

Bill Summary & Status for the 106th Congressnot today**Item 1 of 2****PREVIOUS | NEXT****PREVIOUS:SUMMARY | NEXT:SUMMARY****NEW SEARCH | HOME | HELP | ABOUT SUMMARIES****S.901**

Sponsor: Sen Bingaman, Jeff (introduced 4/28/1999)

Latest Major Action: 4/28/1999 Referred to Senate committee

Title: A bill to provide disadvantaged children with access to **dental** services.**SUMMARY AS OF:**

4/28/1999--Introduced.

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Title VI: Miscellaneous

Children's **Dental** Health Improvement Act of 1999 - **Title I: Expanded Opportunities for Training Pediatric Dental Health Care Providers** - Amends the Public Health Service Act (PHSA), as amended by the Health Professions Education Partnerships Act of 1998, to direct the Secretary of Health and Human Services (HHS) to: (1) develop training materials for use by health professionals to promote oral health through health education; (2) make grants to schools that train pediatric **dental** health providers to meet the costs of projects for developing or improving training programs in providing **dental** health services to children; (3) establish at least ten Pediatric **Dental** Centers of Excellence with not less than 36 additional training positions annually for pediatric dentists at such centers and; (4) determine **dental** site readiness in inner city, rural, frontier, and border areas. Authorizes appropriations.

Increases the amount of appropriations made available under the Health Professions Education Partnerships Act of 1998 for grant and contract awards under PHSA for programs of pediatric or general dentistry.

(Sec. 102) Directs the Secretary to increase the number of **dental** health providers who are skilled in treating children and who become members of the Commissioned Corps of the U.S. Public Health Service assigned to the National Health Service Corps (Corps), so that there are specified numbers of additional dentists and **dental** hygienists in the Commissioned Corps.

Requires the Corps to report annually to Congress on how it is meeting the oral health needs of underserved children in rural, frontier, and border areas.

Directs the Secretary to ensure that at least 20 percent of Corps dentists are Pediatric dentists and that

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Children's Dental
Health Act.

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another 20 percent have general dentistry residency training.

Directs the Secretary to increase the number of dentists selected for student loan repayment.

(Sec. 104) Provides for a **dental** officer multiyear retention bonus for the Indian Health Service.

(Sec. 105) Amends title XVIII (Medicare) of the Social Security Act (SSA) to direct the Secretary to make Medicare payments to approved nonhospital based dentistry residency training programs providing oral health care to children for program operating expenses.

Provides for a permanent **dental** exemption from voluntary residency reduction incentive payment programs under Medicare, and for the removal of dentists from full-time equivalent count averaging requirements under Medicare.

Redefines primary care resident.

(Sec. 106) Amends PHSA to allow the Secretary to designate **dental** health professional shortage areas in areas with a severe shortage of **dental** health professionals, including general and pediatric dentists and **dental** hygienists. Includes **dental** hygienists in PHSA's student loan repayment program.

Title II: Ensuring Delivery of Pediatric Dental Services Under the Medicaid and SCHIP Programs

- Amends SSA title XIX (Medicaid) to: (1) provide for quarterly payment to a State of an amount equal to the greater of the Federal medical assistance percentage or 75 percent of the sums expended during the quarter attributable to **dental** services for children; (2) require a State Medicaid plan to provide for payment for **dental** services for children at a rate designed to create an incentive for providers of such services (but that does not result in a reduction or other adverse impact on the extent to which the State provides **dental** services to adults); (3) set the required minimum Medicaid expenditures each fiscal year for **dental** health services for children; (4) require the State to verify annually sufficient numbers of Medicaid-participating **dental** health professionals and to collect appropriate data; (5) provide for the inclusion of the recommended age for the first **dental** visit in the definition of early and periodic screening, diagnostic, and treatment services (EPSDT); and (6) provide for the use of Children's Health Insurance Program (CHIP) (SSA title XXI) funds to treat certain low-income children with special oral health needs (including advanced craniofacial diseases) who reside in certain States.

(Sec. 207) Amends SSA title V (Maternal and Child Health Services) to direct the Secretary to award grants to States to supplement payments made under State Medicaid and CHIP programs for the treatment of children with special oral health care needs. Defines such children as children with oral, **dental** and craniofacial conditions or disorders, and other acute or chronic medical, genetic, and behavioral disorders with **dental** manifestations. Authorizes appropriations.

(Sec. 208) Directs the Secretary to establish demonstration projects designed to increase access to **dental** services for children in underserved areas. Authorizes appropriations.

Title III: Pediatric Dental Research - Directs the Secretary to: (1) support community-based research designed to improve understanding of the etiology, pathogenesis, diagnosis, prevention, and treatment of pediatric oral, **dental**, and craniofacial diseases and conditions and their sequelae in high risk populations; (2) develop clinical approaches to assess individual patients for pediatric **dental** disease; and (3) support demonstrations of preventive interventions in high risk populations. Authorizes appropriations.

(Sec. 302) Amends PHSA to direct the Administrator for Health Care Policy and Research to conduct and support activities with respect to existing barriers, including access to oral health care for children, and the establishment of measures of oral health status and outcomes.

