

Medicaid Access in Brief: Adults' Use of Oral Health Services

A majority of adults in the United States experience oral health problems, including cavities, gingivitis, and periodontitis, which can have adverse health effects beyond the mouth (NIDCR 2015, KCMU 2012).¹ Individuals with conditions such as diabetes and respiratory infections, including pneumonia and exacerbated chronic obstructive pulmonary disease, also are more likely than their counterparts without those conditions to develop periodontal diseases (Nycz 2014, Sharma and Shamsuddin 2011, Kuo et al. 2008, Mealey 2006).

Adult Medicaid enrollees visit dentists significantly less than they do doctors or other office-based medical providers (MACPAC 2015). Enrollees with incomes at or below 200 percent of the federal poverty level (FPL) have particularly low use of oral health services (MACPAC 2015). Additionally, between 2000 and 2013, the percentage of adults with a dental visit in the past year decreased regardless of insurance status, and the most pronounced drop was among adults with incomes between 100 and 200 percent FPL (Nasseh and Vujicic 2014).

Medicaid coverage of adult oral health services is a state option. State service offerings range from no oral health services, to emergency services only, to comprehensive coverage of oral health services (MACPAC 2015). Medicaid coverage of adult oral health services can also vary according to the enrollee's basis of eligibility. For example, Medicaid might cover more oral health services for pregnant women and individuals with disabilities than it covers for other Medicaid enrollees. Among privately insured individuals, coverage of adult oral health services also varies widely. Slightly more than half of employers who offer health benefits offer or contribute to a stand-alone dental plan in addition to a health plan (Claxton et al. 2014). Adults who purchase health insurance through the individual or small group market may not have oral health coverage in their insurance plan, so some choose to enroll in a stand-alone dental plan.

This issue brief examines access to oral health services for Medicaid-enrolled adults age 19–64 and compares their access to and use of these services to that of their privately insured and uninsured counterparts.² Using respondent-reported data from the Medical Expenditure Panel Survey (MEPS), we found that Medicaid-enrolled adults at all income levels, regardless of race or ethnicity, were less likely than privately insured adults to have had a dental visit in the past year, but more likely to have had one than uninsured adults.³ In addition, regardless of their source of coverage, adults with incomes above 138 percent FPL were more likely to have had a dental checkup than those with incomes at or below 138 percent FPL. Among individuals with incomes at or below 138 percent FPL, Medicaid beneficiaries were less likely to have had a dental checkup than privately insured adults of the same income level.



Insurance Status

Medicaid-enrolled and uninsured adults reported lower levels of dental insurance coverage and used fewer services than their privately insured counterparts (Table 1). Uninsured adults were more likely to report having dental insurance than Medicaid-enrolled individuals, although we do not know about the amount, scope, and duration of such coverage. In all but two states, Medicaid enrollees have access to emergency oral health care, but MEPS data suggest that enrollees may not perceive such coverage as dental insurance (MACPAC 2015).

TABLE 1. Percentage of Adults Age 19–64 Reporting Dental Coverage and Use, by Insurance Status, 2011–2013

Access measure	Medicaid	Private	Uninsured
Reported having dental insurance	1.3%	74.2%*	3.5%*
Had a dental visit in the past 12 months	24.4	50.2*	16.4*
Those with dental visit who received preventive care	55.8	83.1*	56.2

Notes: Preventive care includes cleanings, prophylaxis, and polishing.

* Difference from Medicaid is statistically significant at the 0.05 level.

Source: MACPAC, 2016, analysis of the Household Component of the Medical Expenditure Panel Survey, 2011–2013.

Income level

Medicaid-enrolled adults were less likely to report having a dental visit in the past 12 months than privately insured adults regardless of income level in 2011–2013 (Table 2). Medicaid-enrolled adults with incomes at or below 138 percent FPL were less likely to have a dental visit in 2011–2013 than Medicaid enrollees with higher incomes. Uninsured adults were less likely to report a visit than Medicaid-enrolled adults, regardless of income level.

