

It takes a village to improve oral health for our elders



Diego Rivera, Detroit Institute of Arts

The cost of care (and who pays for it)

Judith A. Jones, D.D.S., M.P.H., D.Sc.D.

Professor and Chair,

Department of General Dentistry

Boston University

**BOSTON
UNIVERSITY**

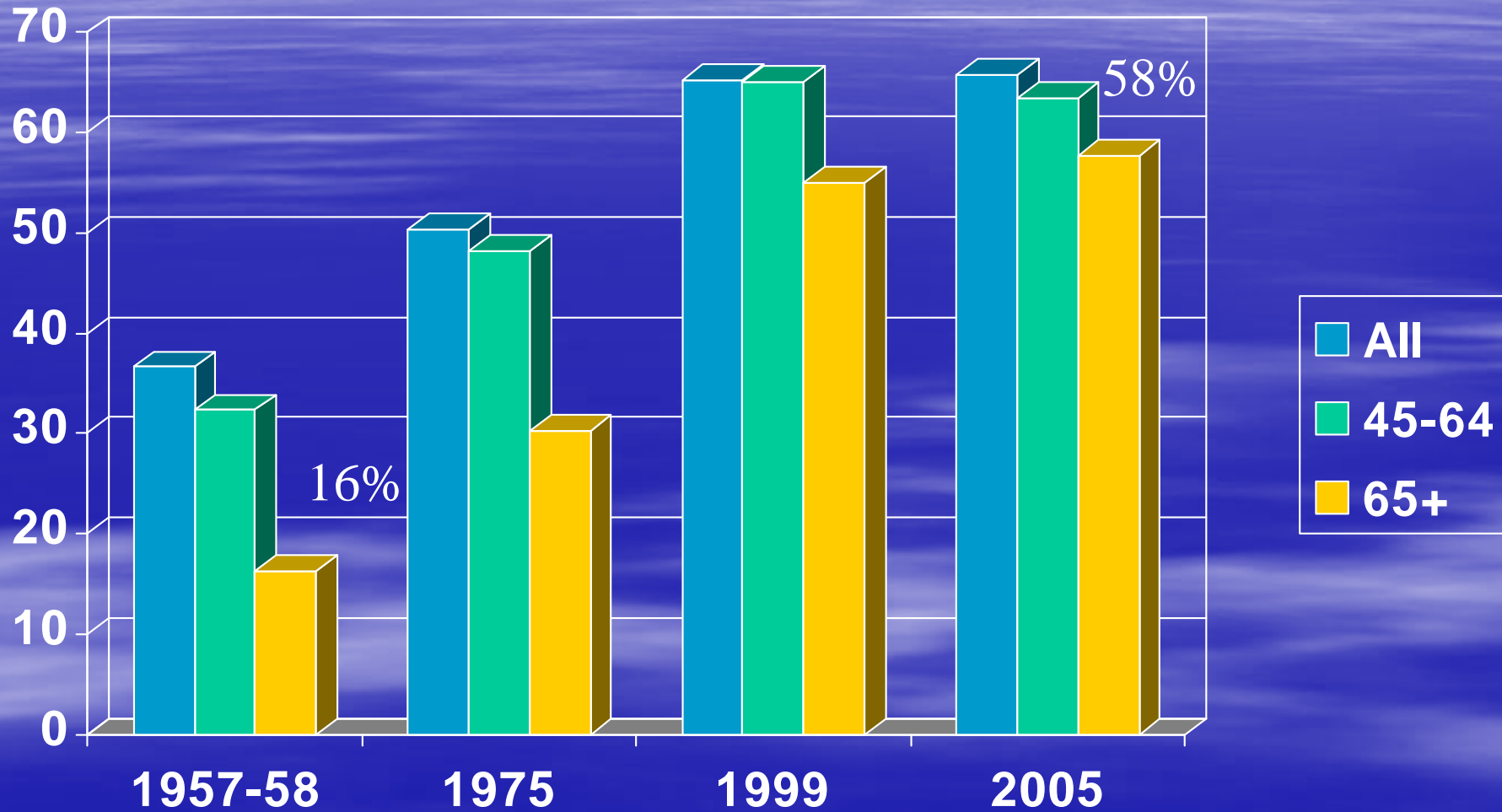
Options

- Extending dental insurance into retirement
- Inclusion of OH into comprehensive plans
- Retiree plans for selected groups
- Optional part “D” for dental in Medicare (minus the donut)
- Prepaying dental care during employment
- EldersHIP like SCHIP

Agenda

- What is the big picture?
- How does dental fit in?
- Financing – what is paid; by whom?
- Reimbursement – what are the options?
- IOM Principles for eliminating underinsurance
- Examples?

