

SOMETHING’S ROTTEN: ORAL HEALTH CARE ACCESS IN THE UNITED STATES

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Access to oral health care in the United States is lacking, and is far worse in some areas, and for some demographics, than others.

We have segregated oral health from general physical health, even as we have embraced parity with other forms of health, such as mental health. Our payment systems reflect that. Those relying upon Medicare, the federal health insurance program for individuals who are 65-or-older or have

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certain disabilities, will find that Medicare does not cover oral health.¹ The number of Americans without dental insurance is four times higher than those without medical coverage.² Moreover, Medicaid, the health insurance assistance plan for low-income individuals and families, may not cover oral health at all, assuming one can even find a dentist willing to take Medicaid.³

Yet, the consequences of untreated oral health conditions *do* bear upon physical health:

Poor oral health has an impact beyond mere toothache. A landmark 2000 report by the U.S. Surgeon General found that oral health is intimately linked to people's overall physical health and is often associated with serious systemic conditions such as diabetes and heart disease, as well as the likelihood of complications in pregnancy.⁴

A recent academic study found a *24 percent increase in cancer risk* among those with severe periodontitis, an inflammatory gum disease, compared to those surveyed with mild to no periodontitis.⁵ And beyond the terrible pain that untreated oral health problems can bring, as one fact-checker noted, “an untreated abscess can infect other parts of the body, either through the bones or the bloodstream. Most people won't die from a toothache, but it's a condition that if left untreated can lead to the worst: a fatal result.”⁶ Evidence also suggests that the oral health of pregnant women

¹ See Ryan Cowmeadow, *It is Time to Demand Dental for Seniors through Medicare*, LANSING ST. J. (Aug. 23, 2018), <https://www.lansingstatejournal.com/story/opinion/contributors/viewpoints/2018/08/23/viewpoint-seniors-deserve-oral-health-coverage-under-medicare/1051090002/> (“Despite the importance of oral health, a majority of older adults are surprised to learn that Medicare does not include dental health coverage.”).

² *Who Has Dental Benefits Today?*, NAT'L ASS'N DENTAL PLANS, https://www.nadp.org/dental_benefits_basics/dental_bb_1.aspx (last visited Feb. 13, 2019).

³ See Rebecca Singer Cohen & Julie Stitzel, *Improving Dental Care Access in Rural America*, PEW CHARITABLE TR.: STATELINE (Nov. 18, 2015), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/11/18/improving-dental-care-access-in-rural-america>. (“Only about one third of dentists accept Medicaid or other public insurance.”).

⁴ Anne Kim, *Cavity Country*, WASH. POST (June 7, 2018), https://www.washingtonpost.com/news/posteverything/wp/2018/06/07/feature/rural-america-has-too-few-dentists-but-also-too-few-jobs-to-create-paying-patients/?noredirect=on&utm_term=.84c6f5dce3bf (citing DEP'T OF HEALTH AND HUMAN SERVS., *ORAL HEALTH IN AMERICA: A REPORT OF THE SURGEON GENERAL* (2000), <https://profiles.nlm.nih.gov/ps/access/NNBBJT.pdf>).

⁵ Dominique S. Michaud et al., *Periodontal Disease Assessed Using Clinical Dental Measurements and Cancer Risk in the ARIC Study*, 110 J. NAT'L CANCER INST. 843, 847 (Aug. 1, 2018).

⁶ Joshua Gillin, *Dentists and the ADA Agree: Ignoring a Toothache Could Potentially Kill You*, POLITIFACT (Jan. 26, 2016, 11:05 AM),

can bear upon birthweight.⁷

This article examines the forces driving a lack of access to dental care, as well as an idea, first implemented statewide in Minnesota, of licensing intermediate-level professionals to provide dental care as a means of improving access. Based upon the evidence, the article concludes that the best solutions to addressing access issues are insurance reform and increased Medicaid coverage and funding.

I. FOR TOO MANY WITH ORAL HEALTH NEEDS, THE DOCTOR ISN'T IN

According to research by the Pew Charitable Trusts, “[m]any rural communities are considered dental shortage areas: 60 percent of the 4,438 total designated dental health professional shortage areas nationally were located in non-metropolitan areas in 2012.”⁸

Anne Kim of the *Washington Post* noted, “[a]bout 43 [percent] of rural Americans lack access to dental care, according to the National Rural Health Association, and West Virginia, among the poorest and most rural states, is at the center of the crisis.”⁹ In West Virginia, for example:

just half of adult West Virginians had visited a dentist in the previous year, and more than one-fifth hadn't seen a dentist in five years. By comparison, a U.S. Centers for Disease Control and Prevention study in 2015 found that 64 percent of all American adults ages 18 to 64 reported seeing a dentist in the previous year. The rate of total tooth loss is 33.8 percent among West Virginians over 65, compared with roughly 19 percent for all seniors nationally.¹⁰

Even if one has dental insurance, one must be prepared to foot the cost of serious dental procedures. One column refers to this as “the Great Divide between medicine and dentistry — especially in how treatment is paid for, or mostly not paid for, by insurers. Many Americans with serious dental

<https://www.politifact.com/florida/statements/2016/jan/26/john-cortes/ignoring-toothache-really-could-potentially-kill-y/>. .

⁷ See, e.g., Ye Shen et al., *A Pilot Study on Maternal Oral Health and Birth Weight of Twins*, 4 OPEN J. EPIDEMIOLOGY (2014).

⁸ Cohen & Stitzel, *supra* note 3.

⁹ Kim, *supra* note 4.

¹⁰ *Id.*

illness find out the same way: sticker shock.”¹¹ In other words, “[u]nderlying this ‘insurance’ system in the U.S. is a broader, unstated premise that dental treatment is somehow optional, even a luxury. From a coverage standpoint, it’s as though the mouth is walled off from the rest of the body.”¹²

David Tuller, a professor at the University of California, Berkeley, wrote:

[P]eople like me learn the hard way that dental insurance isn’t insurance at all—not in the sense of providing significant protection against unexpected or unaffordable costs. My dental coverage from UC-Berkeley, where I have been on the public health and journalism faculties, tops out at \$1,500 a year – and that’s considered a decent plan.¹³

II. THERE IS A STRONG SOCIOECONOMIC DISPARITY IN ORAL HEALTH ACCESS

Despite the gaps in dental health coverage, those with dental insurance are better off than those on Medicaid. Roughly two-thirds of dentists do not accept Medicaid, often forcing the poor into emergency rooms for complications from oral health needs.¹⁴ Pew Research found that “[i]n 2012, there were more than two million dental-related visits to hospital emergency rooms—most of them for preventable conditions that could have been addressed earlier in a dental office. The cost for this care was about \$1.6 billion.”¹⁵ As the *New York Times* notes, “[o]ne study found that after Kentucky’s Medicaid expansion in 2014, the rate of use of the emergency department for oral health conditions tripled.”¹⁶

¹¹ Heidi de Marco et al., *When Is Insurance Not Really Insurance? When You Need Pricey Dental Care*, WASH. POST (May 22, 2018), https://www.washingtonpost.com/national/health-science/when-is-insurance-not-really-insurance-when-you-need-pricey-dental-care/2018/05/22/7aac9656-5cd7-11e8-b656-236c6214ef01_story.html?noredirect=on&utm_term=.6854b944f0a3.