(Sec. 303) Amends PHSA to direct the Secretary to establish a specified oral health research and training program involving qualified oral health professional participants who, pursuant to an agreement with the Secretary, will have a specified portion of their educational loans repaid by the Secretary in exchange for

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prescription drug costs

the program-related research they conduct or the program-related training they provide.

(Sec. 304) Directs the Secretary to convene a Consensus Development Conference to: (1) examine the management of early childhood caries; and (2) support research on the biology and physiologic dynamics of infectious transmission of **dental** caries. Authorizes appropriations.

Title IV: Surveillance and Accountability - Requires the Director of the Centers for Disease Control and Prevention (CDC) to collect and report annually to the appropriate congressional committees on the **dental**, craniofacial, and oral health of residents of at least one State from each HHS region.

(Sec. 402) Amends SSA title XIX to require a State Medicaid plan to provide for the reporting to the Secretary of the following: (1) the percent of expenditures for EPSDT **dental** health professionals licensed in the State and providing services commensurate with State Medicaid plan eligibility; and (3) data on the children being served and the actual services provided.

(Sec. 403) Directs the Administrator of the Administration on Children, Youth, and Families to report annually to the appropriate congressional committees the percent of children enrolled in a Head or Early Start program who have access to and who obtain **dental** care, including children with special oral, **dental**, and craniofacial health needs.

(Sec. 404) Amends the Child Nutrition Act of 1966 to impose on the State involved certain data collection and submission requirements with regard to children under the special supplemental food program for women, infants, and children (WIC) under that Act.

Title V: Oral Health Promotion and Disease Prevention - Authorizes the Secretary to make grants to States or localities for the purpose of increasing the resources available for community water fluoridation. Authorizes appropriations.

(Sec. 502) Directs the Secretary to establish a specified demonstration project designed to assist rural water systems in successfully implementing certain CDC water fluoridation guidelines. Authorizes appropriations.

Authorizes the Secretary to award grants to States or localities to provide for the development of school-based **dental** sealant programs at eligible public elementary or secondary schools to improve the access of certain children to sealants. Authorizes appropriations.

Title VI: Miscellaneous - Establishes the effective dates for this Act, some of which are retroactive to the enactment of the Balanced Budget Act of 1997.

Dental Health Care Providers

Title II: Ensuring Delivery of Pediatric Dental Services Under the Medicaid and SCHIP Programs

Title III: Pediatric Dental Research

Title IV: Surveillance and Accountability

Title V: Oral Health Promotion and Disease Prevention

Title VI: Miscellaneous

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Final 9/04/00 2:45 p.m.
John Pollack

**PRESIDENT WILLIAM JEFFERSON CLINTON
REMARKS ON THE LEGISLATIVE AGENDA
THE WHITE HOUSE
September 5, 2000**

Good morning. As Senator Daschle and Leader Gephardt said so clearly, it's time for Congress to put progress before partisanship, and get back to work for the American people. In our meeting this morning with Senator Reid and Congressman Bonior, we reaffirmed our commitment to breaking the legislative logjam. It's time to move forward with fiscal discipline, responsible tax cuts, and public investments that fuel our prosperity.

For seven-and-a-half years now, we have made the tough choices -- paying down our national debt and investing in our people. This strategy has paid enormous dividends: 22 million new jobs, the longest economic expansion in our history, and the biggest budget surplus America has ever seen.

Unfortunately, the Republican leaders in Congress have been pursuing a strategy that would squander this remarkable success. Month by month and bill by bill, they are attempting to spend our projected surplus for years to come -- an estimated \$2 trillion -- on massive, reckless tax cuts for the privileged few.

This isn't fiscally responsible, and it isn't fair. We owe it to our children to stay on course and pay off the national debt by 2012, so that interest rates stay low, businesses can grow, and generations can know that Social Security and Medicare will always be there for them.

Americans want us to address the pressing issues that affect their day-to-day lives. Yesterday we celebrated Labor Day. The picnics and parades were wonderful -- but they are not enough. Now it's time to act. Let's truly honor working Americans by raising the minimum wage by a dollar an hour. I urge Congress to quit holding up this process and make it the first order of business.

American families also want to see Congress pass a strong Patients' Bill of Rights, so that doctors, not insurance companies, make the life-or-death medical decisions.

American seniors and people with disabilities should not have to wait another year for an affordable, voluntary, Medicare prescription drug benefit. No senior should have to choose between filling their grocery carts, or filling their prescriptions.

And our nation's 44 million uninsured citizens should not have to watch Congress adjourn once again without passing legislation to significantly expand health coverage.

Today, two new studies confirm what we already knew: that our targeted, step-by-step approach to expanding coverage would help millions more uninsured Americans than the other

party's inefficient, tax-based approach. By building on successes like the Children's Health Insurance Program, we can provide such coverage at a much lower cost per person.

We need to keep moving forward on this and on a whole range of issues, or we risk falling behind. We ought to put those extra 50,000 police out on the street, pass commonsense gun safety legislation, and take a strong stand against hate crimes. We need to strip out anti-environmental riders, press for cleaner air and water, combat global warming, and approve permanent conservation funding to protect our natural heritage. We also need to approve equal pay for equal work, pass debt relief for emerging democracies, and normalize trade relations with China.