Elders use of care 3.6* over 50y

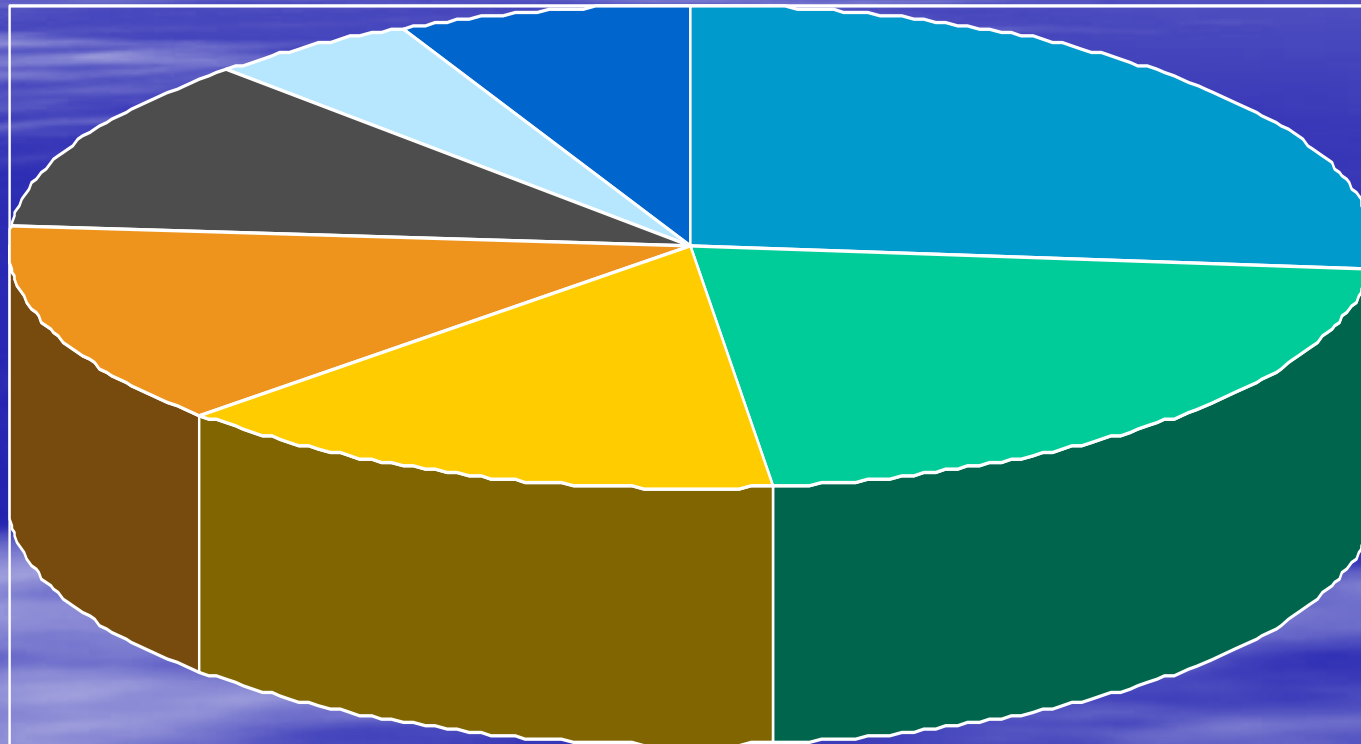


Source: NCHS

Context

- 37.260 million elders in 2006; 12.4%
- 58% of elders used dental care in 2005
- 76 million baby boomers start turning 65 in 2011
- Elders' economic and educational diversity

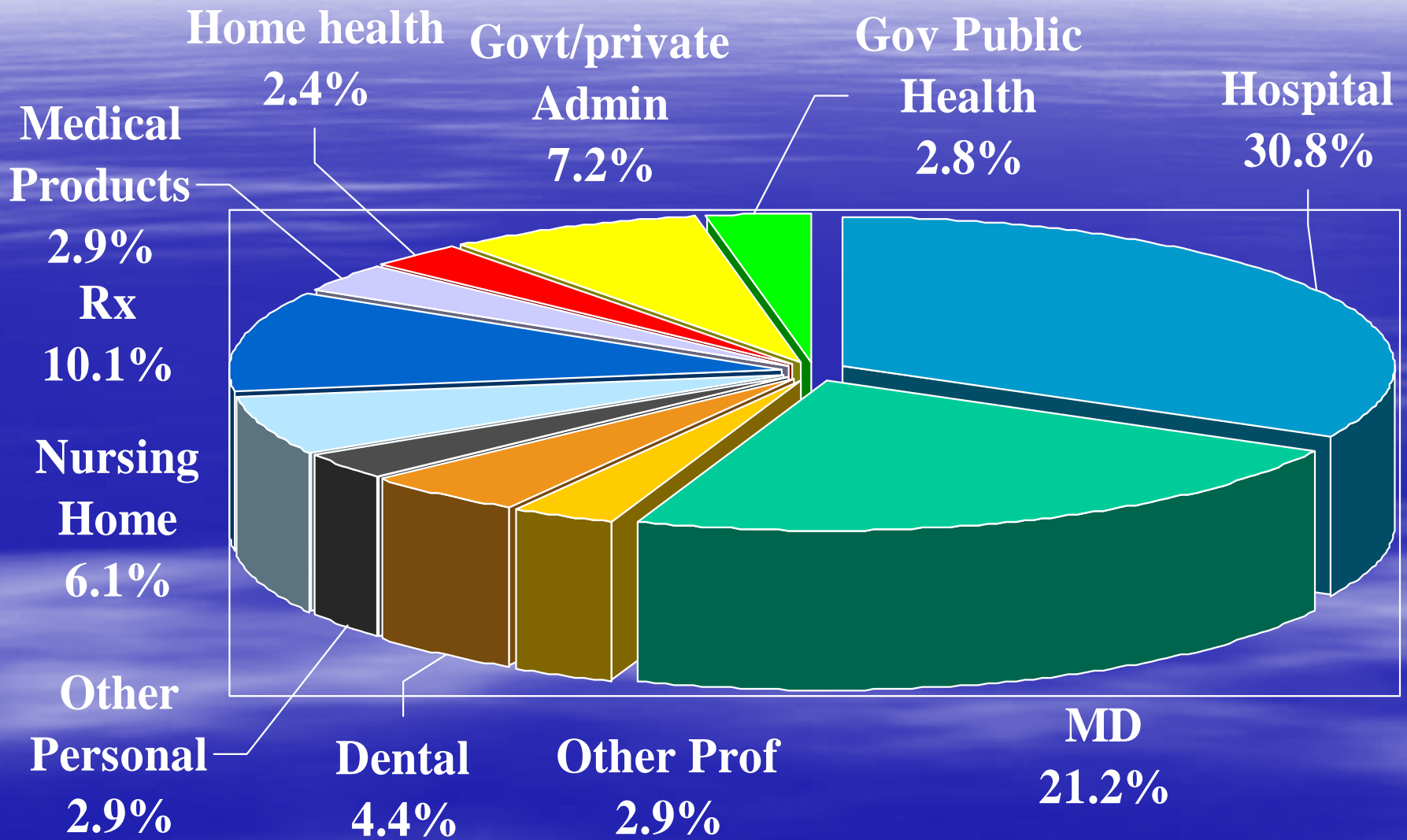
75% of elders: Household income < \$50k (in 2005)