¹² *Id.*

¹³ David Tuller, *When is Dentistry Not Medicine? When Insurance is Involved*, CNN (May 28, 2018, 5:15 AM), <https://www.cnn.com/2018/05/28/health/dental-insurance-partner/index.html>.

¹⁴ See Cohen & Stitzel, *supra* note 3.

¹⁵ *Id.* A more recent figure from the Health Policy Institute at the American Dental Association is that “emergency room dental visits cost \$1.9 billion yearly, 40 percent of which is public money.” Janice Neumann, *A Dental Visit Can Cost You, but a Delay Can Hurt Your Teeth and Budget Even More*, WASH. POST (Dec. 2, 2017), https://www.washingtonpost.com/national/health-science/a-dental-visit-can-cost-you-but-a-delay-can-hurt-your-teeth-and-budget-even-more/2017/12/01/20bef8e8-c405-11e7-aae0-cb18a8c29c65_story.html.

¹⁶ Austin Frakt, *How Dental Inequality Hurts Americans*, N.Y. TIMES (Feb. 19, 2018), <https://www.nytimes.com/2018/02/19/upshot/how-dental-inequality-hurts-americans.html>. At

The U.S. Centers for Disease Control and Prevention (“CDC”) reports that “[a]dults aged 35–44 years with less than a high school education experience untreated tooth decay nearly three times that of adults with at least some college education.”¹⁷ In Indiana, for example:

Statewide, those earning \$50,000 or more per year are nearly twice as likely to have visited a dentist in the past year than those earning less than \$15,000, according to the U.S. Centers for Disease Control and Prevention. In Indianapolis’ 10 poorest census tracts, 60 percent of residents had not visited a dentist within 12 months, according to an IBJ analysis of CDC and Census Bureau research. But in the 10 tracts with the lowest poverty rates, just 25 percent hadn’t.¹⁸

The *Washington Post* notes that “Medicaid includes dental coverage for children and some states expanded Medicaid coverage under the Affordable Care Act [(“ACA”)], but 22 states do not offer dental care for adults via Medicaid while others offer varying degrees of coverage. Marketplaces created under the ACA offer dental coverage in separate plans.”¹⁹ Children of color are especially underserved. As Pew reports:

Lower rates of dental visits and preventive care may contribute to the higher rates of untreated tooth decay among Hispanic and black children and adults. According to data collected in 2011 and 2012, Hispanic and black 2- to 8-year-olds were about twice as likely as whites to have untreated decay.²⁰

This disparity will continue throughout life:

During the same period, black working-age adults were nearly twice as likely to have untreated decay as white working-age adults, 42% compared with 22%.²¹ The CDC

least poor Kentuckians with oral health issues had *somewhere* to go where their care would be paid for.

¹⁷ *Disparities in Oral Health*, CDC, https://www.cdc.gov/oralhealth/oral_health_disparities/index.htm (last accessed Sept. 5, 2018).

¹⁸ Hayleigh Colombo, *Dental Care Out of Reach for Many Poor Indy Residents*, INDIANAPOLIS BUS. J. (Aug. 31, 2018), <https://www.ibj.com/articles/70315-dental-care-out-of-reach-for-many-poor-indy-residents>.

¹⁹ Neumann, *supra* note 15 (emphasis added).

²⁰ Jane Koppelman & Rebecca Singer Cohen, *Dental Health Is Worse in Communities of Color*, PEW CHARITABLE TR. (May 12, 2016), <https://www.pewtrusts.org/en/research-and-analysis/articles/2016/05/12/dental-health-is-worse-in-communities-of-color>.

²¹ *Id.*

also finds that “[t]he 5-year survival rate is lower for oral pharyngeal (throat) cancers among black men than whites (36% versus 61%).”²²

Dental coverage is also one of the ACA’s greatest shortcomings. While one of the essential health benefits covered by the ACA was pediatric dental care,²³ the Obama Administration determined that this coverage as offered by stand-alone dental insurers fell outside the ACA’s out-of-pocket limits.

In questions during the April 2013 Senate Finance Committee confirmation hearing for President Obama’s nominee for administrator of the U.S. Center for Medicare and Medicaid Services, Marilyn Tavenner, Senator Benjamin Cardin (D-Maryland) unloaded: “Congress did not intend to create a market advantage for stand-alone dental plans over an affordable pediatric dental benefit embedded in a comprehensive plan.”²⁴ He criticized Tavenner for allowing “each state to determine its own separate pediatric dental out-of-pocket limit, creating a patchwork of unequal benefits across the nation. Congress did not permit states to set their own out-of-pocket limits for comprehensive health plans—why are you discriminating against oral health?”²⁵

Tavenner responded that “stand-alone dental plans are not subject to the insurance market reform provisions of the Affordable Care Act” and declared that for 2014, “a reasonable limit” on cost-sharing was \$700 per child enrollee or \$1,400 for two or more children.²⁶

The effect of Tavenner’s position, Cardin opined, was “to eviscerate consumer protections for children enrolled in stand-alone dental plans” given that oral health was surely essential to a child’s whole health.²⁷

²² See *Disparities in Oral Health*, *supra* note 17.

²³ 42 U.S.C. § 18022(b)(1)(J) (2018).

²⁴ *Nomination Hearing for Marilyn B. Tavenner to be Administrator of the Centers for Medicare and Medicaid Services: Hearing Before the S. Comm. On Finance*, 113th Cong. 107 (2013) (questions for Marilyn Tavenner).

²⁵ *Id.* (emphasis added).

²⁶ *Id.* at 108; see also Brendan Williams, *ACA Fails in Pediatric Dental Care*, THE HILL (Aug. 11, 2015, 2:00 PM), <https://thehill.com/blogs/congress-blog/healthcare/250786-aca-fails-in-pediatric-dental-care> (declaring “pediatric dental care one of the ACA’s biggest unfulfilled promises.”).

²⁷ *Nomination Hearing for Marilyn B. Tavenner to be Administrator of the Centers for Medicare and Medicaid Services: Hearing Before the S. Comm. On Finance*, 113th Cong. 108 (2013) (questions for Marilyn Tavenner); Press Release, U.S. Sen. Benjamin Cardin of Maryland, Cardin Recognizes National Children’s Dental Health Month (February 25, 2016) (“According to a recent report by the Department of Health and Human Services Office of Inspector General, three out of four children covered by Medicaid did not receive all required dental services over a recent two-year period, with one in four children failing to see a dentist at all.”).

