benefits To Medicaid Adults

Currently, Virginia's Medicaid program provides dental benefits only to children up to age 21; benefits are not provided to adult recipients. House Joint Resolution 296, as forwarded by Speaker Wilkins to the Joint Commission on Health Care (JCHC), directs the JCHC to review the feasibility of providing dental benefits, including dentures, to Medicaid adults.

Staff at the Department of Medical Assistance Services (DMAS) provided an estimate of the cost to provide dental benefits to Medicaid adults. DMAS based its estimate on: (i) information derived from other states which provide dental benefits to adults; (ii) consultations with the department's actuary and dental consultant; and (iii) an analysis of the expenditures for dental benefits for Medicaid children. The DMAS cost estimate assumes the same level of utilization of dental services for adults as the historical level of utilization for children. (DMAS assumed 227,428 adults would be eligible, and that about 23% (63,420) would actually access services.) The adult dental coverage would include restorative care and preventive services, but would exclude crowns, orthodontics, and endodontics. As directed by HJR 296, the DMAS estimate also includes benefits for dentures.

Figure 15

Cost Estimate To Provide Dental Benefits To Adult Medicaid Eligibles

	FY 2001		FY 2002	
	GF	NGF	GF	NGF
General Dental Benefits	$4.92	$5.22	$5.05	$5.26
Coverage for Dentures & Bridgework	$3.07	$3.27	$3.13	$3.32
TOTAL	**$7.99**	**$8.49**	**$8.18**	**$8.58**

Note: Amounts are in millions of dollars

Source: DMAS, JCHC staff analysis

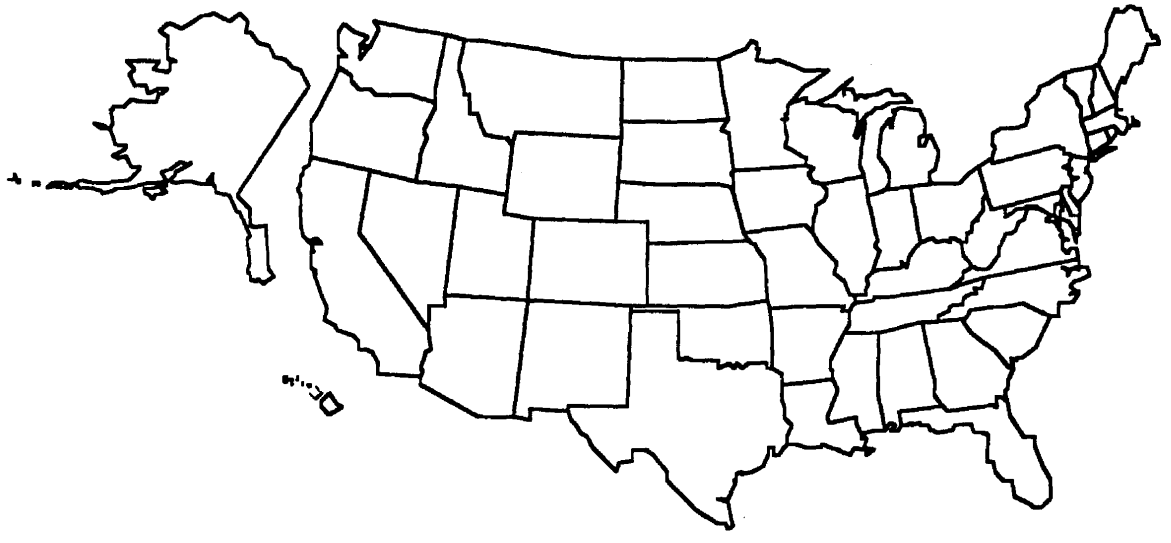
As seen in Figure 15, the general fund (GF) cost to provide general dental benefit coverage to Medicaid adults is estimated to be approximately $5 million per year. The GF cost of providing coverage only for dentures and bridgework would be slightly more than $3 million per year. The GF cost to provide coverage for both general dental services and dentures/bridgework would be approximately $8 million per year.

At Least 27 States Provide Dental Benefits To All Medicaid Eligibles

According to the American Dental Association (ADA), at least 27 other states provide dental benefits to all Medicaid eligibles. Figure 16 identifies these states. Most states offer adults a somewhat "scaled down" version of the benefits offered to children. However, the specific benefit provisions vary from state to state.

Figure 16

States That Provide Dental Benefits To Adult Medicaid Eligibles (1997)



Note: Shaded states provide dental benefits to Medicaid adults

Source: American Dental Association, 1997

Continued Monitoring Of The Number Of Virginians With Dental Insurance Is Needed; More Current Data Are Needed Regarding The Insurance Status Of Virginians

The last survey of the insurance status of Virginians was the Health Access Survey conducted in 1996. This survey, sponsored by the Virginia Health Care Foundation, replicated a survey conducted in 1993. In order to effectively monitor the number of uninsured persons in Virginia, and identify trends in medical and dental coverage, more current data are needed. Few national surveys have a sufficient sample size to produce reliable state-specific estimates. Accordingly, the JCHC may wish to consider requesting the Virginia Health Care Foundation to sponsor another survey of the insurance status of Virginians. As with past surveys, in addition to questions pertaining to insurance coverage, the survey could include questions regarding other current health care issues.

