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Access to Affordable Dental Care: Gaps for Low-Income Adults

By Jennifer Haley, Genevieve Kenney, and Jennifer Pelletier

Although oral health has long been acknowledged as a critical component of overall health and well-being, millions of Americans lack access to affordable dental health services.¹ Oral health problems can be early signs of and even lead to other types of serious diseases. Untreated oral health conditions can cause disfiguring tooth loss and decay that can limit employment options and lower self-esteem. While regular dental care can prevent and treat many oral health problems, financial barriers pose significant dental access problems for many low-income families.²

Private health insurance plans often exclude dental coverage, and those that do include a dental benefit often require high levels of cost-sharing that put care out of reach for many low-income families. Similarly, dental coverage for adults in Medicaid is limited or nonexistent in most states. Those without adequate dental coverage must turn to a health care safety net that often does not focus many resources on oral health, leaving them potentially unable to access needed care.

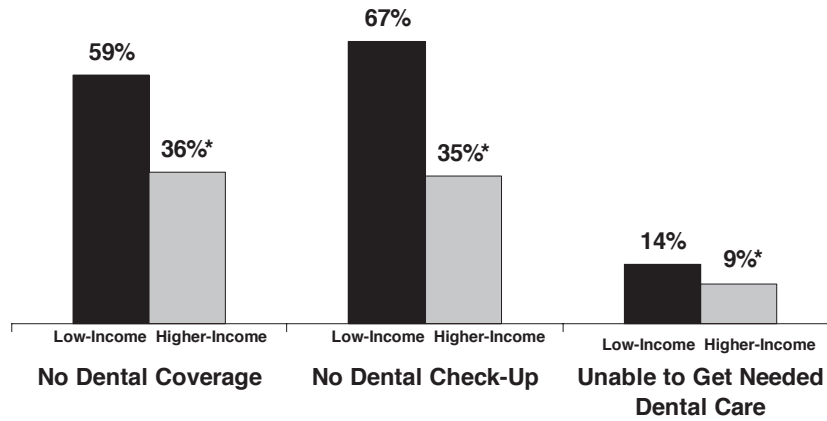
This brief examines the dental access problems experienced by adults ages 19 to 64 in families with incomes at or below 200 percent of the Federal Poverty Level (FPL) using the 2005 Kaiser Low-Income Coverage and Access Survey.³ We find that both dental coverage and access to care are limited for low-income adults and that even low-income adults with dental coverage are not getting sufficient levels of needed dental care.

Much of the Low-Income Population Does Not Have Dental Coverage and Is Less Likely to Receive Adequate Dental Care.

Over half of low-income adults lack dental coverage and most go without routine dental care (Figure 1). Fifty-nine percent of low-income adults have no dental coverage: 38 percent have no insurance coverage at all, and another 21 percent have insurance coverage that does not include dental care.⁴ This is much higher than the 36 percent of higher-income adults with no dental coverage. Low-income adults are also much more likely than higher-income adults to have gone without routine dental care and to have postponed or foregone care – low-income adults are almost twice as likely as higher-income adults to have gone without a dental check-up in the prior year (67 versus 35 percent) and are 1.5 times as likely to have an unmet dental need (14 versus 9 percent).⁵

This paper is part of a series that analyzes data from The 2005 Kaiser Low-Income Coverage and Access Survey. The Kaiser Family Foundation conducted this national survey to examine health insurance coverage, access to care and the impact of health costs on the low-income population. The majority of the uninsured are low-income, and this survey of more than 5,000 low-income adults provides detailed data that can be used to inform the ongoing debate on reforming the U.S. health care system.

Figure 1
Dental Coverage, Receipt of Dental Check-Ups, and Ability to Get Needed Dental Care Among Non-elderly Adults, by Income Group, 2005



Source: 2005 Kaiser Low-Income Coverage and Access Survey
 Notes: Low-income is defined as living in families earning 200% of the federal poverty level (FPL) or less who live in high-poverty Census tracts. Higher-income is defined as living in families earning above 200% of the FPL in any type of tract. Coverage refers to status at the time of the survey; access and utilization are in the prior 12 months. The percentage with no dental coverage combines those with insurance coverage that does not cover dental care (21% for low-income; 26% for higher-income) and those with no insurance coverage at all (38% for low-income; 10% for higher-income).
 * Indicates statistically significant difference from low-income group at the p<.05 level.