Nonetheless, every Senate Democrat voted to confirm Tavenner.²⁸ After obliging the insurance industry in her regulatory role, Tavenner left the Obama Administration to run America's Health Insurance Plans,²⁹ a lobbying group comprised of health insurance company-members.³⁰

Thus, according to one dental professor, “nearly 51 million school hours are lost in the United States because of dental-related illnesses . . . Children with the lowest socioeconomic status are hit hardest, experiencing 12 times more days off than children with high socioeconomic status.”³¹

As there is no ACA requirement for adult dental coverage, far too many adults continue to either live with oral pain or go to emergency rooms for full-blown oral health complications. Maryland, which is among the states trying to address this issue, passed a law in 2018 that “requires the Maryland Department of Health to implement a pilot program for adult dental coverage, which could begin as early as January 2019. The test program will focus on those qualifying for both Medicare and Medicaid benefits.”³²

Even in states that enthusiastically expanded Medicaid, payment rates are so low—for example, \$22.98 for the dental exam of a child under 13 in Washington in 2018—that it acts as a deterrent to providers.³³ And yet early dental care is the key to avoiding future oral health problems, as two North Carolina academics note:

One clear way to reduce costs is by stopping problems before they even start. We need to invest more in prevention efforts so that people don't end up with unnecessary problems that can become serious and much more expensive to treat. A concrete example of this type of

²⁸ Robert Pear, *Acting Chief Wins Confirmation to Run Medicare and Medicaid*, N.Y. TIMES (May 15, 2013), <https://www.nytimes.com/2013/05/16/us/marilyn-tavenner-confirmed-as-medicaid-and-medicare-chief.html>.

²⁹ See Brendan Williams, *ObamaCare's Revolving Door*, THE HILL (July 27, 2015, 2:00 PM), <https://thehill.com/blogs/congress-blog/healthcare/249137-obamacares-revolving-door>.

³⁰ *Member Organizations*, AM.'S HEALTH INS. PLANS, <https://www.ahip.org/about-us/member-organization> (last accessed Feb. 14, 2019).

³¹ Matt Windsor, *Teeth for Two: Why Mom's Oral Health Matters to Her Baby*, UAB: THE MIX (Aug. 7, 2018), <https://www.uab.edu/mix/stories/teeth-for-two-why-mom-s-oral-health-matters-to-her-baby>.

³² David Burger, *Maryland Bill Authorizes Medicaid Adult Dental Coverage Pilot Program*, ADA NEWS (May 16, 2018), <https://www.ada.org/en/publications/ada-news/2018-archive/may/maryland-bill-authorizes-medicaid-adult-dental-coverage-pilot-program>.

³³ See *Provider Billing Guides and Fee Schedules: Dental Program Fee Schedule*, WASH. ST. HEALTH CARE AUTHORITY, <https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules> (last updated Dec. 28, 2018).

prevention effort is to make dental sealants readily available for all elementary school children in our state. According to the Centers for Disease Control and Prevention, dental sealants—plastic coatings placed on the chewing surfaces of teeth—can reduce decay by 80% in the 2 years after placement and continue to be effective for nearly 5 years . . .³⁴

Apart from Medicaid being a nonstarter for many dentists, dental insurance also squeezes dentists and patients alike. The dental health insurance monolith Delta Dental,³⁵ for example, is an ostensible nonprofit, but in 2017 Massachusetts dentists facing a cut in their rates pointed out that “[i]n 2015, the last year for which tax filings are available, eight executives at Delta Dental’s parent company earned more than \$1 million in total compensation, up from just one in 2011. Total compensation includes base salary, bonuses, and retirement benefits.”³⁶ As the *Boston Globe* reported, “hefty compensation numbers anger many dentists, who say the new contract Delta seeks in Massachusetts would slash reimbursement rates for a variety of dental procedures by as much as 30 percent. The company puts the reduction at closer to 20 percent.”³⁷

Another 2017 article in Massachusetts noted that “[d]entists complained to the Legislature . . . that they felt coerced into joining Delta Dental’s new, lower-cost insurance plan, called Total Choice, and they

³⁴ Eun Young Oh & M. Zulayka Santiago, *Why an Equity Lens is Essential for Achieving Oral Health for All: Exploring Collaboration as a Path to System Change*, 78 N.C. MED. J. 390, 392 (Nov. 30, 2017).

Citing expert Dr. Eleanor Fleming, a CNN story notes: “If baby teeth have untreated decay, it can have negative implications on the adult teeth. It can also prevent permanent teeth from growing in properly, according to Fleming, a dentist and part of the National Center for Health Statistics’ Division of Health and Nutrition Examination Surveys.” Erin Gabriel, *Fewer Dental Cavities Found in Young People, but Minorities Still Most at Risk*, CNN (Apr. 16, 2018, 11:08 AM), <https://www.cnn.com/2018/04/13/health/prevalence-of-cavities-study/index.html>.

³⁵ Delta Dental is the nation’s biggest dental insurer, and also parent to subsidiaries. The parent company reported having general reserves of over \$1.5 billion by the end of 2017. DELTA DENTAL, 2017 ANNUAL REPORT 6, <https://www.deltadentalins.com/annual-report/2017/2017-annual-report.pdf>. But that is just the tip of the iceberg. Delta Dental of Minnesota, for example, had reserves at the end of 2017 of \$160 million. See DELTA DENTAL OF MINN., EVERYONE DESERVES A HEALTHY SMILE: 2017 DELTA DENTAL OF MINNESOTA ANNUAL REPORT 1, <https://www.deltadentalmn.org/library/2017-corporate-annual-report-mn.pdf>. At the end of 2015, Delta Dental of Kansas had a reserve of \$56 million. See DELTA DENTAL OF KAN., 2015 ANNUAL REPORT, <http://www.deltadentalks.com/aboutus/companyinfo/annualreports/>.

³⁶ Priyanka Dayal McCluskey, *Delta Dental Wants to Lower Reimbursements. Dentists Have a Different Solution*, BOS. GLOBE (June 11, 2017), <https://www.bostonglobe.com/business/2017/06/11/delta-dental-pays-high-salaries-reimbursements-decline/VxgTM4PknbnKS869oJZddI/story.html>.

³⁷ *Id.*

asked lawmakers to impose more government control over the dental benefits giant.”³⁸ The dentists thus pushed a bill “that would require the insurance commissioner to approve all contracts between Delta and its affiliates, approve dental fees, and discourage dental insurers from attempting to influence members’ choice of dentist.”³⁹

These insurance problems plague dentists in other states as well: in Washington, for example, one-third of Delta’s 4,500 member dentists had signed a petition expressing no confidence in Delta’s chief executive for the state.⁴⁰ An oral surgeon wrote a column about the underlying dispute, noting that dentists had closed their offices in September 2017 to vote on and submit proposed bylaws changes that the Delta Dental of Washington board of directors simply rejected.⁴¹ One “vetoed amendment would have required Delta to dedicate 94 percent of their premium revenues to paying dental claims from patients.” The surgeon noted that “CEO Jim Dwyer, whose salary has more than doubled to \$2.75 million over the last six years, claims Delta can no longer afford to dedicate that much to patient care. The board of directors, each of whom receives “more than \$100,000 for part-time service on a nonprofit board,” agreed with him.”⁴²

Two other dentists, writing in the *Spokesman-Review* in Spokane, noted:

[D]elta is by far Washington’s largest dental insurer, providing most of the group insurance policies to employees of major public and private sector employers in Eastern Washington and around the state. But Delta is exempt from most of the rules other health insurance companies must abide by. This gives them tremendous power to directly influence how your dental care is

³⁸ State House News Service, *Dentists Critical of Delta Dental Plan*, WORCESTER BUS. J. (Oct. 31, 2017), <http://www.wbjournal.com/article/20171031/NEWS01/171039989/dentists-critical-of-delta-dental-plan>.

