CHAPTER 4 ORAL HEALTH INSURANCE COVERAGE

4.1 FINDINGS

Dental care is not covered by most health insurance plans. With the exception of the Federal Employees Health Benefits Plan, similar plans offered to postal workers and children's Medicaid programs, dental coverage generally requires a separate insurance policy. It is not included in Medicare or in the basic military TriCare program. Veterans Health Administration (VHA) provides dental care for veterans with service-connected disabilities, and time-limited coverage for veterans and reservists who saw active duty in certain wars (Kuwait, Iraq and Afghanistan).

As a result, children and adults are less likely to have dental insurance than medical insurance (DHHS NIDCR. 2000). Two public programs designed to address the lack of insurance, and therefore, improve health status for eligible individuals, are Medicaid's Child Health Insurance Program and State Children's Health Insurance Program (CHIP, SCHIP). Generally designed for low income persons and families, Medicaid dental eligibility is not based strictly on income. Eligibility guidelines are established by each state (CMS. 2009). Under the Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT), minimum dental coverage is mandatory for most Medicaid eligible individuals under the age of 21 in all states (CMS. 2009). All Medicaid states are required to offer a minimum dental service package: relief of pain and infections, restoration of teeth, and maintenance of dental health. Sealants are covered by most Medicaid children's programs. The net result is still very limited coverage. Approximately nine percent of Americans receive dental coverage from either Medicaid or SCHIP (DHHS. 2001). In December 2009, two percent of Americans were covered by CHIP programs (Kaiser. 2011).

However, insurance coverage alone is not enough to address oral health disparities. A Government Accountability Office (GAO) report, from September 2008, indicates that only one in three children enrolled in Medicaid received dental care in the prior year. On the positive side, only two Appalachian states, New York and Pennsylvania, reported less than 30 percent of eligibles using dental services (CMS. 2009). The report noted provider unwillingness to participate and lack of awareness among eligibles as the key barriers.

In 2004, dental care represented only two percent of state Medicaid budgets (Borchgrevink, et al. 2008). Dental coverage is optional for Medicaid eligible individuals age 21 or older. Most states provide only emergency dental services for eligible adults; a few states provide more comprehensive dental coverage (CMS. 2009(a)). SCHIP was established in 1997 to provide insurance coverage to uninsured children up to age 19 who did not qualify for Medicaid, but states control the benefits plans and both eligibility and coverage vary among the states (CMS. 2009(b)).

In the United States, the number one chronic disease among children is dental caries. Thus, programs such as Medicaid and SCHIP are correct in their intention to help reduce oral health disparities (CMS. 2009). However, these programs have restrictions that limit their potential to improve oral health status. After the narrow scope of services covered, a primary limitation is dentist participation in Medicaid. Private dentist participation in Medicaid is a challenge. In 2005, among the reporting states, dentist participation in Medicaid ranged from a low of zero to a high of 44 percent in states in the Appalachian Region (Association of State and Territorial Dental Directors. 2008). Medicaid payment is usually low, and Medicaid beneficiaries are more prone to cancel or be late for appointments.

National Academy of State Health Policy Comments on Harvard Study:

Dental problems may represent the biggest unmet health care need among adults as well, as reported by Pew Center on the States and the National Academy of State Health Policy by two Harvard researchers in their book, *Uninsured in America*. "[Researchers] talked to as many kinds of people as they could find, collecting stories of untreated depression and struggling single mothers and chronically injured laborers—and the most common complaint they heard was about teeth. People without health insurance have bad teeth because, if you're paying for everything out of your own pocket, going to the dentist for a checkup seems like a luxury. It isn't, of course."

The use of dental care rises by income: while 56 percent of adults from a high-income family had at least one dental visit during the year, only 27 percent of adults from low-income families had at least one dental visit during the year.

Two key underlying factors give rise to these unmet needs: the relatively low level of public financing to subsidize payments for care and the lack of an adequate safety net system for the roughly one-third of the population not served by the private dental care system. While poor children are guaranteed dental coverage through Medicaid, states are not required to provide dental benefits for adults also covered by Medicaid.

As state budgets wax and wane, this leads to on-again, off-again dental coverage for the adult population. Only 16 states provide dental coverage in all service categories for adult Medicaid enrollees. Additional 16 states offer coverage for emergency services only, and six states offer no dental coverage at all. In tighter fiscal climates, states often opt to limit or eliminate adult dental benefits. In addition, the number of adults and families with private dental insurance, dependent as it is on employment, rises and falls with the health of the economy. When times are tough, optional benefits such as dental care are among the first to be cut by employers. As the costs of health benefits have risen, costs may be passed on to employees, who may opt out of coverage. Of those who work in private industry, only 46 percent have access to dental coverage, with only 36 percent choosing to participate.

Of those who work in state and local government, 55 percent have access to coverage, while only 47 percent choose to participate.

To make matters worse, Medicare does not include dental benefits, so the over-65 population must purchase insurance individual market policies, pay out of pocket or forego care. Some individuals with private dental coverage must carry high deductibles and co-payments and low annual benefit caps. For example, the median national charge in 2005 for a root canal and a basic crown on a bicuspid tooth was $1,326. Kansas state employees would have a co-payment of $485.

Source: Help Wanted, A Policy Maker's Guide to New Dental Health Providers. The Pew Center for States, National Center for State Health Policy, WK Kellogg, Washington DC, 2009
http://www.nashp.org/sites/default/files/Dental_Report_final_Low%20Res.pdf

Dentists limit participation in Medicaid for multiple reasons. Low reimbursement rates and administrative challenges are starters (DHHS. 2000; Fisher, Mascarenhas. 2007; GAO. 2008; Guay. 2004). Limited dentist participation in Medicaid was also associated with low dental utilization by Medicaid-eligible patients. Simply having access to a dentist may not be sufficient to improve dental service utilization in a depressed area such as the Appalachian Region (Fisher, Mascarenhas. 2007; GAO. 2008). Other barriers include lack of information, failure of Medicaid beneficiaries to make scheduled appointments, limited supply of dentists and restrictions on services that can be provided by non-dentists.

Medicaid, SCHIP, and private dental insurance are the only third-party payers for dental care. Data for all of these are limited to state summaries collected by the Kaiser Family Foundation (KFF). Insurance eligibility can change from month to month, depending on a person's income status and employment status. Few non-governmental employers offer dental insurance.

4.2 Methodology

4.2.1 Data Sources

The BRFSS contains no survey questions related to dental insurance coverage, so comparison data on this topic is, at best, restricted to special studies and state level summaries. To compensate, we explored literature studies supported by the Pew Charitable Trust, the National Academy of State Policy and KFF and the GAO. Even these were limited to samples based on review of a limited number of states and a fixed time frame. The most complete pictures were provided by the National Academy of State Policy.

4.2.2 Data Analysis

Because data were so limited, we elected to report only conclusions from the literature search. Any data analysis for the Appalachian Region would rely on samples too limited for conclusive results.

4.3 Discussion

Historical separation of oral health from physical health is now memorialized in employer and government provided health insurance programs. The resultant isolation of dental coverage to an add-on policy, at a time when the costs of dental care are increasing, has moved oral health to a near luxury status. Low income populations are more likely to have a lifetime without dental care. Widespread solution to this national problem may not emerge until health reform initiatives better reflect the true root causes of community health status. Even then, change may require national dialogue on population costs and evidence based interventions.