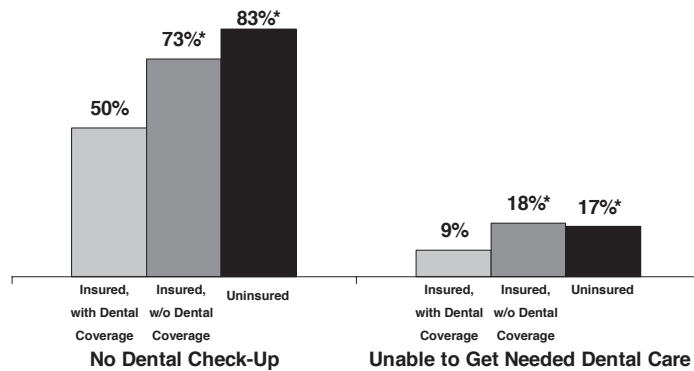
Having Dental Coverage Helps, but Access and Utilization Problems Remain Even for Those Who Have It.

Lack of routine dental care and inability to get needed dental care are much higher for low-income adults without dental coverage than for those with dental coverage (Figure 2).

Among low-income adults, both the insured without dental coverage and the uninsured are significantly more likely than those with dental coverage to have had no dental check-up in the prior year and to report having unmet dental needs. Half of those with dental coverage had no dental check-up in the prior year, while 73 percent of those with health insurance that does not cover dental care and 83 percent of those with no health insurance coverage at all lacked routine care.

Similarly, inability to get needed dental care was reported twice as often among the insured without dental coverage (18 percent) and the uninsured (17 percent) than among the insured with dental coverage (9 percent). This is consistent with other studies showing that dental care utilization is higher among those with dental coverage.⁶

Figure 2
Receipt of Dental Check-Ups and Ability to Get Needed Dental Care Among Low-Income Adults, by Insurance Status and Dental Coverage, 2005