³⁹ *Id.*

⁴⁰ The Herald Editorial Bd., *Delta’s Struggle with Dentists Calls for Extraction*, DAILY HERALD (Mar. 22, 2018, 9:57 AM), <https://www.heraldnet.com/opinion/editorial-deltas-struggle-with-dentists-calls-for-extraction/> (noting that “payment was rejected for somewhere near 75,000 claims” in 2016).

⁴¹ Craig E. Neal, *You and Your Dentist May Have a Bone to Pick with Delta Dental*, SEATTLE TIMES (Nov. 5, 2017, 12:01 PM), <https://www.seattletimes.com/opinion/you-and-your-dentist-may-have-a-bone-to-pick-with-delta-dental/>. As the *Daily Herald* editorial noted, 2,300 dentists had cast ballots, “with 91 percent voting to approve the bylaw amendments.” The Herald Editorial Bd., *supra* note 40.

⁴² Neal, *supra* note 41.

delivered.⁴³

III. DENTAL THERAPISTS AS A POTENTIAL SOLUTION

Stuck in the middle, some consumer advocates have pushed for the licensure of a new category of mid-level providers—“dental therapists”—who would command lower payment rates. This has, predictably, ignited the sort of turf war that typically accompanies medical scope of practice issues, although the *Seattle Times*’ editorial board seemed surprised by the pushback: “Disappointingly, dentist groups have lobbied to prevent states from licensing dental therapists, who can perform such services as cleanings, fillings and pulling teeth.”⁴⁴ Yet it is unremarkable that a profession might not welcome new competition if it already feels squeezed by insurance and if the state of Washington, as the *Times* acknowledges, Medicaid “reimburses only about 29 percent of what dentists charge.”⁴⁵

The example of Washington reveals a paradox about health care, which is that “some of the most liberal states, like Washington, are among the very worst Medicaid dental payers.”⁴⁶ Indeed, as of 2014 “38 other states were ahead of ‘The Left Coast’ states—California, Oregon, and Washington—that have embraced the ACA so enthusiastically.”⁴⁷ Even in states where Medicaid for dental care has been funded generously, it always faces the chopping block in times of budgetary trouble.⁴⁸ In other states, fiscal austerity has created oral health crises.⁴⁹

Legislation pushed in Washington to allow for dental therapists has

⁴³ Mark Paxton & Ashley Ulmer, *Delta Dental Should Adopt Patient-Centered Reforms*, SPOKESMAN-REVIEW (Sept. 2, 2017), <http://www.spokesman.com/stories/2017/sep/02/delta-dental-should-adopt-patient-centered-reforms/>.

⁴⁴ *Seattle Times* Editorial Bd., *Expand Coverage with Dental Therapists and Medicaid Reimbursements*, SEATTLE TIMES (Jan. 8, 2016), <https://www.seattletimes.com/opinion/editorials/expand-coverage-with-dental-therapists-and-medicaid-reimbursements/>.

⁴⁵ *See id.*

⁴⁶ Williams, *supra* note 26.

⁴⁷ *Id.*

⁴⁸ *See, e.g.*, Susan Olp, *Even More Restrictions to Dental Care Come with Proposed Medicaid Cuts in Montana*, BILLINGS GAZETTE (Jan. 28, 2018), https://billingsgazette.com/news/local/even-more-restrictions-to-dental-care-come-with-proposed-medicaid/article_b4e14994-6321-5fdb-ac0e-c4793b826436.html (“Cuts to dental services total \$8.9 million.”).

⁴⁹ *See, e.g.*, Shamane Mills, *Wisconsin Pilot Program Aims to Increase Access to Dental Care for Low-Income Children*, WISC. PUB. RADIO (Feb. 26, 2018, 6:00 AM), <https://www.wpr.org/wisconsin-pilot-program-aims-increase-access-dental-care-low-income-children>, (“Wisconsin ranks last in providing dental care to children on Medicaid, according to state officials citing federal data.”).

been blocked by the dental profession's lobbying, and the *Seattle Times* reported in 2016 that "[s]imilar bills in Texas, New Mexico, North Dakota, Kansas and Vermont lingered in committees in the 2015 legislative sessions."⁵⁰ However, a Washington tribe moved to allow practice by dental therapists, as had occurred for over a decade on native lands in Alaska, without licensing authorization.⁵¹ This resulted in the 2017 passage of authorizing legislation for tribes.⁵²

In 2008, Minnesota became the first state to fully allow the use of dental therapists, with their practice beginning in 2011.⁵³ Very limited evidence suggests it has been helpful in providing access to Medicaid beneficiaries.⁵⁴ However, there were only 70 dental therapists six years after they began practicing in Minnesota, compared to "3,000 dentists, about

⁵⁰ Will Drabold, *State Dentists Lobby is Blocking Potential Source of Low-Cost Care*, SEATTLE TIMES (Jan. 4, 2016, 6:00 AM), <https://www.seattletimes.com/seattle-news/times-watchdog/washington-dentists-lobby-is-blocking-low-cost-care/> (last updated Jan. 6, 2016, 4:57 PM). In North Dakota, there was no more success in 2017: "A bill that would allow licensed dental therapists to practice in North Dakota under the supervision of a dentist failed by a 32-59 vote in the state House." Blair Emerson, *Dental Therapy Bill Fails in North Dakota House*, BISMARCK TRIB. (Feb. 8, 2017), https://bismarcktribune.com/news/state-and-regional/dental-therapy-bill-fails-in-north-dakota-house/article_c6e4e63e-51ba-53c0-9373-f9896726c04d.html. In Kansas, supporters renewed their fight in 2017, but as one newspaper reported, "[i]t's not the first time supporters have fought for dental therapists. Similar bills were considered in 2011, 2013, 2015 and 2016." Katherine Burgess, *Supporters Plan to Continue Fight for Dental Therapists*, WICHITA EAGLE (Feb. 20, 2017, 6:01 PM), <https://www.kansas.com/news/politics-government/article133927899.html>. In New Mexico, a bipartisan group of legislators wrote: "The momentum and support behind dental therapy has continued to grow in New Mexico, and we encourage our colleagues to support this critical effort to address New Mexico's oral health care crisis." Benny Shendo et al., *Dental Therapists Would Fill a Need*, ALBUQUERQUE J. (Dec. 18, 2017, 12:02 AM), <https://www.abqjournal.com/1107893/dental-therapists-would-fill-a-need.html>.

⁵¹ Drabold, *supra* note 50. "In 2005, Alaska became the first state to try out the new dental care model, when therapists began treating native populations." Anna Gorman, *Traditional Dentistry Wary of Dental Therapists*, L.A. TIMES (June 3, 2012), <http://articles.latimes.com/2012/jun/03/local/la-me-dental-battle-20120603>.

