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Dental Benefits Continue to Expand for Children, Remain Stable for Working-Age Adults

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Key Messages

- *More children had dental benefits in 2011 than in 2010. The continued expansion since 2000 was primarily due to Medicaid and SCHIP, which mandate dental benefits for children.*
- *By contrast, more working-age adults are going without dental benefits compared to 2000, although there was no significant change between 2010 and 2011. More adults are in Medicaid compared to a decade ago, but adult dental benefits within Medicaid programs, on average, have eroded since 2000.*
- *Among the elderly, the percent with private dental benefits remained steady from 2000 through 2010, but there has been an uptick in 2011, which may reflect the increasing demand for dental care among this age cohort.*

Introduction

Since 2000, the dental benefits landscape has changed significantly in the United States among all ages. From 2000 through 2010, the percentage of individuals with private dental benefits declined¹ and adult dental benefits through state Medicaid programs eroded.² With the implementation of the Affordable Care Act (ACA), more children will have access to dental benefits through employer-sponsored insurance, the exchanges and Medicaid. However, the law will have a limited impact on the dental benefits for working-age adults.³

Dental benefits are a crucial factor enabling access to dental care and good oral health. People with private dental benefits are more than twice as likely to have an annual dental exam compared to those without benefits.⁴ Since the early 2000s, the percentage of adults, particularly low-income adults, who visit a dentist has been steadily declining.⁵ The erosion

of public dental benefits in state Medicaid programs⁶ and the declining percentage of working-age adults carrying private dental benefits have driven this.⁷ By contrast, utilization of dental care among children increased, driven primarily by increased visits by low-income children, who benefited from increased access to dental benefits through public programs in the past decade.⁸

Dental benefits for adults in public programs vary considerably by state and population. This is because dental benefits are mandatory for children under both Medicaid⁹ and the State Children's Health Insurance Program (SCHIP),¹⁰ but are optional for adults. As of December 2012, only 11 states (AK, CT, IA, NM, NY, NC, ND, OH, OR, RI and WI) provided extensive adult Medicaid dental benefits, 14 states (AR, IN, KY, LA, MA, MI, MN, NE, NJ, PA, SD, VA, VT and WY) and the District of Columbia provided limited adult Medicaid dental benefits, 17 states (AZ, CO, FL, GA, HI, ID, IL, KS, ME, MS, MO, MT, NH, SC, TX, WA and WV) provided emergency-only adult dental benefits in Medicaid and 8 states provided no adult Medicaid dental benefits (AL, CA, DE, MD, NV, OK, TN and UT).¹¹

In this research brief, we analyze recent trends in dental benefits using data from the Medical Expenditure Panel Survey (MEPS). We build upon previous research¹² by analyzing newly released data for 2011.

Data & Methods

We analyzed data from the MEPS that is managed by the Agency for Healthcare Research and Quality (AHRQ). MEPS is a large-scale survey of individuals and families drawn from a nationally representative sample (the "household component"). MEPS is the most complete source of data on the cost and use of health care and health insurance coverage.¹³ We focused on the period 2000 to 2011, the most recent

year for which data are available (data for 2011 were released in September 2013). We used data from the MEPS to analyze the source of dental benefits for children (ages 2 to 18), working-age adults (ages 19 to 64) and the elderly (ages 65 and older).

We classified dental benefits into two categories: public and private. Public benefits include those provided through Medicaid or State Children's Health Insurance Programs (SCHIP). Because dental services are a mandated benefit, children enrolled in these programs were defined as having comprehensive dental benefits. As noted, Medicaid coverage of dental benefits for adults is optional and varies considerably by state. MEPS does not allow us to identify the state of residence, however. This is a limitation of the data set we use. We simply categorize adults covered by Medicaid as publicly insured for dental benefits even though the majority will have either no dental benefits at all or very limited benefits. Because Medicare does not provide dental benefits,¹⁴ persons who only had Medicare coverage were considered uninsured for dental care.

We test for statistical significance across time using a chi-squared test. Our point estimates and statistical inferences take into account the complex survey design of the MEPS.