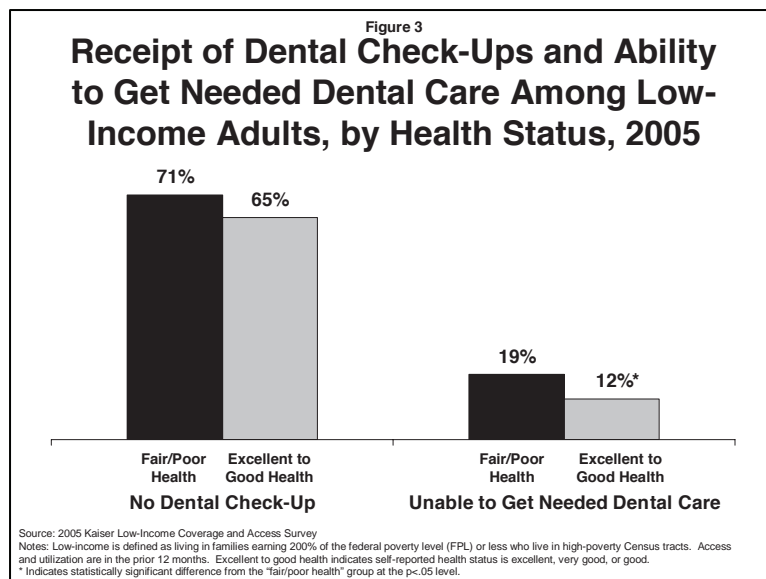


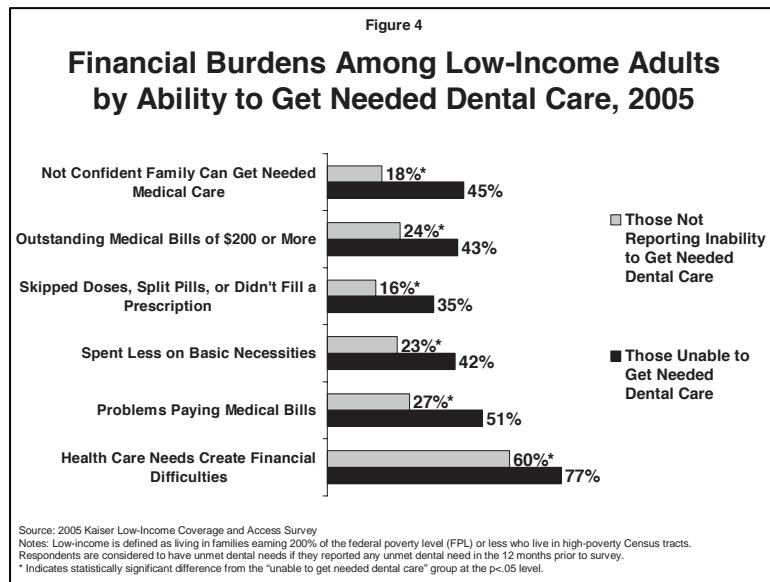
Source: 2005 Kaiser Low-Income Coverage and Access Survey
 Notes: Low-income is defined as living in families earning 200% of the federal poverty level (FPL) or less who live in high-poverty Census tracts. Coverage refers to status at the time of the survey; access and utilization are in the prior 12 months.
 * Indicates statistically significant difference from the "insured, with dental coverage" group at the p<.05 level.

Even among low-income adults who do have dental coverage, access to dental care is not adequate. Among those with dental coverage, half had not had a dental check-up in the past year and nearly 1 in 10 (9 percent) was unable to get dental care when needed (Figure 2). A majority of low-income insured adults with dental coverage – 55 percent – reported at least one of these problems. There are multiple reasons that may explain this low dental access among the insured: coverage of needed services under both public and private plans may be limited; out-of-pocket costs may be too high for low-income families; and, for those covered by Medicaid, care may not be available due to low reimbursement rates that contribute to a lack of providers in their area who accept Medicaid.⁷ In addition, there is evidence that other barriers to care, such as transportation, work and child care arrangements, and cultural barriers, keep many low-income families from obtaining needed care.⁸ This suggests that improved access to dental insurance alone may not solve the dental access problems of low-income adults.

Disparities in Access and Utilization of Dental Care Exist within the Low-Income Population.

Dental access problems are greater for low-income adults in poor health and for those experiencing other unmet health needs and financial difficulties (Figures 3 and 4). Unmet dental needs are higher among low-income adults in worse health than those in better health (Figure 3).⁹ Twelve percent of those in excellent, very good, or good health reported that they were unable to get dental care when they needed it, compared with 19 percent of those in fair or poor health. Lack of routine dental care also appears lower for adults in fair/poor health than those in better health, although this difference is not statistically significant.¹⁰ Low-income adults who are struggling with chronic health problems seem to be disadvantaged when it comes to accessing dental care, which could compound the other health problems they are facing.

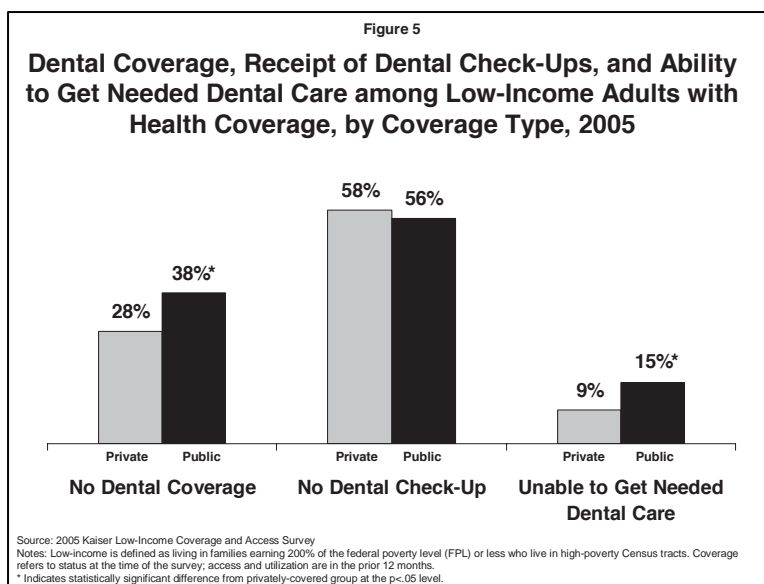




Those experiencing dental access problems are also likely to have difficulty accessing medical care when they need it: 81 percent of those with unmet dental needs also had other types of unmet needs (data not shown).¹¹ In addition, those with dental access problems are more likely to report experiencing financial stress (Figure 4). For example, they are more likely to lack confidence their family can get needed medical care (45 vs. 18 percent); to have outstanding medical bills of \$200 or more (43 vs. 24 percent); to