⁵² See Kathy Hoekstra, *Washington Tribe Beats Dental Lobby, Gets Dental Therapy*, WATCHDOG (Apr. 4, 2017), https://www.watchdog.org/national/washington-tribe-beats-dental-lobby-gets-dental-therapy/article_b34717a9-c38e-5483-8114-f7edb296063c.html; see also WASH. REV. CODE §§ 70.350.010–70.350.020 (2018). As the law notes, among its findings, "[t]he legislature finds further that sovereign tribal governments are in the best position to determine which strategies can effectively extend the ability of dental health professionals to provide care for children and others at risk of oral disease and increase access to oral health care for tribal members. The legislature does not intend to prescribe the general practice of dental health aide therapists in the state." S.B. 5079, 65th Leg. Sess. (Wash. 2017).

⁵³ Stephanie Dickrell, 6 Years In, Dental Therapist Experiment is Working, Experts Say, ST. CLOUD TIMES (Apr. 9, 2017, 7:02 PM), <https://www.sctimes.com/story/life/wellness/2017/04/09/6-years-dental-therapist-experiment-working-experts-say/97958494/> (last updated Apr. 9, 2017, 7:52 PM).

⁵⁴ *Id.*

4,800 dental assistants and about 3,200 dental hygienists”—meaning dental therapists constituted only one percent of the dental profession.⁵⁵ This slow expansion suggests there is more to the issue of dental care access than simply creating a new profession. Minnesota “has some of the lowest reimbursement rates for pediatric dental care services in the nation. As a result, dentists say they can't afford to treat any or many Medical Assistance patients.”⁵⁶

In Arizona, dental therapist legislation was opposed by dentists, with one, Gary Jones, suggesting instead that

Gov. Doug Ducey and lawmakers can start by restoring dental care for adults using AHCCCS [the Arizona Health Care Cost Containment System, or Medicaid], which was zeroed out during the Great Recession. As a result, those suffering from tooth pain turned to emergency rooms, where there are no dentists. Doctors treated the pain or infection, but not the underlying dental problem—guaranteeing that those patients would return. That is neither financially nor morally defensible.⁵⁷

Arizona ended up taking an approach similar to Washington, with a new 2018 law⁵⁸ allowing dental therapists “to practice only in certain settings—tribal settings, federally qualified health centers and other nonprofit community health centers treating low-income patients.”⁵⁹ The Arizona Dental Association ultimately agreed to the bill, while contending it would not remedy real problems of access—including Medicaid rates and adult access to Medicaid.⁶⁰ They also obtained some changes to the bill: “The final version of the law also rolls back the type of extractions a dental therapist can do under supervision. The law stipulates dental therapists may not extract permanent teeth unless under the direct supervision of a

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ Gary Jones, *State Needs Dental Solutions Other Than a New Layer of Therapists*, ARIZ. CAPITOL TIMES (Dec. 8, 2016), <https://azcapitoltimes.com/news/2016/12/08/state-needs-dental-solutions-other-than-a-new-layer-of-therapists/>.

⁵⁸ ARIZ. REV. STAT. ANN. §§ 32-1276–32-1276.08 (2018).

⁵⁹ Stephanie Innes, *Arizona Law Creates Dental Therapists to Handle Fillings, Extractions and Crowns*, ARIZ. DAILY STAR (May 17, 2018), https://tucson.com/news/local/arizona-law-creates-dental-therapists-to-handle-fillings-extractions-and/article_db0aea3-ee46-50e4-86c4-f7c7ac706af6.html, (“Members of the Tohono O’odham Nation southwest of Tucson were among the most vocal supporters of the legislation, as they see it as offering a career path for tribal members to remain on the reservation without spending as much money as it costs to go to dental school.”).

⁶⁰ *Id.*

dentist.”⁶¹

Yet, in 2018, Arizona once again failed to pass a bill to at least provide dental care to pregnant women on Medicaid, even though the oral health of women bears upon birth outcomes.⁶²

The dental therapist fight has played out to a conclusion in two New England states. Most recently, the Vermont Dental Society in 2016 contended that allowing dental therapists would “create a two-tier system of dental care, splitting patients between licensed dentists and dental therapists.”⁶³ It also noted that “the position lacks a pipeline of students ready to become dental therapists.”⁶⁴ Yet, when a bill that would have authorized the practice of dental therapists passed in the House by a 109-32 vote, “Rep. Alison Clarkson, D-Woodstock, called [the bill] an economic development opportunity for women, who she said represents the majority of dental hygienists. Under the bill, those hygienists would be able to study at Vermont Technical College to get licensed as dental therapists.”⁶⁵ An opponent “reiterated the Vermont Dental Society’s arguments on the House Floor, saying licensing dental therapists would create a two-tiered oral

⁶¹ *Id.*

⁶² Stephanie Innes, *Arizona Lawmakers Fail Again to Get Dental Coverage for Pregnant Women on AHCCCS*, ARIZ. DAILY STAR (Mar. 12, 2018), https://tucson.com/news/local/arizona-lawmakers-fail-again-to-get-dental-coverage-for-pregnant/article_03e697e2-5b46-519d-9c46-92e65bae9207.html (The “bill would have given pregnant women enrolled in Arizona’s Medicaid program up to \$1,000 per year in comprehensive oral health benefits, including preventive care. A similar measure failed last legislative session, too.”). Ostensibly legislators ran out of time to pass the bill. *See id.* Yet, while not protecting maternal and newborn health, they *did* find time to pass yet another abortion restriction law, one requiring women seeking abortions to submit to a list of questions, because, as one supporter of that bill was quoted stating, “What I want to be is a voice for the little voices, for the ones whose lives are snuffed out because of the many, many reasons women choose abortion.” Howard Fischer, *Bill Requiring Questioning of Arizona Women Seeking Abortions Heads to Gov. Ducey*, TUCSON.COM (Apr. 12, 2018), https://tucson.com/news/local/bill-requiring-questioning-of-arizona-women-seeking-abortions-heads-to/article_3f3eba69-65f4-5e49-b9cd-8d5546a06a7d.html (internal quotations omitted).

⁶³ Michael Bielawski, *Dentists Split Over Mid-Level ‘Dental Therapist’ Idea*, SUN COMMUNITY NEWS: VT. WATCHDOG (May 17, 2016), <https://www.suncommunitynews.com/articles/the-vermont-eagle/dentists-split-over-mid-level-‘dental-therapist’-idea/>.

⁶⁴ *Id.* This has certainly proved true in Minnesota to date. A more optimistic Vermont dentist, with a nonprofit practice, wrote a column in support of the legislation:

In Vermont, where so many of our dentists have small rural practices, this would be a great way to increase access to care without increasing the cost of care. And because hiring a dental therapist would require a lower salary than hiring another dentist, it would make it easier for dental practices to accept more patients with Medicaid.

Patrick Rowe, *Dental Therapists Could Boost Access to Dental Care*, VT. DIGGER (Apr. 26, 2013), <https://www.voicesforvtrkids.org/blog/2018/7/25/vt-digger-patrick-rowe-dental-therapists-could-boost-access-to-dental-care>.

