In the current debate over national health care reform, oral health has gotten little attention. Long-standing tradition has kept the mouth outside the medical care system for generations. Nearly half of all Americans lack coverage for dental services, compared to 15 percent who lack medical insurance.\textsuperscript{1,2} And the 2010 Patient Protection and Affordable Care Act (ACA) assures dental benefits only for children.\textsuperscript{3} As a result, millions of adults will remain unable to get care for some of the nation’s most prevalent diseases, even after the act takes full effect.

It’s Not Just About Teeth
When most people think of oral health, they think of cavities. And overall, the tooth decay picture has been improving since the 1970s. Fewer than 26 percent of adults 65 years of age and over have lost all their natural teeth, down from 46 percent just 20 years ago.\textsuperscript{4,5} Experts attribute this improvement largely to the wider availability of fluoride, not only through community water fluoridation, but also through toothpastes, rinses, and products applied in the dental office.\textsuperscript{6}

But the most recent surveys suggest that this hopeful trend has reversed among young children, with rates of tooth decay actually increasing in the most recent National Health and Nutrition Examination Survey.\textsuperscript{6} Dental caries is the most common disease among children, affecting 42 percent.\textsuperscript{7}

At first blush, that may not sound like a serious concern. After all, children lose their first set of teeth and start over with a clean slate. But children miss 51 million school hours a year because of dental disease.\textsuperscript{8}

Orofacial pain affects about 10 percent of the population of the United States.\textsuperscript{8} And periodontal disease may pose an even more serious threat. Recent studies have linked these infections of the gum to potentially fatal conditions, including diabetes, stroke and heart disease.\textsuperscript{10} While rates of periodontal disease have also declined since the 1970s, 17 percent of seniors age 65 and over are still afflicted, and 24 percent of black seniors suffer.\textsuperscript{11}

Dentists are getting better at treating these diseases. Though most still devote the majority of their time to filling cavities, leaders in the field now advocate an approach in which dentists identify patients at highest risk for cavities and target them for more aggressive preventive care.\textsuperscript{12}

Dental care can save lives. Dental professionals can spot signs of over 120 diseases, including HIV/AIDS and leukemia.\textsuperscript{13} They are trained to recognize oral cancer in its early stages. Eighty-three percent of oral cancer patients survive five years after diagnosis—if the cancer is detected.
before it spreads. But only 28 percent of those whose cancer is detected after it spreads will live that long.¹⁴

Still, the populations most likely to benefit from oral care are least able to get it. The profession lacks dentists from ethnic minority communities. Dental diseases are highest among the poor, people living in inner cities or remote rural areas, Native Americans, Hispanics and blacks—all of whom have more trouble getting oral care.¹⁵ Among children whose families have low incomes, for example, tooth decay is twice as common as it is among families with high incomes.¹⁶

Among people with dental benefits, 81 percent report seeing a dentist at least twice a year, compared to only 34 percent of people without dental benefits.¹⁷ And having dental benefits correlates with better oral health—including lower rates of tooth decay and periodontal disease.¹⁸

**Progress for Kids**

In 2000, a report by then-Surgeon General David Satcher called attention to the problem of access to dental care, lending impetus to the work activists had already begun in pushing for expanded dental coverage for children.¹⁹ These efforts have achieved steady success over the past decade through lobbying, public awareness campaigns and lawsuits.

One of the most important is the inclusion of dental benefits in the Children’s Health Insurance Program (CHIP), which provides federal matching funds to states that cover children approximately between 100 percent and 200 percent of the federal poverty line. It reaches many of the working poor who cannot qualify for Medicaid. Although CHIP was first enacted in 1997, Congress did not make dental benefits mandatory in the program until its reauthorization in 2009. Most states have complied with that requirement by including these children in Medicaid dental programs.²⁰

Over the past decade, many states have undertaken improvements in their Medicaid dental programs by contracting with third parties, raising reimbursements to dental providers, and simplifying eligibility verification and claims processing.²¹