In Addition To The Issue Of Increasing Access To Health Insurance, The Commonwealth Could Take Steps To Improve Access To Care For Those Who Cannot Afford Insurance

As previously noted, dental insurance appears to be readily available in the marketplace for those who can afford such coverage. However, there is a significant portion of Virginia's population who are indigent and cannot pay for dental insurance. For these individuals, other actions could be taken to improve access to care. Many of these were discussed in last year's JCHC dental report. One potential action that was not included as a Policy Option in last year's report is providing additional funding to the Virginia Health Care Foundation to support programs across the Commonwealth that improve access to dental care.

The Virginia Health Care Foundation Funds Local Public-Private Initiatives Which Increase Access To Primary Health Care For Virginia's Uninsured And Medically Underserved

The Virginia Health Care Foundation (VHCF) is a non-profit entity which was created in June, 1992 by a joint venture between the Governor and the General Assembly. The VHCF's mission is to enhance access to primary care for Virginia's uninsured and medically underserved populations by helping to foster community-based projects that combine resources of local government, health care professionals and the business sector. The Commonwealth appropriates $2,229,810 each year to support the VHCF's activities. The 2000 Appropriations Act language (Item 308 A.1.) directs that the funds be matched with local public and private resources.

Since its inception, the VHCF has helped launch 117 public-private initiatives which have provided nearly 710,000 patient visits. Eighty-five percent of these initiatives have completed their third and final year of VHCF funding and are continuing to sustain themselves at a full level of operation. Included among the 117 projects are 16 grants to organizations across the Commonwealth to improve access to dental care. These grants amounted to approximately $1.65 million. Examples of local dental-related projects are: (i) a school-based dental program in Accomack County; (ii) a school-based dental program and use of a dental trailer to provide care to uninsured adults in Bedford County; (iii) support to the Charlottesville Free Clinic to provide dental services; (iv) support for a full-time dentist to provide care to elementary school children in Buchanan and Dickenson counties; and (v) dental equipment and a part-time dentist to expand patient capacity at the Williamsburg-Olde Towne Medical Center. In addition to these local programs, the VHCF also supports statewide dental projects, including: (i) VCU/MCV School of Dentistry's mobile dental clinic; and (ii) the Virginia Dental Association's Donated Dental Services Program.

Healthy Communities Loan Fund: In addition to the dental-related grants, the VHCF also has established the Healthy Communities Loan Fund. This fund provides low interest rates through First Virginia Banks, Inc. to help primary health care professionals, including dentists, establish practices in underserved communities. The terms of the loan are individually tailored for each applicant and amounts typically range from $50,000 - $250,000. Additionally, there are no bank fees and no points.

Providers who qualify for a loan can use the funds to: (i) provide working capital to develop new practices or to expand an existing practice; (ii) renovate existing facilities or buy new equipment; (iii) fund conversions of practices to rural health clinics; (iv) finance elements of a recruiting package to bring a new provider to the area; or (v) underwrite other similar initiatives.

The VHCF reports that five loans to dentists have been closed. An additional two loans to dentists have been approved by the VHCF's loan advisory group, but have not yet been closed.

Other VHCF Programs: The VHCF also has sponsored "Tooth Talk." This program provides information on: (i) various dental programs in Virginia; (ii) successful dental models; (iii) sources of assistance to dental programs; (iv) dental "best practices;" and (v) patient education materials. The VHCF also has sponsored a program entitled "Models That Made It," which provides information on replicating successful health care model programs in other communities. The goal of each of these programs is to expand access to dental care in underserved areas.

The Joint Commission May Wish To Consider Recommending More Funds Be Appropriated To The VHCF To Support Additional Dental Projects

The VHCF dental projects have been successful in improving access to dental care for uninsured Virginians and those who live in medically underserved areas. Additional state funding for the VHCF that is specifically earmarked to support dental programs would improve access to dental care throughout the Commonwealth. A key advantage of this approach is that a significant percentage of VHCF-supported programs become self-sustaining after the initial three-year grant period which means the services that are begun with state support continue on with other funding sources.

Providing additional funds to the VHCF to support projects for improving access to dental care would address four of the five principal components of the Surgeon General's National Oral Health Plan. Such financial support would be used to: (i) help change perceptions regarding oral health and its inextricable link to general health; (ii) help build an effective health infrastructure that meets oral health needs; (iii) remove known barriers to care; and (iv) increase the use of public-private partnerships to improve the oral health of persons who suffer disproportionately from oral diseases.