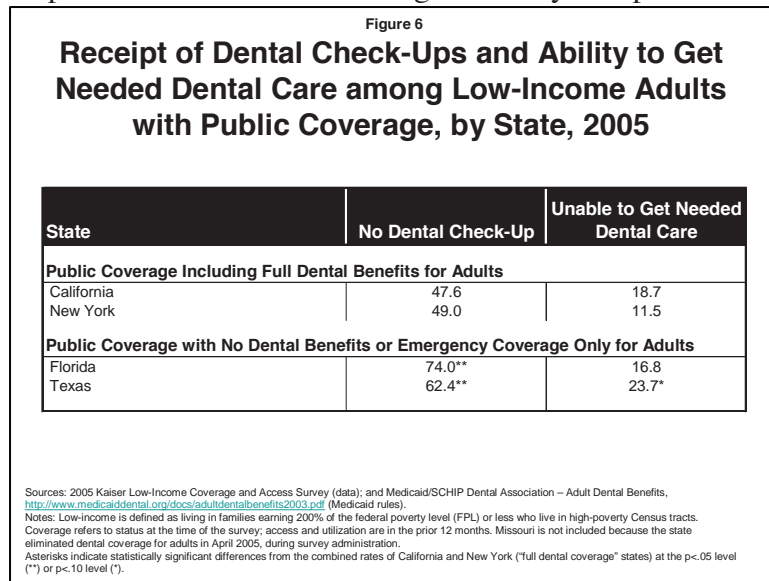
have skipped doses, split pills, or not filled a prescription (35 vs. 16 percent); to have had to spend less on basic necessities (42 vs. 23 percent); to have problems paying medical bills (51 vs. 27 percent); and to report that meeting their family's health care needs creates financial difficulties (77 vs. 60 percent). The cost of dental care for the uninsured and cost-sharing requirements found in many dental insurance plans puts dental care out of reach for many low-income adults.¹² Because oral health is often considered of secondary importance to general health, some adults may be forgoing dental care in the face of financial difficulties or other health priorities.

Access to dental care varies by type of insurance coverage (Figure 5). Although rates of dental check-ups are similar for low-income adults with public and private coverage, those with public coverage are more likely to report being unable to get needed care (15 percent) than those with private coverage (9 percent). To some extent, this difference reflects the lower rates of dental coverage among Medicaid enrollees and their difficulty accessing care without it: the likelihood of lacking dental coverage is greater among those with Medicaid/public coverage (38 percent) than those with employer-sponsored coverage or other private coverage (28 percent). Indeed, the rates of unmet needs are similar for privately- and publicly-covered adults with dental coverage (8 and 11 percent, respectively), while among those without dental coverage, inability to access needed dental care is



much higher for publicly-covered low-income adults than the privately-covered (22 percent versus 11 percent, data not shown). In addition, higher unmet need among the Medicaid-covered population also likely reflects provider participation issues due to low payment rates and the concentration of sicker and poorer individuals in public programs.¹³

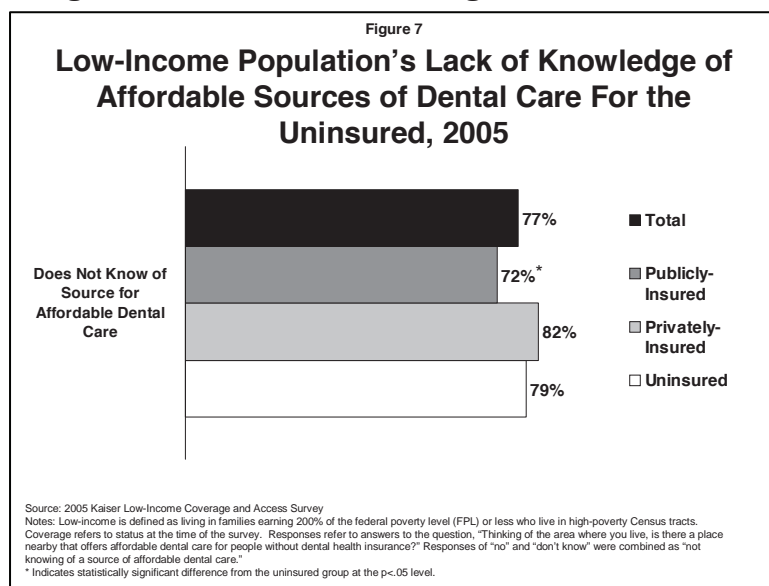
Medicaid enrollees' access to dental care varies by state and appears to be related to states' dental coverage under Medicaid (Figure 6). California and New York provided full coverage of dental benefits for adults in Medicaid in 2005, and these policy choices are reflected by respondents in those states being less likely to report not receiving a dental check-up. Publicly-