Results

In 2000, 57.8 percent of children had private dental benefits, 20.5 percent had public benefits and 21.7 percent had no dental benefits. By 2011, the percentage of children with private dental benefits dropped to 49 percent, while the percentage with public benefits rose to 36.8 percent. Over this period, the uninsured rate dropped to 14.2 percent. Despite the drop in the percentage of children with private dental benefits, the overall percentage of children with any dental benefits rose from 2000 through 2011

(Figure 1). These changes were statistically significant.

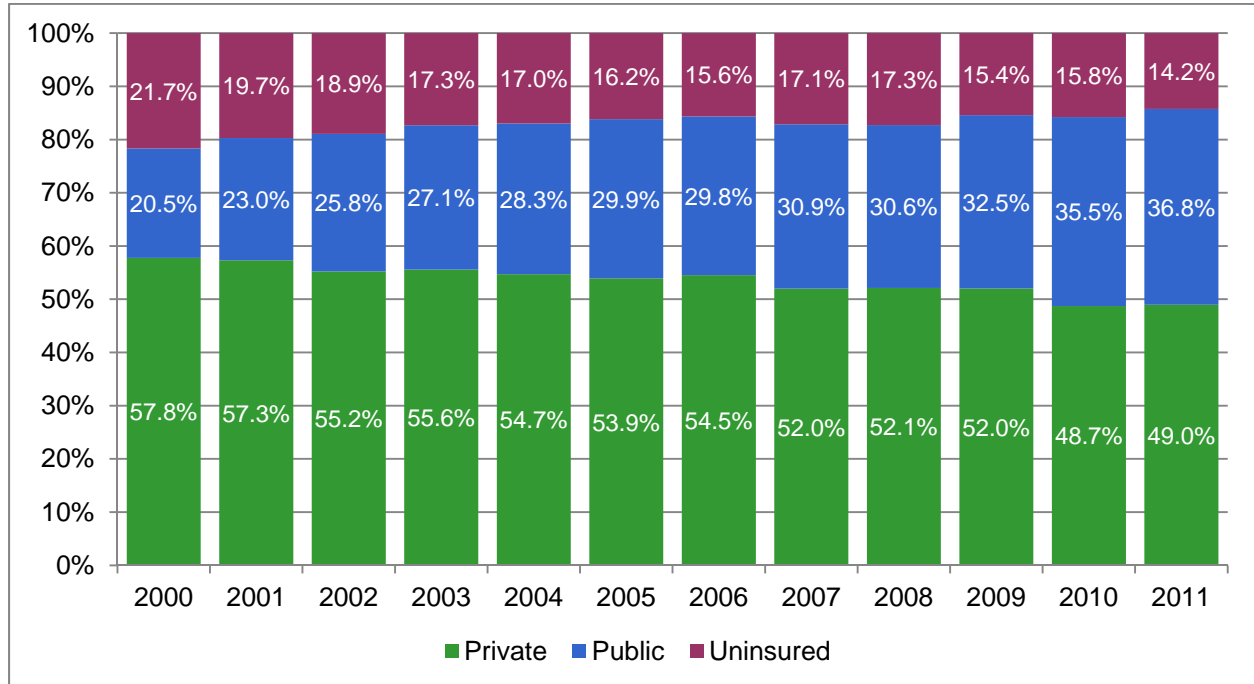
Among working-age adults, the percentage with private dental benefits dropped from 61 percent in 2000 to 56.2 percent in 2011, a change that was statistically significant. From 2001 to 2011, the percentage of working-age adults with public benefits rose from 6.5 percent to 10 percent, and the uninsured rate rose from 32 percent to 33.7 percent, changes that were statistically significant (Figure 2). Again, we emphasize that for adults with public benefits, we are not able to identify the type of coverage (e.g. emergency only, limited, extensive). In fact, some of these adults will have no dental benefits at all if they are covered by Medicaid in states that provide no adult dental benefits at all to Medicaid adults.

