



Why Dentists Don't Cost-Shift

Many public advocacy groups, Department of Health Services' staff and state legislators have asked the Wisconsin Dental Association why dentists do not treat all individuals in need of dental care and cost-shift the losses on to private sector patients, as is done in medicine. The WDA is the voice of the profession in Wisconsin, representing approximately 85 percent of all licensed dentists in the state. We offer this explanation for why dentists don't cost-shift the burdens of an underfunded Medicaid (MA) program to private-pay patients.

(1) Dentistry is dependent on the discretionary expenditures of patients.

Unless in acute pain, the care being sought by most dental patients is not what one would consider "urgent" or life-threatening. Many patients don't have dental benefit coverage, so their dental care expenditures are truly out-of-pocket. Those that do have dental benefits often have a co-pay or deductible, helping make them very aware of the actual costs of the procedures being performed. This is not true in the medical model. Here, patients perceive care as more urgent and life-threatening in nature. Medical patients are also often not the payers for the care they receive (their employer or their insurance plan is). It is rare if a medical patient knows the actual charges applied to his/her plan or the costs of services performed.

If dentists were to cost-shift the underfunded MA program on to the backs of private-sector patients, dental care costs would increase to such a level that private-pay patients would have a great deal of trouble spending their hard-earned discretionary dollars on services unless the services were of a more urgent nature. This would lead to: (a) the delay of routine restorative and preventive dental care for a large number of private-sector patients and (b) a decrease in the number of private-sector patients to whom the costs for the underfunded MA program could be shifted. This would result in a negative spiraling effect with more and more private-pay patients delaying dental care to avoid the cost-shifting. The system would eventually collapse, because it could not successfully sustain itself if dependent only on payments from private-pay patients in need of emergency dental services and/or private-pay patients with unlimited discretionary incomes.

(2) The medical model includes the prevalence of health insurance payment/coverage which disconnects most purchasers from health care costs. Approximately 50 percent of all dental patients pay out-of-pocket for their dental services, while the other 50 percent have "defined benefit payment plans" that cover diagnostic and preventive services and offer cost-sharing or co-pays for other services up to a defined maximum – usually \$1,000 - \$2,000. (Although people refer to this as "insurance" it is not the same as "insurance", because it provides a limited, annual, maximum payment and anything beyond that basic maximum is covered by the employee/patient.) Any major dental work has to be

paid out-of-pocket, making this very different from the medical insurance model where the patient is involved until a certain minimum threshold is met and then the insurance pays the remainder. **Given these differences, private-pay dental patients would notice more quickly and would defer care more frequently if they were faced with the burden of absorbing the cost-shifting that would be necessary to sustain the underfunded dental MA program in Wisconsin.** The burden created by cost-shifting is one of many issues that have led to proposals for a complete overhaul of the medical model. Expanding cost-shifting into dentistry will worsen, not improve, the current situation.

(3) There is no comprehensive system of “free care” in this state. **In the medical model, costs are often shifted to a nonprofit parent hospital which results in tax benefits for its losses or on to the profitable medical arm in the form of a “hidden tax”.** This enables the medical model to continue providing services to MA patients by shifting the losses of the MA program on to other types of medical services. This “hidden tax” essentially increases health care insurance costs for the rest of us, which will eventually decrease the pool of private-pay patients to a level below the threshold necessary to sustain the existence of the underfunded state programs. **In the dental model, care is provided largely in traditional dental office settings which are stand-alone small businesses. Dental MA patients experience a lack of access because dentists cannot absorb MA losses and are forced to place tighter limits on their participation in the state’s underfunded program or they choose not to participate at all and pick other (less-regulated) ways in which to provide charity care to patients in need.**

(4) In the larger picture, the government (representing our society) has decided providing health care (including dental) to those who have low-incomes is a worthy goal. **Instead of openly paying providers for the costs of these services on an up-front basis, the government depends on providers to either personally absorb the cost or to do the government’s job of taxing individuals by cost-shifting the losses to private-sector patients and/or their insurance plans.** The dental community believes the system would operate more fairly and provide better access to those individuals the government has promised care if the government would simply stand by its original commitment and properly fund (on the front end) established health care programs. **We do not believe it should be the job of health care providers to implement a “hidden” tax in order to fulfill the promises made by the government or the society as a whole.** Providing quality care to enrollees in state programs is the provider’s responsibility; finding an appropriate mechanism to pay for the costs of those services is the government’s/society’s responsibility.