Dental Benefits to Expand for Children, Likely Decrease for Adults in Coming Years

Authors: Marko Vujicic, Ph.D.; Sarah Goodell, M.A.; Kamyar Nasseh, Ph.D.

Key Messages

- More children had dental benefits in 2010 than in 2001. This gain was primarily due to Medicaid and SCHIP, which mandate dental benefits for children.
- By contrast, more adults went without dental benefits in 2010 than did in 2001. Although more adults had Medicaid over that period, adult dental benefits within Medicaid programs, on average, eroded during the 2000s.
- Looking forward, a combination of factors, including the Affordable Care Act, will lead to an increase in dental benefits coverage for children. However, there will likely be continued erosion of dental benefits for many groups of adults.

Introduction

Dental benefits are an important enabler of access to dental care, financial protection of patients, and ultimately oral health. People with private dental benefits are more than twice as likely to have an annual dental exam than those without benefits. Emerging evidence indicates that many segments of the U.S. population are increasingly experiencing financial barriers to dental care and oral health. Since the early 2000s, the percent of adults, particularly low-income adults, who visit the dentist has been steadily declining. By contrast, utilization of dental care among children has increased, driven primarily by increased visits by low-income children, many of whom have access to dental benefits through public insurance.

The dental landscape is clearly changing. A convergence of demographic, economic, and fiscal forces are bringing long-term shifts in dental care delivery and financing. A key part of
this challenging landscape is the implementation of the Affordable Care Act (ACA) with its ‘triple aim’ of improving the health of the population, enhancing the patient experience of care (including quality, access, and reliability) and reducing, or at least controlling, the cost of care.\textsuperscript{5}

Dental benefits in public programs vary considerably by state and population. While dental benefits are a required benefit for children under both Medicaid and the State Children’s Health Insurance Program (SCHIP), dental benefits for adults are optional. In 2011, only 12 states provided full dental benefits, defined as preventative, diagnostic, and restorative services as well as extraction. A few more, 16 states, provided a more limited dental benefit. The remaining 22 states covered only emergency dental services or offered no dental benefit at all to adults.\textsuperscript{6} Recent media reports show that more states are eliminating dental benefits to adults in effort to control burgeoning Medicaid budgets.\textsuperscript{7} In addition, while nearly every person over the age of 65 has Medicare for health insurance, Medicare does not provide dental benefits.

There are several aspects of the Affordable Care Act that have implications for dental benefits. First, the ACA provides the option for states to expand Medicaid for adults up to 138 percent of the federal poverty level ($15,415 for individuals in 2012). As of March, 27 states have indicated support for an expansion\textsuperscript{8} and more states are likely to support it now that the Department of Health and Human Services (HHS) has allowed states to expand Medicaid through private insurance.\textsuperscript{9} As noted, however, not all adults will gain dental benefits even if they gain Medicaid coverage. Secondly, the ACA creates health insurance exchanges to facilitate the purchase of insurance for people with incomes too high to qualify for Medicaid but without access to affordable insurance through an employer. The exchanges will be operated by either states or the federal government. Federal subsidies are available for those between 138 and 400 percent of poverty who purchase insurance through an exchange. Stand-alone dental benefit plans can be offered through exchanges. Third, the ACA creates an essential health benefits package, which includes pediatric but not adult dental services. All plans on the individual and small employer market, both inside and outside the exchange, must include the essential health benefits, with the caveat that within the exchange, the pediatric dental benefit could be stand alone and need not be part of a medical plan. Finally, the ACA requires employers to allow young adults up to age 26 to remain on their parents’ plans. This requirement does not apply to stand-alone dental plans, the most common arrangement, but it would apply to dental benefits if they are offered as part of a medical plan\textsuperscript{10}.

In this research brief we examine patterns of dental benefits for adults and children and review important shifts that have happened since the early 2000s. We highlight areas in which the ACA could potentially affect the provision of dental benefits. Finally, we review the best available evidence related to how key purchasers of dental benefits could adjust their behavior in the coming years in response to the Affordable Care Act.

