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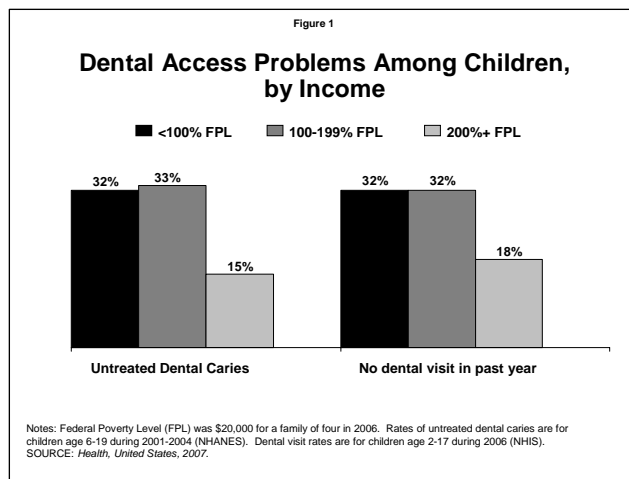
**DENTAL COVERAGE AND CARE FOR LOW-INCOME CHILDREN:
THE ROLE OF MEDICAID AND SCHIP**

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 dental care is their most prevalent unmet health care need. Difficulties obtaining dental care disproportionately affect low-income and minority children. Medicaid and the State Children’s Health Insurance Program (SCHIP) are major sources of dental coverage, reaching millions of low-income children, but inadequate access to dental care among these children remains a critical health policy challenge.

Importance of Oral Health and Dental Care

Tooth decay is the most common childhood chronic disease, affecting five times more children than 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, and heart and lung disease, and other serious health conditions.² Lack of dental treatment has the potential to affect speech, nutrition, growth and function, social development, and quality of life. Children with oral diseases are restricted in their daily activities and are estimated to miss over 51 million hours of school each year. In rare cases, untreated dental disease in children leads to death.

Fluoridation of the water supply, topically applied fluoride treatments, application of sealants, and diagnostic dental services are effective and efficient means of preventing and detecting tooth decay and other oral disease. The average dental costs of children who receive early preventive dental care are 40% lower than those of children who do not receive early care. The CDC estimates that every dollar invested in fluoridation saves \$38 in dental treatment costs.³



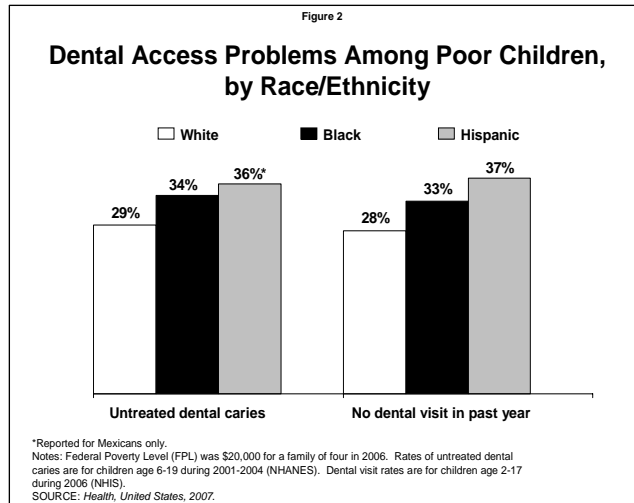
While nine million children lack health insurance coverage, more than 20 million children are not covered for dental services. Regardless of insurance status, dental care is the most prevalent unmet health need among children.