Congress should remember this, too: all across America, millions of children are back in school today. For them, this isn't an election year; it's a school year. They need 100,000 good, new teachers to reduce class size, and a Congress that's determined to replace crowded trailers with 21st-century classrooms.

We believe in sensible tax cuts for middle-class families. Tax cuts that make education and long-term care more affordable, not cuts that threaten our prosperity. Last week I vetoed the Republican Estate Tax repeal because it wasn't fiscally responsible, and it wasn't fair. It was a budget-buster that ignored 98% of American families, and gave \$400 billion to the tiniest fraction of wealthy taxpayers.

Under their plan, about 3,000 of these people would get \$7 million each. At the same time, Republicans have resisted raising the minimum wage by a buck an hour for 10 million working Americans. That does not reflect the values of the American people.

Later this week, the Republicans have scheduled a vote to try to override my veto on the Estate Tax repeal. That's their Constitutional right. It's part of their \$2 trillion plan that would wipe out our entire projected budget surplus, and take us back to the days of deficit spending.

I just wish they'd try as hard to muster up a two-thirds vote to help those Americans still working for the minimum wage, the students sitting in crowded classrooms, the patients fighting for the care they need, and the seniors struggling to pay for prescription drugs. These are the priorities we should be addressing.

We stand ready to work with Republicans in a bipartisan spirit. We're ready to bridge our differences. All of us, Democrat and Republican alike, owe it to America's families to put progress above partisanship, and the national interest above the special interests.

But time is short. We have worked very hard to put America in a position to meet the big challenges of the 21st century. I urge Congress not to let this historic opportunity slip away.

Thank you.

Oral Health: Dental Disease Is a Chronic Problem Among Low-Income Populations (Letter Report, 04/12/2000, GAO/HEHS-00-72).

Pursuant to a congressional request, GAO provided information on the: (1) dental health status of Medicaid beneficiaries and other vulnerable populations; and (2) extent to which these groups have dental coverage and use dental services.

GAO noted that: (1) dental disease is a chronic problem among many low-income and vulnerable populations; (2) GAO's analysis of the most recent national health surveys (1994-1997) showed that relative to more affluent segments of the population, low-income populations had a disproportionate level of dental disease; (3) for example, poor children had five times more untreated dental caries (cavities) than children in higher-income families, and poor adults were much more likely to have lost six or more teeth to decay and gum disease than higher-income adults; (4) minority populations also faced high levels of dental disease; (5) dental problems result in pain, infection, and millions of lost school days and workdays each year; (6) although every state Medicaid program offers dental coverage for children and most programs cover adults eligible for Medicaid, use of dental services by low-income people is low; (7) states are required to provide comprehensive dental benefits for children enrolled in Medicaid, and the State Children's Health Insurance Program provides variable but often substantial levels of dental coverage to eligible low-income children in all but two states; (8) adult dental services, although optional under Medicaid, are covered to some extent in about two-thirds of the states; (9) the availability of coverage does not, however, bridge the income gap to equalize the likelihood of visiting a dentist; (10) for example, GAO's analysis of 1995 Medicaid claims data showed that only 29 percent of enrolled adults had visited the dentist in the preceding year, less than half the rate of higher-income adults; and (11) national survey data also showed that in 1996 poor children and adults visited the dentist at about half the rate of their higher-income counterparts--numbers that had stayed relatively unchanged since 1977.

----- Indexing Terms -----

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 State Children's Health Insurance Program
 Early and Periodic Screening, Diagnosis, and Treatment
 Program
 National Health and Nutrition Examination Survey III
 CDC Behavioral Risk Factor Surveillance System

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GAO/HEHS-00-72

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ADA American Dental Association

AHRQ Agency for Healthcare Research and Quality

BRFSS Behavioral Risk Factor Surveillance System

CDC Centers for Disease Control and Prevention

EPSDT Early and Periodic Screening, Diagnostic, and Treatment

HCFA Health Care Financing Administration

HHS Department of Health and Human Services

MEPS Medical Expenditures Panel Survey

NHIS National Health Interview Survey

NHANES III National Health and Nutrition Examination Survey III

SCHIP State Children's Health Insurance Program

SMRF State Medicaid Resource File

Health, Education, and
Human Services Division

B-283914

April 12, 2000

The Honorable Jeff Bingaman
The Honorable Russell D. Feingold
United States Senate

The Honorable Thomas M. Barrett
The Honorable David R. Obey
House of Representatives

The dental health of most Americans has improved significantly since the 1960s. There is growing concern, however, that low-income and other vulnerable populations continue to have high levels of dental disease. Dental problems not only affect health and well-being but also contribute to lower productivity in the workplace and increased absenteeism at school. This continued vulnerability is a matter of concern to the federal government and the states, which jointly fund Medicaid, a program that pays for health care--including dental care--for low-income and disabled persons. Gauging the extent of efforts to address the problem through Medicaid and related programs has been difficult, because the implementation of these programs differs from state to state. To explore these issues in more depth, you asked us to report on (1) the dental health status of Medicaid beneficiaries and other vulnerable populations and (2) the extent to which these groups have dental coverage and use dental services. At your request, we are also conducting a second study in which we will identify major barriers to dental care and assess federal and state efforts to overcome them.