National Health Expenditures, 2005

- ✓ \$2 trillion
- ✓ 16% of the Gross Domestic Product
- ✓ \$6697 / person on average
 - 55% from private funds
 - 45% from public funds
 - 25.2% of federal expenditures
 - 15.2% of state expenditures

National Health Expenditures 2005



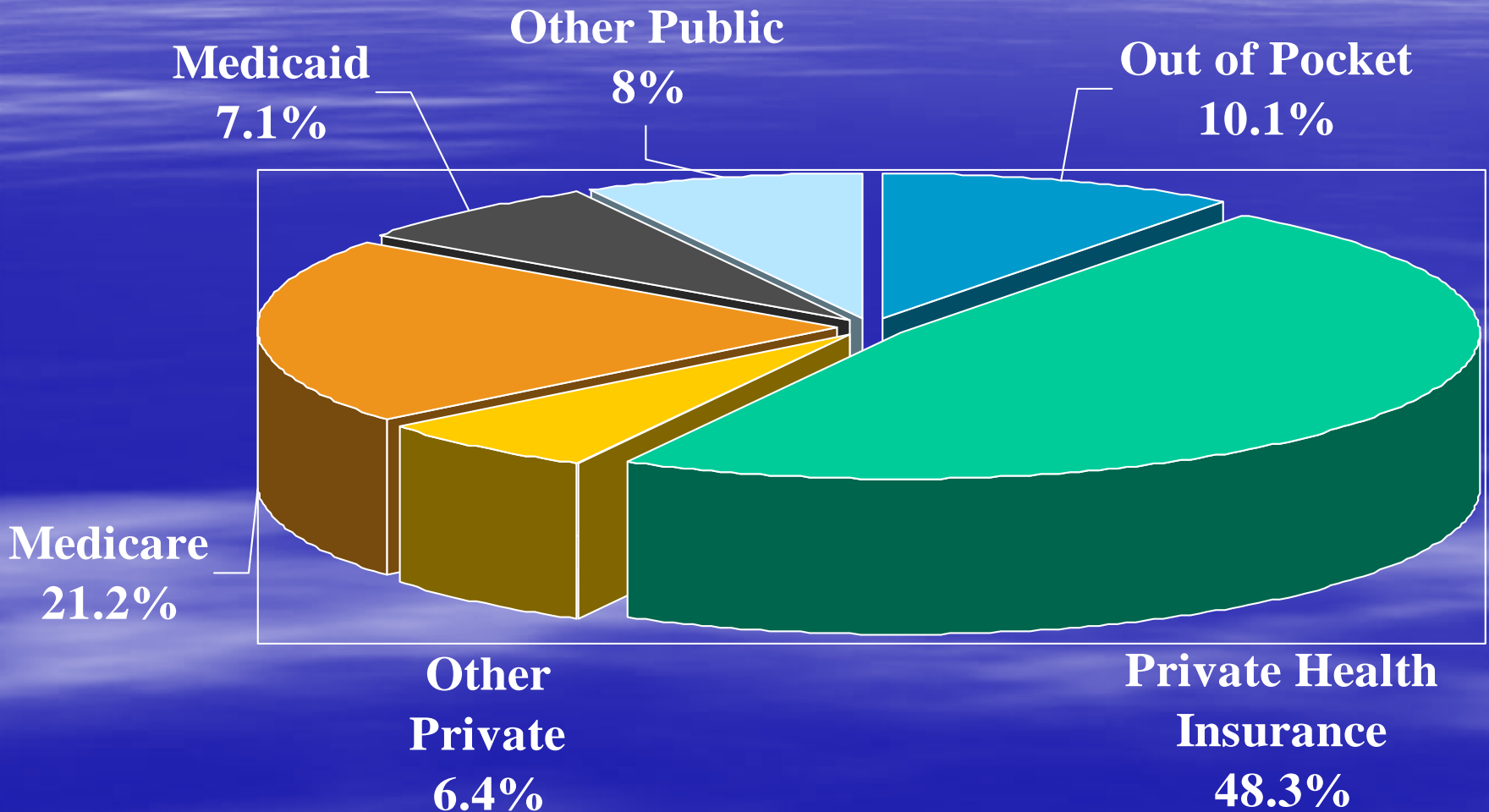
National Dental Expenditures 2005

- ✓ \$86.6 billion (now pushing \$100B)
- ✓ 4.4% of the personal health care expenditures
- ✓ 296.5 million people
