kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

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ORAL HEALTH COVERAGE AND CARE FOR LOW-INCOME CHILDREN: THE ROLE OF MEDICAID AND CHIP

Tooth decay is the most common chronic illness among children. Although it is firmly established that oral health is an integral component of children's overall health and well-being, a large share of children do not receive recommended preventive and primary oral health care, and oral health care is the most prevalent unmet health care need among children. Difficulties obtaining care disproportionately affect low-income and minority children. Medicaid and the Children's Health Insurance Program (CHIP) are major sources of dental coverage, reaching millions of low-income children, but inadequate access to oral health care among these children remains a critical health policy challenge.

Importance of oral health and dental care

Although tooth decay is almost completely preventable, it is the most common chronic disease of childhood, affecting five times as many children as asthma.[1] In 2000, the Surgeon General's first-ever report on oral health documented linkages between oral diseases and ear and sinus infections, weakened immune systems, diabetes, heart and lung disease, and other serious health conditions.[2] Lack of treatment has the potential to affect children's speech, nutrition, growth and function, social development, and quality of life. Children with oral disease suffer restrictions in their daily activities, and over 51 million school hours are lost each year due to dental-related illness.[3] In rare cases, untreated oral disease in children has led to death.

Fluoridation of the water supply, topically applied fluoride treatments, sealants, and diagnostic dental services are effective and efficient means of preventing and detecting tooth decay and other oral disease. A CDC study found that, in communities with over 20,000 residents, every dollar invested in community fluoridation saves $38 in dental treatment costs; savings are larger in larger communities.[4] In other research, Medicaid-enrolled children who received early preventive dental care experienced lower five-year costs related to dental care than children who received their first preventive dental care later; longer delays were associated with higher costs.[5]

For every child who lacks health insurance, as many as three are estimated to lack coverage for dental care.[6 7] In 2006, 1 in 5 children had no dental coverage during the year.[8] Regardless of their insurance status, oral health care is the most prevalent unmet health need among children.

Disparities in oral disease and dental care

Oral disease in children and inadequate access to oral health care are system-wide problems in the U.S., but they are not distributed evenly in the population. Poor children – those in families with income below the federal poverty level (FPL) – have twice the prevalence of dental caries (tooth decay) that higher-income children do, the extent and severity of their decay are more extreme, and their disease is more likely to be untreated. Roughly one-third of low-income children age 6-19 have untreated tooth decay, compared with 15% of children at or above twice the poverty level.[9] In addition, the burden of oral disease is highly concentrated: 80% of tooth

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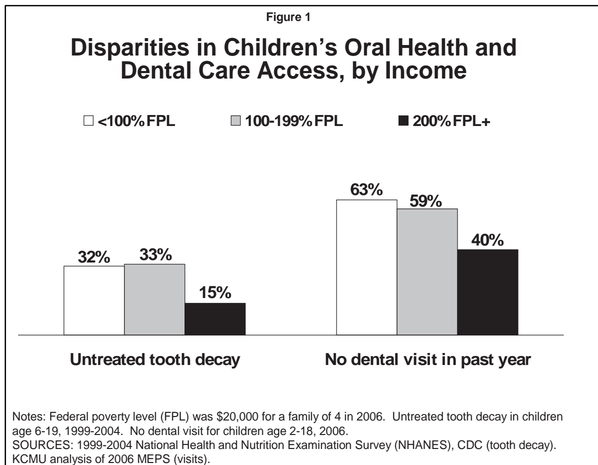
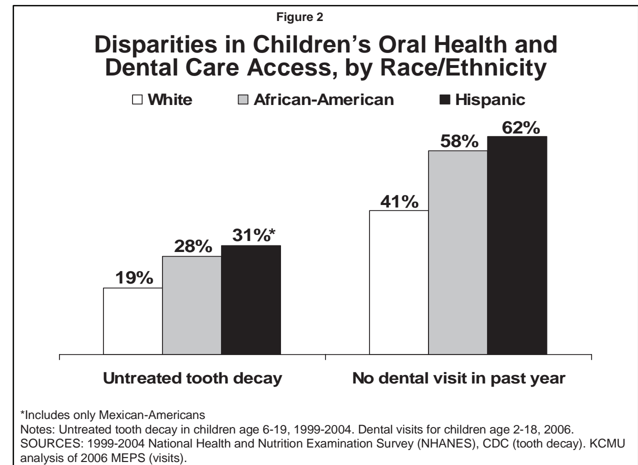
decay is found in 25% of children age 5 to 17, mostly from low-income and other vulnerable groups.[10]

