Dental Benefits Coverage Rates Increased for Children and Young Adults in 2013

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Key Messages

- More children had dental benefits in 2013 than in 2012, a continuation of a trend that began in 2000. 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.
- The percentage of young adults ages 19-25 with private dental benefits continued to increase in 2013, a trend that began in 2010 and is partly a result of the Affordable Care Act.
- The Affordable Care Act has the potential to alter dental benefits coverage patterns. The next release of the Medical Expenditure Panel Survey will provide important insights.

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 utilization2,3 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 Also, over the last decade, many states dropped adult dental benefits from their Medicaid programs,6 which widened the gap in dental care use between poor and non-poor adults in many states.7 Conversely, utilization of dental care among children is at its highest level since the Medical Expenditure Panel Survey (MEPS) began measurement in 1996.8 Increased dental care utilization among children has been driven primarily by the expansion of dental benefits in Medicaid and the Children’s Health Insurance Program (CHIP).9 As of 2012, the percentage of children lacking dental benefits was at its lowest rate since MEPS began tracking dental insurance coverage in 1999.10
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 up to age 26 could stay on their parents’ private dental insurance policies, there is evidence that the dependent coverage policy had a spillover effect on the uptake of dental benefits. Through 2012, private dental benefits coverage and dental care use increased among young adults, while financial barriers to dental care decreased. 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 research and analyze trends in dental benefits through 2013 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. We focused on the period 2000 to 2013, the most recent year for which data are available (data for 2013 were released in September 2015). 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 within Medicaid and SCHIP, 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. MEPS does not allow us to identify the state of residence, however. This is a limitation of the data set we use. We are only able to identify if adults are covered by Medicaid. As a result, our analysis of adults allows us to identify those with private dental benefits as well as those that are uninsured for dental care but not those with dental benefits through Medicaid. Because Medicare does not provide dental benefits, 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.

**Results**

In Figure 1, we break down the source of dental benefits by year for children. The percentage of children with private dental benefits held steady from 2012 (49.7 percent) to 2013 (49.8 percent). The uninsured rate among children decreased from 13.1 percent in 2012 to 12.2 percent in 2013, the lowest level since the MEPS began tracking dental insurance coverage in 1999. The percentage of children with public dental benefits also held steady from 2012 (37.2 percent) to 2013 (38.0 percent). Although changes from 2012 to 2013 were not statistically significant, the overall change in the percentage of children with private dental benefits, public benefits or no dental benefits from 2000 through 2013 was statistically significant at the 1 percent level.

Among working-age adults, the percentage that were uninsured, had private dental benefits, or public benefits did not change significantly from 2012 to 2013 (Figure 2). The percentage with private dental benefits
rose slightly from 55.9 percent in 2012 to 56.2 percent in 2013. The uninsured rate among working-age adults fell from 34.0 percent in 2012 to 33.3 percent in 2013. From 2012 to 2013, the percentage of adults in Medicaid rose from 10.1 percent to 10.5 percent. Again, we emphasize that for adults in Medicaid, we are not able to identify their dental benefits status (e.g. none, emergency only, limited, extensive). Some portion of adults classified as having “public” coverage in Figure 2 will have no dental benefits and some will have extensive dental benefits. All changes from 2012 to 2013 for adults were statistically insignificant. However, the changes in the percentage of working-age adults with private dental benefits or public benefits from 2000 to 2013 were statistically significant at the 1 percent level.