covered adults in Florida (which covers emergency dental care only) and Texas (which does not cover any dental care for its general Medicaid population) report lower rates of utilization and, in the case of Texas, significantly higher rates of being unable to get needed dental care.¹⁴ However, even in the states offering dental coverage for Medicaid adults, only about half of publicly-covered adults received a dental check-up, and rates of reported inability to get needed dental care are moderately high (11.5-18.7 percent).

Very Few Know of Places Offering Affordable Dental Care Services for the Uninsured.

Most low-income adults do not know of a place in their community where the uninsured can get affordable dental care (Figure 7). Less than one-quarter of low-income adults know of



a place in their community offering affordable dental care for people without dental insurance.¹⁵ Those who do know of such a place were most likely to mention a dental clinic as the source for affordable care. Even among the uninsured, who likely have a greater need for affordable care through safety net providers and thus might be more knowledgeable of them, a similar proportion – 79 percent – do not know of places for affordable dental care. This is consistent with the low levels of dental care provision at many community

health centers and other safety net providers.¹⁶ Since the population covered by the 2005 Kaiser Low-Income Coverage and Access Survey lives exclusively in low-income neighborhoods, the supply of dental providers – and corresponding knowledge of them – may be different for the low-income population living in areas of less concentrated poverty.

While not knowing of affordable dental providers is common among all insurance groups, low-income adults with public coverage are more likely to know of an affordable dental provider for the uninsured. Seventy-two percent of those with public coverage are not aware of affordable dental providers, compared with 79 percent of the uninsured and 82 percent of those with private coverage. Among parents, having a child in Medicaid or the State Children’s Health Insurance Program (SCHIP) is also related to greater knowledge of such providers. Seventy-four percent of the parents of Medicaid- or SCHIP-insured children report that they do not know of a source for affordable dental care for the uninsured compared to 88 percent of parents who do not have a child covered by Medicaid or SCHIP (data not shown). This suggests there is an association between having public coverage and familiarity with the safety net – possibly because low-cost providers to the uninsured also provide services to the Medicaid population.

Conclusion

Most low-income adults do not receive regular dental check-ups, and more than one in six of those who lack dental coverage reported being unable to obtain dental care when they needed it during the previous year. The fact that low-income adults without dental coverage experience dental access problems at such high rates is consistent with the finding that very few low-income adults know of places in their community where the uninsured can find affordable dental care. The access gaps demonstrated here confirm findings from other studies showing that dental coverage, access, and use are limited for low-income adults.¹⁷

As the 2000 Surgeon General’s *Oral Health in America* report indicated, “...the public, policymakers, and providers may consider oral health and the need for care to be less important than other health needs, pointing to the need to raise awareness and improve health literacy.”¹⁸ As the recognition that oral health is important to overall health and well-being has gained acceptance, increased consideration has been given to the importance of dental health and the problems caused by lack of dental care.¹⁹ Improving access to dental care is one of the nation’s Healthy People 2010 goals. However, federal law does not require states to cover dental care for adults under Medicaid, and, as a result, only 7 states provided full dental coverage to adults in 2005.²⁰ As states enter a new period of fiscal stress during the current economic downturn, efforts to balance their budgets may lead to further reductions in Medicaid services – such as dental care – that are not required under federal law.²¹ In addition, low reimbursement rates already limit dentists’ participation in Medicaid, and states may make further cuts to these already low rates to find additional savings in their programs, which could further constrain access.

