COVID-19 Pandemic Attack Low-Income American's Oral Health

Josie Wang

Executive Summary

Unemployment rates in Georgia are rapidly increasing because of the COVID-19 pandemic and economic recession. Employees will lose dental insurance sponsored by their employers if they lose jobs. Then, these individuals are likely to enroll in state-based Medicaid programs. However, Georgia Medicaid dental coverage for adults is only limited to emergencies. Therefore, the Georgia State government should take their responsibilities to increase the number of providers and dentists serving Medicaid enrollees, and expand dental benefits for Medicaid enrollees.

Issue

Adequate oral health care coverage and access for low-income adults remain elusive in Georgia. Georgia Medicaid[1] dental coverage for adults is only limited to emergencies[2]. The Georgia Medicaid program is required to cover dental services for children and youth under age 21 years of age but there are no minimum coverage requirements for adults over 21 years of age (age≥21).

[1] Medicaid is a medical assistance program that helps many people who can't afford medical care pay for some or all of their medical bills.

[2] The emergency services include relief of pain under defined emergency situations, e.g., uncontrolled bleeding, traumatic injury, etc.

Improving the oral health of unemployed people cannot be overlooked because poor oral health can limit employability. People with bad teeth will suffer from prejudice in both social environments and the labor market[3].

Given the unprecedented scale of job loss during the COVID-19 pandemic, the Georgia State government plays a critical role in supporting access to health care for unemployed workers and low-income families. The state government's responsibility is to allocate the high-quality health care for the public, especially for the unemployed people.

Context

The GA unemployment rate raised to 12.6% in April 2020, the highest level since the Great Depression. Prior to the pandemic, Georgia's unemployment rate was at an all-time low of 4.6 percent[4]. The unemployment rate for October was 4.5%. Although the unemployment rate has dropped to slightly less than the value prior to the pandemic, the state government still has not formed a new policy to address this issue if the economic depression worsens again.

Low-income adults suffer a disproportionate share of dental disease. MPH senior program officer, Stacy Chazin (2015), reported that low-income adults are 40% less likely to have visited the dentist in the past 12 months than those with higher incomes. Meantime, people are more likely to have poor oral health if they are low-income. According to this report, 42% of

[3] About one-third of adults with incomes below 138 percent of the poverty level reported that the appearance of their teeth and mouth affected their ability to successfully interview for a job. In comparison, only 15 percent of adults with incomes above 400 percent of the poverty level felt that way. (Frakt, 2018).

[4] Download this pdf file. Bar Graph of the state unemployment rate for the last 13 months. https://dol.georgia.gov/unemployment-rate-and-nonagricultural-employment

non-elderly, low-income adults have untreated tooth decay and low-income adults are two-and-a-half times as likely to have untreated tooth decay than higher-income counterparts.

In response to fiscal challenges during the pandemic, many states reduced or eliminated Medicaid dental coverage (CHCS, 2019). Medicaid enrollees often have difficulty finding Medicaid-contracted dental providers because low overall reimbursement rates further deter dental provider participation in Medicaid. Also, the federal government classifies dental coverage for adults as an optional Medicaid benefit. The federal laws do not mandate any minimum requirements for adult dental coverage under Medicaid so adult dental benefits vary widely across different states. Therefore, the low-income adult Georgians could not receive oral health care.

Supporting Information

We can refer to other states' cases to see how they developed their policies. Oregon state has expanded their dental services coverage in 2010. Now, the Oregon Medicaid adult dental benefits covered preventive services, restorative services, dentures, oral surgery services, and orthodontia[5]. Kentucky Medicaid offers a more comprehensive adult dental benefit package than many southeastern states. The keys to success in Kentucky are leadership support, stakeholder engagement, and interagency Collaboration[6]. The Cabinet Secretary has been a true supporter of

[5] Medicaid Adult Dental Services in Oregon. Preventive services: 1 exam per year, 1 cleaning per year, fluoride; Restorative services: Amalgam and resin-based crowns, root canals (not for molars); Dentures: 1 set partial dentures every 10 years, 1 complete denture per lifetime; Oral surgery services: extractions; Orthodontia: removeable and fixed appliance therapy

[6] P45. Kentucky Department for Medicaid Services: Adult Dental Care. Dental Coverage and Access for Adults in Medicaid: Opportunities for States. https://www.chcs.org/resource/dental-coverage-access-adults-medicaid-opportunities-states/

oral health initiatives. The Kentucky Medicaid program collaborates with the Kentucky Dental Association. The Kentucky Department of Public Health, Office of Health Policy and Section 2703 Health Homes formed a cooperative alliance.