Among adults of all income levels, uninsured adults were most likely and privately insured adults were least likely to report being unable to receive necessary oral health care (Table 2). Individuals enrolled in Medicaid reported being unable to obtain necessary oral health care at approximately the same rate whether their household incomes were above or below 138 percent FPL.⁴ In contrast, privately insured and uninsured adults with incomes above 138 percent FPL were more likely to be able to obtain necessary oral health care than their low-income counterparts.

Among all adults who reported not being able to receive necessary dental care, Medicaid-enrolled individuals were less likely than their privately insured and uninsured counterparts to report that they could not afford it, regardless of income level (Table 2). Although other reasons for not being able to receive necessary care, such as not being able to get time off from work and the dentist does not accept the



person's insurance, are reported in the MEPS, we were unable to include them in our analysis because the number of respondents reporting them was too small to be reliable.⁵

TABLE 2. Percentage of Adults Age 19–64 Reporting a Dental Visit or Unable to Get Necessary Dental Care in the Past 12 Months, by Insurance Status and Income Level, 2011–2013

Access Measure	Less than or equal to 138 percent FPL			Greater than 138 percent FPL		
	Medicaid	Private	Uninsured	Medicaid	Private	Uninsured
Had a dental visit in the past 12 months	20.7%	34.0%*	12.2%*	26.0%	48.5%*	18.1%*
Unable to get necessary dental care	11.5	6.0*	14.7*	10.1	2.7*	10.4
Unable to afford care (among those unable to get necessary dental care)	65.6	78.0*	94.8*	74.2	77.8	93.9*

Notes: FPL is federal poverty level.

* Difference from Medicaid, within income category, is statistically significant at the 0.05 level.

Source: MACPAC, 2016, analysis of the Household Component of the Medical Expenditure Panel Survey, 2011–2013.

Race or ethnicity

White non-Hispanic adults were more likely to report having a dental visit in the past year than their Hispanic or black non-Hispanic counterparts, regardless of insurance status (Table 3). Among respondents of all races and ethnicities who had a dental visit, privately insured individuals were more likely to have had preventive care (e.g., cleaning, prophylaxis, or polishing) than Medicaid enrollees, but no significant difference existed between Medicaid-enrolled adults and uninsured adults.

TABLE 3. Percentage of Adults Age 19–64 Reporting a Dental Visit in the Past 12 Months, by Insurance Status and Race and Ethnicity, 2011–2013

Access measure	White non-Hispanic			Black non-Hispanic			Hispanic		
	Medicaid	Private	Uninsured	Medicaid	Private	Uninsured	Medicaid	Private	Uninsured
Had a dental visit in the past 12 months	25.2%	51.2%*	20.3%*	21.7%	35.9%*	10.9%*	19.3%	36.4%*	12.5%*
Had preventive care (among those who had a dental visit)	52.2	84.7*	56.0	55.0	74.8*	46.7	58.4	77.7*	56.9

Notes: Preventive care includes cleanings, prophylaxis, and polishing.

* Difference from Medicaid is statistically significant at the 0.05 level.

Source: MACPAC, 2016, analysis of the Household Component of the Medical Expenditure Panel Survey, 2011–2013