Some of these state programs focus on very young children, sometimes enlisting physicians to reach children who might otherwise go years before their first dental appointment. Forty-four states now reimburse physicians for risk assessment, anticipatory guidance and fluoride varnish application for Medicaid patients,²² up from only 25 in 2008.²³

For example, in North Carolina’s “Into the Mouths of Babes” program, physicians who treat Medicaid children get training in how to conduct a dental exam of a baby or toddler and how to apply fluoride varnish to the child’s teeth. They learn when to refer children with signs of oral disease to dentists, and also encourage parents to take their children for a first dental visit by age one. An evaluation of the program in 2007 found a 39 percent reduction in the need for fillings in front teeth for patients who received at least four preventive procedures before age three.²⁴

Pediatric dentists have become more available, as well. Between 2002 and 2009, the number of pediatric dentistry training programs rose from 39 to 76. Pediatric dentists make up less than 5 percent of active dentists, but they served about 19 percent of the 13 million Medicaid children who saw dentists in 2009.²⁵

Another boost to Medicaid children has come from dental management organizations (DMO’s), which have expanded rapidly in the past decade. These for-profit companies typically employ multiple practitioners and focus on Medicaid children. Some have run into controversy; critics accuse them of trying to bill for the largest number of procedures in the shortest amount of time, sometimes providing unnecessary treatments.

But the best-run DMO’s carefully track practitioners to prevent overtreatment. They make money by locating in depressed areas where rents and salaries are lower, purchasing in bulk and offering flexible schedules that take into account the challenges that many low-income families face in trying to get to appointments.

The gravity of oral health barriers came alive for many people in 2007, when 12-year-old Deamonte Driver died of an infection that resulted from
untreated tooth decay that became abscessed. His story garnered national headlines, lending impetus to oral health initiatives.  

The confluence of these developments appears to be achieving results. After hovering around 20 percent in the 1990s, the percentage of Medicaid children who had a dental visit over a 12-month period rose to 40.2 percent in 2010. The number of children enrolled in Medicaid increased at the same time, from 27 million in 2002 to 33 million in 2010.

Because of this progress, analysts don’t expect the Affordable Care Act to dramatically increase the number of kids accessing dental care through Medicaid. But it should increase the number with dental benefits through private insurance. That’s because the statute includes dental benefits in its definition of “essential health benefits,” which must be included in the plans that most employers will have to offer, and individuals will have to buy if they want to avoid a penalty.

What that dental coverage will include remains to be seen. The federal government has not given detailed specifics, though it has suggested using federal government dental benefits and the Children’s Health Insurance Program dental benefits as a reference.

**A Gap for Adults**

However much the Affordable Care Act helps children, it will do little to expand coverage for adults. And benefits for adults are a serious problem. The proportion of Americans covered by dental benefits was growing until the 2008 recession, when it dipped, later returning to its pre-recession level of about 57 percent.

While the majority of adults may be able to pay for dental care out of pocket, millions have no place to turn. The federal government does not require states to offer dental benefits through Medicaid. As a result, states have historically eliminated dental benefits for adults in Medicaid when tax revenues decline. The number of states with no benefits for adults climbed from 5 in 2008 to 9 in 2011. Fourteen others offered only emergency help.

Federally Qualified Health Centers, other community clinics, dental and dental hygienist schools, and volunteer clinics have increased their capacity to treat indigent patients, but often report that they are overwhelmed by demand.

The problem is particularly severe for many retired people who are no longer eligible for dental coverage through their employers because dental benefits are not part of traditional Medicare. In 2010, a third of Medicare recipients had not seen a dentist in two years or more.

Even those adults who do have dental benefits face obstacles.

- Some of the working poor may not be able to get the child care or time away from work to obtain the dental care they need.
- Many people can’t afford transportation to a dental office, particularly those living in remote areas.
- Community water fluoridation varies widely from one area to another, and a backlash against fluoridation, fed by rumors of health risks, has slowed its progress, despite unwavering support from the American Dental Association and other organizations.
- Those with dental benefits must often cope with limitations in typical plans. Many plans impose annual or lifetime caps on the amounts they will pay out, or limit the frequency of procedures that are covered. And even plans without caps may not pay for every procedure.
- Many dentists charge more than insurance plans are willing to pay.
- Only 38 percent of general dentists will see any patients with Medicaid or CHIP.