VI.
Safety Of Dental Amalgam

Dental Amalgam Is The Most Frequently Used Material To Treat Decayed Teeth

Dental amalgam (commonly referred to silver fillings) has been used for more than 150 years to treat tooth decay. It is the most frequently used material for restoring decayed teeth. The popularity of amalgam arises from its excellent long-term performance, ease of use, and relatively low cost. It is estimated that, in 1979, the total number of amalgam restorations placed by dentists in the United States was approximately 157 million. However, during the past 20 years, the use of amalgam in the United States has been declining largely due to the decreasing incidence of dental caries (cavities), more frequent use of crowns, and the availability of alternative, tooth-colored restorative materials. In 1991, the total number of dental amalgam restorations was estimated to be approximately 96 million. Amalgam continues to be used today in the following situations:

(xiv) In individuals of all ages;

- *In stress-bearing areas and in small-to-mid sized cavities in the posterior teeth;*
- *When there is severe destruction of tooth structure and cost is an overriding consideration;*
- *As a foundation for cast-metal, metal-ceramic, and ceramic restorations;*
- *When patient commitment to personal hygiene is poor; and*
- *When moisture control is problematic with patients.*

Amalgam is not used when:

- *Esthetics are important, such as anterior teeth and in root canal restorations of the anterior teeth;*
- *Patients have a history of allergy to mercury or other amalgam components; and*

- *A large restoration is needed and the cost of other restorative materials is not a significant factor in the treatment decision.*

Dental Amalgam Contains Elemental Mercury That Helps To Bind The Other Materials In Amalgam; The Safety Concern Regarding Dental Amalgam Stems From The Emission Of Minute Amounts Of The Mercury

Dental amalgam is the end result of mixing approximately equal parts of elemental (liquid) mercury (43-54%) and an alloy powder (57-46%) composed of silver, tin, copper, and sometimes smaller amounts of zinc, palladium, or indium. The mercury is used to bind the other materials into a hard and stable restorative material. Elemental mercury is a heavy metal whose toxicity at high intake levels (such as in industrial exposures) is well-established.

The safety concern regarding the use of elemental mercury in dental amalgam arises from the fact that very small amounts of mercury vapor are emitted from the restoration. The mercury vapor dissolves in the intra-oral air or in saliva and is absorbed by the patient through inhalation, ingestion, or other means. There are wide ranging estimates of how the level of mercury absorbed from dental amalgam compares to that absorbed from other sources. The research in this area provides few consistent estimates and suffers from varying definitions, and different experimental conditions and assumptions. One source (Hedegard) cites a World Health Organization report that concluded the amount of mercury vapor from dental amalgam is greater than all other sources of mercury combined. Conversely, the American Dental Association states that "people are exposed to more total mercury from foods, water, and air than from the miniscule amounts of vapor generated from amalgam fillings."

Different Forms Of Mercury Can Produce Varying Types Of Adverse Health Consequences

Mercury is highly toxic and cause serious health problems when persons are exposed to high intake levels. According to the U.S. Environmental Protection Agency (EPA), persons exposed to high levels of elemental mercury vapor (i.e., the type emitted from amalgam) can experience: (i) nervous system damage including tremors, (ii) and mood and personality disorders. Exposure to relatively high levels of inorganic mercury salts can cause kidney damage. Adult exposure to relatively high levels of methylmercury through fish consumption can result in numbness or tingling in the extremities, sensory losses and loss of coordination. Whether any of these symptoms occur, and the nature and severity of the symptoms, depend on the amount of exposure, the duration, and type of contact.

There Has Been A Great Deal Of Controversy Over Whether The Mercury Content Of Dental Amalgam Poses A Health Risk To Patients And Dental Providers

There is little disagreement that elemental mercury is a toxic substance that can cause health problems. There is some research that has shown persons with dental amalgam have higher concentrations of mercury in various fluids and tissues (e.g., blood, urine, kidney and brain) than those without amalgam. However, mercury also is absorbed from many other sources, including food, ambient air, and water. The controversy arises over whether the amount of elemental mercury vapor emitted from dental amalgam is enough to result in any harm to patients and dental care providers (i.e., dentists, dental hygienists and dental assistants). The critical issue of whether the vast majority of persons with dental amalgam experience any clinical effect from this small additional amount of mercury continues to be debated.

Controversy Surrounding Dental Amalgam Began In The 1800s; Since That Time, There Has Been Recurring Debate Over Possible Adverse Health Outcomes Associated With The Mercury Content Of Dental Amalgam

The first documented controversy surrounding the safety of dental amalgam occurred in 1833 when dental practitioners in the U.S. began using a primitive silver paste made of shavings from silver coins mixed with mercury. This material was found to have deleterious side effects that led to vigorous opposition to its use by the prevailing professional group of the day, the America Association of Dental Surgeons. This controversy was resolved in the late 1800s when a more balanced and effective amalgam formula was developed. The specifications for mercury composition in the new amalgam were developed jointly by the American Dental Association and the U.S. Bureau of Standards.

The next significant controversy over the safety of dental amalgam arose in 1920 when a German scientist claimed that mercury could be absorbed by patients, and expressed concern for patient safety. These concerns were questioned and finally repudiated in 1934, and the amalgam controversy essentially remained dormant until the late 1970s.