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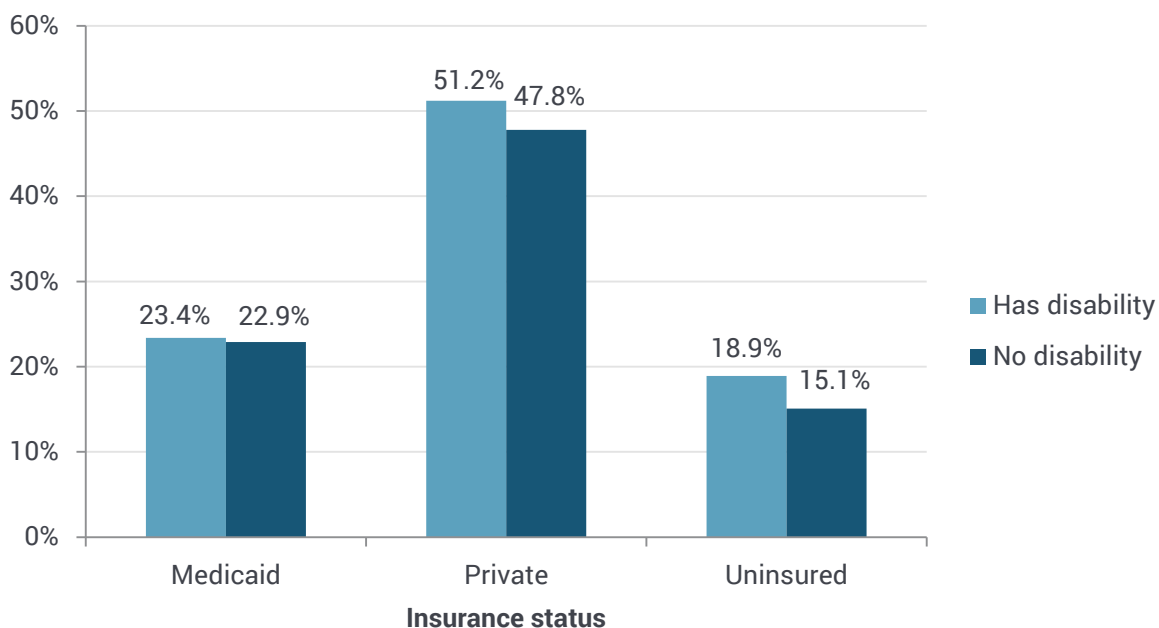
www.macpac.gov

Disability

Individuals with disability are at risk for poor oral health due to limitations in their ability to maintain preventive oral health practices or difficulty finding a dentist who can deliver care tailored to their needs (for example, exam rooms that can accommodate a wheelchair or specialized training in providing care to individuals with certain developmental disabilities) (Waldman and Perlman 2012, Davis 2009, McGinn-Shapiro 2008).

Among adults with the same insurance status, we found no significant difference in the percentage who reported having a dental visit in the past 12 months between those with disability and those without (Figure 1). However, among those with disability, privately insured individuals were more likely to have had one or more dental visits in the past 12 months than either Medicaid enrollees or uninsured individuals. There was no significant difference in the likelihood of having a dental visit between Medicaid-enrolled adults with a disability and their uninsured counterparts in 2013.

FIGURE 1. Percentage of Adults Age 19–64 Reporting a Dental Visit in the Past 12 Months, by Insurance Status and Disability Status, 2013

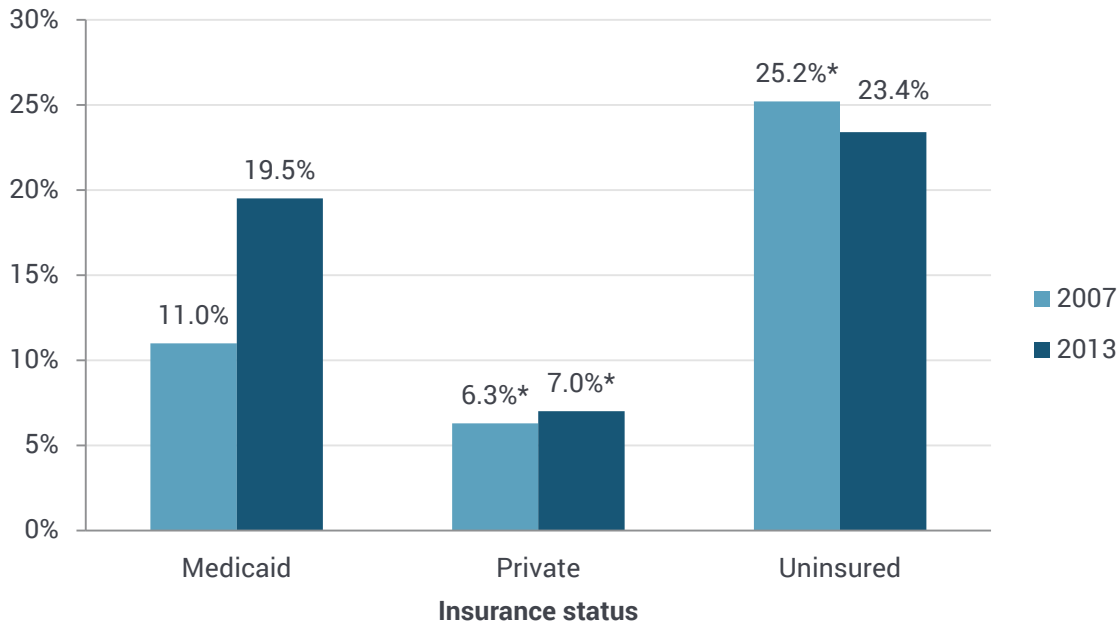


Source: MACPAC, 2016, analysis of the Household Component of the Medical Expenditure Panel Survey, 2013.