To respond to your request, we analyzed dental health and data on the use of dental health care from four national health surveys and surveyed Medicaid and related programs state by state. We also analyzed Medicaid payment data for dental services. Appendix I explains our methodology. We conducted our work from October 1999 to February 2000 in accordance with generally accepted government auditing standards.

Dental disease is a chronic problem among many low-income and vulnerable populations. Our analysis of the most recent national health surveys (1994-97) showed that relative to more affluent segments of the population, low-income populations had a disproportionate level of dental disease. For example, poor children had five times more untreated dental caries

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(cavities) than children in higher-income families, and poor adults were much more likely to have lost six or more teeth to decay and gum disease than higher-income adults. Minority populations also faced high levels of dental disease. Dental problems result in pain, infection, and millions of lost school days and workdays each year.

Although every state Medicaid program offers dental coverage for children and most programs cover adults eligible for Medicaid, use of dental services by low-income people is low. States are required to provide comprehensive dental benefits for children enrolled in Medicaid, and the State Children's Health Insurance Program (SCHIP) provides variable but often substantial levels of dental coverage to eligible low-income children in all but two states. Adult dental services, although optional under Medicaid, are covered to some extent in about two-thirds of the states. The availability of coverage does not, however, bridge the income gap to equalize the likelihood of visiting a dentist. For example, our analysis of 1995 Medicaid claims data showed that only 29 percent of enrolled adults had visited the dentist in the preceding year, less than half the rate of higher-income adults. National survey data also showed that in 1996 poor children and adults visited the dentist at about half the rate of their higher-income counterparts--numbers that had stayed relatively unchanged since 1977.

Medicaid is the largest public program of health care insurance for low-income people. As a joint federal and state program, it finances health care coverage for about 40 million people, over half of whom are children. Nationwide, combined federal and state expenditures were \$177 billion in 1998. The states operate their Medicaid programs within broad federal requirements and can elect to cover a range of optional populations and services, thereby creating programs that differ substantially from state to state. Despite this variation, some services are mandated under federal law. For instance, in 1967 the Congress created the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service within Medicaid to help ensure that children receive needed medical and dental care. Under EPSDT, the states must provide comprehensive medical and dental services for all enrolled children, even if the services are not normally covered by a state's Medicaid program. While EPSDT requires the states to provide certain care for children, many services for adults, such as dental care, are optional under state Medicaid programs.

Although Medicaid covers low-income people, only about half of those living in poverty were eligible for Medicaid in 1996, according to the Congressional Research Service. This is largely because of eligibility restrictions that make benefits available only to certain low-income categories, such as families with children and the aged, blind, and disabled.¹ While the Congress expanded eligibility for pregnant women and children several times beginning in 1984, the states can expand coverage to these populations beyond federal requirements. To expand health coverage to children whose families have incomes that are low, but not low enough to qualify for Medicaid, in 1997 the Congress created SCHIP as title XXI of the Social Security Act. In return for an enhanced federal matching share, states can expand coverage to low-income children in families earning up to 200 percent of the federal poverty level.² To implement SCHIP, the states have three options: They can expand their existing Medicaid program, develop a separate SCHIP program, or do some combination of both. Coverage of dental services is not mandatory for children under SCHIP as it is in Medicaid, but if a state elects a Medicaid expansion, it must offer the same comprehensive benefit package, including dental services, that is required under EPSDT. By September 1999, nearly two million children were enrolled in the 53 operational programs. Fifty-six states and territories had SCHIP programs that the Health Care Financing Administration (HCFA) had approved; three had not begun enrollment.

The federal government collects information on the nation's dental health through several nationwide health surveys. The surveys are designed for different purposes and thus have different strengths and weaknesses. For

example, dental information in the Centers for Disease Control and Prevention's (CDC) National Health and Nutrition Examination Survey III (NHANES III) included examinations that dentists performed. The survey provided a representative sample of dental health nationwide, but the results could not be narrowed to the state level. In contrast, data from CDC's Behavioral Risk Factor Surveillance System (BRFSS) can be examined at the state level, but not all states have conducted the oral health module, and the survey relies on self-reported data that are likely to overlook some conditions such as untreated tooth decay. We examined data from a combination of surveys conducted by CDC and the Department of Health and Human Services' (HHS) Agency for Healthcare Research and Quality (AHRQ) in order to minimize individual survey limitations (see table 1).³

Table 1: Four National Health Surveys With Dental Data, 1988-97

Survey	Data used in study	Description
National Health and Nutrition Examination Survey 1988-94 III (NHANES III), CDC		A nationally representative survey of the prevalence, trends, and risk factors for selected diseases. Oral assessments were conducted by dentist examiners.
National Health Interview Survey (NHIS), CDC	1994	A broad, nationally representative survey that monitors trends in illness and disability and tracks progress toward national health objectives.
Medical Expenditures Panel Survey (MEPS), AHRQ	1996	A nationally representative survey of health care use, expenditures, sources of payment, and insurance coverage. Data are collected through in-person, telephone, and mailed surveys. Providers are contacted to verify and supplement reported events.
Behavioral Risk Factor Surveillance System (BRFSS), 1995-97 CDC		A state-based random telephone survey of the prevalence of major behavioral risks associated with premature morbidity and mortality among adults. Provides state-specific estimates.