In 1976, claims began to appear that mercury was released from amalgam restorations during brushing, chewing, and bruxing (grinding of teeth) resulting in mercury toxicity, and, consequently, a wide range of neurologic, psychiatric and immunologic diseases. Other studies (Abraham 1984, Aronsson 1984, Berglund 1990) concluded that chewing gum raises the level of mercury in intra-oral air. Other studies (Kampe 1986, Siblerud 1990, and 1994) found that groups of individuals with few or no amalgam fillings were healthier than groups of

individuals that had a greater number of amalgam fillings. These claims created a great deal of media attention and generated considerable professional controversy regarding their validity. The controversy escalated even further in the 1990s when the national television program "60 Minutes" reported "miracle cures" for multiple sclerosis and other diseases after removal of dental amalgams. Also, studies from the University of Calgary reported mercury buildup in body tissues of sheep and monkeys as a result of mercury in dental amalgam.

The U.S. Public Health Service Conducted A Comprehensive Review Of The Safety Of Dental Amalgam In Response To The Amalgam Studies Conducted During The 1970s-1980s

In consideration of the recent research reports, the breadth of exposure to dental amalgam among the U.S. population, and the level of public and media concern, the U.S. Public Health Service (USPHS) conducted a comprehensive scientific review of the benefits and risks of dental amalgam. The review, conducted in 1991, served as a basis for reexamining federal policy on the use of dental amalgam as a restorative material. The USPHS convened an inter-agency task force to conduct the review. The task force included a diverse group of scientists, including epidemiologists, toxicologists, and biomaterials experts from within and outside the federal government. Following a two-year study effort in which nearly 500 scientific studies were reviewed, the task force produced a report in 1993. Following its 1993 report, the task force continued to review research findings and conduct further analysis of dental amalgam; a follow-up report was issued in 1997.

The USPHS Review Concluded That There Is No Evidence At Present To Conclude With Certainty That The Mercury In Dental Amalgam Poses A Public Health Risk

The USPHS task force report issued in 1993 addressed a number of the issues raised in previous studies which caused concerns about the safety of dental amalgam. The following summarizes the findings and conclusions included in the USPHS task force's 1993 report:

- *It is clear that a fraction of the mercury in amalgam is absorbed by the body and that people with amalgam have higher concentrations of mercury in various tissues than those without amalgam. Also, a small proportion of individuals may manifest allergic reactions to these restorations.*

- *It is not known whether the vast majority of people with amalgam experience any clinical effect from this small additional body burden of mercury.*

- *Part of the reason for the dearth of information on whether there are health effects from the mercury in amalgam is that the few human studies that have investigated this issue have been too small or flawed in design to detect an effect. To add to the difficulty, if there were long-term effects from the mercury in amalgam, it is likely that they would be subtle in nature and difficult to detect.*

- *In the absence of adequate human studies, it cannot be concluded with certainty whether or not the mercury in amalgam might pose a public health risk. On the one hand there is no evidence at present that the health of people with amalgam is compromised in any way. Likewise, there is not evidence that removing amalgam has a beneficial effect on health.*

The overall position of the USPHS, as stated in the 1993 report, is noted below.

> *"The USPHS believes it is inappropriate at this time to recommend any restrictions on the use of dental amalgam, for several reasons. First, scientific evidence does not show that exposure to mercury from amalgam restorations poses a serious health risk in humans, except for an exceedingly small number of allergic reactions. Second, there is insufficient evidence to assure the public that components of alternative restorative materials have fewer potential health effects than dental amalgam, including allergic-type reactions. Third, there are significant efforts underway in the U.S. to reduce the amount of mercury in the environment. And, finally . . . amalgam use is declining due to a lessening of the incidence of dental caries and the increasing use of alternative materials."*

The 1997 follow-up report published by the USPHS summarized the activities that had taken place since the 1993 report. The following highlights were included in the 1997 report:

- *The Food and Drug Administration (FDA) completed a review of nearly 60 studies that were published in peer-reviewed scientific literature and were cited by citizen groups that petitioned the agency for stringent regulatory actions against dental amalgam. The analysis indicated that the current body of data does not support claims that individuals with dental amalgam restorations will experience adverse effects, including neurologic, renal or developmental effects, except for rare allergic or hypersensitivity reactions.*

- *The National Institute of Dental Research has spent $33 million on research related to development of non-amalgam alternatives. Substantial progress is being made on the development of a non-mercury based material.*

- *The USPHS convened an international summit of government officials to share and elicit information on the state of science relating to amalgam safety. General consensus was reached that no current scientific evidence demonstrates a health hazard to the general public from dental amalgam use, although a small percentage of patients do experience mild, normally transient allergic reactions.*

- *A Working Group on Dental Amalgam working under the USPHS was charged with evaluating 175 citations related to dental amalgam in response to three citizens' petitions. Scientific experts from the FDA, the National Institutes of Health and the Centers for Disease Control conducted the review. The unanimous conclusions drawn by these experts was that none of the studies under review would indicate that individuals with dental amalgam restorations would experience adverse health effects.*

A Few European Countries Have Restricted The Use Of Dental Amalgam; Other Countries Have Concluded No Restrictions Are Necessary

While U.S. government agencies have not recommended any restrictions on the use of dental amalgam, a few European countries have recommended against the use of mercury-containing materials. The governments of Sweden and Denmark have recommended against the use of mercury-containing materials as part of national environmental protection initiatives provided that suitable non-amalgam materials are available. The German government has recommended against the placement of dental amalgam and dental restorative materials in general in patients with demonstrated allergy to such materials, as well as patients with severe renal dysfunction. Germany also has advised against the placement of dental amalgam and the removal of amalgam fillings in pregnant women as a precautionary measure while at the same time acknowledging the lack of evidence that exposure of the unborn to mercury released from the mother's amalgam fillings causes any health damage to the child.

