



Changes in Health Care Financing & Organization (HCFO)

findings brief

The Individual and Program Impacts of Eliminating Medicaid Dental Benefits in the Oregon Health Plan

key findings

- Eliminating dental benefits for some Oregon Medicaid beneficiaries resulted in increased unmet dental needs.
- Dental benefit elimination also resulted in increased use of medical settings—such as the emergency department—for unmet dental needs.

Medicaid is the primary safety-net insurance system in the United States and covers approximately 60 million Americans. Under the Patient Protection and Affordable Care Act (Affordable Care Act or ACA), Medicaid will expand substantially in 2014. Individuals with incomes less than 133 percent of the federal poverty level will be eligible for coverage.¹ While Medicaid covers medical and long-term care, dental coverage is optional for adults. Due to the optional status of this benefit, it is often one of the first items eliminated when states experience budget shortfalls. Additionally, many states only cover emergency dental care and do not cover preventative services.² The elimination of dental benefits implies that they are not perceived to be as valuable as other forms of coverage. There is no specific basis for valuing oral health less than other aspects of health, and some evidence suggests that poor oral health may contribute to other physical problems. Prior research on the experience in Massachusetts³ showed that adults were less than half as likely to receive dental services after benefit elimination and that many were facing pain from untreated dental problems.

Study Overview

In a HCFO-funded study,⁴ Neal Wallace, Ph.D., examined a change in Oregon's Medicaid program that resulted in a natural experiment to explore the impacts of eliminating dental benefits on low-income adults. Oregon Health Plan Standard (OHP Standard) enrollees are the state's Medicaid expansion population—those eligible solely on the basis of low income. Oregon Health Plan Plus (OHP Plus) enrollees are those eligible based on federal statutory criteria. In 2003, Oregon eliminated adult dental benefits for the OHP Standard population (along with other coverage, e.g. outpatient mental health care) and instituted copayments on the remaining covered care. OHP Plus enrollees retained dental benefits.

Dr. Wallace and his colleagues compared OHP Standard and OHP Plus enrollees to examine the impact of eliminating dental coverage from the perspective of both the individual consumer and the Medicaid program. They surveyed members to assess unmet dental needs and receipt of preventative dental care and calculated Medicaid program use and expenditures for outpatient and emergency



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room visits for dental problems. “We just wanted to get a better understanding of the impact of Medicaid dental coverage and this was a unique opportunity in an understudied area,” said Wallace.

Analysis

To inform the analysis, the researchers used a subset of survey data from a larger prospective study of 2,783 individuals that were evenly divided between the OHP Standard and OHP Plus programs. In the larger study individuals were surveyed at 9, 21, and 33 months after the Medicaid program changes. To avoid the effects of uninsurance and to isolate the effects of the changes in dental benefits, this study limited analyses to 718 continually enrolled individuals who completed all three surveys. The survey included questions about unmet dental needs and use of preventative services. The researchers split responses into two categories: at least one visit per year and less than one visit per year. Demographic characteristics from the surveys including age, gender, race, and employment status, were used to create propensity scores.

Study administrative data came from OHP eligibility files, fee-for-service claims, and encounter data from managed care organizations. Dr. Wallace and colleagues used the eligibility files to identify members continuously enrolled for nine months before and after the policy change. Outcomes of interest from the administrative data were probability of dental service use and expenditures for dental problems treated in any ambulatory care setting or emergency department.

Since copayments for general medical treatments were introduced for the OHP Standard population at the same time as the dental benefit change, utilization of medical settings for dental problems was measured as a percentage of all medical utilization. This was to avoid confounding related to any changes in medical service use due to the copayment policy. The final analysis included propensity score matched samples and a difference-in-differences approach, which accounted for any unmea-

sured differences in baseline outcomes and allowed relative change to be assessed if baseline differences existed.

Key Findings

The surveyed OHP Standard group was younger, had higher level levels of employment, and was less likely to be diagnosed with depression than their OHP Plus counterparts. There were large differences between the two groups in access to dental care and utilization of preventative dental services. OHP Standard enrollees were 50 percent more likely to report an unmet dental need and 55 percent less likely to report having an annual dental exam than were OHP Plus enrollees. Even after adjustment for sample differences, the OHP Standard group had three times the odds of having an unmet dental need and one-third the odds of having dental checkups compared to those that kept their dental benefits.