Note: Dental questions vary from year to year within surveys. We used the most recent survey data available for our analyses.

Recognizing the importance of good oral health, HHS established oral health goals as part of its departmentwide Healthy People 2000 initiative. HHS set goals, such as reducing untreated caries in children and increasing regular dental visits by adults, for the population in general and some minority groups. Interim assessments showed that progress toward these goals was mixed, with poor and minority groups being furthest from reaching them. HHS established a new set of oral health goals in its Healthy People 2010 initiative, announced in January 2000.

In April 1997, the Secretary of HHS commissioned the first Surgeon General's Report on Oral Health. Under the direction of the National Institute of Dental and Craniofacial Research, the study will examine the relationships between oral health and general health and well-being. Highlights are expected to include the determinants of oral health, the effects of oral health on daily living, leading-edge technologies, preventive approaches, and community-based interventions to improve oral health. The report's

publication is planned for spring 2000.

Oral health includes prevention or elimination of a number of diseases and conditions that occur in the mouth, such as gum disease and oral cancer. Many factors can affect an individual's oral health, including personal behavior such as oral hygiene and diet, as well as environmental factors, such as community water fluoridation. We used tooth decay as a key indicator for our work because it is the most common oral disease, data are readily available, and it can be a sentinel condition for dental care.

Poor oral health afflicts many low-income and other vulnerable populations. Analysis of key dental health indicators--including untreated tooth decay and restricted activity days for children and untreated tooth decay and tooth loss for adults--showed large disparities between low-income groups and their higher-income counterparts. Many vulnerable populations, including homeless people, minorities, and some rural residents, face similar problems.

Tooth decay, the most common chronic childhood disease, is most prevalent among poor children. About 25 percent of all children have untreated caries in their permanent teeth. Eighty percent of untreated caries in permanent teeth are found in roughly 25 percent of children who are 5 to 17 years old, mostly from low-income and other vulnerable groups. Left untreated, the pain and infection caused by tooth decay can lead to problems in eating, speaking, and attending to learning.

Our analyses of national survey data show that the prevalence of untreated caries in the lowest income group was much greater than that in the highest income group for children of all ages. For example, among children aged 2 through 5 who had family incomes below \$10,000, nearly one in three had at least one decayed tooth that had not been treated. In contrast, only 1 in 10 preschool children whose family incomes were \$35,000 or higher had untreated caries. As shown in figure 1, these income-based disparities generally hold for untreated caries in both children's primary (baby) teeth and permanent teeth across all age groups.

Figure 1: Percentage of Children With Untreated Caries by Family Income
Source: NHANES III, CDC, 1988-94.

Another key indicator of dental health is the number of missed activity days, such as days of school or work, because of dental problems.⁴ Surveys show that missed activity days are concentrated in low-income groups. Poor children suffer nearly 12 times more restricted-activity days, such as missing school, than higher-income children as a result of dental problems (see figure 2).

Figure 2: Restricted Activity Days per 100 Children Because of Dental Problems by Family Income
Source: NHIS, CDC, 1994.

Poor oral health and dental disease often continue from childhood into adulthood because tooth decay and periodontal disease are progressive and cumulative throughout life. Low-income adults have more untreated caries and suffer from greater tooth loss because of decay or gum disease than their higher-income counterparts. For example, among adults aged 19 to 64 who had family incomes of less than \$10,000, nearly one in two had at least one decayed tooth that had not been treated. In contrast, only one in six adults whose incomes were \$35,000 or more had untreated caries (see figure 3).

Figure 3: Percentage of Adults With Untreated Caries by Family Income
Source: NHANES III, CDC, 1988-94.

Another important marker of dental health is tooth loss from decay or gum disease. Left untreated, caries and gum disease eventually lead to tooth loss. Our analysis of CDC survey data shows that low-income adults suffer

more severe tooth loss than their wealthier counterparts. For example, adults in families earning less than \$15,000 per year were more than 2-1/2 times as likely to have lost six or more teeth from decay or gum disease as adults in families earning \$35,000 or more (see table 2).

Table 2: Percentage of Adults With Tooth Loss From Decay or Gum Disease by Family Income

Number of teeth lost	Less than \$15,000	\$15,000-\$34,999	\$35,000 or more
None	34%	40%	51%
1-5	30	33	34
6 or more	34	25	13
Other or no response	2	2	1

Note: Columns may not total 100 percent because of rounding.

Source: BRFSS, CDC, 1995-97.

The same characteristics of poor dental health can be seen in various populations that are generally considered to be at higher risk for dental problems or may have a disproportionate number of persons living in low-income situations. Health surveys consistently show that minority groups have higher levels of unmet dental health needs. Recognizing this disparity, HHS has set specific goals for some minority groups as part of its departmentwide initiatives. Further, in planning for its Healthy People 2010 initiative, HHS reported that minorities, particularly Native Americans, experience significantly greater levels of untreated tooth decay (see table 3).

Table 3: Percentage of Selected Ethnic Groups With Untreated Tooth Decay

Group	Age in years			
	2 to 4	6 to 8	15	35 to 44
Total	16%	29%	20%	27%
Native American	68	69	66	a
Asian and Pacific Islander	30	71	a	a
African American	22	36	29	46
Mexican American	24	43	27	34
White	11	26	195	24

aData not statistically reliable.

