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Affordable Care Act Expands Dental Benefits for Children But Does Not Address Critical Access to Dental Care Issues

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Key Messages

- *Approximately 8.7 million children are expected to gain some form of dental benefits by 2018 as a result of the Affordable Care Act (ACA), an increase of 15% relative to 2010. This will reduce the number of children without dental benefits by about 55%.*
- *Although 17.7 million adults are expected to gain some level of dental benefits as a result of the ACA, almost all of this increase is in Medicaid which varies significantly state to state on adult dental benefits policy. As a result, only 4.5 million of adults are expected to gain 'extensive' dental benefits through Medicaid. An additional 800,000 will gain private dental benefits through health insurance exchanges. Combined, this will reduce the number of adults without dental benefits by about 5%.*
- *There is likely to be significant pressure on Medicaid providers within the dental care delivery system. The ACA is expected to generate an additional 10.4 million dental visits per year through Medicaid by 2018.*

Introduction

Dentistry is at a crossroads. Declining dental care utilization among adults,^{1,2} the rapid growth in larger dental service delivery groups,³ increased financial barriers to care among adults,^{4,5} and improvements in oral health status for most segments of the population⁶ are just a few of the factors bringing significant change to the profession. Overarching all of this, the U.S. health care system is on the verge of unprecedented change due to the Affordable Care Act (ACA).

The ACA's 'triple aim' is to improve the health of the population, enhance the patient experience of care (including quality, access, and reliability) and reduce, or at least control, the cost of care.⁷ The reform does this through several key provisions. An individual mandate will require that most individuals have health insurance in 2014. States have the option to expand Medicaid eligibility to 138% of the federal poverty level with the federal government fully funding the expansion for the first three years.⁸ Health insurance exchanges (HIX) will be established for individuals who do not have access to public coverage or affordable employer insurance with federal subsidies for individuals up to 400% of the federal poverty level. Exchanges will also be available for small employers to provide insurance to their employees and tax credits are available to encourage them to do so. All policies sold to individuals and small employers, both within and outside the exchange, will be required to cover essential health benefits (EHB). All health insurers will be prohibited from denying coverage to people with pre-existing conditions or charging different premiums based on health status and gender. Annual and lifetime limits on most benefits will be prohibited. Employers will face penalties if they do not offer affordable coverage to their employees, with exceptions for small employers.⁹

Several aspects of the ACA relate to dental care.^{10 11} Dental benefits for children under 19 years of age are included in the essential health benefits¹² and are required for individual and small employer plans sold within and outside the exchanges. However, a recent ruling clarified that while exchanges are mandated to offer pediatric dental benefits, consumers are not mandated to purchase them.¹³ Dental benefits for adults are not part of the EHB. As a result, they remain optional for employers, individuals, and state governments (through their Medicaid policy).

There are other provisions in the ACA that affect oral health that may not necessarily become effective due to the appropriations process. These include dental caries disease management, public education campaigns on prevention, school-based sealant programs, workforce improvements, improvements to national oral health reporting and surveillance statistics.¹⁴

In this research brief, we estimate the impact of the ACA on the number of adults and children with dental benefits in 2018 and the additional dental visits and spending this is expected to generate. We provide both national and select state-level estimates.

Data & Methods

Our findings are largely based on a study that the American Dental Association (ADA) commissioned by Milliman, Inc. The study was a comprehensive analysis of the various effects of the ACA on the dental sector. A detailed explanation of the methodology and modeling is available on request. Here we provide a summary of the key aspects.

Milliman, Inc. estimated the impact of the ACA on the number of adults (aged 21 and over) and children (under age 21) who will gain dental benefits from 2010 to 2018 through three separate sources: (a) Medicaid, (b) Employer sponsored insurance (ESI) and (c) Health insurance exchanges (HIXs). At the time of Milliman, Inc.'s analysis, the age for pediatric dental benefits was not set. The analysis used the age of 21 to be consistent with Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) guidelines. Regulations later set the age limit at under 19. Therefore, the analysis overestimates the number of children who would gain dental benefits as a result of the EHB. The analysis used 2018 as the end year rather than an earlier year as it best reflects the steady state environment after all the health reforms have taken effect. Estimates were based on Milliman, Inc.'s

proprietary Health Care Reform Financing Model (HCRFM). This model uses Medical Expenditure Panel Survey (MEPS), U.S. Census, comprehensive claims, and market research data to make projections concerning the impact of the ACA. The model incorporates other data related to the prevalence of dental benefits among populations with health insurance. For example, the model assumes that in 2010, 10% of the individual insurance market, 28% of the small group market and 51% of the large group market had dental insurance.¹⁵