Policy Alternatives

Georgia state only provides emergency dental services for members who are 21 and older. The unemployment people lose their oral health care during the COVID-19 pandemic. If they already have caries, they will finally experience extreme toothache and headache and still cannot pay for the treatments. Therefore, this policy brief provides two policy alternatives as follows.

Option 1: Increasing the number of providers and dentists serving Medicaid enrollees.

According to the Georgia Board of Dentistry, dental care providers are distributed unevenly across the state and most dentists are concentrated in large cities and towns[7]. By implementing this alternative, the unemployment people could get free access to dental school or clinics. The state government does not have to ask for more resources. This option could give dental students more work experience during their academic years and relieve the pressure of current providers. However, this policy alternative needs the federal funds but the Georgia state government do not have Affordable Care Act (ACA)'s enhanced federal funding now[8].

[7] Kabore, H.J., Smith, C., Bernal, J., Parker, D., Csukas, S, & Chapple-McGruder, T. (2014). The Burden of Oral Health in Georgia. Georgia Department of Public Health, Maternal and Child Health, Office of MCH Epidemiology, Georgia Oral Health Program. https://dph.georgia.gov/oralhealthprogramga

[8] Georgia and the ACA's Medicaid expansion. https://www.healthinsurance.org/georgia-medicaid/#:~:text=Georgia%20will%20partially%20expand%20Medicaid,go%20along%20with%20full%20expansion.&text=As%20of%20May%202020%2C%2023,not%20have%20health%20insurance%20coverage.

Option 2: Expanding dental benefits for Medicaid enrollees

Medicaid dental coverage increased the chances that Medicaid-eligible people had dental visits by as much as 22 percent (Choi, 2011). Expanding dental benefits is the most direct method to solve this issue but this policy option is based on the success of option 1 because Georgia need to enlarge the dental professional team and providers enrolled in Medicaid first. Also, Georgia should make a request for enough federal appropriations to expand coverage and issue student loans.

Recommendations

For the first policy alternative, there are three steps to be carried out:

- **Expanding the number of dentists providing services to Medicaid enrollees through loan repayment models.** The Georgia Department of Community Health could provide up to $45,000 student loan payment to dentists in exchange for a two-year commitment to work at underserved and rural areas, e.g., Wayne, Ware, and Brantley, etc[9].
- **Amending the existing state laws to allow dental professionals to practice to the full extent of their education and training; and to allow mid-level dental practitioners or and dental schools to provide specific dental services.** First, we should set new qualification requirements for these new types of licensed professionals and schools.

[9] Figure 14. State of Georgia Dental Health Professional Shortage Areas (DHPSA's). Kabore, H.J., Smith, C., Bernal, J., Parker, D., Csukas, S, & Chapple-McGruder, T. (2014). The Burden of Oral Health in Georgia. Georgia Department of Public Health, Maternal and Child Health, Office of MCH Epidemiology, Georgia Oral Health Program. https://dph.georgia.gov/oralhealthprogramga

Second, the Georgia Medicaid division should propagandize these new choices for enrollees so that they get the latest information. Third, there should be a team tracking the impact of new acts on oral health delivery to Medicaid enrollees.

- **Set more free dental care seasons and mobile dental clinics.** The Georgia Department of Public Health can take these responsibilities. It could set a team to choose clinics and make contracts with these clinics. The team will schedule four seasons in one year and each season will endure for one month to let low-income and unemployed people walk into the certified dental clinics.

In terms of the second policy alternative, the Georgia Medicaid program could allow for up to 12 non-emergency visits per year per person and increases age limit for fluoride varnishes in two years. And then the Medicaid program will consider expanding other dental benefits, such as fillings, root canal and periodontal surgery.

References

Allareddy, V., Rampa, S., Lee, M. K., Allareddy, V., & Nalliah, R. P. (2014). Hospital-based emergency department visits involving dental conditions: profile and predictors of poor outcomes and resource utilization. Journal of the American Dental Association (1939), 145(4), 331–337. https://doi.org/10.14219/jada.2014.7

Altman, D. E., & Morgan, D. H. (1983). The role of state and local government in health. Health Affairs, 2(4), 7-31.

Baicker, K., Allen, H. L., Wright, B. J., Taubman, S. L., & Finkelstein, A. N. (2018). The Effect of Medicaid on Dental Care of Poor Adults: Evidence from the Oregon Health Insurance Experiment. Health services research, 53(4), 2147–2164. https://doi.org/10.1111/1475-6773.12757

Brooks, T., Roygardner, L., Artiga, S., Pham, O., & Dolan, R. (2020). Medicaid and CHIP eligibility, enrollment, and cost sharing policies as of January 2020: findings from a 50-state survey [Internet]. San Francisco (CA): Henry J. Kaiser Family Foundation.