The European Commission, the governments of Canada, Quebec and New Zealand, and the World Health Organization have independently evaluated the current body of science relating to dental amalgam safety and universally concluded that the vast majority of people treated with dental amalgam are not at risk. Notwithstanding this conclusion, Canada and its province of Quebec

have recommended prudence in dental intervention therapies for certain patient sub-populations such as pregnant women.

There Are A Number Of Anti-Amalgam Groups Who Believe Dental Amalgam Causes Adverse Health Consequences

Despite the number of government reviews of the safety of dental amalgam, there continues to be a sector of the general population and a small segment of the dental profession who believe dental amalgam is unsafe. A number of anti-dental amalgam groups exist and argue strenuously to eliminate or restrict the use of amalgam because of safety concerns. Dental Amalgam Mercury Syndrome, Inc. (DAMS) is a non-profit volunteer organization and grass-roots movement dedicated to educating the public about the health hazards of chronic exposure to mercury from silver fillings. The DAMS website states that many of the DAMS members are persons who recovered from serious health problems after having amalgam fillings removed. Another group, the Preventive Dental Health Association, is a non-profit group whose orientation is that harmful substances such as fluoride and mercury need no longer be introduced into the human body. There are numerous other groups such as Citizens for Mercury Relief, and Canadians for Mercury Relief who advocate for eliminating or restricting dental amalgam.

The American Dental Association Believes Dental Amalgam Is A Safe And Effective Restorative Material

The American Dental Association (ADA) has repeatedly indicated that it believes dental amalgam is a safe and effective restorative material. In 1998, the ADA's Council on Scientific Affairs conducted a review of scientific literature. The report noted: "The Council concludes that, based on available scientific information, amalgam continues to be a safe and effective restorative material." The Council's report also stated that "there currently appears to be no justification for discontinuing the use of dental amalgam."

The ADA supports ongoing research in the development of new material that it hopes will someday prove to be as safe and effective as dental amalgam. The ADA also indicates that it encourages scientific inquiry and dialogue on the subject, and that it would promptly inform the dental profession if the scientific community determined that amalgam were unsafe for patients.

VII.
Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to pursue.

Option I	Take no action
Option II	**Introduce a budget amendment to increase the amount of general funds appropriated for the dental scholarship and loan repayment program**
Option III	**Introduce a budget amendment to increase Medicaid reimbursement to dentists to the 85th percentile of UCR**
Option IV	**Introduce a budget amendment to extend dental benefits to adult Medicaid eligibles. The budget amendment could request coverage and funding for: (I) general dental benefits only; (II) dentures only; or (III) coverage for general dental benefits and dentures.**
Option V	**Introduce a budget amendment to provide additional general fund support to the Virginia Health Care Foundation to be used specifically in support of projects to improve access to dental care.**
Option VI	**Introduce a joint resolution requesting the Virginia Department of Health to monitor the continuing research on the safety of dental amalgam and report to the Governor and General Assembly in the event such research indicates the use of dental amalgam poses a health risk.**
Option VII	**Send a letter from the Chairman of the Joint Commission on Health Care to the Virginia Health Care Foundation requesting it consider sponsoring a survey of the insurance status of Virginians to provide more current information regarding the Commonwealth's uninsured population.**

APPENDIX A

HOUSE JOINT RESOLUTION NO. 198
Offered January 24, 2000

Requesting the Joint Commission on Health Care to continue its study of ways to increase access to dental care throughout the Commonwealth.

Patrons-- Melvin, Brink, Clement, DeBoer, Diamonstein, Hamilton and Morgan; Senators: Bolling, Lambert and Schrock

Referred to Committee on Rules

WHEREAS, a 1996 survey of the insurance status of Virginians found that approximately 13 percent, or 858,000 persons are uninsured; and

WHEREAS, research has shown that uninsured persons are one-half as likely as those persons with insurance to regularly visit a dentist; and

WHEREAS, the 1996 Health Access Survey sponsored by the Virginia Health Care Foundation found that less than one-half of all Virginia households used dental insurance to pay for at least part of their dental care; and

WHEREAS, the 1996 Health Access Survey also found that 11 percent of survey respondents reported that they had not seen a dentist in over four years and six percent reported that they had never seen a dentist; and

WHEREAS, the lack of needed dental care often can lead to serious, costly health conditions; and