Medicaid expansion

For Medicaid children, the model assumed that all children in all states would have dental benefits since this is a Medicaid-required benefit and mandated by the ACA.¹⁶ The model projects the number of children who will enter Medicaid by 2018 due to provisions in the ACA compared to 2010 levels. Individuals born during those years who would receive Medicaid as a result of the expansion are included, but not those who would have qualified under pre-ACA Medicaid limits. The Milliman, Inc. model then estimated the additional utilization and expenditure for the expanded child Medicaid population.

For adults, the model first estimated the increase in the number of adults in Medicaid in each state through 2018. The model assumed full Medicaid expansion to the 138% FPL in every state. Even though the Supreme Court made the expansion optional for states,¹⁷ most analyses and policy opinions suggest that eventually all states will expand since it would be financially advantageous for them to do so.^{18 19 20} Nevertheless, this assumption implies our results should be interpreted as an upper bound estimate. Next, each state's policies were reviewed and states were classified by the level of adult dental benefits in Medicaid in 2010 (Table 1). It is important to note that there is no clearly defined, well-established method for

classifying adult Medicaid dental benefits. These categories are consistent with previous methodology developed by the ADA and widely cited, however.²¹

We then updated the adult Medicaid dental benefits policies within each state as of December 2012. A few states changed their policy between 2010 and 2012 and it was important to capture this. We assumed that states would maintain their 2012 adult Medicaid dental benefits policy through 2018. This is an important assumption that is open to debate since states have a history of cutting optional benefits during times of budget crises.²² However, the ACA does not change the incentives for states regarding their adult dental benefits within Medicaid.²³ In fact, there are incentives for states to maintain their current policy. The Milliman, Inc. model then estimated the additional utilization and expenditure associated with each of the four levels of adult Medicaid dental benefits.

Employer-sponsored insurance (ESI)

The Milliman, Inc. model projected the number of children expected to gain dental benefits through employer sponsored health insurance. The model estimated how many children would have ESI in 2018 and what percentage of those would have dental benefits based on an analysis of dental benefits in ESI in 2010. In addition, plans sold to small employers are required to provide pediatric dental benefits. The percentage of children who have ESI through a small employer plan was calculated and it was assumed that all would gain access to dental benefits as a result of the ACA. The model then applied utilization and spending estimates to predict the corresponding change in visits and expenditure generated by this population. The model did not project adults gaining dental benefits through ESI because there is no requirement in the ACA that they be provided.

Health insurance exchanges (HIXs)

The Milliman, Inc. model projected the number of children and adults that would gain dental benefits via the HIXs. For adults and children, the model estimated how much of the expected HIX population had dental benefits. For those with no dental benefits who are entering the HIXs, the model projected the likelihood of purchasing dental benefits. This was done separately for adults and children. For adults, the estimates were developed through an analysis of the literature and proprietary data from Milliman, Inc. For children, the model assumed that all children on the HIX would purchase dental benefits. Since the analysis was done, however, the federal government clarified that pediatric dental benefits must be offered on HIXs but purchase is not mandatory.²⁴ As a result, our estimates are an upper bound.

Results

An estimated 8.7 million children will gain access to comprehensive dental benefits by 2018 through the ACA, a 15% increase compared with 2010 (Table 2). This increase is split roughly evenly between those gaining dental benefits through Medicaid, HIXs and ESI. This will reduce the number of children without dental benefits by about 55% relative to 2010 levels.

Although an estimated 17.7 million adults will gain some level of dental benefits in 2018, nearly all of the increase is a result of Medicaid coverage, which is less than comprehensive in most states when it comes to dental benefits. Three-quarters of the estimated increase in the number of adults with dental benefits occurs in states that provide limited or emergency dental services to Medicaid adults. In fact, only 4.5 million adults will gain extensive Medicaid dental benefits. A negligible number of adults – 800,000 – are expected to gain dental benefits on the HIXs (Figure

1). Overall, this will decrease the number of adults without dental benefits by about 5% relative to 2010 levels.