In their examination of the administrative data, the researchers found that, relative to the OHP Plus group, the OHP Standard group experienced increases in the use of ambulatory care for dental needs ranging from 73 to 101.7 percent. For the OHP Plus enrollees, the probability of using ambulatory medical care for dental needs declined across the domains measured. The trend was the opposite for OHP Standard members—the probability of using ambulatory medical care for dental needs increased by approximately one-third. Although there was an increase in ambulatory medical expenditures due to the policy, the amount represented less than five percent of dental costs incurred by OHP Standard enrollees in the pre-policy period.

Study Limitations

The researchers acknowledge two key data limitations in their study. First, the survey did not have baseline data to illustrate a causal relationship between the elimination of dental benefits and the difference in access and utilization between the two groups. However, there is evidence that prior to the pre-policy period, the rates of dental usage between OHP Standard and OHP Plus enrollees were almost identi-

cal. Additionally, rates of unmet need in the OHP Standard populations were much lower during the pre-policy period than they were after dental benefits were eliminated.

With regard to the administrative data, there were some limitations related to the process of selecting and matching enrollees. The requirement of continuous eligibility yielded OHP Standard enrollees who were more likely than the average enrollee in that program to be female, white, older, have a chronic condition, or to report previous dental use. Finally, while these are the results of one state and may be not generalizable to others, the results are comparable to those found in similar studies conducted in other states.

Policy Implications

The study’s results illustrate some of the issues and trade-offs involved in benefit reductions. For Oregon’s Medicaid program, the elimination of the dental benefit for some enrollees did result in net savings, despite the group’s increased medical utilization for dental problems. Enrollees, however, suffer costs in the form of unmet need, increased out-of-pocket costs, and use of inappropriate care settings for dental needs.

“Once again, the emergency department is the canary in the coal mine that reflects the limits of our primary care coverage,” said Wallace. “But despite large proportional increases in dental treatment in medical settings, expenditure increases were much less than the savings from cutting the benefits. The loss of the value of dental coverage is borne almost entirely by the Medicaid recipients.”

The results point to the larger issue of how Medicaid dental benefits should be valued. Further research is needed on the connection between oral health and physical health and the health status changes that result from the loss of dental coverage.

Conclusion

As states face continued economic challenges, optional Medicaid benefits will continue to be at risk for cuts. While eliminating optional benefits can result in bud-

getary savings, it can also have unintended consequences. As Dr. Wallace and his colleagues show in their work, the elimination of dental benefits for a subset of Oregon's Medicaid population resulted in increased use of ambulatory medical settings for dental needs and significant unmet dental needs.

“One of the most striking findings to me was the extent to which these low-income individuals sought out dental care even without coverage,” said Wallace. “This seems to be at direct odds with the perception that dental coverage is a luxury or of low value. We need a better process for assessing the value of oral health and dental coverage.”

For More Information

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Endnotes

1 Kaiser Commission on Medicaid and the Uninsured. Medicaid Facts: The Medicaid Program at a Glance, June 2010. See also: <http://www.kff.org/medicaid/upload/7235-04.pdf>.

2 McGinn-Shapiro, M. Medicaid Coverage of Adult Dental Services. Washington, DC: State Health Policy Monitor, National Academy for State Health Policy, 2008. See also: <http://www.nashp.org/sites/default/files/Adult%20Dental%20Monitor.pdf>

3 Kaiser Commission on Medicaid and the Uninsured. Eliminating Adult Dental Coverage in Medicaid: An Analysis of the Massachusetts Experience, September 2005.

4 Wallace, N.T. et al. “The Individual and Program Impacts of Eliminating Medicaid Dental Benefits in the Oregon Health Plan,” *American Journal of Public Health*, Vol. 101, No. 8, 2011, pp. 1514-1520. For full grant information and related publications, see also: <http://www.hcfo.org/grants/surviving-perfect-storm-impacts-benefit-reductions-and-increased-cost-sharing-medicaid-progra>.