

Research Brief

Dental Benefits Coverage Increased for Working-Age Adults in 2014

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Key Messages

- *From 2013 to 2014, the percentage of working-age adults lacking dental benefits dropped and the percentage with private dental benefits coverage increased.*
- *The percentage of children lacking dental benefits continued to fall in 2014 and is now at its lowest level since 1999, the first year that data became available.*
- *It is still too early to tell whether increases in dental benefits coverage will boost dental care utilization, particularly among working-age adults.*

Introduction

Dental benefits are an important driver of dental care use. An individual with private dental benefits is twice as likely to visit a dentist compared to a person without any benefits.¹ Studies have shown that expansions in adult Medicaid dental coverage increase utilization^{2,3} and that the capacity exists within dental offices to treat additional patients.⁴ The decline in private dental benefits coverage has been strongly associated with a drop in dental care utilization, particularly among working-age adults.⁵ Conversely, dental care utilization among children and the elderly increased over the past decade. As of 2014, utilization of dental care among the elderly is at its highest level since the Medical Expenditure Panel Survey (MEPS) began measurement in 1996.⁶ Increased dental care utilization among children has been primarily driven by the expansion of dental benefits in Medicaid and the Children's Health Insurance Program (CHIP).⁷ As of 2013, the percentage of children lacking dental benefits was at its lowest rate since the MEPS began tracking dental insurance coverage in 1999.⁸

There is evidence that the Affordable Care Act (ACA) is having an impact on the uptake of private dental benefits, particularly among young adults. Although the ACA did not mandate that young adults under age 26 could stay on their parents' private dental insurance policies,

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there is evidence that the dependent coverage policy had a “spillover effect” on the uptake of dental benefits. Through 2013, private dental benefits coverage and dental care use increased among young adults.⁹⁻¹¹ There is also evidence that more individuals are purchasing dental benefits in the federally-facilitated marketplace (FFM). In 2016, the take-up rate of stand-alone dental plans in the FFM was at 15.1 percent and 13.2 percent among adults and children respectively. Approximately 1.3 million adults and 114,037 children selected a stand-alone dental plan in the FFM in 2016.¹² More broadly, through the health insurance marketplaces and Medicaid expansion, the ACA has the potential to alter the dental benefits landscape for adults and children.

In this research brief, we update previous research¹³ and analyze trends in dental benefits through 2014 using newly released data.

Results

In Figure 1, we break down the source of children’s dental benefits by year for 2000-2014. The percentage of children with private dental benefits held steady from 2013 (49.8 percent) to 2014 (50.3 percent). The uninsured rate among children decreased from 12.2 percent in 2013 to 11.0 percent in 2014, the lowest level since the MEPS began tracking dental insurance coverage in 1999.¹⁴ This change was statistically significant at the 10 percent level. The percentage of children with public dental benefits also held steady from 2013 (38.0 percent) to 2014 (38.7 percent). The overall change in the percentage of children with private dental benefits, public benefits or no dental benefits from 2000 through 2014 was statistically significant at the 1 percent level.

Among working-age adults (Figure 2), the percentage with private dental benefits increased from 56.2 percent in 2013 to 58.1 percent in 2014. The uninsured

rate among working-age adults fell from 33.3 percent in 2013 to 29.4 percent in 2014. From 2013 to 2014, the percentage of adults in Medicaid rose from 10.5 percent to 12.5 percent. Using data from the American Community Survey (ACS), we estimate that 53.8 percent of Medicaid-enrolled adults in 2014 lived in a state that provided adult Medicaid dental benefits. Thus, we estimate that in 2014, 6.7 percent of all working-age adults were enrolled in Medicaid programs that provided adult dental benefits. From 2013 to 2014, changes in the percentage of working-age adults with private dental benefits, Medicaid benefits or no benefits were statistically significant at the 1 percent level. All changes from 2000 to 2014 were also statistically significant.