We estimate approximately 3.2 million children will gain dental benefits via the Medicaid expansion; a 9.9% increase compared to 2010 Medicaid levels. We estimate an additional 3.0 million children will gain dental benefits through the HIXs by 2018 – more than doubling the number of children with dental benefits purchased through the individual market. We project that approximately 2.5 million children will gain dental benefits through ESI as a result of the mandate for pediatric dental benefits in small employer plans, an increase of about 10% compared to 2010 levels.

Assuming that the expansion population utilizes Medicaid dental services in the same pattern as today's Medicaid beneficiaries, the expansion is estimated to generate an additional 2.9 million pediatric dental visits and 7.5 million adult dental visits. The ACA is also expected to add 11 million pediatric private dental visits through expansion of dental benefits through the HIXs and ESI and 1.7 million adult private dental visits through expansion of dental benefits through the HIXs.

The ACA is estimated to increase U.S. dental spending by an estimated \$4 billion, or less than 4% of current total national dental expenditure. The largest effect will be seen in the Medicaid population, generating \$2.4 billion in Medicaid dental spending. This represents a 28% increase over Medicaid dental spending levels in 2010 with adults accounting for roughly two-thirds of the increase. The ACA is also expected to add \$1.6 billion in expenditures by adults and children gaining private dental benefits through HIXs and ESI.

Full state-level projections are available at http://www.ada.org/sections/professionalResources/docs/HPRCBrief_0413_3x.xlsx.

Table 1: Categories of Adult Dental Benefits in Medicaid and Classification of States

Benefit Level	Definition	States
None	No dental benefits.	AL, CA, DE, MD, NV, OK, TN, UT
Emergency	Relief of pain and infection. While many services might be available, care may only be delivered under defined emergency situations.	AZ, CO, FL, GA, HI, ID, IL, KS, ME, MS, MO, MT, NH, SC, TX, WA, WV
Limited	A limited mix of services, including some diagnostic, preventive, and minor restorative procedures. It includes benefits that have a per-person annual expenditure cap of \$1,000 or less. It includes benefits that cover less than 100 procedures out of the approximately 600 recognized procedures per the ADA's Code on Dental Procedures and Nomenclature.	AR, DC, IN, KY, LA, MA, MI, MN, NE, NJ, PA, SD, VA, VT, WY
Extensive	A more comprehensive mix of services, including many diagnostic, preventive, and minor and major restorative procedures. It includes benefits that have a per-person annual expenditure cap of at least \$1,000. It includes benefits that cover at least 100 procedures out of the approximately 600 recognized procedures per the ADA's Code on Dental Procedures and Nomenclature.	AK, CT, IA, NM, NY, NC, ND, OH, OR, RI, WI