As well as having more oral disease than other children, poor and near-poor children are less likely to obtain dental care. In 2006, about 60% of low-income children had no dental visit in the past year, compared with 40% of children who were not low-income (Fig. 1).[11] In another measure of income-related disparities in the burden of oral disease, poor children experience 12 times as many restricted activity days due to dental disease as children in higher-income families.[12]

Racial/ethnic disparities in children's oral health and access also exist. African-American and Hispanic children are both more likely to have untreated caries than White children, and they are less likely to have had a dental visit in the past year (Fig. 2).[13]



Notes: Federal poverty level (FPL) was $20,000 for a family of 4 in 2006. Untreated tooth decay in children age 6-19, 1999-2004. No dental visit for children age 2-18, 2006.
SOURCES: 1999-2004 National Health and Nutrition Examination Survey (NHANES), CDC (tooth decay). KCMU analysis of 2006 MEPS (visits).

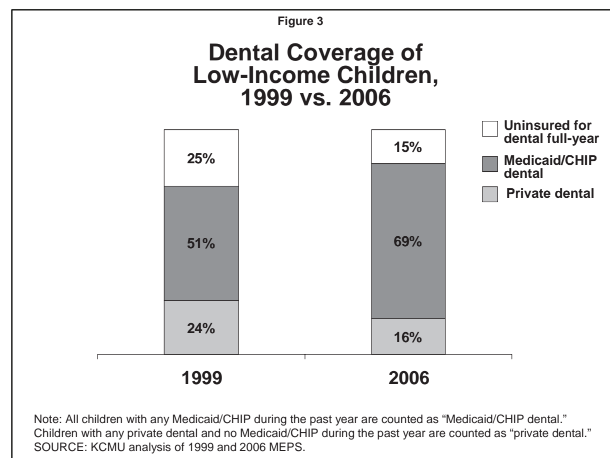


*Includes only Mexican-Americans
Notes: Untreated tooth decay in children age 6-19, 1999-2004. Dental visits for children age 2-18, 2006.
SOURCES: 1999-2004 National Health and Nutrition Examination Survey (NHANES), CDC (tooth decay). KCMU analysis of 2006 MEPS (visits).

Medicaid and CHIP play a large and growing role in providing coverage, including dental coverage, for low-income children

Medicaid and CHIP, the nation's safety-net health insurance programs, are a major source of coverage for children in the United States. In 2007, the two programs covered more than one-quarter of all children and about half of low-income children: Medicaid covered about 29 million poor and near-poor children, and CHIP built on this coverage, providing health insurance for an additional 7 million low-income children.

In 2006, more than two-thirds of low-income children in the U.S. (69%) received dental coverage through Medicaid and CHIP during at least part of the past year. This is a substantial increase relative to 1999, when the rate was just about 50%. In the absence of Medicaid and CHIP, most children covered by these programs would be uninsured. Reflecting this reality and the impact of broader public coverage among children, the share of low-income children with no dental coverage during the past year fell by 10 percentage points between 1999 and 2006, from 25% to 15% (Fig. 3).



Note: All children with any Medicaid/CHIP during the past year are counted as "Medicaid/CHIP dental." Children with any private dental and no Medicaid/CHIP during the past year are counted as "private dental."
SOURCE: KCMU analysis of 1999 and 2006 MEPS.

