

XVII. DEFEND YOUR LIFE

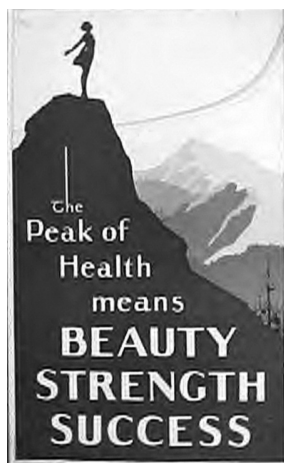
Life is short and the art is long. Hippocrates (c.460-377 B.C.)
Greek, philosopher, physician—"The Art of the Physician".

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*A child of five would understand this. Send someone to fetch a
child of five..* "Groucho" (1890-1977)—Comic, Marx Brother.

ORAL HEALTHCARE DELIVERY:

The U.S. Surgeon General has stated that "oral health is inseparable from total health" and that we have an oral disease epidemic. Research has repeatedly demonstrated that our dental and oral health have direct and significant effects on our general health. The oral cavity and its dentition must be considered a vital organ; it is essential to the overall well-being of our bodies.



According to recent figures (2006), more than 110 million Americans have no dental insurance. Public programs pay for less than three percent of all dental services (www.healthypeople.gov). The importance of oral health makes this lack of coverage unacceptable. Furthermore, regular dental care has never been included with elderly Medicare benefits. This may account for the fact that regular dental visits are not the norm in America's fastest growing population, the 85+ year-old age group.*

Dental health problems are also extremely common in America's youth population. Severe and contagious tooth decay is the most common childhood disease, condemning millions of small children to chronic pain, humiliation and a lifetime of dental disorders.** Fifty-one million school hours are lost annually to dental-related illness.¹

Among all income levels twenty percent of all children ages 2-17 receive no dental care² A landmark "U.S. Surgeon General's Report on Oral

*A Greek saying states, "Everyone wants to go to heaven, but no one wants to die." Health may remain merely the slowest possible rate at which one can die, but today, extending our lives and maintaining our youth seems less explicitly incompatible. With many medical, economic and ethical considerations, it is difficult to anticipate the myriad, lasting effects of our ever-increasing longevity. Societal implications of extending human longevity is challenging for our species and makes for perennial consequential and categorical reflection.

**Some tooth decay has been shown as transmitted through shared eating utensils and/or shared toothbrushes.

Health”, a three-year study published in 2002 and revised in 2006, not only highlights serious problems in oral health within various age groups but also found disparities along racial lines.³ Ethnic and income-based dental-visit figures remain even more alarming. “Dental caries” (tooth decay) is more common among minorities and most common among children from low socioeconomic families.

The 2000/02 U.S. Surgeon General oral-health study also found low-income and poor Americans make up the majority of America’s deficient oral-health population. About eighty percent of child dental disease is concentrated in twenty-five percent of children, primarily those from low-income families and minorities. Ethnically, half of Hispanics Americans (now America’s largest minority), half of African Americans, and sixty-eight percent of Native American or Asian-Pacific American children have untreated tooth decay as compared to fourteen percent of “white” Americans. A successful societal approach to this childhood disease is essential and in everyone’s best interest.

One sound, cost-effective strategy in combating tooth decay is the use of dental “sealants.” These sealants are coatings that can be applied to teeth to protect them from bacterial damage. A study, quoted in an initiative lead by Centers for Disease Control and Prevention, noted that as few as three percent of poor children have dental sealants compared to the national average of twenty-six percent. Extending sealants to poorer children should be of immediate and extremely high priority (see: C.D.C.’s “Healthy People 2010”—Chapter 21 and Health Resources and Services Administration: “Oral Health Initiative”). The Task Force on Community Preventive Services’ recent report noted a sixty percent decay reduction in children treated with sealants. Reaching children at an earlier age is far more beneficial than waiting until they reach high school. The elderly could also benefit from, prevention-oriented, dental sealants.

To improve rural and inner-city access to oral care, the Department of Health and Human Services announced \$10 million in grants for 2006. According to the U.S. Census for 2002, the number of Americans living below the “poverty line” rose by 1.3 million. With 37 million Americans living *below* the poverty line in 2005, these efforts are insufficient.

In private and employer-based dental insurance the problems are similar to those in general health care (see: General Healthcare Delivery, pg.171.) Much managed care contract-language and exclusions are simplistically

defended as effective means to keep member premiums more widely affordable. Without ample accountability on such efforts, and despite expansions in treatment possibilities with associated increased costs, many dental plans' "maximum-yearly-benefit" reimbursement levels have also not been appreciably augmented over the past several *decades*.

Specific to dentistry, "cost-saving" contract language includes the "alternate benefits provision," where a plan will pay only for the least expensive, professionally "acceptable" or "alternative" treatment (LEPAT). In some plans the least expensive service, such as a filling, is the only coverage provided, regardless of what treatment might be desired or even be recognized as more durable and/or beneficial.

Shrouded within many plans, a needed "single crown" or lab-processed "single onlay," can often be agreed to be "medically necessary" for an individual tooth's health. Yet, it is "coded" with "major", only *arguably more elective* services, reserved for multiple-tooth treatments and tooth-replacements, such as "fixed bridge work" (or even costlier options, like "dental implants") that thus receive lesser *percentage* benefit payments.

