

medicaid and the uninsured

June 2012

Children and Oral Health: Assessing Needs, Coverage, and Access

Over a decade ago, *Oral Health in America: A Report of the Surgeon General* – the first-ever such report – raised public awareness about the integral connection between oral health and overall physical health and well-being, and documented the personal and public health consequences of inadequate access to oral health care. In 2007, the death of 12-year-old Deamonte Driver from complications of an abscessed tooth, when his mother could not find a Medicaid-participating dentist to treat him, provided tragic evidence of the most devastating costs of lack of care. Yet dental caries, or tooth decay, remains the most common chronic disease among children ages 6-18.¹ According to the most current estimates, more than 40% of U.S. children ages 2 to 11 have decay in their baby teeth, and, among all children ages 6-18, about one-quarter have untreated decay.^{2, 3} Dental caries and other oral diseases disproportionately affect low-income children and children of color.

Medicaid and the Children’s Health Insurance Program (CHIP) are major sources of health and dental coverage that reach more than one-third of all American children. Still, in 2009, 19 million children, or about one in four, were uninsured for dental care – more than twice the number who lacked health insurance that year.⁴ Substantial gaps in private dental coverage, low dentist participation in Medicaid, and the high cost of dental care mean that many children today go without recommended preventive and primary oral health care, and also that uninsured families and even those with private health insurance may face difficult out-of-pocket burdens when their children need dental care. Perhaps less widely recognized, low-income adults, including many parents of children covered by Medicaid and CHIP, as well as millions of adults without dependent children, are uniquely disadvantaged in obtaining needed oral health care because so many are uninsured and because, in many states, Medicaid covers little or no adult dental care except tooth extractions.

The Affordable Care Act (ACA) achieved major advances for children’s health by broadly expanding affordable coverage through Medicaid and private insurance, and also by specifically including pediatric oral health care among the ten “essential health benefits” that all qualified health plans will be required to cover for children beginning in 2014. (Adult dental benefits were not included.) The effect of these reforms will be to extend health coverage, including dental benefits, to millions of children who now lack such coverage. The codification of children’s oral health care as an essential health benefit represents a landmark in the ongoing efforts to ensure adequate access to care for all children and to improve the oral health of the nation, which remain urgent health policy challenges in the U.S. today.

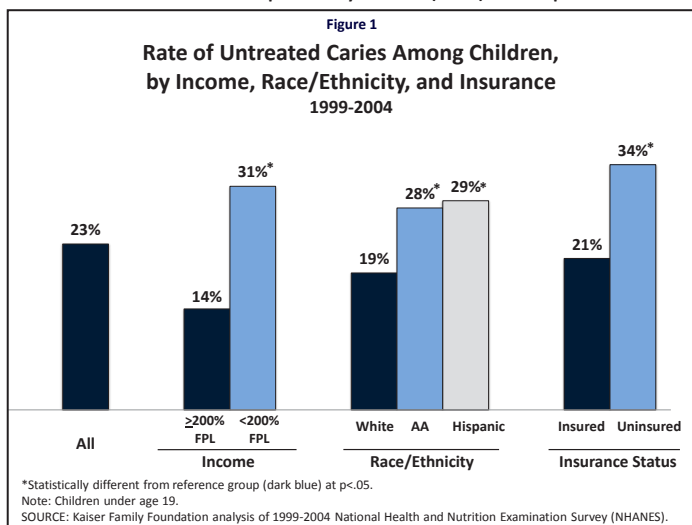
Impact of oral disease

Tooth decay is a bacterial infection and it is largely preventable. It is also contagious; a mother who has active tooth decay can pass it to her baby or child just by sharing a spoon. Dental and oral disease have been linked with ear and sinus infections, weakened immune systems, diabetes, heart and lung disease, and other serious health conditions.⁵ In children, untreated caries can adversely affect speech, nutrition, growth and function, social development, and quality of life. Children with dental-related problems are estimated to miss more than 51 million hours of school each year, and recent research also points to an association between poor oral health and poor school performance.^{6, 7} In rare cases, untreated oral disease in children leads to death.