Employers are also reducing coverage of dental care to hold down the rising costs of insurance coverage.²² Furthermore, a host of other challenges remain for low-income families seeking to obtain dental care, which means that dental coverage on its own may not be enough to significantly improve access to routine dental care and reduce unmet dental needs.²³ Other

barriers, related to issues such as access to providers, difficulties affording the cost of care, transportation, and perceptions of the importance of dental care, will also need to be addressed if dental access and use are to increase among this population.²⁴ In addition, given that the number of uninsured adults is unlikely to decline, at least in the short run, and that nearly three times as many Americans lack dental coverage as lack general health insurance coverage, policies aimed at strengthening the availability of dental services at safety net facilities are critically important.²⁵

Lack of access to preventive dental care can lead to more expensive and invasive procedures, and problems with oral health can exacerbate and cause other serious health conditions.²⁶ Low access to dental coverage combined with the weak dental safety net puts dental care out of reach for many low-income individuals, likely resulting in adverse effects on their health and economic well-being. Given the lack of dental coverage and access among those low-income adults who make up the bulk of our nation's uninsured, policymakers may want to consider this important benefit as they explore broader health reform options.

This brief is part of an ongoing collaborative effort between staff of the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute to examine health coverage, access, and financial burdens facing low-income families using data from the 2005 Kaiser Low-Income Coverage and Access Survey.

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2005 Kaiser Low-Income Coverage and Access Survey Methods

This 2005 national survey was a random digit dial survey of adults ages 19 to 64 living in families with incomes at or below twice the poverty level, with a national all-income comparison sample. The low-income survey sampled the low-income population in the highest poverty Census tracts that account for 20 percent of the low-income population. There were 5,482 low-income completed interviews. The coverage status used for analysis is the coverage status of the respondent at the time of the interview. In contrast, access indicators (inability to get needed dental care, receipt of dental check-up, etc.) refer to the respondent's experiences during the 12 months prior to the interview, which could introduce some measurement error. All indicators of access to and use of health services are reported by the respondent.

The low-income survey yielded a response rate of 31 percent, and a follow up non-response study produced a response rate of 49 percent. The estimates in this paper are all derived from the low-income sample, with the exception of the estimates describing the higher-income comparison group, which are derived from the all-income sample. The survey weights for the low-income survey take into account the selection probability and non-response and are post-stratified to align the data to U.S. Census 2000 data at the tract level for the specific population of interest (<200 percent of the poverty threshold) using the following variables: geography, race/ethnicity, education, sex and age. The standard errors were calculated and significance testing was conducted to take into account complex sampling methodology by using Taylor series linearization in Stata 10.

Notes

¹ US Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

² US Department of Health and Human Services. Oral Health in America, 2000.

Snyder A. and Gehshan S. “State Health Reform: How Do Dental Benefits Fit In? Options for Policy Makers.” Portland, ME: National Academy for State Health Policy. 2008.

³ A complete description of the survey methods can be found in “The 2005 Kaiser Low-Income Coverage and Access Survey: Survey Methods and Baseline Tables”, available at <http://www.kff.org/uninsured/7788.cfm>. See survey methods box at the end of this brief for a short description of the survey. Due to the unique sample of this survey (low-income adults in low-income neighborhoods), we benchmarked our estimates to those of nationally-representative surveys wherever possible.

⁴ Dental insurance coverage was defined by asking those respondents who reported having health insurance coverage whether their current insurance plan covers “routine dental services such as a cleaning or a check-up.” To benchmark this estimate to estimates from a national survey, we examined dental coverage rates for two low-income groups from the 2004 Medical Expenditure Panel Survey (MEPS). According to the MEPS, 59 percent of those with incomes below the FPL have no dental coverage, and 51 percent of those with incomes between 100 and 200 percent of the FPL have no dental coverage. See: Manski, R. J. and Brown, E. Dental Use, Expenses, Private Dental Coverage, and Changes, 1996 and 2004. Rockville (MD): Agency for Healthcare Research and Quality; 2007. MEPS Chartbook No.17. http://www.meps.ahrq.gov/mepsweb/data_files/publications/cb17/cb17.pdf

⁵ Receipt of check-ups was measured by asking whether, in the past 12 months, respondents had “seen a dentist or dental hygienist for check-ups.” According to the MEPS, 27 percent of low-income adults nationally in 2004 had a dental visit of some sort, and most dental visits were preventive or diagnostic. This is roughly equivalent to the 33 percent of low-income adults in low-income neighborhoods reporting receiving check-ups in this survey. See: Manski and Brown 2007.