⁶⁵ Erin Mansfield, *House Passes Bill to License Dental Therapists*, VT. DIGGER (Apr. 22, 2016), <https://vtdigger.org/2016/04/22/house-passes-bill-to-license-dental-therapists/>.

health care system.”⁶⁶ That opposition failed to stop the bill from becoming law.⁶⁷

Debate over dental therapy in Maine was raucous. As the *Washington Post* reported, “[d]uring the Maine debate, so many dentists flooded the statehouse in Augusta that besieged lawmakers taped up signs declaring their offices a ‘Dental Free Zone.’”⁶⁸ In fact, the bill was “the most contentious issue of the 2014 legislative session. It passed only after opponents added multiple restrictions, including a requirement that therapists work only in the presence of a dentist. Supporters failed even to persuade lawmakers to let therapists travel to nursing homes alone.”⁶⁹ Regarding the American Dental Association (“ADA”), the article noted that “[t]he ADA agrees that too many Americans are getting inadequate dental care. They argue that the answer is not the creation of ‘lesser trained’ therapists, but more government funding and ‘community dental health care coordinators’ to educate people and get them to a dentist.”⁷⁰

A *Bangor Daily News* editorial stated:

For the poor and uninsured, it doesn’t matter who provides dental care if it is not affordable. . . . There’s a strong case for extending dental coverage to all adult MaineCare recipients and for raising reimbursement rates. Without this, increasing the number of dental providers in Maine won’t ensure more people get the dental care they need.”⁷¹

Similarly, in her *Washington Post* article, Anne Kim reported that “adding more providers will not solve the problem of rural oral health. People don’t go to the dentist if they can’t afford to, no matter how many dentists there are.”⁷²

Even the Maine State Chamber of Commerce had supported better Medicaid coverage of oral health, observing that “[w]hen the uninsured and adults with MaineCare seek emergency room treatment for dental problems, the costs are passed on to businesses and individuals that purchase private

⁶⁶ *Id.*

⁶⁷ See VT. STAT. ANN. tit. 26, § 613 (2018).

⁶⁸ Mary Jordan, *The Unexpected Political Power of Dentists*, WASH. POST (July 11, 2017), https://www.washingtonpost.com/politics/the-unexpected-political-power-of-dentists/2017/07/01/ee946d56-54f3-11e7-a204-ad706461fa4f_story.html.

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ The BDN Editorial Bd., *More Dental Providers Won’t Help Maine Unless People Can Afford Dental Care*, BANGOR DAILY NEWS (Feb. 14, 2016, 10:38 AM), <https://bangordailynews.com/2016/02/14/opinion/editorials/more-dental-providers-wont-help-maine-unless-people-can-afford-dental-care/>

⁷² Kim, *supra* note 4.

insurance.”⁷³ The Chamber of Commerce noted that, “some struggling to become employed are too embarrassed by the condition of their teeth to interview with potential employers. Businesses also lose money when workers take sick days because of dental pain.”⁷⁴ Something poignantly similar had been reported by the *Indianapolis Business Journal*: “Poor dental care can go hand in hand with other economic challenges, since people embarrassed by their teeth might have trouble eating, communicating or even finding a job, said Gerardo Maupome, associate dean of research for the Indiana University Richard M. Fairbanks School of Public Health.”⁷⁵

Regrettably, the Maine Chamber of Commerce’s enlightened view has not spread among policymakers. For example, in Washington, only 18.7% of dentists participated in Medicaid as of last measure.⁷⁶ Similarly, with only 15.4% of dentists participating, Medicaid participation was even worse in California—which paid dentists a Medicaid rate of only 38.7% of the private insurance rate.⁷⁷

A study by the ADA’s Health Policy Institute “concluded that 22 states could add extensive dental benefits to their existing Medicaid program by adding 1 percent to their Medicaid budgets. Currently most state Medicaid budgets allocate less than 2 percent of their entire Medicaid budget for

⁷³ The BDN Editorial Bd., *supra* note 71 (citing Letter from Peter M. Gore, Vice President of Advocacy and Gov’t Relations, Me. State Chamber of Commerce, to Eric Brakey, Senate Chair, and Drew Gattine, House Chair, Joint Standing Comm. on Health and Human Servs., <http://www.mainelegislature.org/legis/bills/getTestimonyDoc.asp?id=25723> (last accessed Feb. 18, 2019)).

⁷⁴ *Id.*

⁷⁵ See Colombo, *supra* note 18. One columnist notes that “[p]eople with bad teeth can be stigmatized, both in social settings and in finding employment. Studies document that we make judgments about one another—including about intelligence—according to the aesthetics of teeth and mouth.” Frakt, *supra* note 16.

⁷⁶ *Medicaid Fee-for-Service (FFS) Reimbursement and Provider Participation for Dentists and Physicians in Every State*, AM. DENTAL ASS’N: HEALTH POL’Y INST., https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_0417_1.pdf?la=en (last accessed Sept. 5, 2018). The state’s Apple Health for Kids program has long treated kids with special needs like “rotten apples.” See Brendan Williams, *Oregon Takes a Clear Lead over Washington on Health Care*, OREGONIAN (July 29, 2010). However, while failing to substantively address the problem, the Washington State Senate *did* pass a floor resolution to “recognize the valuable role played by the hundreds of Washington dentists who promote access to dental care by volunteering their services to the uninsured, and by treating patients with special needs and those with Medicaid dental insurance[.]” S.R. 8639, 65th Leg., Reg. Sess. (Wash. 2017).

⁷⁷ See AM. DENTAL ASS’N: HEALTH POL’Y INST., *supra* note 76.

dental services.”⁷⁸

While one can concede the point made by many dentists that allowing the use of dental therapists can distract from larger issues of reimbursement, the measured approach taken by Arizona would seem not to impose a competitive threat. Under that approach, dental therapists would be allowed to practice in the following settings:

1. A federally qualified community health center.
2. A health center that has received a federal look-alike designation.
3. A community health center.
4. A nonprofit dental practice that provides dental care to low-income and underserved individuals.
5. A private practice that provides dental care for community health center patients of record who are referred by the community health center.⁷⁹

To oppose even that limited practice is unlikely to be a position to which the general public is unsympathetic, even if dentists can use political

⁷⁸ Press Release, Am. Dental Ass’n, ADA Responds to News Coverage of Dental Therapists (Feb. 21, 2017), <https://www.ada.org/en/press-room/news-releases/2017-archives/february/ada-responds-to-news-coverage-of-dental-therapists>. In Michigan, a dentist who is the president of the Michigan Dental Association wrote:

Currently, 8 out of 10 Michigan dentists accept Medicaid children through the Healthy Kids Dental program. This is because the state funds the Healthy Kids Dental program at an adequate level, unlike the adult Medicaid dental program. The adult program reimburses dental providers about 20 percent of the cost of treatment, and no business, regardless of the provider type, can survive on a nearly 80 percent net loss.

Debra Peters, *Empower Current Dental Workforce to Do More*, LANSING STATE J. (Aug. 24, 2018),

<https://www.lansingstatejournal.com/story/opinion/contributors/viewpoints/2018/08/24/viewpoint-expand-current-dental-scope-expand-dental-access/1062226002/>.