Water fluoridation and topically applied fluoride, dental sealants, and diagnostic services are effective and efficient means of preventing and detecting caries and other oral disease. An economic analysis conducted by the CDC showed that, in communities of more than 20,000 people, every \$1 invested in community fluoridation saved \$38 in dental treatment costs.⁸ Other research has shown that average dental costs were more than 50% lower for low-income pre-school children who received preventive dental care by age 1 than for those who first received it at age 4 to 5.⁹ The prevalence of dental sealants among poor children aged 8 increased significantly between the periods 1988-1994 and 1999-2004, marking important progress toward the Health People 2010 objective on this measure.¹⁰ At the same time, the caries rate among very young children increased – a worrisome development because a history of caries is one of the best predictors of future caries.¹¹

Disparities in oral disease and dental care

Oral disease and inadequate access to oral health care among children are system-wide problems, but they are not distributed evenly; on the contrary, there is important variation by income, race/ethnicity, and health insurance status (Figure 1). Roughly a quarter of all children under age 19 have untreated caries, but the rate is 31% among children below 200% of the federal poverty level (FPL)^{*} compared with 14% among higher-income children.¹² Low-income children suffer more severe and extensive decay as well.¹³ The rate of untreated caries is higher among African American and Hispanic children than White children – 28% and 29%, respectively, versus 19%. And 34% of uninsured children have untreated caries, compared to 21% of children with public or private health insurance.¹⁴ Reflecting these disparities and other factors, the burden of oral disease is highly concentrated, with the vast majority of cavities occurring in a relatively small share of children ages 5-17, mostly from low-income and other vulnerable groups.¹⁵



Utilization data point to disparities in access to oral health care as well as in oral health. In 2010, while a large majority of all school-age children had a reported dental visit within the past 12 months, the rate for low-income children lagged, at 79% compared to 90% for higher-income children.¹⁶ By the same token, children below 200% FPL were more likely to have gone two years or more without a dental visit – 10% compared to 3% for those at or above 200% FPL. It is important to note that Medicaid administrative data on children’s use of any dental care, from the CMS-416 EPSDT report, show much lower rates of use – on average, 40% in 2010 – than the national survey data reported here.¹⁷ Several factors may help to explain the difference. First, the CMS-416 data capture only children covered by Medicaid, whereas the data provided here include all children with income under 200% FPL. Second, the CMS-416 data include all children ages 0-20, while the result reported here excludes children under age 6, only half of whom had a dental visit in the past year, as well as individuals over age 18. Third, as distinct from administrative data, survey data reflect self-reports of utilization by respondents. Finally, the CMS-416 data may not be entirely complete.

* The federal poverty level for a family of four is \$23,050 in 2012.

Racial/ethnic disparities in utilization also exist. Among low-income children, around 80% of Whites and African Americans and 76% of Hispanics had a dental visit in the past year. In all three racial/ethnic subgroups, the share of children who had a visit in the past year was greater in the higher-income population (92%, 87%, and 87%, respectively).

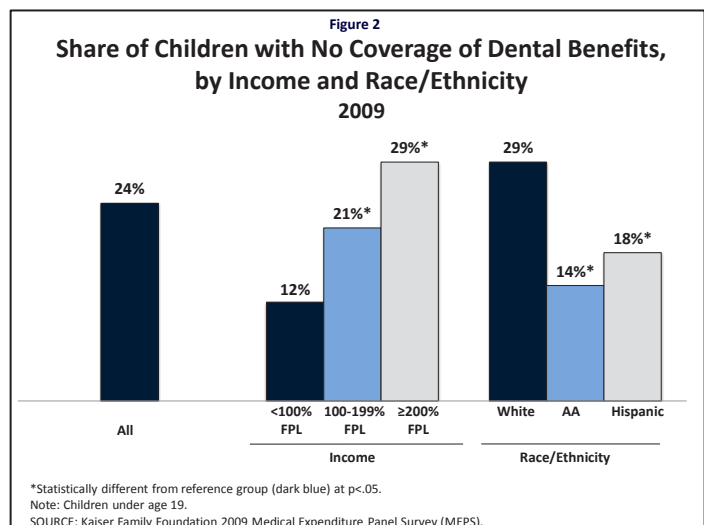
Health insurance, dental coverage, and access to dental care

Although other factors also play a role, health insurance makes a big difference in whether and when people get the care they need. In 2010, a little over half of all U.S. children had private insurance, while Medicaid and CHIP covered about one-third, and one in every ten children remained uninsured.¹⁸ Below 200% FPL, private insurance plays a much more limited role, reaching just about a quarter of children, while Medicaid and CHIP cover nearly 60%, and 16% are uninsured. Among the low-income children covered by Medicaid are many with severe physical and intellectual disabilities, whose needs for care, including dental care, may be very specialized, involving special equipment, services, and capabilities, as well as providers with special expertise and experience.

Under a provision of federal Medicaid law known as “EPSDT,” states have long been required to cover comprehensive dental care for children enrolled in Medicaid and CHIP-funded Medicaid expansions. In 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) mandated that separate CHIP programs also cover comprehensive dental benefits and applied the CHIP cost-sharing limits for medical care to dental care as well. CHIPRA also permitted states to use CHIP funds to offer dental-only coverage for children with other health insurance that lacks adequate dental coverage, if the children meet CHIP’s other eligibility criteria.