Among adults with a disability, Medicaid-enrolled adults were more likely than privately insured individuals to report being unable to receive necessary oral health care in both 2007 and 2013 (Figure 2). In contrast, Medicaid enrollees with a disability were less likely to report being unable to receive necessary oral health care than their uninsured counterparts in 2007, and there was no significant difference between the two in 2013. The percentage of Medicaid-enrolled adults with any limitation who were unable to get necessary oral health care increased significantly between 2007 and 2013.⁶



FIGURE 2. Percentage of Adults Age 19–64 with a Disability Unable to Get Necessary Dental Care, by Insurance Status, 2007 and 2013



Note: * Difference from Medicaid is statistically significant at the 0.05 level.

Source: MACPAC 2016 analysis of the Household Component of the Medical Expenditure Panel Survey, 2007 and 2013.

Data and Methods

All differences discussed in the text of this brief are computed using Z-tests and are significant at the 0.05 level.

Data sources

Data for this report come from the Household Component of the Medical Expenditure Panel Survey (MEPS-HC). The MEPS-HC is a nationally representative longitudinal survey that collects detailed information on health care use and expenditures, health insurance, and health status, as well as on a wide variety of social, demographic, and economic characteristics for the U.S. civilian non-institutionalized population. For more information on the MEPS-HC see

https://meps.ahrq.gov/mepsweb/about_meps/survey_back.jsp.

Insurance coverage

The following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, uninsured for the past 12 months. Not separately shown are the



estimates for those covered by any type of military health plan or other government-sponsored program. Coverage source is defined as of the time of the survey interview. Because an individual may have multiple coverage sources and because sources of coverage may change over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this brief. Private health insurance coverage excludes plans that cover only one type of service, such as accident or dental insurance. The Medicaid category also includes persons covered by other state-sponsored health plans. Individuals are defined as uninsured if they did not have any private health insurance, Medicaid, State Children's Health Insurance Program (CHIP) coverage, Medicare, state- or other government-sponsored health plan, or military plan during the past year. Individuals were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accident or dental coverage only.

Disability

In the MEPS-HC, adults with a disability are identified as receiving help or supervision with instrumental activities of daily living, receiving help or supervision with activities of daily living, or having difficulty in performing certain specific physical actions (called functional and activity limitations). Individuals who identified having a limitation in any of the pertinent rounds of questions were included as adults with a disability in our analysis.

Access questions

This analysis uses questions that were chosen as indicators of how much oral health care was received by adults age 19–44 of differing insurance types and income levels and by adults with limitations of activity. In addition to asking about individuals' insurance status, questions asked whether an individual had a dental visit in the past 12 months and if so, did it involve preventive care such as cleaning, prophylaxis, or polishing. Questions also asked about the frequency of dental checkups. Two questions were chosen as indicators of unmet need: whether the individual was unable to get necessary oral health care and the reason they were unable to get it.

Endnotes

¹ Periodontitis is a gum infection that damages the soft tissue and bone that supports the teeth.

² In this brief, we refer to private health insurance as defined by the Household Component of the Medical Expenditure Panel Survey (MEPS-HC). By this definition, private health insurance often does not include dental insurance. As well, separate, stand-alone dental plans are not included in the definition of private insurance. The measures used in this analysis (which are described in the methods section), do not account for differences that may exist in need for services, in the quality of the services received, or in the amount, scope, and duration of dental coverage. However, low utilization rates by some population subgroups may be an indicator of unmet need.

³ Data used in this brief are from years prior to the Medicaid expansion to the new adult group introduced by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).