Disparities in Children’s Dental Care

Poor children are more likely than higher-income children to have dental caries (tooth decay) and the extent and severity of the decay are more extreme. About half of poor children age 2-11 have cavities in their primary teeth, compared with about one-third of children in families with income at or above twice the federal poverty level (FPL). Poor children also have about twice the rate of untreated caries in their primary teeth.⁴

As well as having more dental disease than other children, poor children are less likely to obtain dental care. In 2006, roughly 1 in 3 poor and near-poor children had no dental visit in the past year, compared with about 1 in 5 children who were not low-income (Figure 1).⁵ In another measure of the income-related disparity in the burden of oral disease, low-income children experience 12 times as many restricted activity days due to dental disease as children in higher-income families.⁶

Racial/ethnic disparities in children's dental health and care are also evident, even within the same income group. Among poor children, children of color are more likely than whites to have untreated caries, and they are less likely to have had a dental visit in the past year (Figure 2).⁷



Coverage of Dental Care in Medicaid and SCHIP

Today, a quarter of all children in the U.S. and about half of low-income children receive their health coverage through the nation's public coverage programs. Medicaid covers about 29 million poor and near-poor children; SCHIP builds on this coverage, providing health insurance for an additional 6 million low-income children.

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. 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. The states cannot limit their dental services or spending for children.

In SCHIP programs that are Medicaid expansions, the EPSDT requirements apply. In separate SCHIP programs, dental benefits are optional. Currently, all state SCHIP programs except Tennessee cover at least some dental care. But because dental benefits are optional in separate SCHIP programs, they are vulnerable to cuts when state budgets are tight. Several states have cut and subsequently reintroduced dental benefits for children (Texas and Utah). The dental benefits covered under SCHIP programs vary widely across states. Fourteen states with separate SCHIP programs offer benefits identical to those offered to children in Medicaid. Other states with separate SCHIP programs provide more limited benefits, with seven capping annual dental expenditures or limiting the number of services that are allowed per year. For example, Montana has a \$350 annual benefit cap – which treatment for one abscessed primary tooth could exhaust.⁸

Access to Dental Care

Children enrolled in Medicaid and SCHIP have better access to dental care than uninsured children. In 2006, 73% of children age 2-17 with public coverage had a dental visit in the past year, compared with 48% of uninsured children (Figure 3).⁹

Publicly covered children are also more likely to have a usual source of dental care and to receive preventive dental care, and less likely to have unmet dental needs relative to uninsured children.¹⁰ In focus groups and other studies, dental care for children emerges as one of the benefits of Medicaid and SCHIP that parents value most.¹¹

However, children covered by Medicaid and SCHIP still face problems obtaining access to dental care. The American Academy of Pediatric Dentistry recommends that all children visit the dentist at least once before the age of 1 and bi-annually thereafter. Thus, the one-quarter of publicly insured children who had no dental visit in the past year indicates a substantial gap in dental access. Other data also suggest that dental access is inadequate: parental assessments show that unmet dental care needs among publicly insured children exceed all other unmet needs combined, including specialist, hospital, physician and prescription drug services.¹² Finally, state data reveal that access to dental care in Medicaid is uneven across the country.¹³

Inadequate supply and limited participation of dentists in Medicaid/SCHIP contribute to dental access problems for enrollees. The supply of dentists, especially pediatric dentists, is inadequate in our health care system overall. Currently, there are ten times more practicing pediatricians than pediatric dentists.¹⁴ Low participation in Medicaid among dentists is a longstanding barrier to access, and many dentists who participate in Medicaid 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 reimburses dentists for less than half of their charges.¹⁵ Administrative hassles associated with Medicaid also consistently emerge as a major obstacle to dentists' participation.