Medicaid and CHIP dental benefits

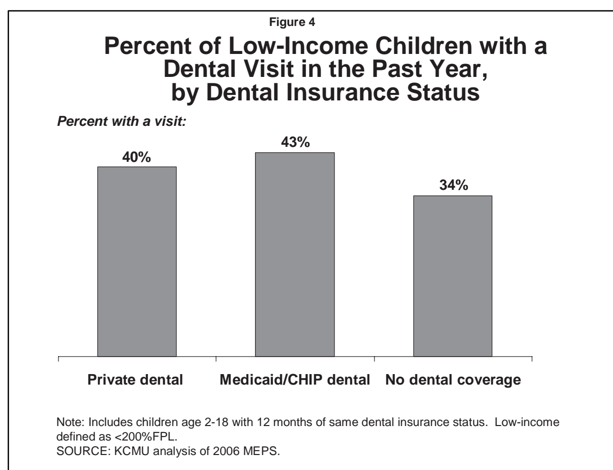
Medicaid covers comprehensive dental care for children through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which federal law requires all states to provide to children enrolled in the program. A distinctive focus of EPSDT is prevention-oriented care to maximize children's health and development and avert the health and financial costs of long-term disability. Under EPSDT, states must cover all medically necessary dental services for children, including screening and diagnostic services and needed treatment and follow-up care. States cannot limit their dental services or spending for children enrolled in Medicaid or in CHIP programs that are Medicaid expansions.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), signed by President Obama on February 4, 2009, guarantees dental benefits under CHIP as well.[14] Beginning October 1, 2009, all CHIP programs must cover dental benefits "necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions." States can meet this requirement in separate CHIP programs by providing dental coverage equivalent to one of three benchmark dental benefit packages: the plan under the Federal Employees Health Benefits Program (FEHBP) selected most frequently by employees seeking dependent coverage; the state employee benefit plan selected most frequently by employees seeking dependent coverage; or the commercial dental plan in the state that has the largest non-Medicaid enrollment of dependents.

CHIPRA also gives states a new option to offer a dental-only supplement or cost-sharing protection for dental services to children who would qualify for CHIP except that they have other health coverage. In addition, the law includes numerous provisions to improve children's dental care access and quality in Medicaid and CHIP. It requires a program of oral health education for new parents, provides for reporting on children's use of dental care in Medicaid and CHIP, includes dental measures in federal quality and access monitoring efforts in these programs, improves enrollee information on dental providers, and requires a GAO study of dental access in Medicaid and CHIP.

Dental access in Medicaid and CHIP

Low-income children enrolled in Medicaid or CHIP fare at least as well as low-income children with private insurance in obtaining a dental visit. In 2006, 43% of low-income children with full-year Medicaid or CHIP had a dental visit in the past year, similar to 40% of full-year privately insured low-income children (Fig. 4).[15] Uninsured children were less likely to secure a dental visit (34%). Relative to uninsured children, children with public coverage are also more likely to have a usual source of dental care and to receive preventive dental care, and they are less likely to have unmet dental needs.[16] In focus groups and other studies, dental care for children emerges as one of the benefits of Medicaid and CHIP that parents value most.[17]



Note: Includes children age 2-18 with 12 months of same dental insurance status. Low-income defined as <200%FPL.
SOURCE: KCMU analysis of 2006 MEPS.

But system-wide inadequacies in children's oral health care hit low-income children, whose care needs are high, especially hard. The American Academy of Pediatric Dentistry recommends that all children visit the dentist at least once before the age of 1 and every six months thereafter. Thus, the finding that more than half of publicly insured, as well privately insured, low-income children had no dental visit in the past year highlights a substantial gap in dental access for these children. Between 1999 and 2006, the share of Medicaid-enrolled children who had a dental visit in the past year improved, but dental disease did not decrease in most age groups. Compared with privately insured children, who are generally higher-income, children in Medicaid are substantially more likely to have more extensive and untreated tooth decay and to be in urgent need of dental care.[18] Parents with publicly insured children report that unmet dental care needs exceed all their children's other unmet needs combined, including needs for specialist, hospital, physician and prescription drug services.[19]

Dental workforce shortages and low dentist participation contribute to dental access problems in Medicaid/CHIP. The supply of dentists is inadequate in our health care system overall, and shortages of dental specialists, including pediatric dentists, are especially acute. Currently, there are ten times more practicing pediatricians than pediatric dentists.[20] Low participation in Medicaid among dentists exacerbates underlying shortages, and dentists who do participate in Medicaid often limit the number of Medicaid patients they accept. The principal reason dentists cite for not accepting Medicaid patients is low payment rates. In many states, Medicaid pays dentists less than half their charges.[21] Slow payment and a variety of administrative burdens associated with Medicaid also pose major obstacles to dentists' participation.