⁴ The expansion of Medicaid to the new adult group may have changed Medicaid enrollees' ability to obtain necessary dental care. Thirty of the 32 expansion states cover the same dental benefits for the new adult group and other adults enrolled in Medicaid on a basis other than disability, although North Dakota limits dental benefits for the expansion population, and Iowa offers dental benefits on a tiered basis determined by the number of preventive dental visits an enrollee receives (MACPAC 2015). Once data are available from 2014 to present, more will be known about the expansion's effect on Medicaid enrollees' access to dental care.

⁵ Respondents gave the following reasons for their inability to get necessary care: the individual's insurance would not cover the care, the doctor did not accept the individual's insurance, the individual was not able to get time off work, and the individual did not know where to get care.

⁶ Between 2008 and 2012, nine states reduced their Medicaid coverage of adult dental benefits, including some states with large numbers of Medicaid enrollees, such as California and Florida; three states increased their Medicaid coverage of adult dental benefits during the same time period (MACPAC 2015). The net reduction in enrollees with Medicaid adult dental benefits may be a contributing factor to the statistically significant increase in Medicaid recipients' reported inability to get necessary dental care between 2007 and 2013.

References

Claxton, G., M. Rae, N. Panchal, et al. 2014. *The Kaiser Family Foundation and Health Research & Educational Trust employer health benefits 2014 annual survey*. Menlo Park, CA: Kaiser Family Foundation and Chicago, IL: Health Research & Educational Trust. <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>.

Davis, M.J. 2009. Issues in access to oral health care for special care patients. *Dental Clinics of North America* 53, no. 2: 169–181.

Kaiser Commission on Medicaid and the Uninsured (KCMU). 2012. *Oral health and low-income nonelderly adults: A review of coverage and access*. Washington, DC: KCMU. <https://kaiserfamilyfoundation.files.wordpress.com/2013/03/7798-02.pdf>.

Kuo, L., A.M. Polson, and T. Kang. 2008. Associations between periodontal diseases and systemic diseases: A review of the inter-relationships and interactions with diabetes, respiratory diseases, cardiovascular diseases and osteoporosis. *Public Health* 122, no. 4: 417–433. <https://www.ncbi.nlm.nih.gov/pubmed/18028967>.

McGinn-Shapiro, M. 2008. *Medicaid coverage of adult dental services*. Portland, ME: National Academy of State Health Policy. <http://www.nashp.org/sites/default/files/Adult%20Dental%20Monitor.pdf>.

Mealey, B.L. 2006. Periodontal disease and diabetes: A two-way street. *Journal of the American Dental Association* 137, Suppl.: 26S–31S. <https://www.ncbi.nlm.nih.gov/pubmed/17012733>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. Chapter 2: Medicaid coverage of dental benefits for adults. In *Report to Congress on Medicaid and CHIP*. June 2015. Washington, DC: MACPAC. <https://www.macpac.gov/publication/coverage-of-medicaid-dental-benefits-for-adults-3/>.



Nasseh, K., and M. Vujcic. 2014. *Dental care utilization rate highest ever among children, continues to decline among working-age adults*. Chicago, IL: American Dental Association Health Policy Institute.

http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_4.ashx.

National Institute of Dental and Craniofacial Research (NIDCR), National Institutes of Health. 2015. Dental caries in permanent (adult) teeth.

<http://www.nidcr.nih.gov/DataStatistics/FindDataByTopic/DentalCaries/DentalCariesAdults20to64.htm>.

Nycz, G. 2014. Blossoming opportunities to improve diabetes care and reduce costs. Presentation before the National Academy for State Health Policy 27th Annual Conference. October 8, 2014, Atlanta, GA. <http://www.nashpcloud.org/2014-presentations/public/SESSION.23.NYCZ.G.pdf>.

Sharma, N., and H. Shamsuddin. 2011. Association between respiratory disease in hospitalized patients and periodontal disease: A cross-sectional study. *Journal of Periodontology* 82, no. 8: 1155–1160.

Waldman, H.B., and S.T. Perlman. 2012. Individuals with disabilities: What about dental services? *Exceptional Parent* 42, no. 4: 17–18.