- ✓ \$292.30 / person, on average
- ✓ \$444 / person who used care

Financing *versus* Reimbursement

- Financing – what comes in; to whom?
 - mechanisms by which money enters the health care system to pay for the delivery of services by varying types of providers (dentists, hospitals, MDs...)
- Reimbursement – how?
 - mechanisms by which providers are paid

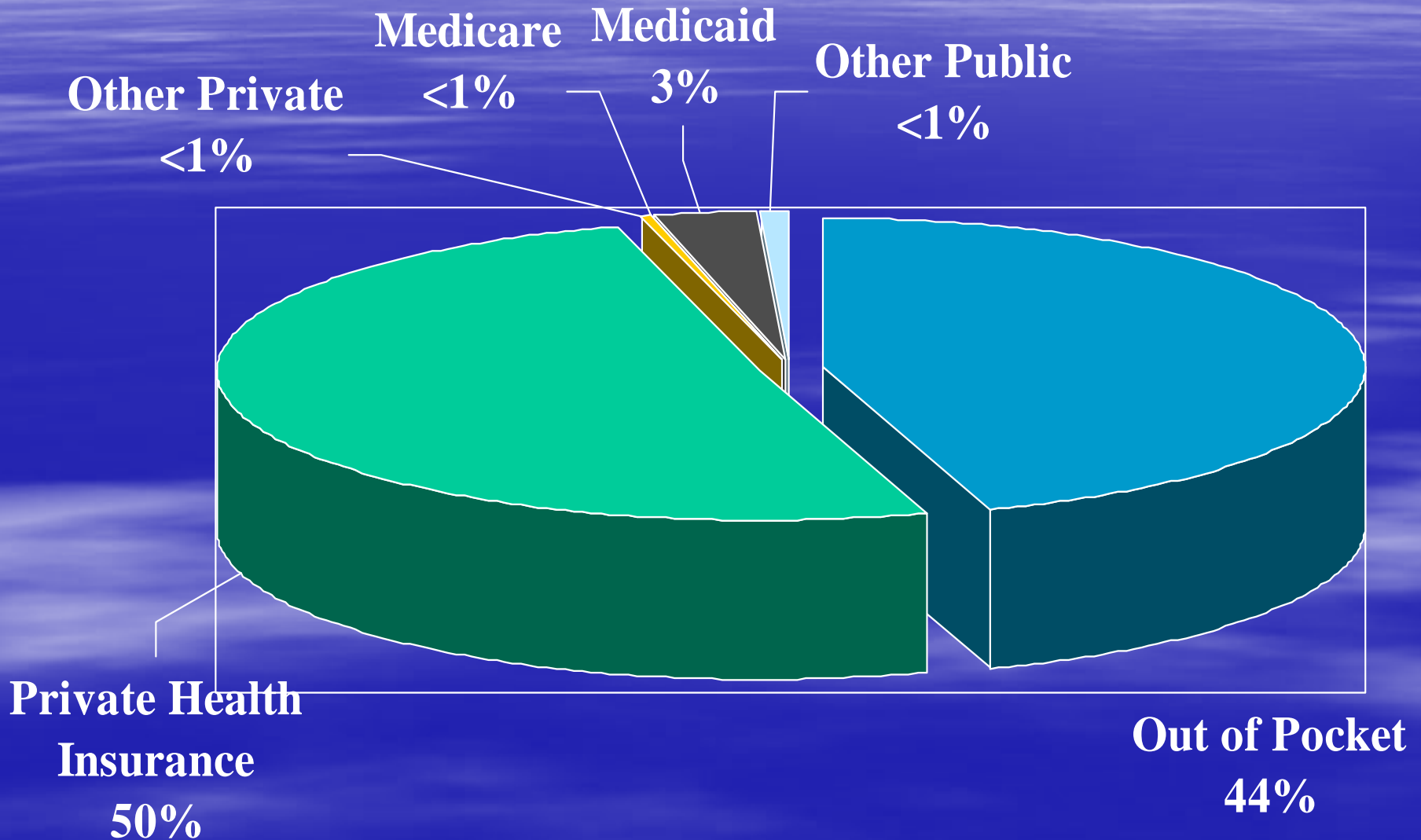
Physician Services by Source of Payment, 2005



