

Dental Insurance is Essential, But Not Enough

By Myron Allukian, Jr., DDS, MPH
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While more than 43 million Americans lack medical insurance, there are over 150 million Americans with limited or no dental insurance, according to the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services (HHS). Unlike medical conditions, dental diseases affect almost the total population, with nearly everyone needing dental care. For example, 84 percent of 17 year-olds have had tooth decay, with an average of 8 affected tooth surfaces; and 99 percent of 40-44 year-olds have had tooth decay, with an average of 30 affected tooth surfaces.

Those most likely not to receive needed dental services are the vulnerable or high-risk population groups, such as the low income, the least educated, racial and ethnic minorities, immigrants, the developmentally and medically compromised or disabled, the elderly, persons with HIV, and the uninsured. For example, lower income children have almost five times more untreated dental disease than higher income children, according to the National Health and Nutrition Evaluation Survey III.

How much are we spending on dental services?

Although \$50.6 billion was spent for dental care in the U.S. in 1997, a majority of Americans don't have dental insurance. According to the Health Care Financing Administration (HCFA), 47 percent of dental services are paid for out-of-pocket. (See Table 1.) Only 4.4 percent of dental care expenditures were from public funds, with most it (roughly 4 percent or \$2 billion) being from Medicaid.

Lack of dental insurance affects dental utilization and oral health status. For example, 48.2 percent of people without private dental insurance did not have a dental visit in the last year, compared to 28 percent with insurance, according to data from Dental Services and Oral Health: United States, 1989. Of people who had dental visits, those without private dental insurance had 1.7 visits a year, compared to 2.8 for those with insurance; and 27 percent of persons over 65 without dental insurance had no teeth at all, compared to 18.3 percent with dental insurance.

Dental Medicaid

Even when high risk groups have dental Medicaid, they may not receive needed dental care. For example, according to a 1996 study done by the U.S. Inspector General, more than 80 percent of the 21.1 million Med-

icaid-eligible children did not receive preventive dental services.

The six states with the highest proportion of Medicaid-eligible children who did not receive preventive dental services were Arizona (99.7 percent), Hawaii (99.3 percent), New Mexico (93.8 percent), North Dakota (92 percent), Montana (91 percent), and Kentucky (90.6 percent).

The six states with the lowest proportion of Medicaid-eligible children who did not receive preventive dental services were New Hampshire (55.2 percent), Wyoming (56.7 percent), Indiana (59 percent), Kansas (64.6 percent), Oregon (65.3 percent), and Nebraska (66.5 percent).

Unfortunately, too many low income children, over 16 million, are not receiving dental care even though they have dental insurance coverage through Medicaid. Even for the state with the highest dental utilization of Medicaid in our country, New

Hampshire, 55.2 percent of Medicaid-eligible children did not receive required preventive dental services. Some studies have even shown that children with dental Medicaid have worse oral health status than low income children without dental insurance.

The Inspector General's report states that the reasons few children received dental care were complex, but there were three major reasons: 1) few dentists serve Medicaid children; 2) Medicaid families give dental services a low priority; and 3) the youngest children are the most difficult to serve and frequently are not screened at all. (See Table 2.)

The American Academy of Pediatric Dentists recommends that dentists examine all children before their first birthday. However, 99.6 percent of these children did not receive these services even though 20 states have adopted this standard, 12 states recommend screening at age 2 years, and the rest at age 3 years.

Unfortunately, dental care is an optional service for adults in the Medicaid program. Vulnerable adult population groups like the homeless, homebound, elderly, minorities, uninsured, low income, persons with HIV, and medically compromised or disabled have even greater difficulty accessing dental services.

The reasons given for dentists not participating in Medicaid, according to this report were low fees, slow payment, arbitrary denials and requirements for prior authorization for routine care. Also, many dentists had difficulty treating Medicaid families and general dentists didn't wish to treat younger children. From the family perspective, oral health was a low priority given other needs, and families were unwilling or unable to wait, travel, or obtain child care for dental appointments.