For the elderly, there was little change in the percentage of individuals with private dental benefits, public benefits or no insurance. The percentage with private dental benefits rose from 27.4 percent in 2013 to 27.9 percent in 2014, a statistically insignificant change. However, the overall increase in the percentage of elderly adults with private dental benefits from 2000 (23 percent) to 2014 (27.9 percent) was statistically significant at the 1 percent level (Figure 3).

In Figure 4, we examine the percentage of the population with private dental benefits for narrower age groups. From 2013 to 2014, the percentage of adults ages 19-25 with private dental benefits held steady from 2013 to 2014. The percentage of adults ages 26-34 with private dental benefits increased from 52.5 percent in 2013 to 55.0 percent in 2014, a change that was statistically significant at the 10 percent level. The percentage of adults ages 35-49 with private dental benefits increased from 59.1 percent in 2013 to 61.5 percent in 2014, a change that was statistically significant at the 5 percent level. Among adults ages 50-64, the percentage with private dental benefits also increased from 2013 (57.2 percent) to 2014 (59.4

percent), a change that was also statistically significant at the 5 percent level.

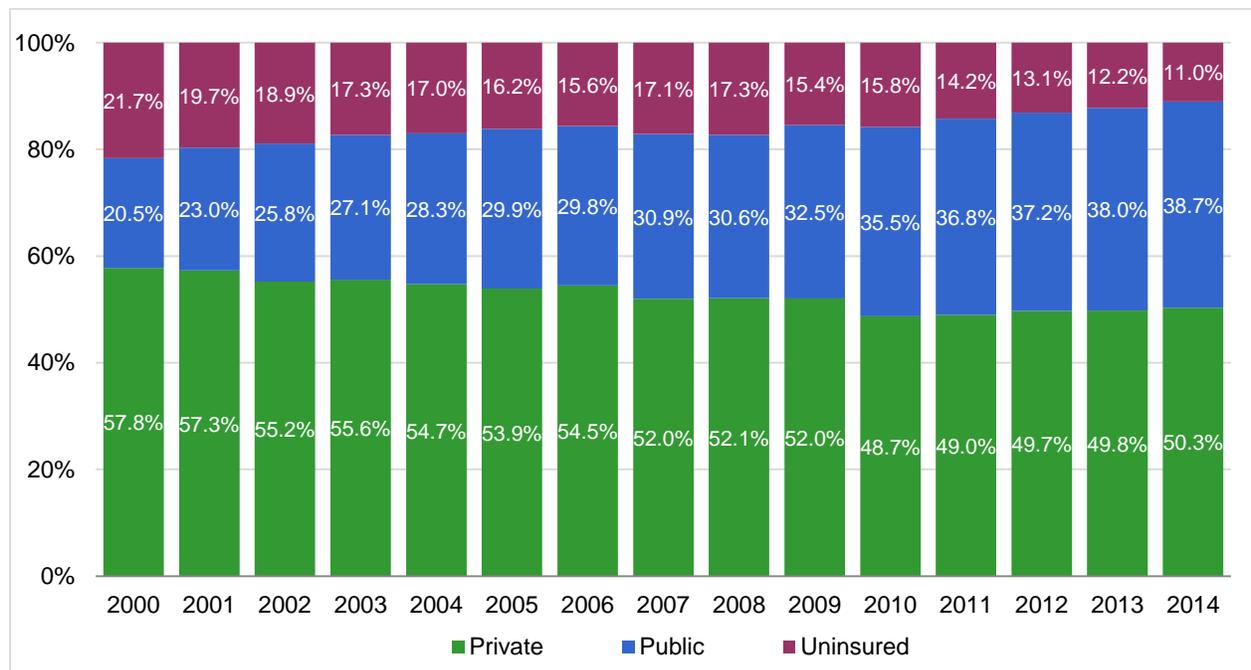
Discussion

In 2014, working-age adults made gains in dental benefits coverage. Compared to 2013, a higher percentage of working-age adults, particularly adults ages 35 to 64, had private dental benefits. In addition, we estimate that 6.7 percent of working-age adults had dental benefits through Medicaid in 2014. These 2014 trends could be a result of the Affordable Care Act, namely the Medicaid expansion provision as well as the establishment of health insurance marketplaces where adults can purchase dental benefits. Since most adults with private dental benefits obtain them through their employer, economic trends could also play a role.