Source: HHS, Healthy People 2010 Conference Report: Oral Health Survey of Native Americans, Indian Health Service service areas, 1999; California data for Asian and Pacific Islander, 1994; all other, NHANES III, CDC, 1994.

Among the most vulnerable low-income populations are homeless people. For millions of homeless men, women, and children, maintaining personal hygiene in general is a challenge, and finding a place to practice routine good oral hygiene may be nearly impossible for some. Homeless persons have more grossly decayed and missing teeth than even low-income persons who live in stable housing. Homeless children are more likely to never have visited a dentist. One-third of homeless families responding to a 1999 survey reported their children had never visited a dentist, and 17 percent reported that their children had needed to see a dentist in the preceding year but were unable to do so.⁵ For homeless adults, the survey found 54 percent had not seen a dentist in at least 2 years, and 46 percent reported they needed to see a dentist in the preceding year but were not able to do so.

of Coverage

While the states offer comprehensive dental coverage to most low-income children and some adults, the use of dental care is low. In response to our survey, state Medicaid agencies reported comprehensive dental coverage for children but more limited coverage for adults. Our analysis of two key

markers of the use of dental care--the rate of dental visits in the past year for children and adults and the use of sealants for children--showed that low-income populations use dental services at a much lower rate than more affluent groups. Our comparison of state Medicaid coverage for adults and rates of dental visits showed a small increase in use as coverage increased.

National surveys have shown little improvement in the use of dental care among low-income populations over the past two decades. In 1996, persons in low-income groups made dental visits at about half the rate of their higher-income counterparts, a finding similar to survey results in 1977 and 1987 (see figure 4).

Figure 4: Percentage of Population Who Made a Dental Visit in the Preceding Year: 1977, 1987, and 1996

Note: The federal poverty level for a family of four was \$6,191 in 1977, \$11,611 in 1987, and \$16,036 in 1996.

Source: AHRQ unpublished data: National Medical Care Expenditure Survey, 1977; National Medical Expenditure Survey, 1987; MEPS, 1996.

Adults' Coverage Varies

Under EPSDT, all states are required to provide comprehensive dental services to enrolled children. While the states have considerable flexibility in the benefits packages they can offer under SCHIP, all but Colorado and Delaware offer substantial dental coverage. Adult dental coverage is optional under Medicaid, but about two-thirds of the states indicated that they cover some dental services. However, many impose considerable limitations. (See table 4.)

Table 4: Number of States That Provide Dental Coverage for Children and Adults

Category of services (typical service)	Children		Adult Medicaid
	EPSDT	SCHIP	
Emergency	51	49	42
Preventive (prophylaxis, sealants)	51	49	27
Diagnostic (clinical oral evaluations)	51	49	32
Routine restorative (amalgam, resin restoratives)	51	49	29
More complex (crowns, bridges, dentures)	51	43	30

Source: GAO Jan. 2000 survey of 50 state Medicaid and SCHIP agencies and the District of Columbia.

Although the states offer comprehensive dental coverage to all enrolled children and many adults, a significant gap exists between the number who are eligible and the number who are enrolled. An estimated 4.7 million uninsured children were eligible for Medicaid but not enrolled in 1996. While comparable estimates are not available for adults, a 1999 HCFA-sponsored study estimated that, nationwide, 46 percent of the persons who were potentially eligible were not enrolled in Medicaid.

Having poor oral health and armed with Medicaid or SCHIP dental coverage, poor people might be expected to make substantial use of dental services. However, they often do not receive the care they need. Our analysis of national surveys shows that low-income children and adults do not visit the dentist as often as their higher-income counterparts. A separate analysis of Medicaid billing data for 1995 confirms the low use of dental care in Medicaid's fee-for-service programs in the 27 states where data were available. We could not, however, determine from either the survey or billing data the extent to which low use was the result of individuals' not seeking dental care or a lack of available dental services.

Most Children of Low-Income Families Do Not Visit the Dentist Regularly

National survey data from 1996 show that low-income children were largely not receiving regular dental care. For example, about 36 percent of 6-to-18-year-olds living at or below the federal poverty level had visited a dentist in the preceding year compared with about 71 percent living in families with incomes higher than 400 percent of the federal poverty level. At all ages, children in the highest income group were about twice as likely to have made a dental visit as children at or below the federal poverty level (see figure 5).

Figure 5: Percentage of Children Who Made a Dental Visit in the Preceding Year by Family Income

aData insufficient for the 101 to 200 percent category.

Note: The federal poverty level for a family of four was \$16,036 in 1996.

Source: MEPS, AHRQ unpublished data, 1996.

Although the large number of eligible recipients not enrolled in Medicaid or SCHIP explains part of the absence of dental care, it is not the only reason. Children enrolled in Medicaid, as a subset of all low-income children described above, also show low use of dental care. We analyzed data from HCFA's State Medicaid Resource File to assess the extent to which individual state Medicaid programs had been billed for dental care for children. This analysis of 1995 data (the most recent available) from 27 state Medicaid programs showed that only about one in three children (34 percent) enrolled in Medicaid fee-for-service plans had visited the dentist in the preceding year.⁶

Another indicator of the use of dental care by children is the use of sealants on permanent teeth. Sealants are plastic-like coatings that can dramatically reduce the likelihood of caries. HHS established a Healthy People 2000 goal of having at least 50 percent of children with sealants on permanent molars. Our analysis showed that none of the income groups had achieved this goal and that the poorest children were furthest away. For example, only 12 percent of children aged 6 to 14 living at or below the federal poverty level had at least one sealant--roughly one-third the incidence of children in higher-income families (see figure 6).