Table 1. U.S. Dental Care Expenditures, 1997

Total	\$50.64 billion	
Private Funds	\$48.37 billion	(95.5%)
Private Insurance	24.25 billion	(47.9%)
Out-of-Pocket	23.86 billion	(47.1%)
Public Funds	\$ 2.27 billion	(4.4%)
Federal Medicaid	1.12 billion	(2.27%)
State/Local Medicaid	.87 billion	(1.7%)
Medicare	.07 billion	(0.1%)

Source: Health Care Financing Administration, 1999.



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The Medicaid dental problems have been acknowledged by some decision-makers on the state and national levels. However, progress had been slow. In some states, such as California, Connecticut, Maine, Pennsylvania, and more recently New York, legal suits have forced states to improve Medicaid programs. In other states such as Arizona, Indiana, Massachusetts, Nebraska, North Carolina, Oklahoma, Pennsylvania, and Virginia, oral health partnerships, coalitions, constituencies, and state legislative actions also have helped to improve the program.

Children's Health Insurance Program

There were 11 million American children who had no health insurance in 1997, of which about 3 million were eligible for Medicaid, according to the Institute of Medicine. Congress passed the Balanced Budget Act of 1997 which included provisions for the State Children's Health Insurance Programs (CHIP). The bill originally included dental services, but by the time it passed Congress, dental services were optional and could only be included at the discretion of individual states.

The nature of the CHIP program is determined by each individual state upon approval by HCFA, and it may be an expansion of the state's existing Medicaid program, a new separate program, or a combination of Medicaid expansion and a new separate program. About \$25 billion in federal money for all health services will be available to the states for this initiative over a five-year period.

Dental Services in CHIP

As of April 1999, 48 states have submitted CHIP proposals to HCFA and all but three, Delaware, Colorado, and Montana, have some dental services. Florida's plan only provides dental services for children up to age 5 years. Of the 48 state proposals, 18 (plus Washington, D.C. and Puerto Rico) include dental in an expanded Medicaid program under CHIP, 8 include dental in a separate CHIP program, and 18 states include dental in a combination of both.

The scope of dental services varies and dental partnerships, constituencies, coalitions, and legislation on the state level can help improve the dental benefit package in the CHIP program. CHIP dental programs built upon the Medicaid program can only be successful if the Medicaid programs are expanded, upgraded, and improved.

Other Initiatives



HHS's Healthy People 2010 has national objectives to help close disparities in oral health status among high-risk populations. Two federal agencies, HCFA and

the Health Resources and Services Administration (HRSA), have an oral health initiative to improve access to the underserved by stimulating statewide planning and providing technical assistance and some modest funding.

HCFA and HRSA also sponsored a dental workshop for state Medicaid directors and other interested parties in 1998 to help improve the dental Medicaid programs, and a number of strategies and recommendations are included in their report. They are also trying to provide guidance to the states through their regional offices so more high-risk populations groups will be served. On May 25, 1999, Vice President Gore approved a new

Department of Justice regulation assuring families that immigration status will not be affected for those who enroll in Medicaid or CHIP and/or who receive other benefits such as school lunch or child care. This will help reduce a potential barrier to dental care for some cultural and linguistic minorities.

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Recommendations

Studies have shown that the financing of dental care by itself does not ensure that the oral health of a population will improve. Unfortunately, the dental Medicaid program is a prime example of this failure. Although improving the financing of dental care is essential, the following must also be done to improve oral health status in our country.

1. Oral health must be a much higher priority on the local, state, and national levels.
2. The dental component of Medicaid and CHIP must be upgraded, expanded, and improved.
3. Special initiatives must be promoted and implemented for vulnerable and high-risk populations including adults, to improve their access to dental care.
4. Individual- and population-based prevention services and programs must be promoted and implemented, especially for children and high-risk populations.
5. All communities with a central water supply must be fluoridated. To close the gap for a healthier America, we must all work together to respond to the neglected epidemic of oral diseases and its neglected financing system.

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Table 2. Percent of Medicaid-Eligible Children Who Did Not Receive Preventive Dental Services, by Age, 1993

All ages	<1 year	1-5 years	6-14 years	15-20 years
80.3%	99.6%	84%	70%	80.5%

Source: 1996 Report of the Office of Inspector General, U.S. Department of Health and Human Services.