CareSource. (2017). Georgia Medicaid Covered Dental Benefits Quick Reference. https://www.caresource.com/documents/ga-covered-dental-benefits-quick-reference-guide/

Center for Health Care Stratigies (CHCS). (2019). Medicaid Adult Dental Benefits: An Overview. CHCS. https://www.chcs.org/resource/medicaid-adult-dental-benefits-overview/

Chazin, S. (2015). Dental Coverage and Access for Adults in Medicaid: Opportunities for States. Center for Health Care Strategies (CHCS). https://www.chcs.org/resource/dental-coverage-access-adults-medicaid-opportunities-states/

Choi, M. K. (2011). The impact of Medicaid insurance coverage on dental service use. Journal of health economics, 30(5), 1020-1031.

Choi, S. E., Simon, L., Riedy, C. A., & Barrow, J. R. (2020). Modeling the Impact of COVID-19 on Dental Insurance Coverage and Utilization. Journal of Dental Research. https://doi.org/10.1177/0022034520954126

Edwards, C. (2015). Lighting levels for isolated intersections: Leading to safety improvements (Report No. MnDOT 2015-05). Center for Transportation Studies. http://www.cts.umn.edu/Publications/ResearchReports/reportdetail.html?id=2402

Elani, H. W., Sommers, B. D., & Ichiro Kawachi. (2020). Changes In Coverage And Access To Dental Care Five Years After ACA Medicaid Expansion. Health Affairs, 39(11), 1900–1908. https://doi.org/10.1377/hlthaff.2020.00386

Elani, H., Kawachi, I., & Sommers, B. (2020). Changes in emergency department dental visits after Medicaid expansion. Health Services Research [Internet].

Feinberg, M. (2015). Minority Oral Health in America: Despite progress, disparities persist. American Institute of Dental Public Health. https://www.ada.org/~/media/ADA/Advocacy/Files/160523_Kelly_Report_Dental_Chapter.pdf?la=en

Fisher-Owens, S. A., Barker, J. C., Adams, S., Chung, L. H., Gansky, S. A., Hyde, S., & Weintraub, J. A. (2008). Giving policy some teeth: routes to reducing disparities in oral health. Health Affairs, 27(2), 404-412.

Frakt, A. (2018). How Dental Inequality Hurts Americans. New York Times. Retrieved from: https://www.nytimes.com/2018/02/19/upshot/how-dental-inequality-hurts-americans.html

Institute of Medicine & National Research Council. (2012). Improving Access to Oral Health Care for Vulnerable and Underserved Populations. National Academies Press.

Institute of Medicine and National Research Council. (2011). Improving Access to Oral Health Care for Vulnerable and Underserved Populations. Washington, DC: The National Academies Press. https://doi.org/10.17226/13116.

Kabore, H.J., Smith, C., Bernal, J., Parker, D., Csukas, S, & Chapple-McGruder, T. (2014). The Burden of Oral Health in Georgia. Georgia Department of Public Health, Maternal and Child Health, Office of MCH Epidemiology, Georgia Oral Health Program. https://dph.georgia.gov/oralhealthprogramga

Medicaid and CHIP Payment and Access Commission (MACPAC). (2015). Coverage of Medicaid Dental Benefits for Adults. Retrieved from: https://www.macpac.gov/publication/coverage-of-medicaid-dental-benefits-for-adults/

Nasseh, K., & Vujicic, M. (2020). Modeling the impact of COVID-19 on US dental spending—June 2020 update. Health Policy Institute Research Brief. Chicago (IL): American Dental Association.

Norris, L. (2020). Georgia and the ACA's Medicaid expansion. Retrieved from: https://www.healthinsurance.org/georgia-medicaid/

Northridge, M. E., Kumar, A., & Kaur, R. (2020). Disparities in Access to Oral Health Care. Annual review of public health, 41, 513–535. https://doi.org/10.1146/annurev-publhealth-040119-094318

Patrick, D. L., Lee, R. S., Nucci, M., Grembowski, D., Jolles, C. Z., & Milgrom, P. (2006). Reducing oral health disparities: a focus on social and cultural determinants. BMC oral health, 6 Suppl 1(Suppl 1), S4. https://doi.org/10.1186/1472-6831-6-S1-S4

Tang, N., Eisenberg, J. M., & Meyer, G. S. (2004). The roles of government in improving health care quality and safety. Joint Commission journal on quality and safety, 30(1), 47–55. https://doi.org/10.1016/s1549-3741(04)30006-7

U.S. Department of Health and Human Services Oral Health Coordinating Committee (2016). U.S. Department of Health and Human Services Oral Health Strategic Framework, 2014-2017. Public health reports (Washington, D.C.: 1974), 131(2), 242–257.