**Data & Methods**

We analyzed data from the Medical Expenditure Panel Survey (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.\textsuperscript{11} We focused on the period 2000 to 2010, the most recent year for which data are available. We used data from the MEPS to analyze the source of dental benefits for children (2-18 years old), adults (19-64 years old) and the elderly (ages 65+).
We classified dental benefits into two categories: public and private. Public dental 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 states of residence, however. So even for adults considered to have public coverage in our analysis, the majority will not have dental benefits. Because Medicare does not provide dental benefits, persons who only had Medicare were considered uninsured for dental care.

For insight into attitudes, preferences, and future behavior of key purchasers of dental benefits we undertook a literature review. We reviewed studies published in both the peer-reviewed and grey literature that relate to employer, government, and individual attitudes and behaviors toward dental benefits. We were particularly interested in studies that were forward looking and focus on the ACA. Published studies also, in many cases, provided important data on key variables in our analysis.

Results

In 2001, 57.3% of children were covered by private dental benefits, 23% by Medicaid and 19.6% had no dental benefits (Figure 1). By 2010, the percent of children with private dental benefits had fallen to 48.8%, but that decline was offset by a significant increase in Medicaid coverage. As a result, fewer children went without dental benefits in 2010 compared with 2001.

By contrast, fewer non-elderly adults had dental benefits in 2010 than in 2001. In 2001, 61.7% of non-elderly adults reported having private dental benefits, 6.5% reported being enrolled in Medicaid programs and 31.8% reported having no dental benefits. In 2010, the percent of adults with private dental benefits dropped to 56.4%. A larger share of adults reported having no dental benefits and being enrolled in Medicaid programs (Figure 2). Even though more adults were enrolled in Medicaid in 2010 than in 2001, because states have scaled back adult dental benefits over the last decade, it is unlikely that the increase in Medicaid enrollment has resulted in a significant increase in dental benefits. At any rate, the percent of non-elderly adults without any dental benefits increased in from 31.8% to 34.3%.

The decline in private dental benefits rates among adults is not uniform by age (Figure 3). By far, the most significant declines over time have been among younger adults (19-34 year olds), who across all years had the lowest levels of private dental benefits. For those ages 50-64, there has been very little decline in the percent with private dental benefits.

For the elderly, dental benefit levels have remained steady, but very low (Figure 4). In 2010, nearly two out of every three people over the age of 65 did not have dental benefits. This is largely unchanged from 2001.

Turning to the future, the pediatric dental benefits mandate in the ACA is expected to increase the number of children who have dental benefits in 2018 by about 8.7 million or 15% compared to 2010. This is through a combination of expanded Medicaid, purchases of private dental benefits in the exchanges, and children gaining private dental benefits through employer-sponsored insurance of their parents. Medicaid expansion is expected to increase the number of adults who have extensive dental benefits by only about 4.5 million by 2018, and that is assuming states make no changes to their policies.

Because adult dental benefits are not part of the essential health benefits requirement, future dental benefit patterns will depend on how purchasing
behavior evolves among three key groups: employers, individuals, and state governments.

Employer-sponsored dental benefits are closely linked with employment and the offer of medical insurance. Ninety-five percent of those with private dental benefits receive them through an employer and the majority of firms that offer health insurance also offer a stand-alone dental plan.15

Several studies and the Congressional Budget Office estimate that firms employing the majority of workers will continue to have an economic incentive to offer health benefits post-ACA.16 Employer premium contributions remain tax exempt and large employers that do not offer affordable insurance will pay a financial penalty. As a result, the financial incentive to provide health insurance to employees is strong. While offers of health insurance are nearly universal for firms with more than 200 employees, only about 60% of firms with fewer than 200 employees offered health insurance in 2012.17 Furthermore, the ACA exempts employers with fewer than 50 fulltime workers from the mandate to offer health insurance. While small employers are eligible for tax credits, most experts predict the credit will not have a significant impact of offers of health insurance.18 In addition, it may be more feasible for employers with low-wage workers to pay the penalty and have their employees purchase coverage in an exchange, rather than provide health insurance.19