Similarly, blanket contract exclusions on "attrition and abrasion treatments" that are unfortunately standard in most current dental plans, can be very harmful (see previous, XI. "BRUXISM," "ATTRITION," "EROSION" & "FUNCTION" and/or *Dentistry Today: "Enamel Loss and Functional Occlusal Vertical Dimension™—Current Considerations for Treatment"* by R. L. Chacona, D.M.D. at www.LongevityLogic.com: Links—FOVD™.)

Allegedly to reduce claims that have primarily cosmetic origins, some exclusions are commonly used to "legally" deny patients primarily health-oriented treatments. Such contractual exclusions can currently uphold benefit denials, even when the treatment can easily be verified as both medically and functionally beneficial, or medically and functionally indicated under the most currently accepted medical and dental standards.

Additionally, insurer time-limitations for "retreatment" should not categorically deny benefit-coverage when any (less than adequate) prior treatment needs immediate attention. More appropriate cost-savings strategies could be explored, such as financial incentives for "higher-quality" doctor-care and a well-defined patient education program. Specific treatment "procedural steps," if verifiable and recognized as beneficial toward higher-quality treatment "results" or "durability" could also be more cost-effectively rewarded.

At present, certain, more costly, procedures have strict five-year "re-treatment" payment-limitation. To reduce longer-term cost and improve care, the functional "durability" of a treatment could be given "economic incentives" and any short-term treatment failure equitably penalized. Additionally, while some health- and auto-insurance premium-discounts are provided for non-smokers or for a member's auto-safety efforts; similar wellness-discounts are non-existent in dental-insurance. Dental plan premium-discounts could be based on certified oral-health education, or good hygiene verification, and research-based beneficial dietary considerations.

Insurance "Codes for Dental Treatment" (CDT) are used to standardize descriptions of dental services for insurance "reimbursement" or payment. Implemented on January 1 of 2007, "CDT 2007/2008" is the most current code-revision now being used. "Usual and customary reimbursements" (UCRs) or fees are monitored and can be adjusted by zip code, to compensate for varying, regional, cost-of-doing-business factors. Each insurance company assigns an amount to their "covered" CDT benefit in relation to UCRs. These UCRs should always have a fairly reviewed region-by-region component. Covered CDTs are assigned specific benefit amounts by each insurance company; actual dollar-amounts paid call for more impartial calculation with more patient-consumer and service-provider input.

Every new cavity requires a filling; fillings need periodic replacements and sometimes may lead to even more extensive treatments like crowns and root canals, even tooth loss and tooth replacement. Over time, the average "cost-savings" alone, derived from each and every "prevented" cavity/filling on each and every patient is about \$2,000.⁴

Codes for specific prevention-oriented services that involve more patient-education can be explicitly verifiable and should also become eligible for reimbursement. Establishing UCRs for CDTs such as "D9450", defined as, "case presentation and extensive treatment planning", and D0170, "accessing the status of a preexisting condition" would encourage their implementation. When such valuable, patient-education, services are verified as actually being provided, they should be eligible for adequate payment. Additional, innovative codes that further promote relevant patient inclusion and patient involvement in decision making should be considered in future CDT revisions.

Currently, there are no regulations for full disclosure of the process used in the determination of allowed insurance-benefits or adequate oversight on dollar-amount treatment-reimbursement levels (also see class-action suit: “ADA vs Aetna Insurance”—08/15/01.) Currently, there are also no consistent regulations requiring that a plan’s benefits “exclusions” be medically reviewed, be subject to any “validity” debate, or be suitably, or *independently authorized*.

Full disclosure of the process for the resolution of possible future disagreements or disputes needs to be reviewed and must be more clearly spelled out. Dispute resolution should be timely, equitable, and independent and should allow for patient input. Again, patient education is vital, however, it should be recognized that knowledgeable, more impartial, dentists and physicians might still be necessary to reconcile certain disputes. To help prevent and/or mediate conflict, better systems with empowered means for more ethical, fully independent patient-advocacy may be needed (also see: www.LongevityLogic.com.) If we merely accept various underlying flaws in the present system, many of its serious problems will continue.

Access to care is also problematic. If medicine extends life span, are the wealthy simply entitled to longer life than the poor? In professional education statistics, new minority dental school applications and admissions are far lower than would be expected based on current minority population (see: 9/20/2004 Sullivan Commission Report—“Missing Persons: Minorities in the Health Professions.”)

Increasing minority health care scholarship programs might be one way to help to improve minority communities’ access to health care. To expand dentist participation in Medicaid delivery, Colorado and Delaware offer loan forgiveness programs to dentists who participate in their Medicaid plans. Alabama instituted transportation services, patient education and public awareness campaigns to emphasize the need for dental care. Arizona and Arkansas have also instituted similar programs. The value of these initiatives should be reviewed and the results, widely publicized.

Nationally, low-income families and the elderly may be in the greatest danger. Health-disparities among such “priority populations”, including children and racial and ethnic minorities, are redelineated in a 2009 report from the department of Health and Human Services (HHS). (see a summary: www.hhs.gov/news/press/2009pres/06/20090609c.html).