WHEREAS, the Joint Commission on Health Care recently completed a study of ways to improve access to dental care throughout the Commonwealth pursuant to House Joint Resolution 644 of the 1999 Session of the General Assembly; and

WHEREAS, the Joint Commission on Health Care study identified a number of access issues that are being addressed through legislative and budgetary actions recommended to the 2000 Session of the General Assembly; and

WHEREAS, additional analysis is needed to identify ways to increase the number of persons with dental insurance as a means of improving access to dental care; and

WHEREAS, recent efforts to increase the number of dentists participating in Medicaid need to be monitored to determine the effectiveness and if additional actions are needed; and

WHEREAS, following the 1999 Joint Commission on Health Care study, concern was expressed about potential safety issues regarding the presence of mercury in dental amalgam or "silver fillings"; now, therefore, be it

RESOLVED, by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care, in cooperation with the Virginia Department of Health, the Department of Medical Assistance Services, the Virginia Dental Association, the Virginia Dental Hygienists' Association, the Virginia Commonwealth University School of Dentistry, the Virginia Board of Dentistry, the Virginia Association of Free Clinics, and the Virginia Health Care Foundation, continue its study of ways to increase access to dental care throughout the Commonwealth.

The study shall include, but not be limited to, an analysis of: (i) various ways to increase the number of persons with dental insurance; (ii) the number of dentists participating in the Medicaid program, the results of recent actions taken to increase the number of participating dentists, and other actions that could be taken to increase further the number of participating dentists; (iv) potential safety concerns regarding the use of dental amalgam; and (v) barriers to access to care and other appropriate issues identified by the Joint Commission on Health Care.

The Joint Commission on Health Care shall submit its findings and recommendations to the Governor and 2001 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 296
Offered January 24, 2000

Requesting the Department of Medical Assistance Services to study the feasibility of expanding coverage for dental care, including dentures, to Medicaid recipients.

Patrons-- Crittenden, Barlow, Baskerville, Christian, Darner, Diamonstein, Grayson, Hamilton, Jones, J.C., McEachin, Melvin, Plum, Spruill and Williams; Senators: Maxwell and Miller, Y.B.

Referred to Committee on Rules

WHEREAS, preventive dental care is necessary to keep aging teeth, dentures and gums healthy; and

WHEREAS, today, nearly 60 percent of people 65 years of age or older retain some or all of their natural teeth, compared to only 44 percent in 1960; and

WHEREAS, for the growing proportion of older Americans, dental problems are a leading cause of discomfort, impaired quality of life, and even fatal disease; and

WHEREAS, most low-income families cannot afford the costs of private health insurance to pay for preventive and comprehensive dental care services; and

WHEREAS, although Medicare provides basic health care coverage, it does not pay for dental care and dentures; and

WHEREAS, Medicaid does not cover most adult dental services and does not provide reimbursement for dentures; and

WHEREAS, accessibility to good dental care should exist for all citizens of the Commonwealth; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Medical Assistance Services be requested to study the feasibility of expanding coverage for dental care, including dentures, to Medicaid recipients. In conducting the study, the Department shall examine eligibility, coverage, reimbursement and administrative policies, and determine appropriate guidelines for providing such services.

All agencies of the Commonwealth shall provide assistance to the Department for this study, upon request.

The Department of Medical Assistance Services shall complete its work in time to submit its findings and recommendations to the Governor and the 2001 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE OF DELEGATES
RICHMOND

S. VANCE WILKINS, JR.
SPEAKER

SPEAKER'S ROOM
STATE CAPITOL
POST OFFICE BOX 406
RICHMOND, VIRGINIA 23218

TWENTY-FOURTH DISTRICT

COMMITTEE ASSIGNMENTS:
RULES (CHAIRMAN)

March 10, 2000

Mr. Patrick W. Finnerty
Executive Director, Joint Commission on Health Care
Old City Hall, Suite 115
1001 East Broad Street
Richmond, Virginia 23210

Dear Mr. Finnerty:

During the 2000 Session of the General Assembly, the House Committee on Rules considered House Joint Resolution 198, patroned by Del. Kenneth R. Melvin, which directed the Joint Commission on Health Care, in cooperation with certain affected entities, to continue its study of ways to increase access to dental care in the Commonwealth. House Joint Resolution 296 (Crittenden), which requested the Department of Medical Assistance Services to study the feasibility of expanding coverage for dental care, including dentures, to Medicaid recipients, was incorporated into HJR 198. In an effort to reduce the number of study resolutions, House Joint Resolution 198 was among those that were not reported. However, the House Rules Committee believes that the issues addressed by the resolutions merit review. Therefore, the Commission is directed to undertake the study and to submit a written report of its findings and any recommendations to the Governor and to the 2001 Session of the General Assembly. It is requested that you notify Del. Melvin of any meetings that are scheduled by the Commission to consider the study issues, and that you regularly apprise the patron concerning the Commission's deliberations on such matters. In addition, you are requested to cooperate and coordinate your efforts with the Virginia Commonwealth University School of Dentistry as it conducts its study, pursuant to HJR 172 (Morgan). Further, please note that this study request expires at the end of the 2000 legislative year. I am enclosing copies of HJR 198, HJR 296, and HJR 172 for informational purposes so that you may be informed of the objectives of the study.