“Inability to get needed dental care” refers to whether or not there was a time during the prior 12 months that the respondent needed “dental care (including check-ups)” but “postponed or didn’t get” the needed care. Although there is no direct comparison of the results from this survey to other surveys, a 1994 survey asking about whether respondents “wanted dental care but could not get it at that time” found that 16 percent of adults with family incomes below 150% of the FPL had such “unmet dental health care wants” compared with 6 percent of those with higher incomes. See: Mueller CD, Schur CL, Paramore LC. Access to dental care in the United States. *J Am Dent Assoc* 1998 Apr;129(4):429-37.

⁶ Manski and Brown 2007.

Manski, R.J. and Magder, L.S. “Demographic and Socioeconomic Predictors of Dental Care Utilization.” *JADA*. 129: 195-200. 1998.

Kenney, G., McFeeters, J. and Yee, J. “Preventive Dental Care and Unmet Dental Needs Among Low-Income Children.” *American Journal of Public Health*. 95(8): 1360-1366. 2005.

Newacheck PW et al. Access to health care for children with special needs. *Pediatrics* 2000;105(4):760-6.

⁷ Snyder and Gehshan 2008.

Mertz and O’Neil 2002.

U.S. General Accounting Office. “Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations.” Report to Congressional Requesters. GAO-HHS-00-149. Washington, DC: Government Printing Office. September 2000.

⁸ Ibid.

⁹ Unmet dental health needs are also significantly higher for low-income adults with a chronic health condition than for those without a chronic health condition (18.8 vs. 9.2 percent), which is not surprising given the correlation between poor health and presence of chronic health conditions (78 percent of those reporting fair or poor health also report having a chronic health condition).

¹⁰ The p-value for this difference is .158, which does not meet the conventional standards of being below .10.

¹¹ Other unmet needs reported in the survey include prescription medications, mental health care or counseling, eyeglasses, pregnancy or related prenatal care, a treatment or therapy recommended by a doctor, and medical supplies.

¹² Snyder and Gehshan. 2008.

¹³ Kaiser Commission on Medicaid and the Uninsured. “Who Needs Medicaid?” Washington, DC: Kaiser Family Foundation. 2006.

¹⁴ Separate estimates are not presented for Missouri, the fifth of the five states oversampled by the National Survey, because coverage of dental care in Missouri’s Medicaid program ended in 2005, during survey administration.

¹⁵ Responses of “no” (47 percent) and “don’t know” (30 percent) were combined to define “not knowing.”

¹⁶ U.S. General Accounting Office 2000.
Mertz and O’Neil 2002.

¹⁷ Manski and Brown 2007.
Mueller et al. 1998.

¹⁸ US Department of Health and Human Services. Oral Health in America, 2000.

¹⁹ US Department of Health and Human Services. Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

US Department of Health and Human Services. Oral Health in America. 2000.

²⁰ In addition to the 7 states providing full dental benefits, 18 states provided limited dental benefits, another 18 states provided emergency benefits only, and 8 states provided no dental benefits at all. See: Medicaid/SCHIP Dental Association’s Adult Dental Benefits chart at <http://www.medicaidental.org/docs/adultdentalbenefits2003.pdf>.

Gehshan and Straw 2002.

²¹ Pryor, C., and M. Monopoli. September 2005. “Eliminating Adult Dental Coverage in Medicaid: An Analysis of the Massachusetts Experience.” Kaiser Commission on Medicaid and the Uninsured Report #7378.

²² Anstett, P. “UAW deal with GM offers fewer health plan options.” *Detroit Free Press*. 5 Oct 2007.
<http://www.freep.com/apps/pbcs.dll/article?AID=2007710050425>

Abelson, R. “A big gap in dental care as U.S. coverage is cut.” *International Herald Tribune*. 29 Dec 2004.

²³ Mertz and O’Neil 2002.

²⁴ U.S. General Accounting Office 2000.

US Department of Health and Human Services. Oral Health in America, 2000.

²⁵ Snyder and Gehshan 2008.

²⁶ Snyder and Gehshan 2008

US Department of Health and Human Services. Oral Health in America. 2000.



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