Health, United States 2007

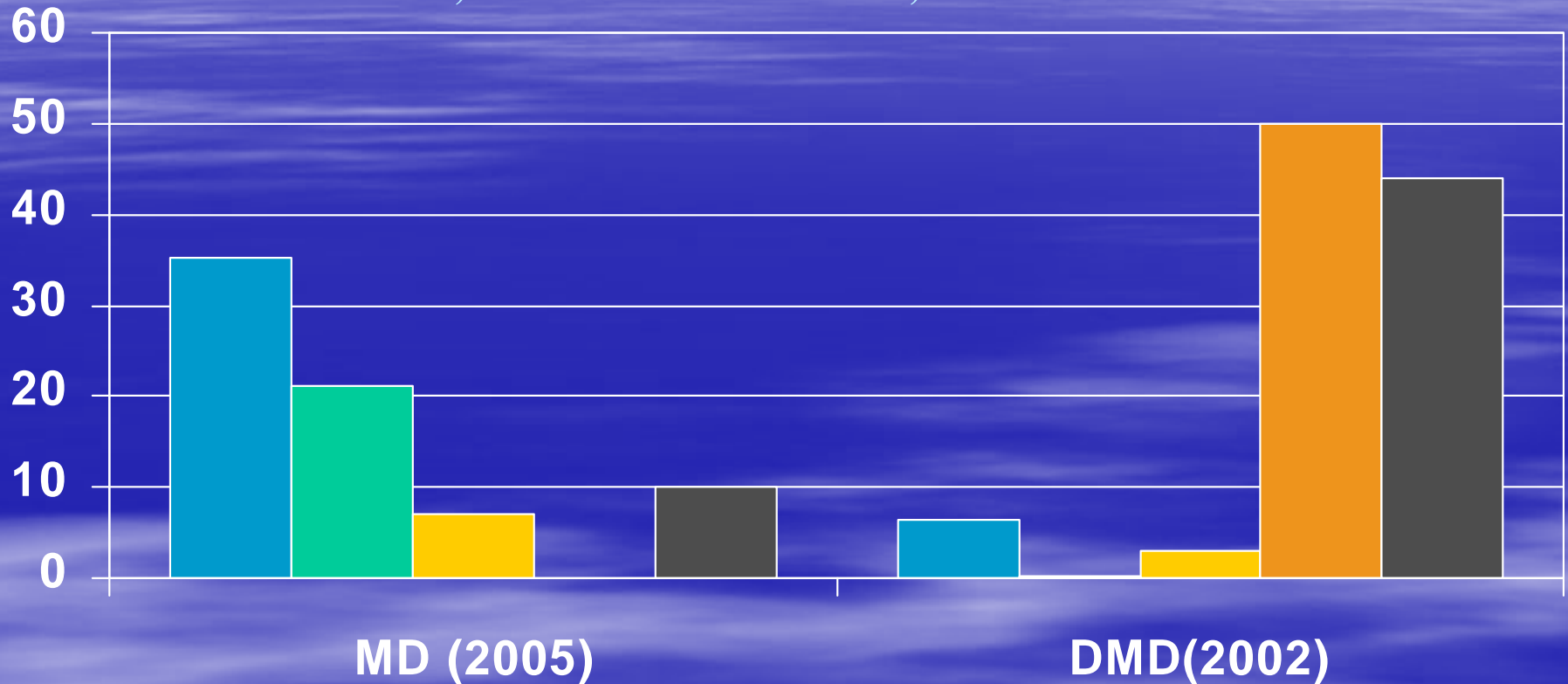
Dental Services by Source of Payment, 2002

(CMS, August 2004)



