kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

June 2012

Oral Health and Low-Income Nonelderly Adults: A Review of Coverage and Access

Oral health is an important factor in overall health for people of all ages, yet millions of adults lack access to affordable and regular dental care. Untreated oral health conditions can lead to pain and tooth loss that can lower the quality of life as well as jeopardize employment.[1] Research has also identified associations between poor oral health and other chronic diseases, such as diabetes, heart and lung disease, and stroke.[2] Despite large strides in improving oral health care since the 1970s, gaps and disparities in access and care persist.[3] Low-income individuals and families, as well as racial and ethnic minorities, are disproportionately affected by oral health problems.

The lack of resources to pay for dental services, either through dental insurance or out-of-pocket, is a major barrier to oral health care for many low-income Americans.[4] The problem is particularly acute for low-income adults, who are more likely to be uninsured than low-income children because Medicaid eligibility is much more limited for low-income adults than for children, and because low-income adults also lack access to private health insurance. In many states, adults who do qualify for Medicaid lack dental benefits. Adult dental benefits in Medicaid are offered at state option, and states often limit their coverage to extractions or other emergency dental services only. When states face budget pressures, adult dental services in Medicaid are among the first targets of cutbacks.[5] Finally, private health insurance frequently does not cover dental services, and when plans do cover dental care, cost-sharing can be high.[6]

Under the Affordable Care Act (ACA), millions of uninsured adults will gain health coverage through a broad expansion of Medicaid, and through subsidies for private insurance purchased through new health insurance Exchanges. While this expansion of coverage promises to improve access to health care for low-income adults, the large gaps in access to dental care for adults will remain largely unaddressed. Under the ACA, the "essential health benefits" that, beginning in 2014, must be covered by all qualified health plans, and by Medicaid "benchmark benefits" for those newly eligible for Medicaid, include oral health care for children, but not for adults.[7] Thus, while millions of adults will gain health insurance, many will still be without coverage for oral health care.

Oral disease and its impact

Dental caries, or tooth decay, has been declining among nonelderly adults since the early 1970s, and the number of adults who are missing all their natural teeth has declined to a low of 5%.[8] Still, despite these improving trends, about 26% of nonelderly adults have untreated caries, and low-income and minority adults are disproportionately affected by this condition.[9] In addition, most adults show signs of periodontal or gingival diseases.

Although poor oral health can be largely prevented through regular self-care and the detection and treatment of problems by a dental provider, it adversely affects the quality of life for many adults.[10] Untreated oral health issues in adults can affect appetite as well as the ability to eat, often leading to nutrition problems.[11] In addition, poor oral health can cause chronic pain that can affect daily activities such as speech or sleep.[12] Oral health problems also affect the ability to work; employed adults lose more than 164 million hours of work a year related to oral health problems or dental visits.[13] Adults who work in lower-paying industries, such as customer service, lose 2 to 4 times more work hours due to oral health-related issues than adults who have professional positions.[14]

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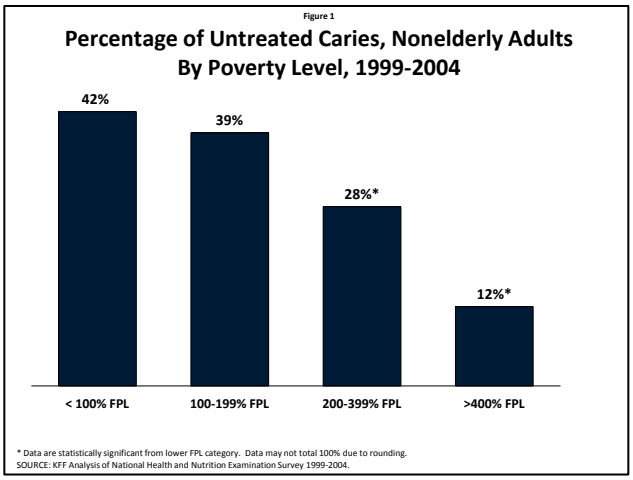
Disparities in oral disease and use of dental care

Despite advances in oral health care, disparities in the prevalence of oral disease continue to exist. In part, these disparities reflect systemic factors such as the lack of water fluoridation in communities, which has been shown to reduce the prevalence of dental caries.[15] Adults, particularly those with low income, may not have transportation or the flexibility to take time from work to see a dental provider.[16] Gaps in health literacy and public understanding of the important role of oral health in overall health, and the lack of a focus on oral health among primary health care providers, are additional variables in the oral health equation.[17]