The percentage of children without any form of dental benefits continued to fall in 2014 and is now at its lowest level since the MEPS began tracking dental insurance coverage in 1999. There was also a slight uptick in the percentage of elderly adults with private dental benefits in 2014, although this change was not statistically significant.

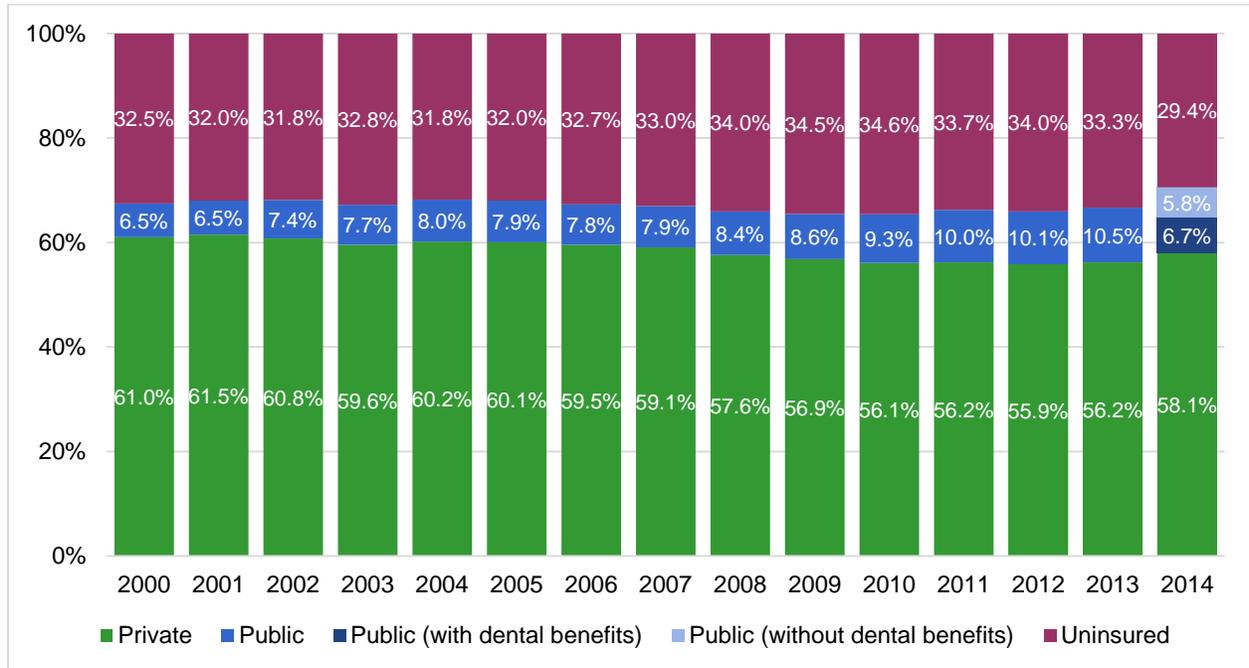
As we show in a companion analysis, there were no significant changes in the percentage of children, working-age adults or elderly adults with a dental visit in 2014. Although not statistically significant, there was a 2.5 percentage point increase in the share of low-income working-age adults who visited the dentist.⁶ Financial barriers to dental care are also falling among poor adults.¹⁵ However, we will need additional years of data to determine whether the ACA, and Medicaid expansion in particular, are having a lasting impact on access to dental care, particularly among the poor.

