



Should We Be Concerned About the Future of Dental Insurance?

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ABSTRACT Paying for dental services is a complex interaction of insurance, government, and out-of-pocket expenditures. The increasing demands to control health costs, in response to the competitive nature of national and global economics, raise the specter that the escalating need for services (e.g., for an increasing geriatric population) could affect adversely third-party support for dental services. A call for a proactive stance is made. A review of the related factors considers the basis for this concern.

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“Of each dollar spent for dental services, (in 2004 and 2005) the private sector pays 94 cents and the public sector 6 cents, primarily through federal and state Medicaid reimbursements. Patients pay 44 cents out of pocket and private benefits cover 50 cents.”^{1,2}

The costs of dental services are felt to a far greater extent than the costs of other health services. In 2005, out-of-pocket spending accounted for more than 44.2 percent of dental costs compared to 15.0 percent for all personal health expenditures, 3.3 percent for hospital care, and 10 percent for physician services.² Nevertheless, virtually half (49.8 percent) of dental costs are covered by private health insurance arrangements (a greater share of coverage of costs than for all other major health services). The deficit in coverage lies in

the extremely limited input by government agencies for dental services.

Since 1980 (with projections through 2011) federal, state, and local governments' proportion of spending for overall personal health expenditures ranged from 39 percent to 44 percent; 40 percent in 2005.² During this period, government spending represented between approximately:

- 53 percent and 60 percent of all hospital costs;
- 30 percent and 35 percent for physician services;
- 11 percent and 23 percent for prescription drug costs; and
- 49 percent and 64 percent for nursing home costs.

By contrast, government spending for dental services ranged from 2.9 percent in 1990 to 6 percent of the \$86.6 billion spent in 2005, with a projection that it would reach 7.3 percent in 2011 (**TABLE 1**).

TABLE 1

Percent of Government Spending for Personal Health Services, Selected Years 1980-2011¹⁻³

	All Services	Hospitals	Physicians	Prescription Drugs	Nursing Homes	Dentists
1980	40.3%	54.3%	30.5%	13.9%	54.2%	4.9%
1990	39.0	53.2	30.6	11.6	49.2	2.9
2000	43.4	59.0	33.2	21.8	60.6	4.6
2004	44.4	56.3	34.6	27.5	60.8	6.0
2005	44.9	56.7	35.2	27.2	62.3	6.0
Projection						
2011	44.4	59.8	34.9	23.1	64.0	7.3

Lack of Health Insurance

“... the Census Bureau reported that the number of uninsured in 2006 had increased by 2.2 million Americans, largely because of a decline in employer sponsored insurance.”⁴

In 2006, 2.1 million of the additional individuals without health insurance were nonelderly, including 1.4 million adults and 710,000 children. Almost 70 percent of the uninsured children were in families with incomes at 200 percent or more of the federal poverty level. Reversing years of steady declines, the number of uninsured children grew by 1 million over the past two years.

As debate continued on reauthorization of the State Children’s Health Insurance Program, 48 percent of the increase in uninsured children from 2005 to 2006 was among families with incomes between 200 percent and 399 percent of the federal poverty level (roughly \$40,000 to \$80,000 for a family of four in 2006). Among children, the share with employer-sponsored insurance declined by 1.2 percent. The decline of employer-sponsored coverage for children was reported at all income levels. But there was no change in the share of Medicaid or SCHIP coverage to offset the employer-sponsored decline since most children in this income group are not eligible for public coverage under current rules.⁴

“In 2006, there was an actual decline in the number of people in poverty. Even in this economic environment, the number of uninsured increased substantially.”⁴

The number of children without health insurance increased to 8.7 million, 11.7 percent of the child population. The number of uninsured adults increased by 1.4 million, bringing the total to 37 million, 20.4 percent of the adult population. In 2006, a total of 47 million Americans lacked health insurance.⁵ In contrast to children, public coverage generally is not available to adults, even at low-income levels. As a result, nearly half of the growth of uninsured adults was among those with incomes below 200 percent of poverty.⁴

Spending for Health Care

In 2005, per capita national health expenditure was \$6,697 (ranging, in 2004, from less than \$4,000 in Utah to almost \$6,700 in Massachusetts⁶). A total of \$1.988 billion was spent nationally in 2005 for health services, 16 percent of the gross national product.⁴ By the year 2016, the Centers of Medicare and Medicaid Services project that health spending will be nearly one-fifth of the GDP (19.6 percent). The aging of the population with its associated complexity of health needs will have an added “... impact on

cost growth in the years to come.”⁷

Per capita expenditures in 2004 “... was about 13 percent higher than in the next highest spending country, and about 90 percent higher than in many other countries that we would consider global competitors.”⁷

Health Insurance

“The average premium for family (overall health insurance) coverage in 2007 is \$12,106, and workers on average now pay \$3,281 out of their paychecks to cover their share of the cost of a family premium.”⁸

Health insurance premiums consistently have outpaced inflation and the growth of workers’ earnings. As a result, workers have to spend more of their income each year on health care to maintain coverage, either through increased contribution for premiums or reduced benefits, or indirectly as when employers forgo wage increases to offset increases in premiums.⁸