⁷⁹ ARIZ. REV. STAT. ANN. § 32-1276.04(A)(1)–(5) (2018). One Minnesota dentist who supports dental therapy writes that “[f]ederally qualified health centers using dental therapists are able to use the savings in staff salaries to provide more free and low-cost care to the uninsured.” John T. Powers, *Dental Therapists are Making a Difference in My Practice and in My State*, ARIZ. CAP. TIMES (Apr. 16, 2018), <https://azcapitoltimes.com/news/2018/04/16/dental-therapists-are-making-a-difference-in-my-practice-and-in-my-state/>. The list of practice settings in Arizona law should be expanded to include nursing homes. See Catherine Saint Louis, *In Nursing Homes, an Epidemic of Poor Dental Hygiene*, N.Y. TIMES: WELL (Aug. 4, 2013, 2:30 PM), <https://well.blogs.nytimes.com/2013/08/04/in-nursing-homes-an-epidemic-of-poor-dental-hygiene/>. For such residents there are special problems: “Nearly two-thirds of those who stay in a nursing home long term have dementia, and many resist oral care, clenching their mouth shut or even trying to hit aides.” *Id.*

clout to defeat dental therapist legislation.⁸⁰ The headline for one *Boston Globe* columnist's piece hyperbolically characterized the fight in Massachusetts: "Dentists to poor people: Drop dead."⁸¹ Yet Minnesota's slow take-up of licensure opportunity also shows that the benefits of dental therapy should not be oversold.⁸²

IV. MEDICAID FUNDING AND INSURANCE REFORM AS THE BEST SOLUTION TO EXPANDING ORAL HEALTH CARE ACCESS

One dental therapist in Minnesota acknowledged that "[dental therapists] are not a silver bullet for helping access to dental care, but [they]

⁸⁰ It is important to note that even in Minnesota dental therapy is "limited to primarily practicing in settings that serve low-income, uninsured, and underserved patients or in a dental health professional shortage area." MINN. STAT. § 150A.105(2) (2018).

⁸¹ Alex Beam, *Dentists to Poor People: Drop Dead*, BOS. GLOBE (Sept. 5, 2017), <https://www.bostonglobe.com/opinion/2017/09/04/dentists-poor-people-drop-dead/8HgFbCFW1XdFOi85WrUEDl/story.html>. That the column is objectively unfair is, perhaps, beside the point in this age of over-the-top rhetoric. Even the Boston City Council urged legislators to support dental therapy. *Id.* According to one article, "[s]everal Democratic lawmakers, Republican Governor Charlie Baker, and health care and employer groups support legislation to allow for dental therapy in Massachusetts." Priyanka Dayal McCluskey, *Mass. Studies Use of Dental Therapists*, BOS. GLOBE (Sept. 30, 2017), <https://www.bostonglobe.com/business/2017/09/29/minn-dental-therapists-offer-lessons-mass-weighs-expanding-role-mid-level-providers/mOwJ9wqIjif7XdMthvLEVI/story.html>. Massachusetts dentists have shown some movement:

The Dental Society, which represents about 5,000 dentists, supports creating a new kind of mid-level practitioner to work under the direct supervision of a dentist. That's a stricter standard than advocates of Minnesota-style dental therapy would like. The Dental Society wants these mid-level practitioners to work in geographic areas known to have a dental care shortage, and to focus almost entirely on Medicaid patients.

Id. Compromise legislation, however, died in 2018 in a legislative conference committee. H.R. 4454, 190th Gen. Court, Reg. Sess. (Mass. 2018); *see also* Editorial, *That Last-Minute Rush on Beacon Hill? So Not Necessary*, BOS. GLOBE (Aug. 2, 2018), <https://www.bostonglobe.com/opinion/editorials/2018/08/02/that-last-minute-rush-beacon-hill-not-necessary/fbHHFJf55gCnaytTOuywoI/story.html> (noting that "the clock ran out on conference committees trying to reconcile important health care and education legislation. A zoning reform bill and a proposal to allow dental therapists never saw the light of day.").

⁸² As of state figures published on February 6, 2019, there were 92 dental therapists licensed in Minnesota (compared to 4,029 dentists). *Active Licensee Totals*, MINN. BOARD OF DENTISTRY (Feb. 6, 2019), https://mn.gov/boards/assets/ActiveAll%2002-06-19_tcm21-371187.pdf. In Maine, no dental therapists were licensed as of September 6, 2018. *See* E-mail from Teneale E. Johnson, Exec. Sec'y, Me. Bd. of Dental Practice, to author (Sept. 6, 2018, 09:41 EDT) (on file with author).

are a great tool.”⁸³ Those advocating for dental therapist licensure should advocate just as strongly for effective dental insurance regulation⁸⁴—so insurers cannot squeeze providers and patients alike—and for adequate

⁸³ Bob Salsberg, *They're Not Dentists. Would You Let Them Fill Your Cavities?*, ALBUQUERQUE J. (Feb. 16, 2017, 8:34 AM), <https://www.abqjournal.com/951196/theyre-not-dentists-would-you-let-them-fill-your-cavities.html>. More cynically, a Minnesota dentist contends, “[w]hile the Pew Foundation and its allies declare Minnesota’s dental therapist experiment a spectacular fireworks show, it’s really nothing more than a few people standing around waving sparklers.” Robert S. Roda, *Don’t Follow Minnesota’s Failed Dental Therapist Experiment*, ARIZ. CAP. TIMES (Mar. 29, 2018). He asserts that, in Minnesota, “the governor asked for a substantial increase in Medicaid dental reimbursement rates, which are so low that dentists won’t sign up. Legislators, having been assured dental therapists were the panacea, saw no need to raise those rates.” *Id.* Whether this is true or not, any push for dental therapist licensure *cannot* distract from the need for adequately funding Medicaid. Policymakers are happy to have any excuse not to spend money.

⁸⁴ Stand-alone dental insurance is generally so lightly-regulated that insurers need do no more than file-and-use their rates, with no rate approval. *See, e.g.*, Nicole Spector, *The Reason Your Dental Work Isn’t Covered by Medical Insurance*, NBC (Oct. 24, 2017, 12:59 PM), <https://www.nbcnews.com/better/health/reason-your-dental-work-isn-t-covered-medical-insurance-ncna813666> (last updated Oct. 24, 2017, 2:57 PM) (quoting “Dr. Adam C. Powell, president of Payer+Provider Syndicate”: “Dental insurance, unlike medical, is not regulated and it tends to be very constrained,”). Occasionally there is some minimal regulation. *See, e.g.*, COLO. REV. STAT. § 10-16-107(1)(b) (2018) (“Rate filings that do not involve a requested rate increase, or that involve a requested rate increase of *less than five percent for dental insurance*, do not require preapproval, and the carrier may implement the rate upon filing with the commissioner.”) (emphasis added).

