Dental Benefits Expanded for Children, Young Adults in 2012

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Key Messages

- More children had dental benefits in 2012 than in 2011. The increase represents a continuation of more than a decade-long trend. The percentage of children lacking dental benefits is at its lowest rate since the Medical Expenditure Panel Survey began tracking dental insurance coverage in 1999.

- Among adults, 2012 did not bring any major changes in dental benefits patterns except for a noticeable increase in private dental benefits coverage for adults ages 19-25.

- The Affordable Care Act has the potential to alter dental benefits coverage patterns among the U.S. population.

Introduction

Dental benefits are a crucial factor enabling access to dental care. People with private dental benefits are more than twice as likely to have an annual dental exam compared to those without any benefits.\(^1\) Expanded Medicaid dental benefits also increase dental care use.\(^2\) Dental benefits coverage for adults has been declining and this trend has been strongly associated with the decrease in in dental care utilization among working-age adults over the past decade.\(^3\) By contrast, utilization of dental care among children has been increasing, driven primarily by gains among low-income children\(^4\) which, in turn, resulted from the expansion of Medicaid and the Children’s Health Insurance Program (CHIP).\(^5\) The divergent trend in access to dental care between adults and children is driven, in part, by the “tale of two safety nets.”\(^6\) Adult dental benefits within Medicaid are optional for states, while for children, they are mandatory in both Medicaid and CHIP.\(^7\) From 2000 through 2011, the percentage of individuals with private dental benefits declined\(^8\) and many states eliminated adult dental benefits in state Medicaid programs.\(^9\)

In this research brief, we update previous research\(^10\) and analyze trends in dental benefits through 2012 using newly released data.
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.11 We focused on the period 2000 to 2012, the most recent year for which data are available (data for 2012 were released in September 2014). 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 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,12 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

Among children, dental benefits patterns continue to change (Figure 1). In 2011, 49 percent of children had private dental benefits, 36.8 percent had public benefits (Medicaid and CHIP) and 14.2 percent had no dental benefits. By 2012, the percentage of children with private dental benefits rose slightly to 49.7 percent, while the percentage with public benefits increased to 37.2 percent. The uninsured rate dropped to 13.1 percent, the lowest level since 1999 when the MEPS began tracking dental insurance coverage.13 The changes from 2011 to 2012 were not statistically significant. However, the overall change in the percentage of children with private dental benefits, public benefits or no dental benefits from 2000 through 2012 was statistically significant.

Among working-age adults, dental insurance patterns did not change substantially between 2011 and 2012. The percentage with private dental benefits dropped from 56.2 percent in 2011 to 55.9 percent in 2012, a statistically insignificant change. From 2011 to 2012, the percentage of working-age adults with public benefits rose from 10 percent to 10.1 percent, and the uninsured rate rose from 33.7 percent to 34 percent, changes that were also statistically insignificant (Figure 2). However, the changes between 2000 and 2012 were statistically significant. Again, we emphasize that for adults with public insurance we are not able to identify the actual level of dental benefits (e.g., emergency only, limited, extensive). Thus, some portion of adults classified as having “public” coverage in Figure 2 will have no dental benefits and some will have extensive dental benefits.

From 2011 through 2012, there was a slight decline in the percentage of the elderly with private dental benefits, from 26.1 percent to 25.9 percent. The overall change in the percentage of elderly adults with private dental benefits from 2000 (23 percent) to 2012
(25.9 percent) was statistically significant at the 10 percent level (p-value=0.052) (Figure 3).

In Figure 4, we examine the percentage of the population with private dental benefits for narrower age groups. There was a slight uptick from 2011 through 2012 in the percentage of children and adults ages 19-25 and 26-34 with private dental benefits. In contrast, the percentage of adults ages 35-49 and 50-64 with private dental benefits declined slightly from 2011 through 2012. None of these changes, however, were statistically significant. It is interesting to note that the percentage of adults ages 19-25 with private dental benefits increased from 46.2 percent in 2010 to 50.9 percent in 2012, a statistically significant change. No other age group experienced an increase in private dental benefits coverage from 2010 through 2012.

