EDITORIALS

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Impact of the ACA on Oral Appliance Therapy

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The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA), has had an impact on oral appliance therapy for obstructive sleep apnea, not necessarily directly, but rather in the role that it has played in contributing to the "perfect storm" for oral appliance therapy.

Prior to the enactment of the ACA, the sleep center industry was rapidly evolving on its own. With the sharp uptick in interest in diagnosing patients with sleep apnea, the amount reimbursed by private and public insurers for sleep testing was rapidly escalating. From 2001 to 2009, the amount spent by Medicare for sleep testing jumped from $62 million to $235 million. With the prospect of a potentially explosive rise in insurance reimbursements for sleep testing, reimbursements were sharply cut back, and home sleep testing, viewed as a less expensive alternative to in-laboratory diagnostic testing, was adopted.

In the midst of this industry-wide turbulence, the ACA was signed into law by President Obama on March 23, 2010. The landmark legislation represented one of the most significant regulatory overhauls of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. The ACA was enacted to increase the quality and affordability of health insurance, lower the uninsured rate, and reduce healthcare costs for individuals and the government. Although enacted in 2010, the ACA was not implemented all at once; rather implementation of various parts of the legislation was stretched out over many years, prolonging the upheaval that often comes with disruptive change.

Against this backdrop, oral appliance therapy emerged as a validated treatment modality for obstructive sleep apnea. In 2011, Medicare began covering oral appliance therapy both as first-line therapy for patients with mild-to-moderate obstructive sleep apnea as well as for patients with severe obstructive sleep apnea for whom PAP therapy was contraindicated or could not be tolerated. Validation by the Medicare program was extremely important since it opened the door for all other insurers to follow. Medicare fees generally serve as the benchmark against which most private insurers, Medicaid, and other government programs base their fee schedule.

Thus, at the very moment when oral appliance therapy should have gained a preeminent voice in the professional dialogue on the treatment of obstructive sleep apnea, a tsunami of changes both within the field of sleep medicine and throughout the landscape of the U.S. health care system was occurring. These changes proved to be formidable headwinds for a treatment modality that was in its early stages of evolution in the healthcare marketplace.

Sleep centers had realized early on that by adding sales of PAP devices to their product/service mix they could significantly enhance their net profits. As the reimbursements for sleep studies dropped precipitously and patient volume declined in the aftermath of the adoption of home sleep testing, the pressure to sell PAP devices increased even more. Many sleep centers were able to break even on diagnostic testing but were reliant on the sale of PAP devices to generate profits. By adding to the sale of PAP devices a resupply program, designed to provide patients with supplies and accessories for the PAP device on an ongoing basis, sleep centers found a way to further strengthen their bottom line.

Thus, in an environment in which the sale of PAP devices was viewed as the antidote to sharp cuts in patient volume and price, oral appliance therapy was not enthusiastically embraced, for what did an oral appliance represent to a sleep center but a lost opportunity to sell a PAP device.

The ACA added another layer of complexity to the challenges faced by dental professionals providing oral appliance therapy. By prohibiting certain strategies as, for example, denying policies to individuals with preexisting conditions, the ACA forced insurers to turn to other cost drivers, such as provider prices, to deliver more competitive premiums. One way to effect lower prices was to limit the number of providers in network and, in effect, buy in bulk. By working with fewer providers in network, insurers had more leverage to demand lower prices. The concept of "narrow networks" was not new, but the ACA certainly fueled wider adoption of this strategy.

Under the ACA, many insurers revamped their network design and culled their rosters of in-network providers to create smaller networks. Thousands of primary care physicians and specialists were terminated from insurance plans, sparking a battle between physicians and insurers. And in the midst of this increasingly restrictive environment, many dental professionals sought in-network status to provide oral appliance therapy for obstructive sleep apnea but were unsuccessful.

Along with negatively impacting healthcare providers, many of the insurers' initiatives under ACA also adversely affected patients. One of the essential objectives of the ACA was to lower the uninsured rate. The ACA did indeed increase the number of insured individuals. However, the expansion came at the expense of incurring higher out-of-pocket costs for many Americans in the form of higher premiums, deductibles, copayments, and coinsurance. In response to higher costs, many patients became more cost conscious; others simply elected to forego treatment. More Americans may have gained coverage but were not accessing health care services as frequently as before.

Again, the oral appliance market was affected. Although studies indicate that patients generally prefer oral appliance therapy to PAP therapy, when price is a factor, the decision is not as straightforward. In most cases, PAP therapy carries lower up-front costs than oral appliance therapy, and cost-conscious patients take this factor into consideration. Consequently, even if oral appliance therapy is an option, many patients are electing PAP therapy in order to limit their out-of-pocket expenses.

In short, the ACA to date has not been favorable to oral appliance therapy. However, that is not to say that in the future the

ACA may not be instrumental in fueling its growth. One of the new ideas introduced by the ACA is a revised payment methodology that is based on outcomes. Should outcomes become a critical component in the calculation of reimbursements, the ACA may indeed force the issue that custom-made oral appliances have a higher compliance rate than PAP devices, often resulting in better treatment outcomes.

In the meantime, the oral appliance market still remains strong despite the strong headwinds that dental professionals have faced over the last several years. According to a recent research paper published by Frost & Sullivan, the oral appliance market in the U.S. is projected to double by the year 2020.[1]

In my opinion, there are potentially two strategies that dental professionals may elect to pursue to further nurture growth of oral appliance therapy going forward—the first strategy being directed to the patient and the second to the sleep center. As patients become more accountable for their own healthcare and responsible for a greater share of the payments for services rendered, they will be the ultimate decision-makers in their treatment. Consequently, patient education is likely to play a more prominent role in fueling growth of the therapy. The time spent upfront educating patients during the screening process may yield significant dividends later on when treatment plans are formulated.

Secondly, from the sleep center's perspective, dentists are of great value to them as a source of patient referrals. One dentist alone may not impact the financial results of a sleep center, but groups of dentists aligning with one sleep center in their community may make a profound difference especially if the group consistently refers a significant number of patients to the sleep center on an ongoing basis. In numbers, dental professionals have a stronger voice to more effectively articulate their issues and concerns. In numbers, dental professionals are better positioned to become stronger partners in the treatment of obstructive sleep apnea at these sleep centers.

In my opinion, the worst of the "perfect storm" is over. Although the future of the ACA may be uncertain, the future of oral appliance therapy looks bright largely because of the enduring strength of the dental profession and its ability to provide oral appliance therapy under all circumstances and in any environment.

CITATION

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DISCLOSURE STATEMENT

Dr. Ziwot has indicated no financial conflicts of interest.