Figure 1: Source of Dental Benefits, Children Ages 2-18, 2000-2014



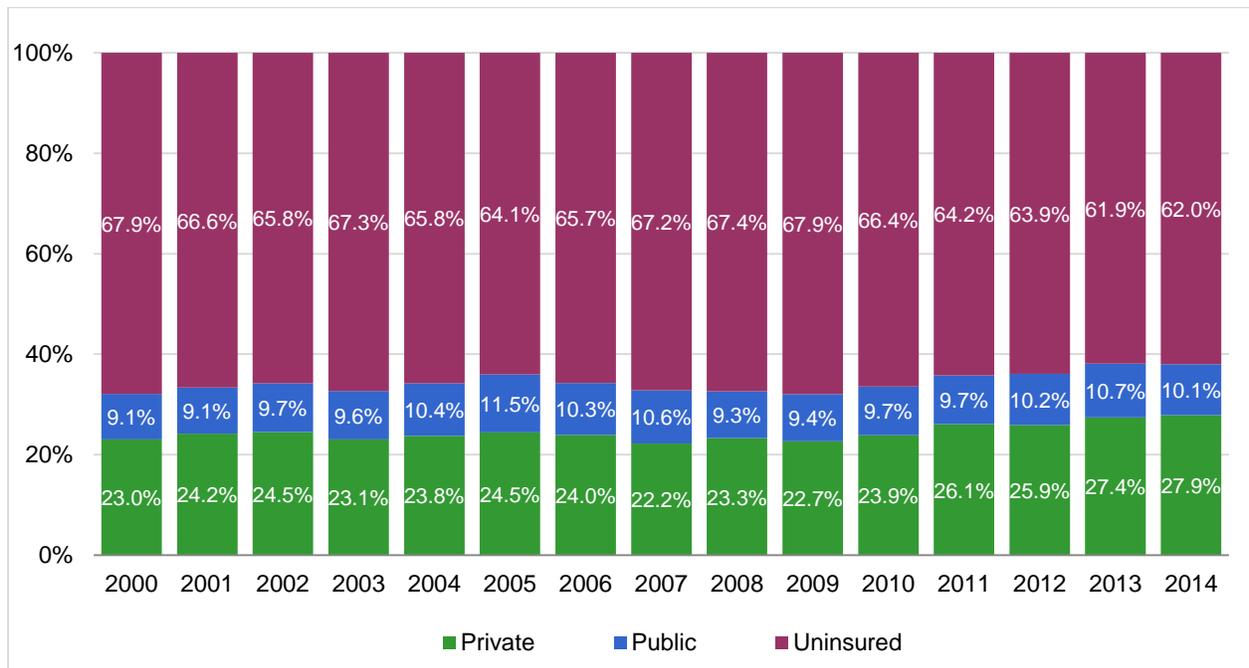
Source: Health Policy Institute analysis of the Medical Expenditure Panel Survey, AHRQ. **Notes:** All changes were significant at the 1% level (2000-2014). The change in uninsured from 2013 to 2014 was statistically significant at the 10% level.