Your cooperation and assistance in this matter are appreciated.

Sincerely,

S. Vance Wilkins, Jr.
Speaker

/bhe
Enclosure (HJR 198, HJR 296, HJR 172)
cc: The Honorable Kenneth R. Melvin
The Honorable Flora D. Crittenden
The Honorable Harvey B. Morgan
The Honorable Bruce F. Jamerson
The Honorable Susan Clarke Schaar

APPENDIX B

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: Improving Access to Dental Care Study (HJR 198/HJR 296)

Organizations Submitting Comments

A total of 8 organizations and individuals submitted comments in response to the HJR 198/HJR 296 report on improving access to dental care in Virginia:

- Virginia Primary Care Association
- Virginia Association of Free Clinics
- Delta Dental Plan of Virginia
- Virginia Poverty Law Center
- Virginia Health Care Foundation
- Virginia Dental Hygienists' Association
- Virginia Dental Association
- Old Dominion Dental Society

Policy Options Included in the HJR 198/HJR 296 Issue Brief

Option I **Take No Action**

Option II **Introduce A Budget Amendment To Increase The Amount Of General Funds Appropriated For The Dental Scholarship And Loan Repayment Program**

Option III **Introduce A Budget Amendment To Increase Medicaid Reimbursement To Dentists To The 85th Percentile Of UCR**

Option IV **Introduce A Budget Amendment To Extend Dental Benefits To Adult Medicaid Eligibles. The Budget Amendment Could Request Coverage And Funding For: (I) General Dental Benefits Only; (II) Dentures Only; Or (III) Coverage For General Dental Benefits And Dentures.**

Option V **Introduce A Budget Amendment To Provide Additional General Fund Support To The Virginia Health Care Foundation To Be Used Specifically In Support Of Projects To Improve Access To Dental Care**

Option VI **Introduce A Joint Resolution Requesting The Virginia Department Of Health To Monitor The Continuing Research On The Safety Of Dental Amalgam And Report To The Governor And General Assembly In The Event Such Research Indicates The Use Of Dental Amalgam Poses A Health Risk**

Option VII **Send A Letter From The Chairman Of The Joint Commission On Health Care To The Virginia Health Care Foundation Requesting It Consider Sponsoring A Survey Of The Insurance Status Of Virginians To Provide More Current Information Regarding The Commonwealth's Uninsured Population**

Overall Summary of Comments

Option II received the greatest level of support with 6 of the 8 commenters expressing specific support for increasing the amount of funding appropriated for dental scholarships and loan repayment. Options IV and V were supported by 5 of the 8 commenters. Three commenters expressed clear support for Option III. Options VI and VII received less support among the commenters with only 3 supporting Option VII and 2 expressing support for Option VI. There

was very little specific opposition to any of the Policy Options. One comment was received in opposition to both Options IV and VI.

Three commenters, the Virginia Dental Hygienists' Association (VDHA), the Virginia Poverty Law Center (VPLC) and the Virginia Association of Free Clinics (VAFC) also commented in support of some policy options from last year's study that were not included in this report. The VDHA and VPLC expressed strong support for providing less restrictive supervision of dental hygienists. The VAFC commented that the Commonwealth should address legal and regulatory issues to ensure maximum participation of dental professionals in providing access to care. VDHA also commented in support of funding the dental hygienist scholarships. The VPLC commented in support of authorizing licensure by endorsement for dentists and increasing the salaries of public health dentists.

Summary of Individual Comments

Virginia Primary Care Association (VPCA)

The VPCA expressed support for Options II-V. In response to Option VII (replication of the 1996 survey of the insurance status of Virginians), the VPCA commented that although there may be slight changes in the uninsured population detected by the survey, it recommends that resources be used for direct dental services for underserved populations rather than an additional survey.

Virginia Association of Free Clinics (VAFC)

The VAFC expressed support for Options II, III, IV, and VII. In support of Option IV, VAFC favors dental benefits for Medicaid adults that includes both general dental benefits and dentures. The VAFC commented that the Commonwealth should invest substantial additional resources in developing and strengthening the dental care delivery system for the underserved. VAFC also commented that "in addition to more funding, the Commonwealth should address legal and regulatory issues to ensure maximum participation of dental professionals in providing access to dental care." Lastly, VAFC

indicated that it is important for both public and private entities to work together more effectively to develop solutions that will improve access to care, and that it is helping to facilitate the formation of a broad-based coalition to address dental care access issues.

Delta Dental Plan of Virginia (Delta)

Delta's comments included specific support of Options II and V. In support of Option V, Delta indicated that the additional support provided to the Virginia Health Care Foundation should address the need for additional education of the general public on the importance of good dental care and hygiene. With respect to Option III (increased Medicaid reimbursement for dentists), Delta indicated it neither opposes nor supports this action, and that further study of this issue may be required to determine an appropriate level of reimbursement. Delta expressed opposition to Options IV and VI.