Figure 6: Percentage of Children With at Least One Sealant by Family Income

Source: NHANES III, CDC, 1988-94.

Most Low-Income Adults Do Not Visit the Dentist Regularly

Low-income adults also make fewer visits to dentists than their higher-income counterparts. Adults living at or below the federal poverty level are less than half as likely to have seen a dentist in the past year as adults earning more than four times the poverty level (see figure 7).

Figure 7: Percentage of Adults Who Made a Dental Visit in the Preceding Year by Family Income

Note: The federal poverty level for a family of four was \$16,036 in 1996.

Source: MEPS, AHRQ unpublished data, 1996.

Our analysis of Medicaid payment data also shows low utilization by enrolled adults. Dental claims billed to Medicaid in 1995 for the 18 states that cover adult dental services show that only 29 percent of adults enrolled in Medicaid fee-for-service had visited the dentist in the preceding year.⁷ In comparison, nationwide AHRQ data for 1996 showed that 44 percent of adults aged 19 to 64 had made a dental visit in the preceding year. Our analysis was limited to fee-for-service encounters because consistent and reliable data for Medicaid beneficiaries enrolled in managed care plans were not

available.

In general, residents of rural areas are slightly less likely to have visited a dentist in the past year than urban residents. While access to dental care is a persistent problem for residents of many rural areas, our analysis of national data for all nonmetropolitan counties shows, in general, these residents just slightly behind metropolitan area residents in dental visits (see table 5).

Table 5: Percentage of Residents Making a Dental Visit in 1996 by Metropolitan Area and Income

Area	Family income as a % of the federal poverty level		
	0-200%	201%-400%	401% or more
Central metropolitan counties	29%	43%	58%
Other metropolitan counties	29	49	57
Nonmetropolitan counties adjacent to metropolitan areas	29	41	58
Nonmetropolitan counties not adjacent to metropolitan areas	22	47	53

Note: The federal poverty level for a family of four was \$16,036 in 1996.

Source: MEPS, AHRQ unpublished data, 1996.

The rates at which dental services are used vary significantly for all income groups among the states. CDC survey data show that the proportion of adults who made a dental visit in the preceding year ranged from a low of 33 percent in Arkansas to a high of 61 percent in Hawaii for those with less than \$15,000 annual family income.⁸ Higher income groups show similar variations of between 66 and 83 percent. Within states, utilization was not uniform among income groups. For example, Alaska had one of the higher rates for the low-income group (55 percent) but one of the lower rates for the highest income group (69 percent). Conversely, Kentucky had one of the lowest rates for the low-income group (35 percent) but one of the highest rates for the highest income group (79 percent). Appendix I contains data for all 46 states that reported data from the optional BRFSS oral health module.

To determine whether Medicaid coverage affected the variation among states, we compared rates for the use of dental services for the 27 states reporting Medicaid payment data. Our analysis of HCFA's 1995 fee-for-service payment data showed wide variations between states for both children and adults. For children enrolled in Medicaid, the proportion who made a dental visit in the preceding year ranged from a low of 22 percent in Delaware to a high of 58 percent in Vermont. By comparison, in states that cover partial or full adult dental care under Medicaid, adults' use of dental care was generally much lower, ranging from less than 6 percent in Colorado to 46 percent in Iowa. While Medicaid's policy of mandatory dental coverage for children and optional coverage for adults may explain these differences, it does not explain the wide variation among states for children. Appendix I contains data for all 27 states that submitted payment data to HCFA in 1995.

Dental disease is a chronic problem among low-income populations. Key markers of dental health and the use of services for dental problems, such as untreated caries and lost teeth, show that low-income populations bear a disproportionate level of dental disease and make fewer dental visits. Disparities exist despite coverage of dental services under Medicaid and SCHIP programs. The poor oral health and relatively low use of dental care even among Medicaid enrollees suggest that barriers other than access to insurance coverage contribute to the problems faced by low-income populations. Frequently cited barriers include a shortage of dentists in some areas, unwillingness of dentists to participate in Medicaid, low Medicaid reimbursement rates and the program's administrative burden, and

unresolved patient education issues. In a subsequent report, we will examine these barriers in more detail, as well as federal and state initiatives to address them.

We provided a draft of this report to HHS for comment. HHS concurred with our findings and reiterated its commitment to eliminating dental access disparities and promote oral health, particularly for disadvantaged populations. It also delineated a wide array of initiatives that are planned or under way by its various component agencies, including intra- and interagency collaborative strategies, to help address concerns about oral health disparities. HHS also provided technical comments, which we incorporated where appropriate. HHS's comments are included in full in appendix III.