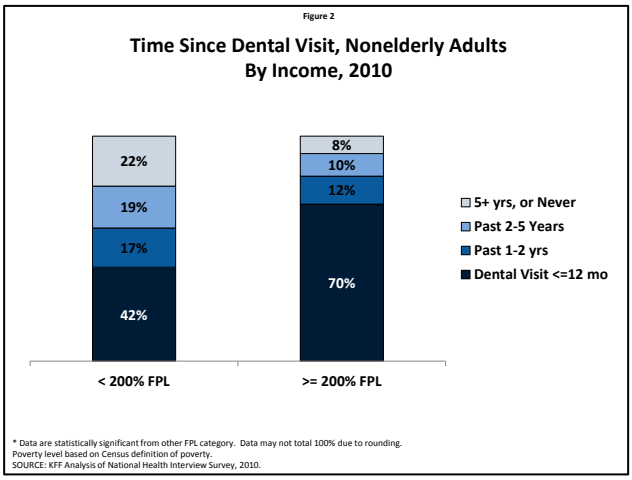
Overall, 26% of nonelderly adults ages 19-64 have untreated dental caries.[18] But the rate is highest among adults with income below 100% FPL,[*] who are more than three times as likely to have untreated caries as adults with income above 400% FPL (Figure 1).[19] Also, African-American and Hispanic adults have higher rates of untreated caries than White adults – 39% and 41%, compared to 22%.[20] And adults with any health insurance are less likely to have untreated caries than uninsured adults (22% versus 43%).[21]

Figure 1



* Data are statistically significant from lower FPL category. Data may not total 100% due to rounding.
SOURCE: KFF Analysis of National Health and Nutrition Examination Survey 1999-2004.

Figure 2



* Data are statistically significant from other FPL category. Data may not total 100% due to rounding.
Poverty level based on Census definition of poverty.
SOURCE: KFF Analysis of National Health Interview Survey, 2010.

Regular dental care is important to maintaining good oral health. Low-income adults are less likely to have seen a dental provider within the last year than higher-income adults.[22] In 2010, just 42% of adults with income below 200% FPL had a dental visit in the last year, compared to 70% of adults with income above 200% (Figure 2).[23] More than 1 in 5 low-income adults reported that they had not had a dental visit in five years or more, or had never had a visit.[24]

The largest disparities in access to dental care are associated with income, but racial and ethnic disparities also exist. In 2010, while a majority of low-income adults in all racial/ethnic groups had not had a dental visit in the last year, Hispanic adults were the population least likely to have had a visit. Hispanic adults were also the most likely to have gone five years or more without a visit, or never to have had a visit – 27% of low-income Hispanic adults fell into this category, compared to 20% of low-income White adults.[25]

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

Limited Medicaid coverage of adult dental benefits and frequent cutbacks

While federal law mandates coverage of dental care for children in Medicaid, coverage of adult dental services is a state option. Also, states define the amount, duration and scope of the benefits they cover. Almost all states currently provide some dental benefits for adults in Medicaid, but nearly half cover only dental care for pain relief or emergency care for injuries, trauma, or extractions.[26] Furthermore, adult dental benefits are among the first Medicaid benefits states target for cuts when they are under budget pressure. When California and Massachusetts cut Medicaid adult dental benefits in response to budget pressures, negative outcomes followed for beneficiaries. Both states experienced major declines in the utilization of dental services and in dental provider participation in Medicaid.[27] Many adult beneficiaries experienced pain due to untreated oral health conditions, and they were frequently unable to access care, even from safety-net providers.[28] Both states saw a decline in spending, but costs were often shifted to other care settings such as community health centers. [29] Despite such consequences, cutbacks in adult dental benefits in Medicaid are a perennial issue – 13 states recently reported that they cut dental benefits in FY 2011 or had plans to do so in FY 2012.[30]

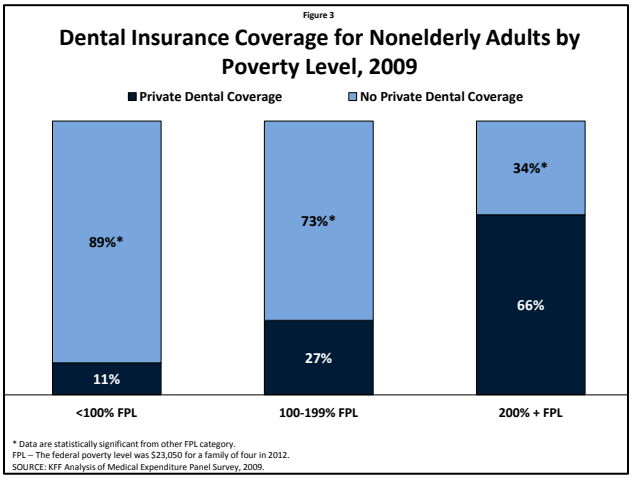
As of 2009, 24 million nonelderly adults, including many with severe disabilities, were covered by Medicaid. Because most state Medicaid programs do not cover comprehensive dental benefits for adults, these very low-income adults largely go without needed preventive and primary oral health care.[31] Among the states that cover dental exams and cleanings for adults, many require copayments that may be hard to afford for low-income adults. States that do cover preventive exams and/or cleanings may not cover restorative dental services, such as fillings or root canals.[32] States may also limit their coverage of dental procedures to a specific dollar amount or impose caps on the number of certain services they will cover. The lack of consistent or comprehensive coverage continues to leave adult Medicaid enrollees without necessary care and unprotected from high-cost procedures.