In addition to commenting on the specific Policy Options, Delta also commented that it believes the number of actively practicing dentists stated in the report may be overstated, and that the number of dentists needed to eliminate shortages in underserved areas is significantly higher. Delta indicated that the number of dentists leaving active practice is increasing thereby reducing the number of "productive chair hours." In response to this concern, Delta identified three possible actions: (i) increase efficiency/ productivity through implementation of new technology and practice management systems; (ii) increase the dental school enrollment; and (iii) increase the availability of and expand the roles for dental auxiliaries.

Delta also commented that direct reimbursement of dentists increases the underlying cost of dental care which is contrary to the study's stated objective of improving access to care. Lastly, Delta suggested that consumer education of the importance of good dental care is "the critical first step to improving oral health among all Virginians, especially Virginia's children. The General Assembly might consider charging the Department of Education, working with the Department of Health, to evaluate, design, and implement

programs to educate Virginia's school-age children and the parents about the importance of good oral health."

Virginia Poverty Law Center (VPLC)

The VPLC commented in favor of Options II-V and VII. The VPLC also expressed strong support for easing the supervision restriction of dental hygienists. VPLC commented that "the best way to quickly increase the availability of dental services throughout the state is to allow dental hygienists to work outside the 'direct (physical) supervision' of dentists. . . Forty-five states have found an acceptable way to do this, and certainly Virginia can too." The VPLC also commented in support of authorizing licensure by endorsement for dentists. In support of this issue, the VPLC noted that "[C]onsidering the enormity of Virginia's underserved population, I support licensure by endorsement so long as it is tied to some kind of reasonable public service obligation." Lastly, the VPLC also expressed support for increasing the salaries of public health dentists.

Virginia Health Care Foundation (VHCF)

The VHCF did not express any specific support for any of the Policy Options; however, VHCF commented that it "would be honored and grateful to receive additional state money targeted to supporting community based dental initiatives. VHCF would bring the same responsible stewardship to any new funds that it brings to its current appropriation. In FY99, VHCF generated over $6 for every state dollar received. At the same time, 85% of VHCF's 'graduated' projects were sustaining themselves at a full level of operations for at least three years after VHCF funding." The VHCF concluded its comments by offering to help improve access to dental care in any way it can.

Virginia Dental Association (VDA)

The VDA specifically expressed support for Options II, V, VI, and VII. Regarding Option III, the VDA indicated that it applauds the

JCHC for putting the option forward to try to increase Medicaid reimbursement to the 85th percentile. VDA commented in response to Option IV that while providing dental coverage to Medicaid adults is an important issue, it "realizes that there are limitations within the budgetary process. It is going to be difficult for the General Assembly to increase funding, both for Medicaid services for children as well as for adults."

In addition to commenting on the specific Policy Options, VDA also provided information on several programs and activities it has been involved in to improve access to care. These programs/activities include: (i) the "Donated Dental Services" program, (ii) VDA members providing care at 20 Free Clinics, (iii) the Child Health Investment Program in Charlottesville, (iv) working to establish a coalition of various groups to advocate for improved access to dental care; and (v) outreach programs such as the recently completed "Mission of Mercy Project" in Wise County that took place in mid-July.

Virginia Dental Hygienists' Association (VDHA)

The VDHA commented in support of Options II-VII. In supporting Option VII, the VDHA noted that it "supports this option only to the extent that it does not detract from the Virginia Health Care Foundation's abilities to devote resources to dental projects which directly improve access to care."

In addition to commenting on the Policy Options included in the report, the VDHA also noted that "it finds the Draft Issue Brief glaringly deficient in its failure to take a closer look at the need for legislation to authorize less restrictive supervision of dental hygienists. . . Modification of this restriction is within the scope of this study, and it is one of the best ways of increasing access to care by many of the Virginians who are unable to obtain services that dental hygienists are qualified to provide. Continuation of the current restriction only exacerbates the dental care crisis among Virginia's underserved populations, so now is the time make a change." The VDHA also commented that "[A]nother element missing from the Brief is a policy option to support a budget amendment to fund dental hygiene scholarships. . . The VDHA urges the Joint

Commission to include such an amendment among the policy options it recommends."

Old Dominion Dental Society (ODDS)

The Old Dominion Dental Society commented in favor of Option IV. In its comments, the ODDS noted that "[W]ith poor mastication and gum disease the person can develop heart disease, strokes, intestinal problems, etc. Even if there is an additional cost to the state for adult dental care, there will also be a savings on medical care. I feel that Virginia should join the majority of states that provide some type of dental coverage for Medicaid adults."

JOINT COMMISSION ON HEALTH CARE

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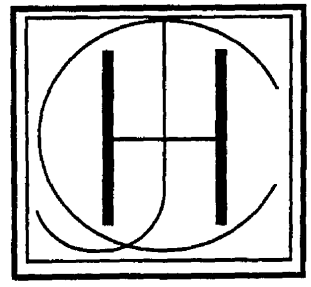

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