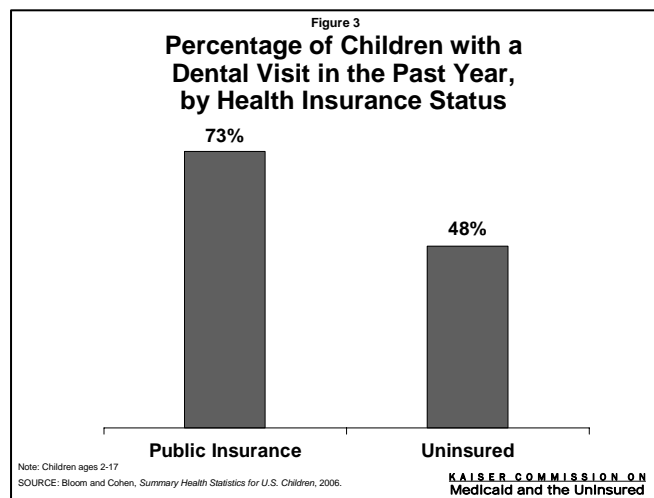
Low access to dental care in certain areas is attributable in part to the uneven geographic distribution of dentists. With the majority of dentists choosing to practice in urban areas, 38% of rural counties have been designated as having a dental health professional shortage. Children who live in rural areas must travel further and are less likely to have access to dental care than children who live in urban areas.

Increasing Access to Dental Care for Children

The tragic deaths of two youngsters in Maryland and Mississippi last year due to complications from untreated tooth decay focused national attention on the gravity of the dental access problems

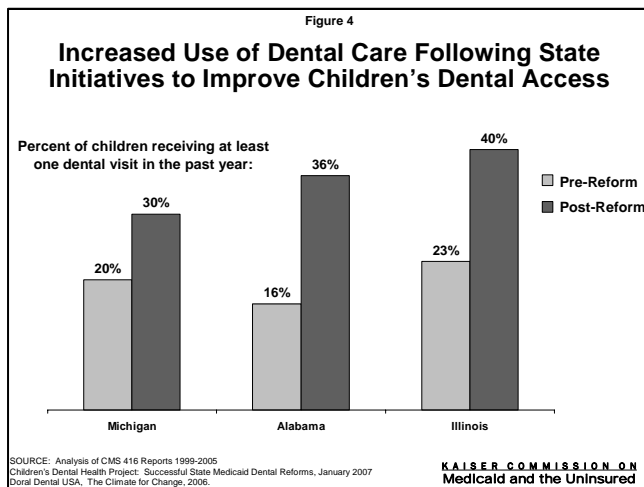
facing children in low-income families and have spurred significant efforts at the federal level to improve dental access for children with public coverage. Congress included provisions in the Children's Health Insurance Program Reauthorization Act of 2007 (CHIPRA) that would have mandated dental benefits and provided for increased monitoring of dental care access, use, and quality among children in Medicaid and SCHIP. Although the

legislation was vetoed and the proposed new federal requirements died with the measure, the requirements are an example of how Medicaid and SCHIP could be vehicles for better meeting the oral health care needs of children.¹⁶



Other federal legislative initiatives have included proposals to increase children’s access to dental care by expanding community health centers in medically underserved areas, providing grants to increase the number of pediatric dentists, developing prevention programs for high-risk populations, and improving efforts to track children’s dental health.¹⁷

Many states have also taken steps aimed at increasing dental access, including raising provider payment rates, contracting with a dental benefits manager to administer benefits, streamlining the billing process, and allowing 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 services for enrolled children (Figure 4).¹⁸



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.¹⁹ Research also indicates that family coverage leads to improved access to care for children. A study of low-income children showed that parents who received preventive dental care were five times more likely to take their children for a dental visit, compared with parents who received no dental care or visited the dentist only in an emergency situation.²⁰

Looking ahead

Low-income children experience more and worse oral disease than other children and have less access to recommended dental care. Children with Medicaid and SCHIP coverage fare much better than their low-income uninsured counterparts, but their access to dental care falls short of meeting dental needs. The SCHIP reauthorization effort last year set the stage for major improvements in oral health care that are likely to receive further consideration when SCHIP reauthorization is again taken up in 2009. In the meantime, many states are moving ahead on their own or considering action to improve dental access in their Medicaid and SCHIP programs. As the health care reform debate takes shape in the coming months, these developments help to keep the importance of children’s access to oral health care in sharp focus.

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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