Percent of Care by Source of Payment

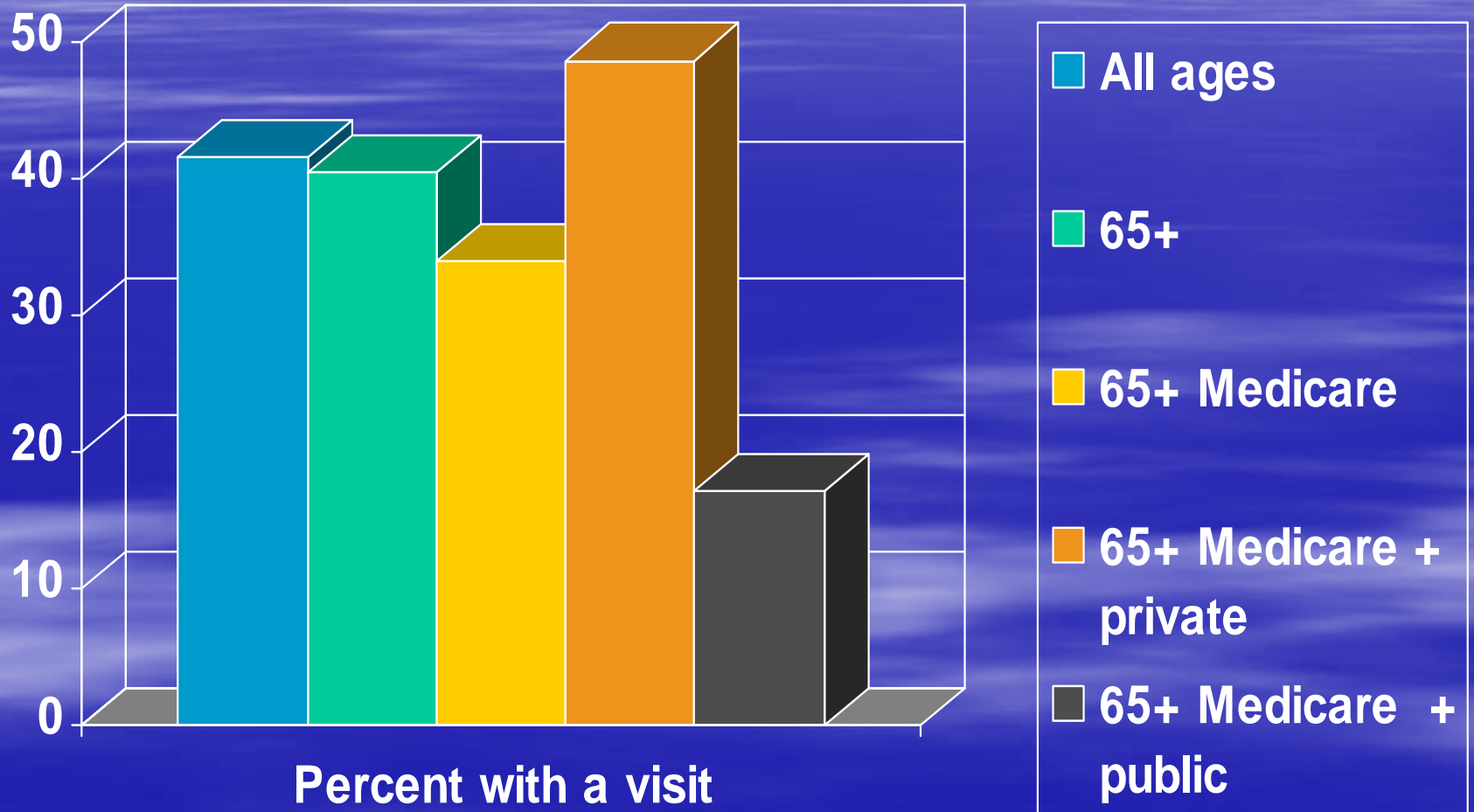
Health, United States 2007; CMS 2004



All Public Funding **Medicare** **Medicaid**
Private **Out of Pocket**

Dental visit by age and insurance

(2000 MEPS)



Plan Type by ability to pay (SES)

SES	LOW
Public	Medicaid Medicare-D ELDERSHIP
Private	
Out of Pocket	Low

Plan Type by ability to pay (SES)

SES	LOW	MEDIUM	HIGH
Public	Medicaid ELDERSHIP	Medicare - D? Medicare Advantage HSA,...	
Private	Medicare-D	Extending plans into retirement, Tricare, AARP, ...	
Out of Pocket	Low	Moderate	High

Questions to think about

- What do we need to know to better plan for oral health for all older Americans?
- Financing – What options do we have?
- Reimbursement - What options can we envision?
- How can health literacy be brought to bear on the access issues?

Principles for Eliminating Uninsurance

(IOM: Insuring America's Health)

- Oral health care coverage should be:
 - Universal
 - Continuous
 - Affordable to individuals and families
 - Affordable and sustainable for society
 - Enhance health and well-being by promoting access to high quality care

Principles for eliminating uninsurance

(IOM: Insuring America's Health)

- Coverage should be universal
 - Are individuals required to obtain coverage?
 - Are employers required to offer it?
 - Who is eligible / not eligible?
 - What type of coverage is it?
 - Is it easy to enroll?
 - Are there subsidies for low income elders?

Principles for eliminating uninsurance

(IOM: Insuring America's Health)

- Oral health care should be continuous
 - Is re-enrollment required? How frequently?
 - How streamlined is re-enrollment?
 - What happens to people who change jobs?
 - What happens to people with change in income?
 - Does it continue into retirement?
 - What about early retirees?

Principles for eliminating uninsurance

(IOM: Insuring America's Health)

- Oral health care coverage should be affordable
 - How much do elders contribute to their premiums?
 - What premiums, co-payments and deductibles?
 - Do they vary with income, health status, functional status?
 - Do they vary by venue (nursing home, home health care?)
 - Are subsidies available? How can elders qualify for them?

Principles for eliminating uninsurance

(IOM: Insuring America's Health)

- Oral health care insurance should be affordable / sustainable for society
 - How realistic are estimates of use and cost?
 - Does everyone contribute? If not, why?
 - Are revenues stable in tough economic times?
 - Are utilization controls / cost-controls built in?
 - Does the benefit package encourage cost-effective services?
 - Does the strategy emphasize simplicity and efficiency?

Principles for eliminating uninsurance

(IOM: Insuring America's Health)

- Oral health care insurance should enhance health and well-being
 - Is the care high quality, effective, efficient, safe, timely, patient-centered and equitable?
 - Are preventive and screening services covered and encouraged?
 - Are there incentives to avoid overuse / inappropriate use of services?
 - Are there incentives to offer high quality care consistent with scientific evidence?