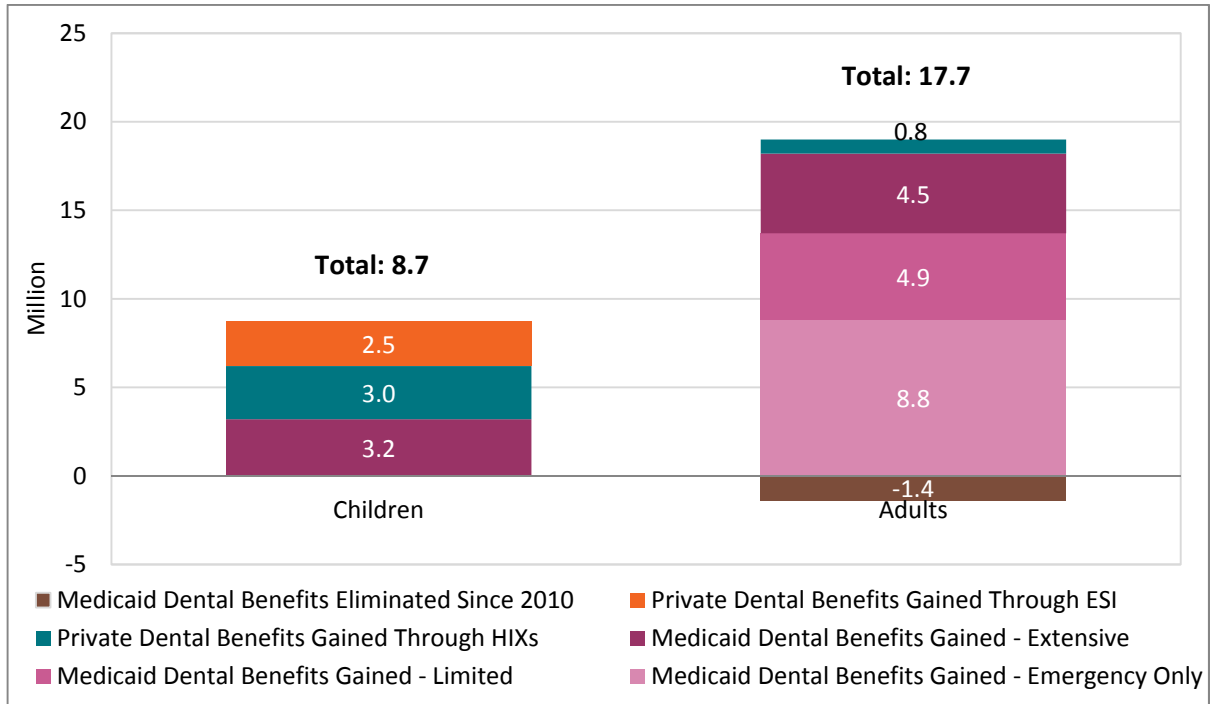
Source: Analysis of state-level policies related to Medicaid by the ADA. **Notes:** Classification of states reflects policies in place as of 2012. The District of Columbia is included.

Table 2: Number of Adults and Children with Dental Benefits by Source, 2010 and 2018 (millions)

	2010				Increases Due to ACA by 2018			
	Sources of Dental Benefits				Sources of Dental Benefits			
	Medicaid	Individual	Employer	Total	Medicaid	Individual	Employer	Total
Children	32.3	2.1	24.9	59.3	3.2	3.0	2.5	8.7
Adults	17.5	4.1	92.2	113.8	16.9	0.8	-	17.7

Source: Milliman, Inc. analysis commissioned by the ADA; Analysis by the ADA Health Policy Resources Center. **Notes:** 2010 Medicaid, individual and employer dental beneficiary population for children and 2010 Medicaid adult dental beneficiary population estimated by Milliman HCRFM. 2010 employer adult dental beneficiary population estimated by 2010 private dental insurance rate from MEPS, 2010 U.S. adult census population and percent of privately insured individuals with group insurance from 2011 NADP/DDPA Joint Dental Benefits Report. 2010 individual adult dental beneficiary population estimated by 2010 private dental insurance rate from MEPS, 2010 U.S. adult census population and percent of privately insured individuals with individual insurance from 2011 NADP/DDPA Joint Dental Benefits Report. Adults are aged 21 and over. Children are under age 21.

Figure 1: Number of Children and Adults Gaining Benefits through the ACA, by Source of Dental Benefits (millions)



Source: Milliman, Inc. analysis commissioned by the ADA; Analysis by the ADA Health Policy Resources Center.

Discussion

Based on the analysis, we expect that there will be approximately a 15% increase by 2018 relative to 2010 levels in the number of children with extensive dental benefits due to the ACA. Roughly, one-third of this expansion will come through Medicaid, and two-thirds through private dental benefits either purchased on the HIXs or provided by employers through ESI. We stress that this estimate – about 8.7 million children – should be viewed as an upper bound since the purchase of pediatric dental benefits is not actually mandated within the exchanges. We expect only 5.3 million adults to gain extensive dental benefits due to the ACA, almost all of which (4.5 million) is due to Medicaid expansion in states that provide extensive adult dental benefits. An additional

12.4 million adults are expected to gain emergency or limited dental benefits. Here too we stress that this should be viewed as an upper bound since it assumes all states will expand Medicaid eligibility to 138% FPL for adults and states will not change their current policies through 2018.

Since much of the increase in Medicaid adult dental beneficiaries will come through states that offer emergency or limited benefits only, the quality of dental benefits and access to dental care these adults will receive will not be sufficient to promote good oral health. With a large inflow of adults moving into Medicaid programs that provide very limited dental benefits, poor adults could increasingly be resorting to other options, including visiting an emergency room for

dental care. This not only diminished access to oral health, it also increases overall health care costs unnecessarily.