It is anticipated that premium growth will continue to exceed per capita disposable personal income through 2014. “This may further strain the current system of employer-sponsored health insurance coverage.”⁹ Rather than increasing employees’ share of insurance premiums, employers continue to seek cost savings by increasing the use of coinsurance, adding deductibles, and eliminating coverage for specific treatments or prescription drugs. “These actions might slow premium growth for employees, but they ultimately increase the burden on individuals as their direct out-of-pocket costs increase.”²

“Rising medical bills may prompt some employers to develop strategies to manage the costs associated with the provision of coverage as they attempt to strike a balance between attracting and retaining talented employees and minimizing labor costs.”¹⁰

Spending for Dental Care

During the past 35 years, total current and constant dollar (removing the effects of inflation) spending for dental services has increased steadily; constant dollar spending has more than doubled. Total personal care costs, however, increased at a greater rate. As a result, the dental service share of expenditures for health services decreased from 7.4 percent to 5.2 percent, with a projection that it will decrease to 4.3 percent by 2011 (TABLE 2).

Since 1990, there has been limited change in constant dollar per capita spending for dental services (TABLE 3). As a result, the increase in constant dollar national expenditures for dental services would, to some degree, be a reflection of the ongoing increases in the general population.

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Whether it is manufacturing an automobile, building a new bridge or ship, employing service workers, educating the next generation of youngsters, or insuring the needs of retired employees, the cost of health services (including dental care) is an increasing reality and a major factor in our highly competitive national and global economies.

Now add some additional developments that could (will?) strain further the economics of health costs during the practice careers of increasing numbers of dentists:

- Twenty percent of the population will be age 65 and older. In six states — Florida, Maine, Wyoming, New Mexico, Montana, and North Dakota — more than 25 percent of the population will be 65 years and older.¹³ “Adults aged 65 and older have the highest health care spending, averaging \$8,647 per person in 2004.”⁷

- Increasing numbers of individuals

TABLE 2

Expenditures for Dental Care as a Component of Total Personal Health Care Costs: Selected Years 1970-2011^{2,3,11}

Year	Expenditures (in billions)			Percent of Total Personal Health Care Cost
	Current Dollars	CPI (1982-84=100)	Constant Dollars	
1970	\$4.7	39.2	\$11.9	7.4%
1980	13.3	78.9	16.8	6.2
1993	38.9	188.1	20.7	5.0
2000	62.0	258.5	23.9	5.4
2005	86.6	324.0	26.7	5.2
Projection				
2011	104.6	na	na	4.3

TABLE 3

Current and Constant Dollar Per Capita Expenditures for Dental Services: Selected Years 1990-2004^{11,12}

Year	Expenditures (in billions)		
	Current Dollars	CPI (1982-84=100)	Constant Dollars
1990	\$120	155.8	\$77
1995	156	206.8	75
2000	205	258.5	79
2001	219	269.0	81
2002	235	281.0	83
2003	244	292.5	83
2004	256	306.9	83

with a wide range of disabilities, many of whom in the past succumbed to their conditions, are living longer, and 1) require increased health and supportive services, and 2) reside in our communities. In 2006, 15.1 percent of U.S. residents, age 5 years and over (more than 41 million individuals) had one or more disabilities including sensory, physical, mental, and self-care disabilities.¹⁴

In such an increasing competitive environment to provide for burgeoning health care costs, will private insur-

ance arrangements continue to provide for 49.8 percent of dental costs, or will other components of health services be emphasized further in union-employer contract negotiations? Will government agencies continue to maintain only 6 to 7 percent coverage for dental costs?

At present, the economics of dental practice continue to be favorable. The average net income for an independent private practitioner who owned all or part of his or her practice in 2004 was \$185,940 for a general practitioner,

and \$315,160 for a specialist.¹⁵ Whether this positive economic picture can be sustained in the event of a downturn in dental insurance coverage, that would in turn require increases in out-of-pocket spending by the public, is the question to consider as the profession prepares for the challenges posed by employer and government agency efforts to control health care costs.

While it may run counter to current efforts to showcase cosmetic dentistry, emphasizing the relationships between oral health and an individual's general medical status would be better suited to make the case for continued third-party support for dental services. Similarly, emphasizing the need to provide care for the growing population of the elderly and individuals with special health care needs would garner needed support for third-party coverage of dental care.

Directions

In the past, the dental profession remained in the shadows of the American Medical Association during the debates over the enactment of Medicare/Medicaid legislation in the 1960s and general proposals for national health insurance in the 1970s and 1980s. Similarly, during the contentious political conflict over the legalization of denturism in the state of Oregon in the late 1970s and 1980s, the dental profession attempted to respond to the full-denture needs to the population only after it appeared that the voters would approve the initiative. But it was too late, the legalization of denturism was approved by two-thirds of the voters.¹⁶ Presently, the dental profession continues to remain in the shadows of the medical profession over the explosion of litigations, the associated sky-rocketing of malpractice premiums (somehow assuming there is limited need for concern), and governmental efforts to reduce

hospital and physician reimbursements under the Medicare/Medicaid programs.

We may remain in the position of *responders* to government and other third-party intrusions into dental practice. We could, however, *participate* in current and future debates over health care reform and promote those efforts that improve the shrinking availability of health benefit dollars, preserve the tax deductibility of dental services, and develop programs to ensure dental cost coverage among the tens of millions of individuals who currently lack adequate insurance and, who as a result, are far less likely to seek needed oral health services.

Or are we prepared to just wait and see whether labor management negotiators will remember to support dental services in future health insurance packages? ■■■■

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