

## Universal Health Care: Parameters to Define a Position for Oral and Maxillofacial Surgeons

The impetus toward change is unfortunately often due to a progression of untenable choices that eventually makes the status quo look ridiculous. The system of health care reimbursement that seemed so straightforward and so simple and indeed so fair just 3 decades ago is now conversely, insanely convoluted, unmanageably complex, and inherently unfair. In the period of nonprofit health insurance until the 1980s, only "the Blues," Medicare, Medicaid, HMOs, unions, and some very large employers such as General Motors offered exclusively not-for-profit health insurance. Administrative costs were generally less than 10% of premium dollars. Care was delivered and reimbursed to physicians on a fee-for-service model.

Now many physicians are enrolled in more than 100 plans with nearly all plans being either for profit or virtually for profit. Government-sponsored plans have developed legislative waivers state-by-state to control costs and limit access. Thus government plans such as Medicare and Medicaid support as many as dozens of for profit plans in each state. Each plan has its own defined benefit packages, its own provider network, its own provider rules, its own credentialing. The premium retention (that portion of premium kept by the company for overhead and profit) in some cases exceeds 50% of premium dollars.

Access to health care is not only limited for the 47 million Americans without health insurance (and the 160 million without dental insurance), but deductibles, copays, maximum benefits, and services not covered have created a poisonous brew that limits access to most Americans even (or perversely more so) to those who have health insurance. Oral and maxillofacial surgeons now must hire highly trained and assertive staff to simply negotiate this heady environment on behalf of our patients. Interaction with the insurance company in OMS offices now routinely exceeds the amount of time devoted to the delivery of care. The business-support costs can exceed the labor costs used in OMS practice for clinical support in the direct delivery of care. Sadly, many former clinical staff, especially nurses, find themselves in administrative positions devoted to the payer's needs. Clinical documentation directed toward payment hinders the primary goal of care which is to improve the patient's

health. Finally, the payers often remain unwilling to reimburse for care in spite of the clinical team's best efforts.

Our payers' unwillingness to cover necessary care can be summed up as:

*"We don't cover that because it's (fill in the blanks)*  
*experimental*  
*not cost-effective*  
*not necessary care*  
*not evidence-based care*  
*not proven to extend quality life*  
*a quality of life issue*  
*delivered by a high-cost provider*  
*delivered by a resident or student*  
*not delivered by a physician*  
*another party is responsible for payment*  
*only local anesthesia is necessary*  
*dental not medical*  
*behavioral*  
*cosmetic*  
*reproductive medicine*  
*the wrong body part and excluded by our policy*  
*(eg, temporomandibular, orthognathic)"*

Payers can and do use these methods to refuse payment for many of the procedures we perform including (as every oral and maxillofacial surgeon can report) both elective and nonelective procedures. OMS is also uniquely in the wedge where responsibility for payment is obscured by 2 separate business entities, the medical and dental insurance companies.

In this untenable environment, the handful of physicians that supported national health insurance and universal coverage in the past has now swelled to 59% of all physicians in the United States.<sup>1</sup> Physicians likely have very limited confidence in the ability for change to improve this impossible situation that now saps more than 16% of our GDP. But both political parties now recognize that fundamental improvements in our nation's health care reimbursement system are absolutely necessary.

Rather than debate whose approach will be best, oral and maxillofacial surgeons need to promote ideas

that will enhance the health of our patients by improving their oral and maxillofacial health.

As presented to the nation in the Surgeon General's Report on Oral Health, we must ensure that oral health is recognized as integral to overall health. Only a society with good oral health can truly be healthy. Inflammation from third molars can contribute to premature low birth weight babies and extension of periodontal disease resulting in cardiovascular and CNS disease. Deformities, tumors, and trauma to the oral and maxillofacial region place a major burden on Americans' health. More than 1 million school days are lost each year due to children with dental infections. Any national plan must recognize that oral health must finally be considered necessary to human health.

As an example, any universal medical plan, even the most basic plan, must provide full access for necessary health care. In oral and maxillofacial surgery this includes the management of:

1. Maxillofacial trauma
2. Head and neck infection including odontogenic infection and the removal of third molars
3. Admission to the hospital for medical management during the course of necessary oral health care for both children and adults
4. Surgical treatment of temporomandibular disorders
5. Tumors of the oral and maxillofacial region including benign and odontogenic tumors
6. Correction of functional skeletofacial deformities
7. Surgical treatment of obstructive sleep apnea
8. Cleft lip and palate care including revisions
9. Ambulatory anesthesia performed according to AAOMS standards

While universal access has emerged as a common goal for patients, doctors, and politicians, its implementation is likely to be arduous. The same pressures that led us to this point are likely to emerge powerfully when the debate is joined. It is clear however, that only oral and maxillofacial surgeons are in a position to speak for our patients' oral and maxillofacial health and the best vehicle to ensure that we are heard is by donating to OMSPAC. To win a victory for our patients, we must look to ourselves as a specialty first, an item to be addressed in the next *JOMS* editorial.

*"If I am not for myself, who will be?  
And when I am for myself, what am I?"  
And if not now, when?"*  
—Hillel<sup>2</sup>

LEON A. ASSAEL, DMD

## References

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2. Hillel the Elder. Available at: [http://en.wikipedia.org/wiki/Hillel\\_the\\_Elder](http://en.wikipedia.org/wiki/Hillel_the_Elder). Accessed April 4, 2008