Assumptions

- Hypothetical population of 1 million elders
 - 54% are 65-74
 - 34% are 75-84 and
 - 13% are 85+
- 95% community dwelling
- 5% will be in institutions
- 80% have 1 chronic condition
- 50% have at least 2 chronic conditions

Assumptions

- 10% have diabetes
- 10% have dementia and
- 10% have visual impairments
- 25% have hearing impairment
- 50% have arthritis and
- 50% need assistance with 1 or more Activities of Daily Living

Development of a statewide Elders' Oral Health Insurance Program similar to SCHIP

Stephen A. Eklund, DDS, DrPH

University of Michigan

Delta Dental Plans of Michigan, Ohio, and
Indiana

- Sponsoring Organization
 - Likely joint federal state program, as is SCHIP
- Plan development
 - Would come from legislation that developed overall program design, and appropriated necessary federal funds
 - If like SCHIP, it would be optional for states to implement
 - If linkage to Medicaid is an option for states, this could diminish the effectiveness of the program

- Population covered

- Poor

- Below federal poverty level
 - 10.4% of 65+ population in 2002
 - Approximately 3.7 million people in 2002

- Near-poor

- between poverty level and 125% of poverty
 - 6.4% of 65+ population in 2002
 - Approximately 2.3 million people in 2002

- Plan type (HMO, PPO, Indemnity, etc.)
 - Likely to vary by location between and within states
 - HMO and PPO will depend on state and local panel availability
 - Panel size will affect access

- Level of care covered
 - Diagnostic and preventive services, emergency, and basic restorative services most likely
 - This population is likely to have high levels of untreated need
 - Level of care covered will have major effect on cost

- Who pays the premiums?
 - Federal and state funds pay all or most of the premium
 - By definition, this population does not have resources to pay all of the premium
 - Could be some small premium contribution, especially from near-poor

Out of pocket cost to participant

–annual premiums

- This population is likely to have high levels of untreated need
- Level of care covered will have major effect on cost
- Even a small contribution could be a significant part of the total cost

- Out of pocket cost to participant (cont.)
 - annual premiums (continued)
 - even a small contribution could be a significant part of the total cost
 - copays
 - probably not on diagnostic, preventive, and emergency services
 - should be small, if at all, especially for poor

Out of pocket cost to participant (cont.)

–non-covered services

- crowns, could profoundly affect cost, especially considering likely need in this population

–annual maximum

- modest annual maximum, e.g., \$600, could be an effective cost control

- Annualized cost per participant
 - Will depend on many factors
 - level of care covered
 - who enrolls (adverse selection)
 - access
 - utilization

– Examples

- \$300/user/year, with 40% utilization, would cost \$120/enrolled/year (\$10 pmpm)
- \$450/user/year, with 60% utilization, would cost \$270/enrolled/year (\$22.50 pmpm)

- Advantages

- If done well, would get significant amounts of care to the elderly population most in need
- Splitting cost 4 ways, would make cost more palatable for all involved (fed/state/premium/copay)
- Total cost (to be split) only .75 to 2.0 \$Billion
- Will encourage more providers to devote a significant part of their practices to elderly patients

- Disadvantages

- Total cost .75 to 2.0 \$Billion
- Voluntary enrollment will miss many people, and could lead to adverse selection and an unfavorable cost situation
- Means testing for eligibility and possible premium contribution will be cumbersome
- Separation from medical coverage could perpetuate misperception that oral health care is not a mainstream part of health care
- Linkage to Medicaid could limit effectiveness

Elders' Oral Health Summit

What do we need to know to eliminate disparities in access to and outcomes of oral health care in elders?

Max Anderson

Delta Dental Data Analysis Center

Prepaid Insurance Plans

- Sponsoring organization (existing or potential) Washington Dental Service or any other Insurance Plan or Financial Institution.
- Plan development and history – Project at WDS, not yet implemented

PRINCIPLES

- Annuity Product
- Voluntary for Groups
- \$2000/Yr maximum
- Minimum pay-in period
- Coverage options
 - 100/100/50
 - 100/80/50

Prepaid Insurance Plans

- Universal?
 - Individuals required to have it? No – Voluntary
 - Employers required to offer it? No
- Eligibility –
 - Population covered – Currently insured with minimum pay in period
 - Population not covered – Uninsured?
- Easy to enroll? Yes
- Subsidies? Not as configured but no reason not to in a different labor market

Prepaid Insurance Plans

- Continuous
 - Re-enrollment required? No
 - Is re-enrollment streamlined?
 - Change of jobs? Yes
 - Change of circumstances?
 - Retirement? Starts paying out on retirement (65)
 - Early retirement? Pay at 65.
- Choice of dentists – Yes, POS program

Prepaid Insurance Plans

- Affordable for individuals and families?
 - Contributions to the premium? 100% plus accrued interest
 - What types of premiums, deductibles and co-payments are included? Normal 100/80/50 or 100/100/50 (model)
 - Are subsidies available? Perhaps
 - How to qualify? .. To be defined

Prepaid Insurance Plans

- Out of pocket costs to participants
 - Annual premiums –
 - while working but not while retired
 - Co-payments –
 - Yes at plan's designed level
- Annualized cost per participant – yes, \$25.00 / year admin charge

Prepaid Insurance Plans

- Affordable / sustainable for a segment of society.
- Are assumptions / estimates realistic?
 - Cost/person – Calculate ad libitum
- Level of care covered?
 - Choice at market rates
- Who bears the main burden? –
 - The employee while working.
- Are revenues stable in tough times?
 - Yes, on the output side.