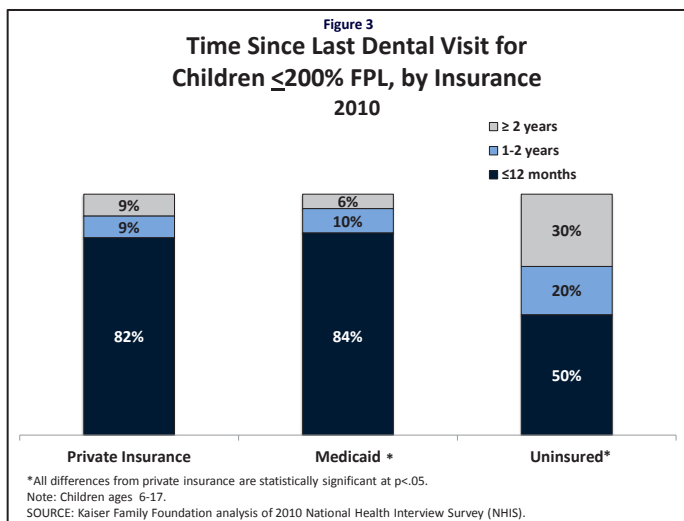
In contrast to Medicaid and CHIP, private health insurance frequently does not cover dental benefits, although many families purchase stand-alone private dental policies. The scope of private dental coverage varies by insurance product, and may be subject to annual dollar caps and other types of limits. Private dental coverage may also require substantial deductibles and cost-sharing for dental services. In 2009, nearly 30% of children under age 19 with private health insurance lacked any dental coverage.¹⁹ Between this gap in private health insurance and the fact that millions of children lack any health insurance, almost a quarter of all children had no coverage for dental care.

Because Medicaid and CHIP cover dental care, low-income children are actually less likely than higher-income children to lack coverage for dental services. Twelve percent of poor children lack dental benefits, while the rate is 21% for near-poor children, and 29% among children at or above 200%FPL (Figure 2).²⁰ Dental coverage rates show a different pattern of racial and ethnic disparities than is typical in the health care context. Overall, and specifically among poor and near-poor children, Whites are more likely to lack dental coverage than both African Americans and Hispanics; Hispanics fare worse than African Americans. At income levels of 200%FPL or



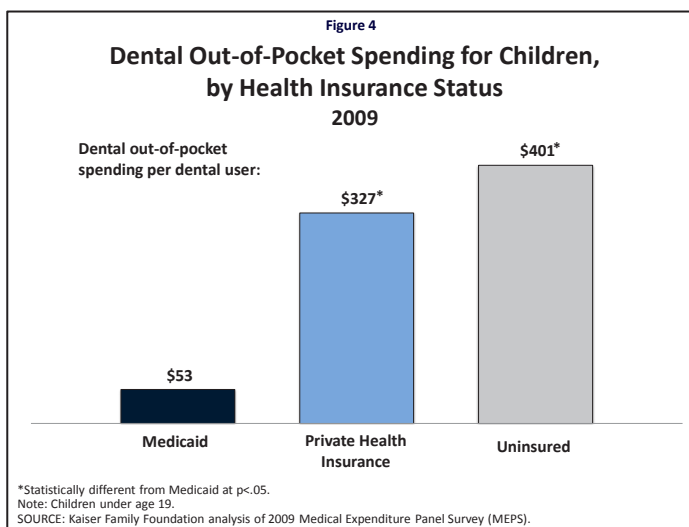
higher, as eligibility for Medicaid and CHIP phases out, African American and Hispanic children lose ground, reaching the same levels without dental coverage that White children experience. Nearly 30% of all three groups of children with income at or above 200% FPL report no dental coverage.

Insurance coverage does not necessarily translate into access to care. For example, insured children may be unable to obtain dental care if no dentists are located in their community, no dentist is accepting new Medicaid patients, cost-sharing is too high, or parents do not realize the importance of oral health care. Still, children with any health insurance are much more likely than uninsured children to have had a dental visit within the past 12 months. In 2010, more than 80% of low-income, insured children had a recent visit, with the rate slightly higher among Medicaid children than among privately insured children; by contrast, just 50% of low-income, uninsured children had a recent visit (Figure 3).²¹ By the same token, fewer than one in ten insured children, whether they had Medicaid or private coverage, had gone two years or more since their last dental visit, but the rate was 30% for uninsured children. Across all three insurance groups, higher-income children were more likely to have had a recent dental visit, suggesting that income has an independent, positive correlation with access. Access among uninsured children varied by income: in the higher-income group, the share with a dental visit within the past 12 months increased by 15 points, to 65%, and the share with no visit in two years or more fell by 13 points, to 17%.