Employers’ offers of dental benefits differ by firm size, much like offers of health insurance. Of firms with 200 or more workers that offer health insurance, 89% offer a stand-alone dental benefit. By contrast, in firms that offer health insurance and have fewer than 200 workers, only about half offer dental benefits.20

Researchers have not looked at dental benefits when modeling potential changes to employee benefits. We could find very little credible evidence on employers’ decisions regarding dental benefits post-ACA.

The studies we reviewed emphasize that employer behavior regarding health insurance following the implementation of the ACA is subject to a high degree of uncertainty. As a result, it is useful to understand how individuals might react if employer-sponsored dental benefit offerings were dropped. A recent survey of households provides some insight.21 When asked whether they would purchase dental benefits if their employer stopped providing them, about half of respondents would be ‘likely’ or ‘very likely’ to buy coverage. Most, however, indicated they would purchase a lower-priced, preventative care plan.

A third key purchaser of dental benefits is the state government through its policy on adult dental benefits in Medicaid. The past decade has seen an overall erosion of adult dental benefits within Medicaid programs.22 A recent survey of state Medicaid budget officers found that nine states reduced or intended to reduce dental benefits in the next year compared with four states that planned to expand dental benefits.23 Clearly, state governments do not appear to be expanding adult dental benefits within Medicaid programs.
**Figure 1:** Source of Dental Benefits, Children Ages 2-18

![Bar chart showing the source of dental benefits for children ages 2-18 from 2001 to 2010. The chart shows that private dental benefits increased from 57.3% in 2001 to 48.8% in 2010, while public dental benefits decreased from 23.0% to 35.5%.

**Source:** Medical Expenditure Panel Survey, AHRQ. **Note:** All differences significant at the 5% level.

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

![Bar chart showing the source of dental benefits for adults ages 19-64 from 2001 to 2010. The chart shows that private dental benefits increased from 61.7% in 2001 to 56.4% in 2010, while public dental benefits decreased from 31.8% to 9.3%.

**Source:** Medical Expenditure Panel Survey, AHRQ. **Note:** All differences significant at the 5% level.
**Figure 3:** Percent with Private Dental Benefits for Select Age Groups, 2000-2010

![Bar chart showing the percentage of private dental benefits for select age groups from 2000 to 2010.]

**Source:** Medical Expenditure Panel Survey, AHRQ. **Note:** Differences from 2000-2010 significant at the 5% level for 19-34 and 35-49 age groups.

**Figure 4:** Source of Dental Benefits, Adults Ages 65+

![Bar chart showing the source of dental benefits for adults ages 65+ from 2001 to 2010.]

**Source:** Medical Expenditure Panel Survey, AHRQ. **Note:** Differences from 2001 to 2010 are not statistically significant.
Discussion

A full analysis of the reasons behind the decline in private dental benefits among adults is beyond the scope of this research brief. However, the vast majority of adults with private dental benefits obtain them through their employer. While offers of dental benefits by employers have been relatively stable over the last several years, it is likely employers are passing more of the cost on to employees, similar to what is happening with health insurance premiums. This may result in fewer employees enrolling in an available plan. The decline in the percent of adults with private dental benefits began prior to the recent economic downturn, and it suggests that more than just cyclical factors are at play.

There are many simulation studies modeling how employers might respond to the mandates and trade-offs in the ACA when it comes to health insurance, but similar models for dental benefits do not exist. However, if employers make comparable decisions for dental benefits as they do for health insurance, it is likely that the greatest declines will be among small employers and employers with low wage workers. Given that these firms are less likely to offer dental benefits in the first place, it is unlikely that the ACA itself will have a significant impact on overall levels of employer-sponsored dental benefits.