**Figure 1:** Source of Dental Benefits, Children Ages 2-18, 2000-2012

![Figure 1: Source of Dental Benefits, Children Ages 2-18, 2000-2012](image)

*Source:* Medical Expenditure Panel Survey, AHRQ

*Notes: All changes were significant at the 1% level (2000-2012). Changes from 2011 to 2012 were not statistically significant.*
Figure 2: Source of Dental Benefits, Adults Ages 19-64, 2000-2012

Source: Medical Expenditure Panel Survey, AHRQ
Notes: Changes for private and public benefits were significant at the 1% level (2000-2012). Changes for the uninsured were significant at the 5% level (2001-2012). Changes from 2011 to 2012 were not statistically significant.

Figure 3: Source of Dental Benefits, Adults Ages 65 and Older, 2000-2012

Source: Medical Expenditure Panel Survey, AHRQ
Notes: Changes for private dental benefits were significant at the 10% level (2000-2012). Changes for the uninsured were significant at the 5% level (2000-2012). Changes from 2011 to 2012 were not statistically significant.
Discussion

Generally, 2012 did not bring any major changes in current dental benefits trends. The percentage of children without any form of dental benefits continued to fall in 2012 and is now at its lowest level since the MEPS began tracking dental insurance coverage in 1999. Among both working-age adults and the elderly, there were no major changes in dental benefits patterns.

An important exception, however, is the significant change in dental benefits coverage among young adults. There has been a noticeable increase from 2010 through 2012 in the percentage of young adults ages 19-25 with private dental benefits, a reversal of the downward trend that existed from 2000 through 2010. Recent research we carried out using data from the National Health Interview Survey (NHIS) has shown that this increase in dental benefits coverage among young adults is due to the Affordable Care Act (ACA). In 2010, the ACA allowed children to stay on their parents’ health insurance policy until their 26th birthday. While this provision does not apply directly to dental benefits, our analysis indicated that firms voluntarily extended dental benefits coverage creating a ‘spillover’ effect.

Looking forward, dental benefits coverage patterns are poised for significant change. Up to 9 million more children could gain dental benefits through Medicaid, employer-sponsored insurance or the health insurance marketplaces through the ACA. Up to eight million adults could gain dental benefits through Medicaid as a result of the Medicaid expansion. As of April 19, 2014, at least 1,073,248 adults and 88,101 children signed up for private dental benefits in the 36 states operating in the federally facilitated health insurance marketplace and California. The dental benefits take-
-up rate is highest among young adults aged 26-34, with roughly one out of four obtaining private dental insurance. Among children, the take-up rate is 20.1 percent, although this is likely to be a significant underestimate given that the data do not include dental benefits obtained through medical insurance plans.¹⁹

On the Medicaid side, simply expanding dental benefits for low-income adults and children will not guarantee access to necessary dental care. Without proper enabling conditions, Medicaid and CHIP beneficiaries will likely experience challenges obtaining dental care.²⁰ Low reimbursement rates, poor patient outreach and burdensome administrative processes are some of the challenges within Medicaid programs.²¹,²²,²³ Evidence shows that these challenges can be overcome. For example,

Connecticut,²⁴ Maryland,²⁵,²⁶ and Texas²⁷ increased dental provider reimbursement, streamlined administrative processes and improved patient outreach which led to significant increases in access to dental care.²⁸ Recent evidence shows that there is existing capacity within the dental care system²⁹ and that this capacity can be leveraged to expand the dental care safety net in the face of Medicaid expansion³⁰. In 2006, Massachusetts restored adult dental benefits through its Medicaid program that were previously cut in 2002 and expanded dental benefits through its state health insurance exchange for adults below the poverty line.³¹ States ought to consider evidence-based policy initiatives to increase dental benefits coverage and access to dental care in the coming years.
References


Suggested Citation