Out-of-pocket costs for dental care

Medicaid prohibits cost-sharing for most services for school-age children below 100% FPL and for younger children up to at least 133% FPL. States can impose limited cost-sharing on children above these income thresholds, but not for preventive care. Also, certain groups of children are exempt from cost-sharing entirely. Total Medicaid premiums and cost-sharing charged to a family cannot exceed five percent of the family's income. CHIP strictly limits cost-sharing as well. Exposure to out-of-pocket costs for dental care is greater for children with private health insurance. As already discussed, private health insurance often



does not cover dental services, so children without a separate dental policy in these cases would have to pay out-of-pocket for their dental care. Even children whose private health insurance includes dental benefits may face deductibles, copays, and costs for care not covered by the policy. Uninsured children, of course, are the most exposed to out-of-pocket costs. In 2009, dental out-of-pocket spending per

dental user was \$245 overall, but the amount varied from about \$50 for poor children and those covered by Medicaid, to over \$300 for children with private health insurance, and \$400 for uninsured children (Figure 4).²²

Supply-side challenges to access

The overall supply of dental providers is inadequate, and shortages of dental specialists, including pediatric dentists, are especially acute. Further, many dentists do not participate in either private or public insurance, reducing financial access to their care. Dentists' participation in Medicaid is particularly low, and many dentists who do participate in Medicaid limit the number of Medicaid patients they accept. The chief reason dentists cite for not accepting Medicaid patients is low payment rates – many state Medicaid programs pay dentists less than half their charges.²³ Slow payment and administrative hassles have also been cited as obstacles to participation.

The geographic maldistribution of the dental workforce also contributes to shortfalls in access to care. Fifteen percent of the U.S. population lives in Dental Health Professional Shortage Areas (HPSAs).²⁴ Children living in rural areas must travel further and are less likely to have access to dental care than children residing in urban areas. But even in urban areas where the supply of dentists is concentrated, a lack of alignment between the location of low-income communities and dental practices contributes to disparities in access. A growing number of health centers are expanding their dental capacity, but not all underserved areas have health centers, and not all health centers can provide dental care.

A number of approaches can help to address current gaps in the supply and distribution of dental care and increase access for children. In the Medicaid realm, states that have taken steps such as raising their dental payment rates, contracting with a dental benefits manager to administer benefits, and streamlining and automating the billing process for dentists, have increased provider participation and improved access to dental care for children in the program. Other strategies that have been adopted include state licensure of new types of mid-level dental providers to expand the supply of dental care, training and providing Medicaid reimbursement for pediatricians and other primary care providers to apply fluoride varnish, and school-based sealant programs.

The ACA and looking ahead

When the ACA is fully implemented, it will have the potential to reduce the number of uninsured children substantially by expanding Medicaid and providing subsidies for private coverage through the new health insurance Exchanges, and by requiring streamlined, coordinated eligibility and enrollment processes designed to maximize participation. In addition to expanding coverage, the ACA specifically included oral health care for children in the essential health benefits that must be covered by all qualified health plans, closing a key gap between many private insurance plans and Medicaid and CHIP. These two elements of the health reform law, taken together, represent a significant stride forward in promoting access to dental care for American children. The expansion of health insurance coverage will most benefit the lowest-income children, who have the highest uninsured rates. However, higher-income children, including many privately insured children who now lack dental benefits, stand to gain from the inclusion of pediatric oral health care in the minimum benefit package. Notably, the improvements in dental coverage for children will probably not carry over to adults, as adult oral health care was not required in the essential health benefits package.

For the promise of coverage of oral health care for children to be more fully realized, improved Medicaid payment for dental care and other strategies to improve dentists' participation in Medicaid are needed. State efforts to broaden the oral health care workforce, expanding the available supply of care, are also an important policy lever for increasing access. Between such changes and the ACA provisions for children, there are unprecedented opportunities to reduce current gaps and disparities in children's coverage of and access to oral health care. Other ACA provisions, including increased funding for health centers and the National Health Service Corps, public education to promote oral health, grants for school-based sealant programs, and workforce training and development programs, enhance the prospects for progress. Close monitoring and analysis of changes in children's coverage, access, utilization, and oral health will be instrumental to tracking progress toward improved oral health for all the nation's children.

This policy brief was prepared by Julia Paradise of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

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