The reasons dentists most often cite for not seeing Medicaid patients are low reimbursement rates, the hassle of government paperwork, and the problems that low-income patients have in keeping appointments.

That may make dentists sound a little hard-hearted, especially since their average income is about $200,000 a year. But some—especially the youngest—have little choice about focusing on the bottom line. On average, dental school graduates start out their careers with $170,000 in debt. If they want to buy their own practices, they typically need additional loans of $450,000. While the cost of education keeps increasing (68 percent for private schools and 104 percent for public schools and the Children’s Health Insurance Program dental benefits as a reference.

---

**States with Fluoridation Activity**

January 2011–May 2012

A total of 43 states saw some type of fluoridation activity during this time period. The states without any reported activity include Delaware, Hawaii, Kentucky, Nevada, Rhode Island, South Dakota and West Virginia.

Source: American Dental Association
schools in the past 10 years, dentists’ average incomes have stagnated.

**Ideas for the Future**

Some initiatives to remove barriers to oral health care are already being tried, but on a small scale. The ACA authorizes some public education in oral health, but this provision in the law remains unfunded.

Some existing programs provide debt relief for newly graduated dental professionals, particularly those willing to work in underserved areas, and the Affordable Care Act authorizes increases in these funds, though, once again, the money has not been appropriated.

Other experts have proposed increasing the number of dentists, particularly in areas with the shortest supply, by starting new dental schools. Between 1986 and 2001, seven dental schools closed. Since then, eight new schools have opened.

Experts in the field debate whether we have enough dentists now, and whether we will in the future. On one hand, the demand for dental appointments may increase as more children gain coverage. Many dentists are near retirement age. More dentists are women, and female dentists work slightly fewer hours on average. On the other hand, rates of tooth decay are lower than in the past, so fewer dentists may be needed to fill cavities. And, the amount of financial aid available may not increase to keep pace with the number of new students, increasing the debt for the average student.

Many states are considering controversial legislative proposals to address the licensing, education, and scope of practice of midlevel providers—those falling between hygienists and dentists. Advocates argue that these practitioners can learn enough to perform many dental procedures, including routine fillings and extractions, with fewer than the six to eight years of higher education required to become a dentist.

Needing less education, the midlevel providers could afford to charge less for their services, the advocates say. Also, with lower educational hurdles, more practitioners could be recruited from underserved communities, bringing into the profession their cultural knowledge.

Organized dentistry, led by the American Dental Association, has opposed the creation of these new provider models. Opponents argue that only fully-trained dentists can handle the complications that may arise when cutting or removing parts of a human body. As an alternative way to help indigent patients, the ADA and other groups have advocated reducing administrative burdens and increasing reimbursement within Medicaid, and requiring that states include benefits for adults in their Medicaid programs.

The conflict over midlevel providers echoes similar struggles in medicine where, for example, anesthesiologists have wanted to limit the scope of nurse anesthetists. So far, only Minnesota has launched its own dental therapy program. Other states, like New Hampshire, have reached compromises in which hygienists and dental assistants have gained slightly wider scopes of duty. A federal program in Alaskan indigenous communities allows dental therapists with two years of education after high school to do most dental procedures.

Historically big strides in coverage have required bold legislation. But as the bruising fight over the Affordable Care Act continues at the federal level, and budget cuts continue in state government, oral care could remain a policy concern for years to come.

---

**Acknowledgements**

This publication was made possible by a grant from the Robert Wood Johnson Foundation. The Alliance is grateful for that support.

The Alliance also thanks Laird Harrison, who wrote the original draft.

The Alliance is a nonpartisan, not-for-profit group committed to the education of journalists, elected officials and other shapers of public opinion, helping them understand the roots of the nation’s health care problems and the trade-offs posed by various proposals for change.

Design by Yael Konowe of Yael Design, Reston, VA.

Printed on recycled paper. c. 2012.
Endnotes