While the individual market has not historically been a large source of dental benefits, accounting for only 4% of the market, health insurance exchanges could change that, but this remains highly uncertain. One goal of the exchanges is to make the buying process easier for consumers. While the ACA does not change the incentives for adults to purchase dental benefits, if stand-alone dental plans are offered in exchanges, adults may still voluntarily purchase them.

A complication could arise if pediatric-only dental benefit products expand significantly. If pediatric dental benefits are provided mainly through stand-alone plans within the exchanges and if these stand-alone dental plan products cover only children, parents may forgo dental benefits for themselves and purchase coverage only for their children. Moreover, the purchase of pediatric dental benefits is not mandated. As a result, if dental care is integrated into medical plans, this is likely to increase the purchase of pediatric dental benefits in the exchanges compared to if dental benefits are stand alone and separate from medical plans. The best way to ensure that all members of the family have dental benefits is by linking them in the purchase of a family policy.

Regarding children, surprisingly, the final rule on essential health benefits weakened the requirement for dental benefits. In this rule, HHS clarified that a qualified health plan in the exchange is not required to include the pediatric dental benefit if a stand-alone dental plan providing those benefits is available. Further, in such cases, individuals are permitted to purchase the health plan only and are not required to purchase the stand-alone dental plan. Outside of the exchange, health plans do not have to provide pediatric dental benefits if an issuer is “reasonably assured” that an individual has obtained that coverage through a stand-alone dental benefit certified by the exchange. As a result, the current estimate of 8.7 million children expected to gain dental benefits may be inflated.

The ACA does not provide strong incentives for states to change their adult dental benefits in Medicaid from current levels. In other words, states are incentivized to ‘lock in’ to their existing policy. For those states that already provide some level of adult dental benefit, the federal government will fully fund the expenditure associated for the expansion population for the first
Research Brief

Three years. Recently, a further complication was introduced, however, when it was clarified that the federal funding of benefits for the expansion population will not necessarily be based on pre-ACA state Medicaid benefits but some benchmark. At the time of writing, there is still some uncertainty over this potential ‘two-tier’ funding arrangement for existing Medicaid beneficiaries and the expansion population. Beyond 2017, the federal government contribution gradually falls to 90%, which is still a very high level.\textsuperscript{28} In other words, even though adult dental benefits are not mandated by the ACA, if states already provide the benefit to adults in Medicaid, the additional fiscal burden of maintaining the benefit is likely to be minimal.

States that do not currently provide any adult dental benefits in Medicaid will face very weak financial incentives to add them. If these states add adult dental benefits, they would have to provide that benefit to either the same or larger number of Medicaid enrollees (depending on whether the state expands eligibility). The financing arrangement would remain as it is pre-ACA and will depend on the existing federal match rate level (between 50% and 73% depending on the state’s per capita income). But if pressure on Medicaid budgets continues to grow in the coming years, as many analysts believe it will, states are unlikely to add optional benefits, such as adult dental benefits.

Our analysis sheds light on several important shifts in adult dental benefits that have been occurring in recent years. These include a steady decline in the percent of adults with private dental benefits, an increase in the percent of adults with no dental benefits, and a general erosion of adult dental benefits in Medicaid programs. Based on the limited data available, we feel that the ACA will not accelerate these trends, but more importantly, it will not reverse them either. This ‘missed opportunity’ could have very negative consequences on oral health, as dental benefits – particularly for vulnerable groups – are such a key driver of dental care utilization. The ACA does expand dental benefits for children, and this is positive. But significant challenges will remain in ensuring that all adults, particularly low-income adults and the elderly have access to dental benefits and, ultimately, improved oral health.
References


13 Ibid


17 KFF & HRET, 2012.

18 Avalere, 2011.

19 Avalere, 2011.


Suggested Citation