Oral Health and Well-Being in the United States

Commentary – So What? Now What?

In 2000, the Surgeon General issued a landmark **report** that convincingly made the case that oral health is a critical part of overall health. While this seems like a no-brainer to anyone who has dealt with oral health issues, it was actually a breakthrough moment for oral health advocates. The report highlighted that oral health is tied to chronic conditions like diabetes and can impact child learning and employment outcomes.

Since the report's launch, oral health has been improving among children in the United States. For example, the percentage of children with **untreated cavities** has been falling for decades. There are still **oral health disparities** by income and race that need to be addressed, but generally the trends for children are headed in the right direction. Part of the reason is more and more children are visiting the dentist, particularly those within low-income populations. A recent **study** revealed that in every state except one, low-income children are "catching up" to high-income children in terms of their dental care utilization rate.

The trends for adults, however, are very different. Fewer adults are visiting the dentist, especially those within low-income populations. **Income disparities** in dental care utilization have actually grown for adults. **Cost** is the top reason adults cite for not visiting the dentist, and several studies, including one from the Federal Reserve, show that dental care is perceived as being the **least affordable** of any health care service. **Emergency department** visits for preventable oral health conditions have skyrocketed over the past decade, a trend driven mainly by young and low-income adults. Not a rosy picture.

When one looks at how dental care is handled in U.S. health care policy, it is not surprising that children and adults are experiencing very different trends. Dental coverage for children is compulsory both in Medicaid and the Children's Health Insurance Program (CHIP), which together cover 40 percent of children in the United States. The **basket of dental care services** that are covered is quite extensive, including medically necessary orthodontia, and there is no **cost-sharing in Medicaid** and limited **cost-sharing in CHIP**. Dental care for children is also one of the ten essential health benefits under the Affordable Care Act. In contrast, dental care for adults is not considered "essential" under the Affordable Care Act. Similarly, dental coverage for adults is not required within Medicaid and **22 state Medicaid programs** do not pay for anything beyond emergency dental care services. In short, health care policy disconnects the mouth from the body when children turn into adults.

Whatever the rationale for treating an adult mouth differently than a child mouth in U.S. health care policy, new data

NOW WHAT?

Health care policymakers need to focus on three things going forward:

1 **Reconsider the separation of mouth and body in state and federal health care policy**

2 **Explore alternative designs for adult dental benefits in Medicaid and private dental benefit plans**

3 **Implement systems to measure oral health and well-being based on HPI's new measures**

demonstrate the implications. The ADA Health Policy Institute has released a comprehensive, state-by-state report on **oral health and well-being in the United States** which, for the first time, shows how seriously oral health issues are impacting the lives of adults. At the national level, 29 percent of low-income adults report that the condition of their mouth and teeth affects their ability to interview for a job. More than two out of five low-income adults report difficulty biting and chewing because of the condition of their mouth and teeth. Nearly one in four report they have reduced participation in social activities because of oral health issues. Most concerning are the sharp disparities in all aspects of oral health and well-being according to income level. Expectations differ markedly by income, as well. While about half of high-income adults say they expect to lose some of their teeth as they age, among low-income adults this is a much higher 74 percent. Cost is the top reason for not visiting the dentist more frequently among all age and income groups, including high-income adults with private dental coverage.

Where do we go from here?

Given the trends in access to dental care, specifically the different trajectory for adults compared to children, it might be time to reconsider how dental care is handled in the U.S. health care system. There are three specific areas that merit further debate.

First, we need to revisit the separation of mouth and body for adults in federal and state health care policy. Within Medicaid, adult dental benefits are optional and most states provide only **basic coverage**. Implementing a comprehensive dental benefit for Medicaid adults is estimated to cost **$1.4 to $1.6 billion** per year. The estimated state portion of this bill translates to about one percent of total Medicaid spending. Compare this to the **$1.6 billion** spent each year on hospital emergency room visits for dental conditions, one third of which is paid for by Medicaid. Expanding Medicaid adult dental benefits has been shown to increase access to care under proper enabling conditions. There is strong evidence of **excess capacity** in the dental care system in many states that could **absorb an expansion** in adult dental care utilization. There are also numerous **state experiences** to draw on that serve as good practice models in managing adult dental benefits in Medicaid.

Second, we need to re-examine the structure of dental benefits for adults in Medicaid programs as well as the private dental coverage market. The fact that cost is the top reason why both Medicaid and privately insured adults avoid dental care strongly suggests that the status quo model of dental "insurance" is not actually providing financial protection. Bigger picture, it is time for dental benefits to be structured so that they actually pay for oral health and well-being – the things measured in the ADA Health Policy Institute survey – rather than for checklists of procedures with arbitrary dollar limits. The dental benefit design for children in Medicaid and CHIP provides a good blueprint to draw on. Several states have seen dramatic increases in dental care utilization among Medicaid children in a relatively short period of time through effective, evidence-based **policy reforms**. Beyond Medicaid, policymakers ought to also examine how dental benefits for children and adults are handled in the health insurance marketplaces. While more and more private medical insurance plans in the **health insurance marketplaces** are covering dental benefits for children, there are far fewer options for adults. This is despite the fact that dental care is a high priority among adults, **especially young adults**, when they are shopping for health insurance.

Third, oral health needs to be defined and measured differently. The current focus of many government agency data collection efforts is to measure the presence and severity of dental disease – often limited to cavities and gum disease – and the frequency and type of dental care services people use. There is very little emphasis,

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in contrast, on measuring the contribution of oral health to physical, social and emotional well-being. These are the ultimate outcomes of interest that any dental care delivery system ought to be designed around. The new measures developed by the ADA Health Policy Institute are a significant advancement in this area but are meant to be a starting point for other research organizations, including the Centers for Disease Control and Prevention and the Agency for Healthcare Research and Quality, to build on. A robust oral health and well-being measurement system would also enable a shift toward outcomes-based delivery and reimbursement models, a critical future direction in health care in the United States.

As the Surgeon General said, "you can't be healthy without good oral health." It is time to re-engineer the health care system that actually delivers oral health and well-being. We need to put more effort (and perhaps money) where our mouth is.