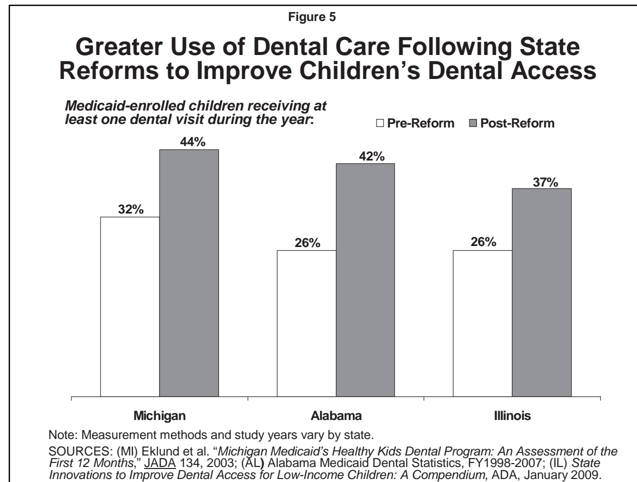
Compounding the capacity and access problems that stem from workforce shortages and low provider participation is the uneven geographic distribution of dentists. With the majority of dentists choosing to practice in urban areas, rural areas are particularly likely to be underserved. Children who live in rural areas must travel further and are less likely to have access to dental care than children who live in urban areas.

Disruptions in coverage reduce children's access to care. A growing body of research provides evidence that children who experience disruptions or gaps in coverage have reduced access to and use of ambulatory care and more unmet need, including unmet dental care need, relative to continuously insured children.[22] [23] Discontinuities in Medicaid and CHIP enrollment, often due to burdensome renewal requirements, are a significant concern and cause millions of eligible children to go uninsured.[24] States have broad flexibility under federal law to streamline the procedures for enrolling in and renewing Medicaid and CHIP coverage. Many states are taking steps in this direction (e.g., annual rather than 6-month renewal cycles), seeking to stabilize coverage for low-income children and improve their access to care, including oral health care.[25]

Increasing access to oral health care for low-income children

The tragic deaths of two youngsters in Maryland and Mississippi in 2007 due to complications from untreated tooth decay focused national attention on the gravity of the dental access problems facing children in low-income families. CHIPRA's oral health-focused provisions represent a major federal commitment to address this challenge through expanded dental benefits and coverage and improved education, information, monitoring, and quality. Other provisions of CHIPRA that give states new financial incentives to boost their Medicaid enrollment may support gains in access to oral health care for low-income children by promoting more vigorous outreach and enrollment of eligible children. The importance of developing an adequate oral health workforce and delivery system to ensure access to care is also receiving increased federal attention.[26]

Many states have taken steps to increase the supply of dental care in Medicaid, including raising Medicaid payments to dentists, contracting with a dental benefits manager to administer benefits, streamlining the billing process, and enabling dentists to submit claims electronically. There is evidence that states that have implemented these strategies have increased provider participation and improved access to dental care for enrolled children (Fig. 5).[27]



Separate from efforts to increase the availability of oral health care to children, strategies for improving oral health education also have an important role. The disconnect between the large share of low-income children who receive no dental visit in a year and relatively modest reported rates of unmet need reveal gaps in oral health "literacy" – that is, a lack of understanding of what adequate, appropriate oral health care means. As parent education about oral health increases, the likelihood of their children receiving preventive dental care also rises.[28] Recent studies suggest that parents' access to and use of dental care is an important pathway for low-income children's access to dental care.[29] For example, one study found that caregivers who had visited a dentist for preventive reasons were five times more likely to have taken their children to visit the dentist than parents who had never been to a dentist.[30] More generally, research shows a linkage between family coverage and improved access to care for children.[31]

Looking ahead

Low-income children experience more and worse oral disease than other children and have less access to recommended oral health care. Children with Medicaid and CHIP coverage fare much better than their low-income uninsured counterparts, but their access to oral health care falls short of meeting oral health care needs. The improvements made by CHIPRA strengthen the ability and accountability of Medicaid and CHIP to ensure access to oral health care for children in the years ahead. This progress in the nation's public programs helps to secure the place of oral health care in the benefit package for American children – an important development that can inform the health care reform debate in the coming months.

This Policy Brief was prepared by Julia Paradise, Principal Policy Analyst, for the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

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