Prepaid Insurance Plans

- Affordable / sustainable for society – yes for this sector
- Are utilization controls built in? Yes
- Are cost-controls built in? Yes
- Does the plan encourage cost-effective services? At market.
- Is the plan administratively efficient? Yes

Prepaid Insurance Plans

- Enhance health and well-being by promoting access to high-quality care
 - Effective, efficient, safe, timely, patient-centered and equitable –
 - Standard plans
 - Incentives for screening and prevention?
 - Standard plans
 - Incentives to avoid overuse?
 - As in standard plans
 - Incentives to providers to offer high quality care consistent with scientific evidence?
 - Standard payment as it evolves.

Prepaid Insurance Plans

■ Advantages

- Good for one segment
- Helps plan for the future
 - fixed income
- May improve access to care (removes barrier)
- Easy to administer
- Easily available
- Reinsurance covers risk
- Annuity to heirs
- Many vendors - competition

■ Disadvantages

- Limited market
- May be hard to understand
- It's not free
- Locked in for payment

Elders' Oral Health Summit

Optional Part “D2” For Dental Medicare

What do we need to know to eliminate disparities in access to and outcomes of oral health care in elders?

Plan 1 - PPO

- Sponsoring organization (existing or potential)
 - Private Sector in conjunction with CMS/Medicare

PPO

- Advantages
 - Reasonable cost from network providers
 - Wide panel selection
- Disadvantages
 - High cost for out- of - network providers
 - Limited panel selection

PPO

- Plan Summary
 - Premium of about \$16 a month or \$200 a year per person (final premium to be actuarially determined).
 - Limited to Panel Providers
 - First dollar coverage for prevention (with limits and exclusions to be determined by profession and experts)
 - Pay the first \$250 for non preventive services.

PPO

- Plan Summary
 - Pay 20% of discounted fees for restorative and surgical services above \$250.
 - Pay 50% of discounted fees for other services above \$250.
 - Annual limit of \$1500
 - Additional options to help low income persons pay the out-of-pocket costs.
 - Subsidy available to pay for premiums for low income persons.

Plan 3 – HSA

Health Savings Accounts

- Sponsoring organization (existing / potential)
 - Private Sector in conjunction with CMS/Medicare

HSA

- Advantages
 - Simple
 - Freedom of Choice
- Disadvantages
 - Limited assistance for high out-of-pocket expenditures

HSA

- Plan Summary

- No Premium – Subscriber places self determined amount of funds in a tax free account
- Pay 100% of non-discounted fees with tax free dollars.
- Freedom of Choice

HSA

- Plan Summary (cont.)
 - Additional options to help low income persons pay the out-of-pocket costs.
 - Supplemental coverage available to assist with high out-of-pocket expenditures (above \$1500/yr) with premium to be actuarially determined by experts

Lowell D. Daun, DDS

Voluntary, Self-Insured
Dental Programs
For Individuals

100% enrollee-paid dental plans

- Dental insurance generally limited to groups, employers, etc.
- Oral health is important for all age groups -- for smiling, eating, overall health
- Demand exists for dental insurance in the older population

What consumers want ?

- Affordable cost
- Comprehensive benefit
- Access to quality care
- Customer service
- Value

TRICARE Retiree Dental Program

- Dental program for retired members of uniformed services and their family members
- Mandated by Congress
- Implemented by the DOD
- 100% premium paid by enrollees

TRICARE Retiree Dental Program

- Delta awarded initial 5-year contract in 1998 for basic program
- Program enhanced in 2000
- Delta awarded second 5-year contract in 2003

Popular changes to contract

- Coverage for crowns, dentures, bridges and 2 cleanings per year
- Orthodontics added (including adults)
- Annual maximums increased
- Waiting period for major restorations reduced to 12 months
- Enrollment commitment reduced to 12 mos
- Increased Participating Dentist Locations

Daun, cont.

- Advantages: Available to individual population that has not been served for on an individual basis
- Disadvantage: It is not universal and is not available to everyone. Ex. Parents, grandparents, the disabled, college kids and older siblings.

Options for financing/reimbursement

- Extending dental insurance into retirement
- Inclusion of OH into comprehensive plans
- Retiree plans for selected groups
- Optional part “D” for dental in Medicare
- Prepaying dental care during employment
- EldersHIP like SCHIP

Plan Type by ability to pay (SES)

SES	LOW	MEDIUM	HIGH
Public	Medicaid ELDERSHIP	Medicare - D? Medicare Advantage, PPO, HSA	
Private	Medicare-D	Extending plans into retirement, TRICARE, AARP, Prepaid	
Out of Pocket	Low	Moderate	High