Millions of low-income, mostly uninsured, adults are expected to gain Medicaid coverage in 2014 under the ACA, and millions of other adults will gain private health insurance through the new Exchanges.[33] The health reform law mandates a set of essential health benefits that both the Medicaid "benchmark" package for the expansion population and all qualified health plans must cover. While the federally required essential health benefits include oral health services for children, they do not include such coverage for adults.[34]

Low rates of dental coverage among low-income adults

The uninsured rate among low-income adults is high and, for every adult without health insurance, three lack coverage of dental care. This reflects limited Medicaid coverage of adult dental care and the fact that private health insurance often does not cover dental benefits. Few adults living in or near poverty have any private dental coverage, and even among adults with incomes above 200% FPL, just two-thirds do (Figure 3).[35] Adults with Medicaid or private health insurance are the least likely to have private dental coverage (4%), making their access to oral health care marginal.[36] Overall, in 2009, fewer than half of all adults ages 19-64 had private coverage for dental care.[37]

Figure 3

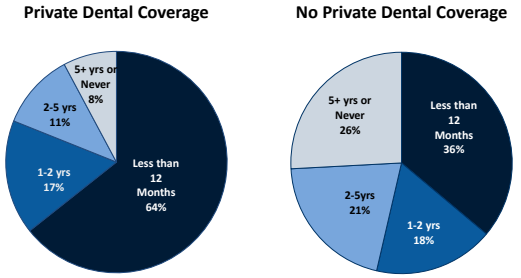


Positive impact of dental coverage on access

Private dental coverage improves access to dental care, but access still remains lower for those with incomes below 200% FPL than for those above 200% FPL. In 2010, nonelderly adults with private dental coverage were more likely to see a dental provider in the past 12 months than those without private dental coverage. Among low-income adults, about two-thirds of those with private coverage for dental care had a dental visit in the last year compared to 36% of adults without private dental coverage (Figure 4). A quarter of low-income adults without private dental coverage had not seen a dental provider in five years or more, or ever, compared with 8% of adults with private dental coverage.

Figure 4

Last Dental Visit, Low-Income Nonelderly Adults by Insurance Status, 2010



* Data are statistically significant from other insurance category. Data may not total 100% due to rounding.
Data are for 19-64 under 200% FPL. Poverty level based on Census definition of poverty.
SOURCE: KFF Analysis of National Health Interview Survey, 2010.

Low self-reported unmet dental need may reflect gaps in health literacy

About 8% of nonelderly adults reported an unmet dental need; that is, they were unable to get care or delayed care.[38] However, the percentage of adults who have not seen a dental provider in over two years is much higher. It is possible that many adults do not realize that they need regular preventive and primary oral health care, in part because public awareness of the importance of oral health has lagged behind awareness of other key health needs.

Adults without private dental coverage reported unmet need at three times the rate for those with such coverage.[39] The most frequently cited reason for not being able to get care was cost.[40] Not surprisingly, adults with incomes below poverty report the highest percentage of unmet need.[41] These adults are less likely to have health insurance coverage, or coverage of dental benefits, and out-of-pocket costs are more likely to be out of reach for them. About 1 in 4 nonelderly adults with income between 100-199% FPL who had Medicare reported unmet need.[42]

High share of dental spending is out-of-pocket

National spending on dental services totaled over $100 billion in 2009, and accounted for about 5% of total health care expenditures in the United States.[43] Half of the total dental spending is paid for by private insurance, and another 42% is paid for out-of-pocket by consumers.[44] The remaining 10% of dental spending is paid for by Medicaid and other government programs.

Out-of-pocket spending on dental services varies among dental users, primarily by dental insurance status. Although out-of-pocket spending on adult dental services is about $310 per dental user overall, adults with private coverage for dental care spend about $100 less than those without such coverage.[45]

Out-of-pocket and total spending on dental services increases for families with income above 100% FPL, which may indicate that lower-income nonelderly adults are not getting as many dental services, or are not getting more advanced dental services. Total spending per dental user for nonelderly adults under

100% FPL is $523, but spending increases to $709 for adults with income above 200% FPL.[46] Nonelderly adults without private dental insurance report a lower share of their total out-of-pocket spending attributable to on dental services, as compared to adults with private coverage for dental care.[47]

Looking ahead

Low-income and minority adults experience more oral disease and have less access to affordable dental care than higher-income adults and non-minorities. Adults with private coverage for dental care are less likely to have untreated caries and other oral health problems, but access remains a problem even for those with coverage, partly due to the high cost of dental services. The ACA will expand health insurance coverage substantially for adults, significantly reducing the high uninsured rate particularly among low-income adults, and lowering the financial barriers to care that many face. For children, the ACA will also help to increase access to oral health care as well as other needed care, by requiring oral health services for children in the minimum essential health benefits package. However, adult dental care was not required in the minimum package, leaving improvement in access to oral health for adults a continuing challenge.

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

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