From 2000 through 2010, there were no statistically significant changes in the percentage of the elderly with private dental benefits, public benefits or without any dental benefits (Figure 3). From 2010 through

2011, however, there was an uptick in the percentage of the elderly with private dental benefits from 23.9 percent to 26.1 percent, although this was not statistically significant. The overall change in the percentage of elderly adults with private dental benefits from 2000 (23 percent) through 2011 (26.1 percent) was statistically significant.

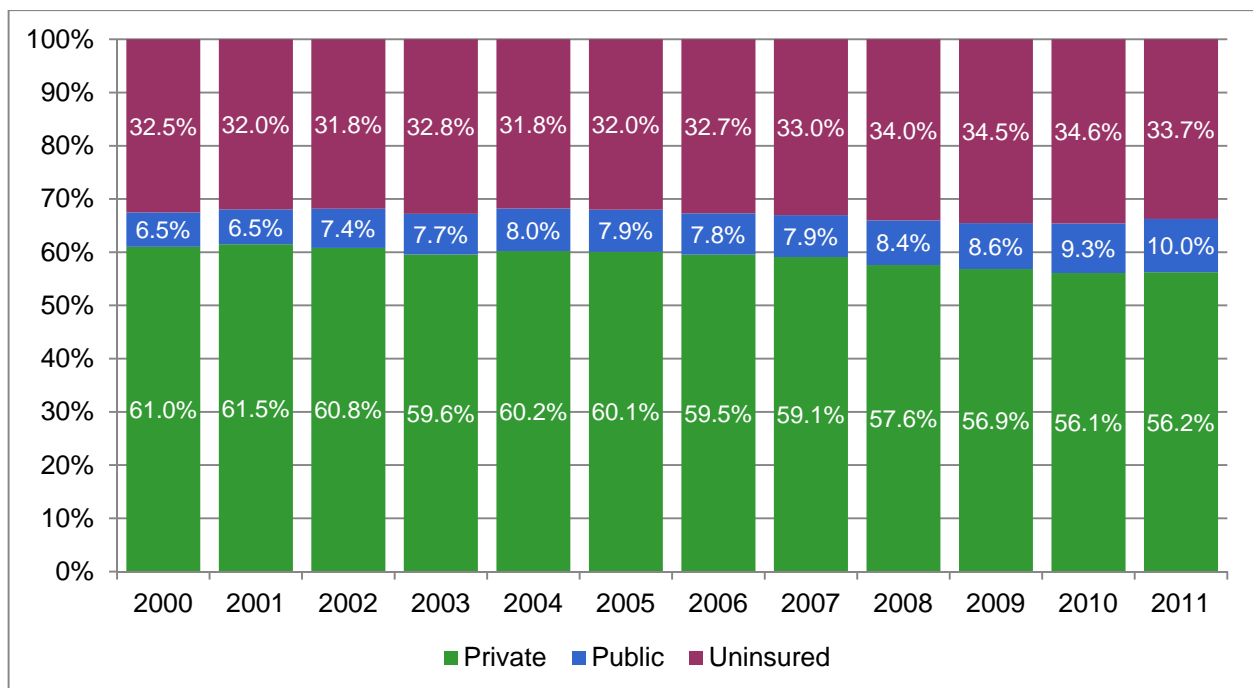
Figure 4 reorganizes the data to examine the percentage of individuals with private dental benefits for select age groups. Among children and working age adults ages 19 to 34 and 35 to 49, the percentage with private dental benefits dropped from 2000 through 2011, changes which were all statistically significant. Among working-age adults ages 50 to 64, the percentage with private dental benefits dropped significantly from its peak in 2002 (60.6 percent) through 2011 (57.3 percent). However, there was a noticeable uptick the percentage of young adults ages 19 to 34 with private dental benefits from 2010 (50.8 percent) to 2011 (52.5 percent), a change that was weakly statistically significant at the 10 percent level.