In states that currently offer adult dental benefits through Medicaid and retain these benefits going forward, there is likely to be significant pressure on the dental care delivery system. Even though the increase in the number of children entering Medicaid programs is much smaller, this too will put pressure on the dental safety net. Currently, many adults face financial barriers to dental care.²⁵ Providing benefits does not necessarily equate to increased dental care utilization. Even in states that provide dental benefits, adults on Medicaid often have inadequate access to care due to various reasons, including administrative inefficiencies and low provider reimbursement levels.²⁶ Recent studies show that reforming Medicaid,²⁷ including increasing reimbursement rates closer to market levels,²⁸ is associated with an increase in dental care utilization. Such reforms are urgently needed if the increased demand for dental care on the part of Medicaid adults and children is to be met. Unfortunately, the ACA does little to accelerate the reforms needed to improve the dental care delivery system for Medicaid beneficiaries.

It is important to note that the issue of inadequate reimbursement in Medicaid, for example, has been recognized for broader health care services. To ensure effective access to care, the ACA requires states to increase Medicaid reimbursement rates to Medicare levels for family physicians, internists, and pediatricians for many primary care services. On average, this will raise Medicaid reimbursement rates by 73%.²⁹ There has not been any similar directive issued by the federal government to increase reimbursement rates for dental services within Medicaid.³⁰ In part, this may be due to the fact that dental care for adults is not an essential health benefit mandated by the ACA. As a result, a major concern

going forward is whether there is sufficient capacity to absorb the significant increase in demand for dental care among Medicaid adults.

Another critical issue going forward is whether states that currently provide some level of adult dental benefits in Medicaid will continue to provide them. In a separate research brief, we argue that the incentive structure encourages states to 'lock in' their current policy.³¹ In other words, for states that provide adult dental benefits, there is an incentive to continue to provide them – even though they are not mandated – while states that do not provide them have an incentive to continue not providing them. This is because the federal government will fully finance the Medicaid expansion – even for optional services such as dental care – through 2017 and at 90% past 2020.³² While the exact level of funding for optional benefits within the expansion population has not been determined, there will still be a financial incentive for state governments to maintain adult dental benefits through Medicaid.

On the other hand, due to tight budgetary constraints and various other factors, many states will look at cost savings options and this could include reductions in optional benefits in Medicaid programs.³³ This has, in fact, been a recent trend as many states have slashed adult dental benefits. In 2012, Illinois limited adult dental benefits in its Medicaid program.³⁴ California dramatically limited dental benefits in its Medicaid program in 2009, which has led to a significant drop in dental care utilization among poor adults.³⁵ A recent survey found that nine states reduced or intended to reduce dental benefits over the next year compared with four states that planned to expand dental benefits.³⁶

There have also been recent instances where states have expanded dental benefits to underserved adults. In 2006, Massachusetts passed a health care reform law, which was later the template for the ACA. But

unlike the ACA, the law mandated dental benefits for adults eligible for Medicaid (MassHealth), and expanded coverage to low income adults through Commonwealth Care, which operates the HIX in the state.^{37 38} Through 2010, the reform increased adult dental care utilization significantly in Massachusetts, particularly among the poor.^{39 40} Overall, we feel that while the ACA will significantly reduce the number of children who lack dental benefits, it is a missed opportunity to address some of the other critical access to dental care issues in the United States. This is particularly true for low-income adults, who face the most significant financial barriers to dental care. In this respect, the ACA fails one of its primary aims – to expand access to health care, particularly to the underserved adult population. The ACA also fails to address important dental care delivery system barriers, including administrative burdens within Medicaid programs and inadequate provider reimbursement levels. Limiting dental benefits for low-income adults and, more broadly, leaving many of the Medicaid dental care delivery system issues unaddressed could leave millions of Americans with diminished access to dental care and oral health. Cuts in adult dental

benefits in many states, such as Oregon, have led to increases in costly preventable emergency room visits for dental conditions.⁴¹ In fact, in recent years the rate of preventable dental-related emergency room visits has increased considerably⁴² – exactly the type of situation the ACA's triple aim is meant to discourage. In the coming years, advocates for oral health will have to consider innovative ways to increase access to dental care, mainly for low-income adults. The ACA, at least for now, remains a key missed opportunity.

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