Figure 2: Source of Dental Benefits, Adults Ages 19-64, 2000-2014



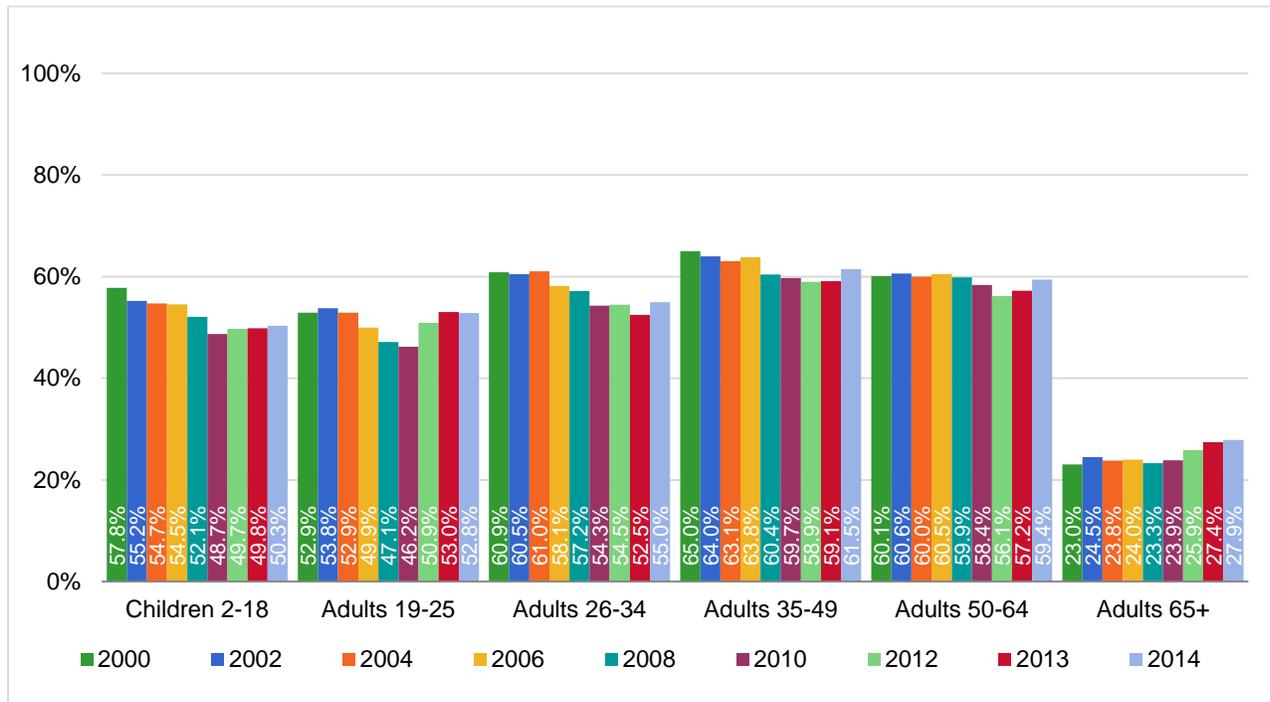
Source: Health Policy Institute Analysis of the Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes for public and uninsured were significant at the 1% level (2000-2014). Changes for private were significant at the 5% level (2000-2014). All changes from 2013 to 2014 were statistically significant at the 1% level.

Figure 3: Source of Dental Benefits, Adults Ages 65 and Older, 2000-2014



Source: Health Policy Institute analysis of the Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes in private and uninsured were significant at the 1% level (2000-2014). All changes from 2013 to 2014 were not statistically significant.

Figure 4: Percentage with Private Dental Benefits for Select Age Groups, 2000-2014



Source: Health Policy Institute Analysis of the Medical Expenditure Panel Survey, AHRQ. **Notes:** Changes for children 2-18, adults 26-34 and adults 65 and older were statistically significant at the 1% level (2000-2014). Changes for adults 35-49 were significant at the 5% level (2000-2014). Changes for adults 26-34 from 2013 to 2014 were significant at the 10% level. Changes from 2013 to 2014 for adults 35-49 and adults 50-64 were significant at the 5% level.

Data & Methods

We analyzed data from the Medical Expenditure Panel Survey (MEPS) that is managed by the Agency for Healthcare Research and Quality (AHRQ). The MEPS is a large-scale survey of individuals and families drawn from a nationally representative sample (the “household component”). The MEPS is the most complete source of data on the cost and use of health care and health insurance coverage.¹⁶ We focused on the period 2000 to 2014, the most recent year for which data are available (data for 2014 were released in September 2016). We used data from the MEPS to analyze the source of dental benefits for children (ages 2-18), working-age adults (ages 19-64), 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 CHIP. Because dental services are a mandated benefit within Medicaid and CHIP, all children enrolled in these programs were defined as having public dental benefits. As noted, Medicaid coverage of dental benefits for adults is optional and varies considerably by state. The MEPS does not allow us to identify the state of residence. However, we use the 2014 American Community Survey (ACS) to determine the share of publicly insured working-age adults in 2014 that live in states that provide an adult Medicaid dental benefit.¹⁷ Because Medicare does not provide dental benefits,¹⁸ persons who only had Medicare coverage (and no form of private dental benefits) 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.

This Research Brief was published by the American Dental Association's Health Policy Institute.

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Suggested Citation

Nasseh K, Vujcic M. Dental benefits coverage increased for working-age adults in 2014. Health Policy Institute Research Brief. American Dental Association. October 2016. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_1016_2.pdf.