Figure 1: Source of Dental Benefits, Children Ages 2 to 18



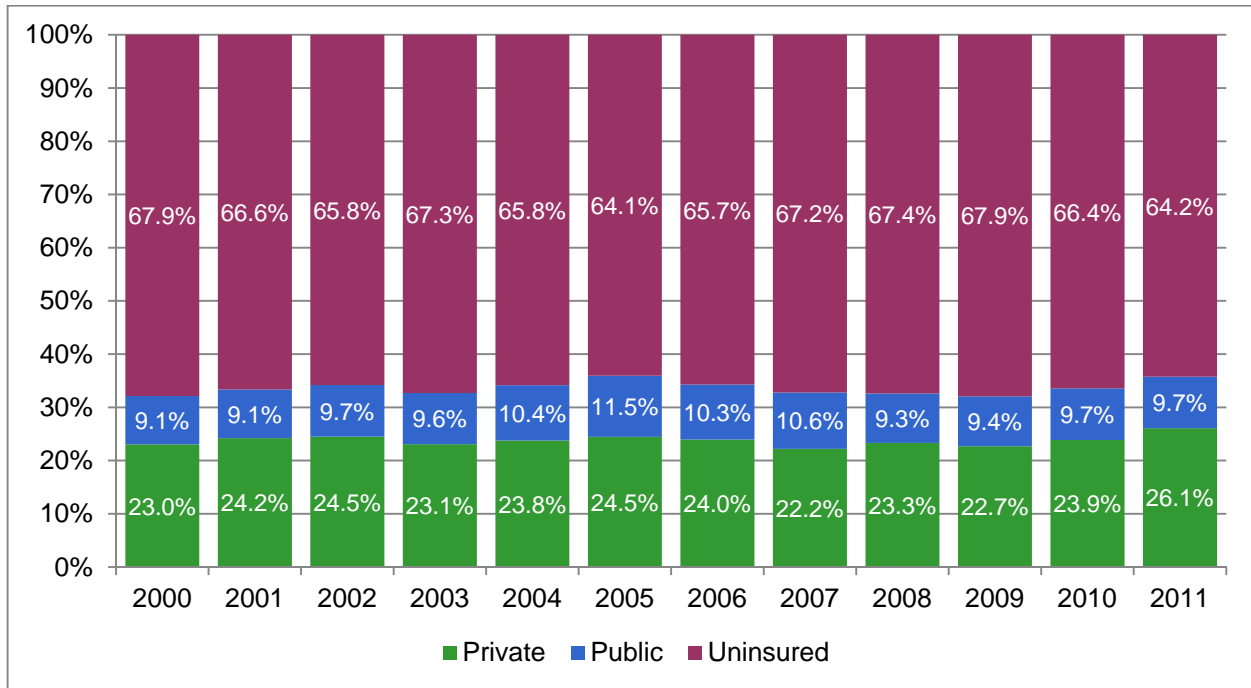
Source: Medical Expenditure Panel Survey, AHRQ. **Notes:** All changes are significant at the 1% level (2000-2011).