For the elderly, the percentage with private dental benefits rose from 25.9 percent in 2012 to 27.4 percent in 2013. This change was not statistically significant. However, the overall increase in the percentage of elderly adults with private dental benefits from 2000 (23 percent) to 2013 (27.4 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 2012 to 2013 the percentage of adults ages 19-25 with private dental benefits rose from 50.9 percent to 53.0 percent, continuing an upward trend that began in 2010. This one-year change was not statistically significant. However, the change from 2010 to 2013 in the percentage of adults ages 19-25 with private dental benefits was statistically significant at the 1 percent level. The percentage of adults ages 26-34 with private dental benefits declined slightly from 54.5 percent in 2012 to 52.5 percent in 2013, a statistically insignificant change. The percentage of adults ages 35-49 and 50-64 with private dental benefits also changed very little from 2012 to 2013.
**Figure 1:** Source of Dental Benefits, Children Ages 2-18, 2000-2013

Source: Health Policy Institute analysis of the Medical Expenditure Panel Survey, AHRQ. Notes: All changes were significant at the 1% level (2000-2013). All changes from 2012 to 2013 were not statistically significant.

**Figure 2:** Source of Dental Benefits, Adults Ages 19-64, 2000-2013

Source: Health Policy Institute Analysis of the Medical Expenditure Panel Survey, AHRQ. Notes: Changes for private and public were significant at the 1% level (2000-2013). All changes from 2012 to 2013 were not statistically significant.
**Figure 3:** Source of Dental Benefits, Adults Ages 65 and Older, 2000-2013

*Source:* Health Policy Institute analysis of the Medical Expenditure Panel Survey, AHRQ. *Notes:* Changes in private and uninsured were significant at the 1% level (2000-2013). Changes in private and public from 2012 to 2013 were not statistically significant. Changes in uninsured from 2012 to 2013 was statistically significant at the 10% level.

**Figure 4:** Percentage with Private Dental Benefits for Select Age Groups, 2000-2013

*Source:* Health Policy Institute Analysis of the Medical Expenditure Panel Survey, AHRQ. *Notes:* Changes for children 2-18, adults 26-34, adults 35-49 and adults 65 and older were statistically significant at the 1% level (2000-2013). The decline from 2000-2010 and the increase from 2010-2013 for adults 19-25 was statistically significant at the 1% level. Changes from 2012 to 2013 were not statistically significant.
Discussion

In 2013, there were no reversals in recent trends in dental benefits coverage. As in 2012, the percentage of children without any form of dental benefits fell in 2013 and is now at its lowest level since the MEPS began tracking dental insurance coverage in 1999. Among working-age adults, there were no major changes in dental benefits patterns. There was an uptick in the percentage of elderly adults with private dental benefits in 2013, although this change was not statistically significant. Continuing a trend that began in 2010, the percentage of young adults with private dental benefits continued to increase in 2013, a development associated with spillover effects from the ACA’s dependent coverage policy.18,19

The 2013 data presented in this brief provide us with a benchmark with which to measure future changes in dental benefits trends associated with the ACA. Recent research has estimated that up to 8.3 million adults gained dental benefits in 2014 in states that expanded Medicaid and have adult Medicaid dental benefits.20

Through April 2014, the take-up rate for stand-alone dental plans in the federally facilitated marketplaces was 15.8 percent for children and 18.8 percent for adults.21 In 2014, financial barriers to dental care declined for working-age adults and the poor,22 suggesting a potential ACA effect.

We plan future research to assess whether dental benefits patterns changed in 2014, whether any change is associated with the ACA, and whether changes in dental benefits coverage translate to improved access to dental care. Expanding dental benefit coverage for low-income adults and children will not guarantee access to dental care. Without proper enabling conditions in place, such as sufficient dental provider participation in Medicaid, low-income individuals will face barriers to dental care.23,24,25 States have the opportunity to implement initiatives through both their health insurance marketplaces and Medicaid that could enhance access to care for both adults and children. This, too, is an area we plan to monitor as the ACA roll out continues.
References


3 Nasseh K, Vujicic M. Health reform in Massachusetts increased adult dental care use, particularly among the poor. Health Aff (Millwood). 2013;32(9):1639-1645


17 In 1999, the uninsured rate among children ages 2-18 was 22 percent. Agency for Healthcare Research and Quality (AHRQ). MEPS HC-038: 1999 Full Year Consolidated Data File. September 2014. Available from:


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