Medicaid reimbursement.⁸⁵

In the state of Washington, a promising bill introduced in 2019 has an intent section that states, in part: “Insurers offering dental only coverage have engaged in unfair practices that have harmed consumers, and consumers have not had the necessary tools to challenge these practices.”⁸⁶ As introduced, the bill would prohibit a dental only plan from denying “a claim for a covered dental service provided by a treating dentist to a covered person. If the carrier denies a claim for such a service, the carrier may not advertise in promotional materials or an explanation of benefits sent to prospective or current members that the carrier covers the dental service.”⁸⁷ The bill would also protect dentists from an insurer’s “punitive action” that might be threatened, or taken, due to a dispute over coverage or a charge.⁸⁸

In conclusion, it is well past time that we recognize that oral health is an integral part of whole-body health and should not be marginalized. Creating new classes of providers as an excuse for insufficient Medicaid

⁸⁵ Several years after pioneering the full practice of dental therapists, “Minnesota ranks 49th among the 50 states in reimbursement rates for children needing dental care, according to the Minnesota Dental Association.” John Lundy, *How Hibbing Changed Dental Training in Minnesota*, DULUTH NEWS TRIB. (Aug. 30, 2018, 8:11 PM), <https://www.duluthnewstribune.com/business/healthcare/4492942-how-hibbing-changed-dental-training-minnesota>. Given the objective need for more Medicaid funding, it seems worrisome that the far-right Heartland Institute has joined the fight for dental therapists. See, e.g., Press Release, Michael Hamilton et al., Heritage Inst., Heartland Institute Experts React to Defeat of North Dakota Dental Therapy Licensure Bill (Feb. 8, 2017), <https://www.heartland.org/news-opinion/news/press-release-heartland-institute-experts-react-to-defeat-of-north-dakota-dental-therapy-licensure-bill>. They are unlikely advocates for health equity. The Heartland Institute’s president, Rep. Tim Huelskamp, has decried the “exploding costs” of Medicaid. See Tim Huelskamp, *Medicaid Due for an Overhaul*, DETROIT NEWS (Nov. 19, 2017, 10:48 PM), <https://www.detroitnews.com/story/opinion/2017/11/19/medicaid-overhaul-huelskamp-health-care-americans/107856362/> (last updated Nov. 20, 2017, 10:57 AM). In Congress, as the Tea Party Caucus chair, Huelskamp appeared “in a documentary that links homosexuality to communism, likens LGBT rights to Nazi oppression and claims same-sex marriage could bring about the return of Jesus Christ.” Justin Wingerter, *Rep. Tim Huelskamp Took Part in Film Likening LGBT Rights to Nazi Oppression, Homosexuality to Communism*, TOPEKA CAP.-J. (July 19, 2015, 9:16 PM), <https://www.cjonline.com/news/2015-07-19/rep-tim-huelskamp-took-part-film-likening-lgbt-rights-nazi-oppression-homosexuality>. The Heartland Institute has, among other things, sought to dissuade teachers from teaching about climate change. See, e.g., Katie Worth, *Climate Change Skeptic Group Seeks to Influence 200,000 Teachers*, PBS: FRONTLINE (Mar. 28, 2017), <https://www.pbs.org/wgbh/frontline/article/climate-change-skeptic-group-seeks-to-influence-200000-teachers/>. It has even applauded “Big Tobacco” and denounced “anti-smoking zealots.” See Lindsey Stroud, *Public Health Groups Should be Applauding Big Tobacco’s Harm Reduction Efforts*, THE HILL (July 6, 2018, 7:30 AM), <https://thehill.com/opinion/healthcare/395528-public-health-groups-should-be-applauding-big-tobaccos-harm-reduction> (Stroud is a state government relations manager at The Heartland Institute).

⁸⁶ H.R. 1018 § 1(2), 66th Leg., Reg. Sess. (Wash. 2018).

⁸⁷ H.R. 1018 § 3(1)(c), 66th Leg., Reg. Sess. (Wash. 2018).

⁸⁸ H.R. 1018 § 3(1)(b), 66th Leg., Reg. Sess. (Wash. 2018).

payment is not enough. Increasingly we are recognizing that failure to proactively treat mental illness means that psychiatric emergencies crowd hospital emergency rooms.⁸⁹ Even Republican policymakers loath to spend money are working to end this practice.⁹⁰ So why do we tolerate a status quo where untreated oral health conditions force people into emergency rooms at tremendous cost?⁹¹

For kids, toothaches are a top reason for missing school.⁹² Moreover, the consequences of oral health neglect escalate the older one gets: “Nearly half of all Americans age 30 and older have some form of gum disease; in people 65 and older, 70 percent have some degree of periodontal disease, according to the Centers for Disease Control and Prevention.”⁹³ That may heighten their risk of cognitive decline,⁹⁴ and further burden long-term care settings.⁹⁵ As Gayathri Subramanian, a professor at the Rutgers School of Dental Medicine, wrote, “[w]e cannot afford to walk away from our obligation to strive for oral-health equity—an integral part of achieving overall health equity—no matter the financial implications.”⁹⁶

⁸⁹ See Anne Zink, *Mental Health Patients, with Nowhere Else to Go, Are Overwhelming Emergency Departments*, STAT (Oct. 18, 2018), <https://www.statnews.com/2018/10/18/mental-health-care-emergency-departments/>.

⁹⁰ See, e.g., Jason Moon, *In Sununu’s Budget Address, Health Spending is Front and Center*, N.H. PUB. RADIO (Feb. 14, 2019), <https://www.nhpr.org/post/sununu-budget-address-health-spending-front-and-center#stream/0> (noting that New Hampshire’s Republican governor is seeking to end “emergency room boarding,” which occurs when “patients are held at emergency rooms across the state, sometimes against their will, without rigorous psychiatric treatment or a due-process hearing.”).

⁹¹ See Neumann, *supra* note 15. This can facilitate opioid dependency: “In interviews, many emergency department doctors acknowledged that they write plenty of prescriptions for opioids for patients complaining of dental pain, but they feel they face a conundrum.” Catherine Saint Louis, *E.R. Doctors Face Quandary on Painkillers*, N.Y. TIMES (Apr. 30, 2012), <https://www.nytimes.com/2012/05/01/health/emergency-room-doctors-dental-patients-and-drugs.html>.

⁹² See Leslie Ovall, *Oral Health Equity Summit Raises Awareness of Links Between Healthy Teeth and Social Justice*, WLRN (Mar. 28, 2018), <http://www.wlrn.org/post/oral-health-equity-summit-raises-awareness-links-between-healthy-teeth-and-social-justice> (noting that “[t]oothaches are the number one reason Florida children miss school, according to the Florida Dental Association.”).

⁹³ Suzanne Allard Livingston, *Does Gum Disease Have a Link to Cancer, Dementia, Stroke?*, WASH. POST (Oct. 1, 2016), https://www.washingtonpost.com/national/health-science/scientists-search-for-link-between-gum-disease-and-cancer-dementia-stroke/2016/09/30/bb966cba-7e9d-11e6-8d0c-fb6c00c90481_story.html?noredirect=on&utm_term=.42822e8f9b78.

⁹⁴ See *id.*

⁹⁵ See Saint Louis, *supra* note 79 (“Even when care is available, few staff members are trained to cope with the rising numbers of residents with dementia who resist routine dental hygiene.”).

⁹⁶ Gayathri Subramanian, *Why Don’t We Treat Our Teeth as if They Are Part of Our Overall Health?*, WASH. POST (Dec. 31, 2016), https://www.washingtonpost.com/national/health-science/why-dont-we-treat-our-teeth-as-if-they-are-part-of-our-overall-health/2016/12/29/135ceb94-b647-11e6-a677-b608fbb3aaf6_story.html?noredirect=on&utm_term=.d7cd8efd8c33.