Figure 2: Source of Dental Benefits, Adults Ages 19 to 64



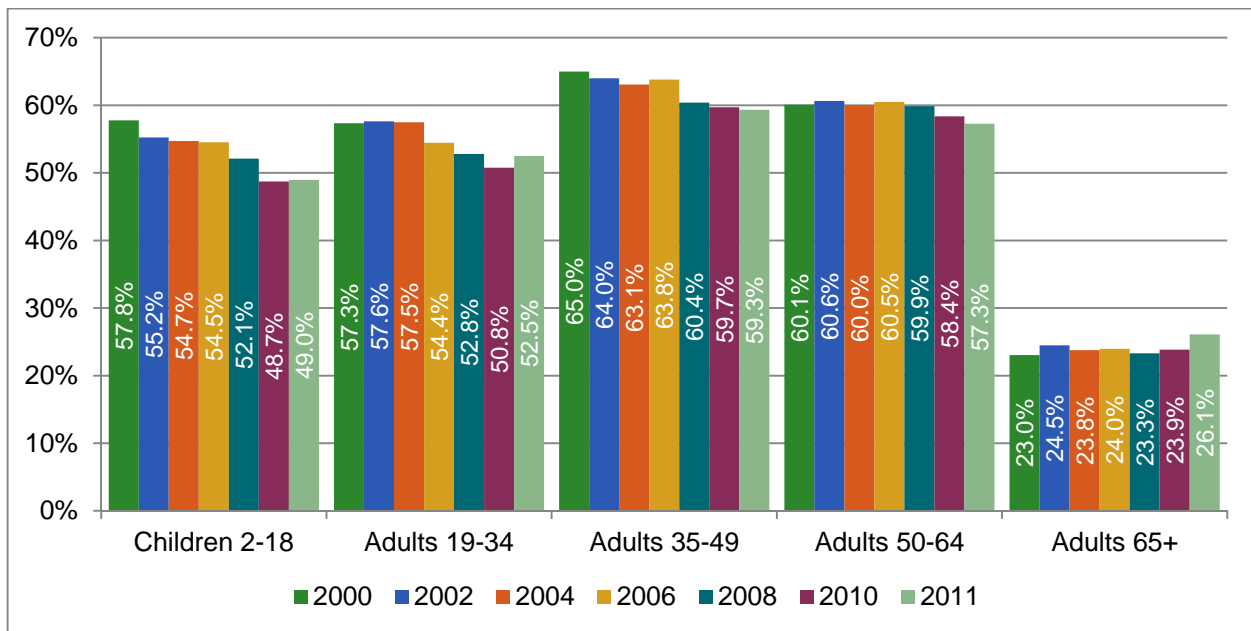
Source: Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes for private and public benefits are significant at the 1% level (2001-2011). Changes for the uninsured are significant at the 5% level (2001-2011).

Figure 3: Source of Dental Benefits, Adults Ages 65 and Over



Source: Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes for private and public benefits are significant at the 1% level (2001-2011). Changes for the uninsured are significant at the 5% level (2001-2011).

Figure 4: Percentage with Private Dental Benefits for Select Age Groups, 2000-2011



Source: Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes for children 2-18 significant at the 1% level (2000-2011). Changes for adults 19-34 and adults 35-49 are significant at the 1% level (2000-2011). Changes for adults 50-64 are significant at the 5% level (2002-2011). Changes are significant for adults 65 and over at the 5% level (2000-2011). Changes for adults 19-34 are significant at the 10% level (2010-2011).

Discussion

The percentage of children without any form of dental benefits continues to fall, due mainly to increased coverage by Medicaid and SCHIP. This trend suggests that the public safety net has been resilient to external factors, such as the recession of 2007-2009, and the decade-long expansion of public dental benefits coverage for children is continuing.

Among non-elderly adults, the percentage with private dental benefits continues to fall, a trend that emerged well before the recent economic downturn. However, a key exception is a noticeable uptick in the percentage of young-adults ages 19 to 34 with private dental benefits from 2010 to 2011, a development we believe we are the first to have uncovered. In 2010, the ACA mandated that children could stay on their parents' health insurance policy until their 26th birthday.¹⁵ This provision does not apply to dental benefits. However, previous research has shown that 95 percent of those with private dental benefits receive them through an employer¹⁶ and the majority of firms that offer health insurance also provide private dental benefits.¹⁷ These early trends suggest that there may be some spillover effects from the increase in dependent health insurance coverage into private dental benefits coverage. Additional research is needed to investigate

this further. Research has already shown that through 2011, the ACA had helped young adults ages 19 to 25 gain health insurance coverage.¹⁸

There was also an uptick in the percentage of elderly adults with private dental benefits from 2010 to 2011. In separate analyses, we show that dental care utilization rose from 2010 to 2011¹⁹ and that per-patient dental expenditures rose significantly from 2000 to 2010 for this age cohort.²⁰ Among the elderly, these trends suggest that demand for dental services is increasing.

Looking forward, the ACA is likely to have a limited impact on adult dental benefits, although the law does expand benefits for children.²¹ Fortunately, states still have the opportunity to expand dental benefits for adults either through Medicaid or their health insurance exchanges policies.²² Policy initiatives led by the states, such as increases in dental reimbursement,²³ streamlined administrative processes,²⁴ patient outreach, oral health literacy campaigns, or expansion of Medicaid dental benefits^{25 26 27} are viable strategies to increase access to dental benefits and dental care for adults.

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