



Penobscot Community
Health Care

Administrative Services Center

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Testimony submission letter for LD 1955

Penobscot Community Health Care (PCHC) favors LD 1955, An Act to Promote Cost-effectiveness in the MaineCare Program and Improve the Oral Health of Maine Adults and Children.

Penobscot Community Health Care (PCHC) submits these comments in favor LD 1955, An Act to Promote Cost-effectiveness in the MaineCare Program and Improve the Oral Health of Maine Adults and Children. As a community health center with the largest dental practice in the state, PCHC supports expansion of Medicaid benefits to include preventive dental. The list of reasons why this bill should pass are long. However, these comments will focus on the critical need to think of dental care as healthcare, and healthcare as a *system*. An increased investment in preventive dental coverage – as with all preventive *medical* coverage – will reduce overall costs to the system. In other words, the State will save money by investing in preventive dental. PCHC is the state's largest federally qualified health center (also called community health centers) providing preventive primary and dental care, mental health care, and specialty services. PCHC is home to the largest stand-alone dental center not affiliated with an academic dental center east of the Mississippi River – a 46-chair facility located on Union Street in Bangor, Maine. At our dental center, we provide preventive dental (typical of FQHCs), as well as specialty dental care, including dental surgery and orthodontics (less typical in health centers). We employ 16 dentists (including 3-4 dental residents each year) and 7 dental hygienists. We operate the only dental residency program in the state and consider this residency crucial to helping address the state's shortage of dentists and to providing much-needed care to low income populations throughout our region.

In 2019, we saw approximately 40,000 patient visits in our health center and treated patients from all across Penobscot, Piscataquis, Waldo County, and beyond. We provided about \$1.5 million in uncompensated care in 2019 alone and thus know first-hand the human cost and the strain on the system due to a lack of dental coverage for low income Mainers.



Penobscot Community
Health Care

Additionally, we see the significant degree to which lack of dental coverage under Mainecare only exacerbates inequities, separating the “haves” from the “have nots” and creating rather than removing barriers for people wishing to pull themselves out of poverty.

Our staff live the reality of the lack of preventive dental coverage and access challenges daily. We see thousands of people who cannot eat fresh vegetables because of poor oral health, which prohibits them from eating well and accelerates the decline of overall health. As a result of lack of preventive care, we see patients losing teeth prematurely at an alarming rate.

While it can seem daunting from this Committee’s vantage point to consider investing in dental coverage, *it should not be*. The total cost of care will decline as we invest in preventive dental. As a country and in this state, investments in low-cost prevention, including primary medical and dental care, lag far behind all other developed countries. This leads to far higher costs on the other end – in emergency room and hospital care. We are the only developed country in the world that treats dental health as separate from medical care – an insanity that is peculiarly American. Other countries figured out long ago that the teeth are connected to the body, and poor dental health is both a symptom and often a cause of poor overall health. Dental care is indeed healthcare, and covering preventive dental – rather than only emergency dental – will **lower** total costs to the healthcare system in Maine.

A study by the Muskie Institute in 2010 concluded that the top diagnostic reasons for ED visits “among both Mainecare and uninsured young adults aged 15 through 24, and adults aged 25-44 was dental disease.” The study further found that most of the ED visits were “preventable if care can be provided in an alternative setting.” See

<http://muskie.usm.maine.edu/Publications/PHHP/Maine-Emergency-Department-Use.pdf>. We are all aware of the high cost of emergency room visits, and the preventable nature of most such visits. Preventive dental coverage will significantly reduce ER utilization over time.



Penobscot Community
Health Care

Moreover, research has shown that the more missing teeth an individual has, the higher the risk of developing and exacerbating other systemic diseases. Multiple research studies suggest that being edentulous (missing teeth) is linked to malnutrition, obesity, cardiovascular disease, rheumatoid arthritis, cardiovascular disease, diabetes, COPD, respiratory infections, among other things. (See Felton, David A., DDS, MS, FACP, "Complete Edentulism and Comorbid Diseases: An Update," David A. Felton, *Journal of Prosthodontics* 25 (2016), pp. 5-20). These statistics are alarming, and not including dental care as adult primary preventive care, actually increases the incidence of developing systematic diseases, therefore increasing health care costs all around. Additionally, the National Association of Dental Plans concluded based on data from the Medical Expenditure Panel Survey, that when preventive dental benefits were provided to Medicaid recipients, "medical costs for patients with seven chronic conditions were lowered from 31 to 67 percent." The chronic health conditions studied included diabetes, high blood pressure, coronary heart disease, stroke, cancer, and asthma, among others.

<https://www.nadp.org/mobilewebsite/mobilenews/2017/11/23/nadp-analysis-shows-adults-with-medicaid-preventive-dental-benefits-have-lower-medical-costs-for-chronic-conditions>. The

authors of this study further observed that where dental coverage is lacking, "not only are health costs increased for the chronic conditions identified by this analysis, but Medicaid patients without dental care are more likely to seek out dental care in hospital emergency rooms rather than lower cost community health centers or private offices." *Id.*

Finally, the problem with failure to provide dental coverage goes beyond the exponential increase in costs when individuals delay care and are forced to seek care in high cost locations (EDs) and the exacerbation of chronic diseases. The moral cost, the cost to the dignity of Mainers, and the shortened life span as a result of higher rates of chronic disease is unacceptable. Moreover, the stigma associated with poor dental health is well known. In a *New York Times* Op-ed from 2018, "How Dental Inequality Hurts Americans," author Austin Frakt observed that "the problems go beyond health. People with bad teeth can be stigmatized, both in social settings and in finding employment." <https://www.nytimes.com/2018/02/19/upshot/how-dental-inequality-hurts-americans.html>. All of us make judgments about lack of intelligence, education level, and employability when people have visibly poor dental health. This simply compounds the problem for individuals, and creates yet another obstacle to them climbing out of poverty. Poor oral health prevents individuals from seeking employment (thus leading to increased dependence on public benefits) and inhibits the creation of healthy social connections, both contributing to higher rates of chronic disease and mental health struggles.

For all the above reasons, I urge this committee to approve LD 1955, to improve health, reduce the total cost of healthcare, and improve the quality of peoples' lives.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Lori L. Dwyer".

Lori L. Dwyer, JD
President & CEO
Penobscot Community Health Care