As we agreed with your offices, unless you publicly announce the report's contents earlier, we plan no further distribution of it until 14 days from the date of this letter. We will then send copies to the Honorable Donna E. Shalala, Secretary of HHS, and others who are interested. We will make copies available to others upon request. This report was prepared under the direction of Frank Pasquier, Assistant Director. Other individuals who made key contributions include Rashmi Agarwal, Sophia Ku, Terry Saiki, Stan Stenersen, and Kim Yamane. Please call me at (202) 512-7118 if you or your staff have any questions.

Kathryn G. Allen
Associate Director, Health Financing
and Public Health Issues

Scope and Methodology

To determine the oral health status and use of dental care of Medicaid and other low-income populations, we analyzed data by income group, age, urban and rural locations, and insurance status from several nationally representative health surveys, including

- National Health and Nutrition Examination Survey III (NHANES III), Centers for Disease Control and Prevention (CDC), 1988-94;
- National Health Interview Survey (NHIS), CDC, 1994;
- Medical Expenditures Panel Survey (MEPS), Agency for Healthcare Research and Quality (AHRQ), 1996; and
- Behavioral Risk Factor Surveillance System (BRFSS), CDC, 1995-97.

Data from the different surveys we examined produce somewhat different results for similar questions.⁹ Differences in survey design, collection methods, timing, and other factors affect survey results. Important trends and disparities were, nevertheless, consistent across all four surveys. Differences in survey design also affect our ability to compare results between surveys. For example, some surveys ask for specific income levels and family size and thus can be converted to federal poverty levels, while others ask for income only in general categories that cannot be expressed in terms of poverty level.

To determine which dental benefits were covered by state Medicaid and the State Children's Health Insurance Programs (SCHIP), we analyzed data from the American Dental Association (ADA) and the Health Care Financing Administration (HCFA). We also surveyed each state Medicaid agency to complete and update data on dental coverage under state Medicaid and SCHIP.

To assess available data on state Medicaid dental care for children and adults covered by fee-for-service arrangements, we analyzed HCFA's State Medicaid Resource File (SMRF). This database provides summarized information on Medicaid eligibility, claims, and utilization for states that participate

in the Medicaid Statistical Information System. To facilitate research, HCFA has adjusted and reformatted the data and added service and eligibility codes. The data are arranged in five separate research files: Drug Claims, Inpatient Claims, Long-Term Care Claims, Other Ambulatory Claims, and Person Summary. Claims information is not available for children and adults in Medicaid managed care arrangements, and reliable data on health care services provided to managed care enrollees were not available at the time of our review.

We used the Person Summary and the Other Ambulatory Claims files to determine the percentage of children aged 0 to 18 and adults aged 19 to 64 who had received dental services in 1995. The Person Summary file contains characteristics such as date of birth and dates of coverage for each person covered by Medicaid during the year. The Other Ambulatory Claims file contains records for dental services received. Our analysis was limited to 1995 data from the 27 states that provided data to HCFA for that year. According to HCFA officials, 1995 is the most recent year for which reliable claims data are available.

We performed separate analyses for children aged 0-18 and adults aged 19-64. We limited our analysis to children and adults for whom the data indicated that they were covered by Medicaid for the entire year in order to make sure that we did not include beneficiaries who may have switched to, and received care from, a managed care plan during the year.

Other than making these control checks, we did not independently verify the SMRF data because (1) HCFA's process for modifying the data includes quality control phases in which the data are analyzed with a number of statistical tools and crosswalks and (2) the data originated at the state level and the benefit of tracking them back to their source would not have outweighed the considerable cost and staff resources that this would have entailed. These data represent the most current and complete data available on state-level billing within Medicaid fee-for-service programs.

State Data Tables

Table 6: Percentage of Adults Who Made a Dental Visit in the Preceding Year by Annual Family Income

Continued

State	Less than \$15,000	\$15,000-\$34,999	\$35,000 or more
Alabama	43%	62%	77%
Alaska	55	67	69
Arizona	55	61	74
Arkansas	33	58	66
California	45	58	71
Colorado	43	56	73
Connecticut	46	65	81
Florida	51	62	74
Georgia	45	63	74
Hawaii	61	72	80
Idaho	42	57	75
Illinois	41	61	74
Indiana	48	58	74
Iowa	47	58	70
Kansas	45	55	76
Kentucky	35	56	79
Louisiana	40	57	72
Maine	38	58	77
Maryland	46	62	70
Massachusetts	54	60	73
Michigan	43	66	81
Mississippi	35	56	73
Missouri	42	56	70

Montana	53	63	75
Nebraska	44	65	80
Nevada	42	49	72
New Hampshire	49	67	80
New Jersey	53	61	78
New Mexico	45	63	77
New York	53	64	79
North Dakota	49	63	77
Ohio	43	61	83
Oklahoma	41	57	77
Oregon	54	64	77
Pennsylvania	48	61	79
Rhode Island	49	61	69
South Dakota	56	68	83
Tennessee	37	58	78
Texas	37	54	71
Utah	55	66	78
Vermont	55	64	77
Virginia	41	60	76
Washington	46	63	70
West Virginia	34	54	76
Wisconsin	60	66	78
Wyoming	51	60	70

Note: Dental data not available for Delaware, Minnesota, North Carolina, and South Carolina.

Source: BRFSS, CDC, 1995-97.

Table 7: Medicaid Coverage of Adult Dental Care

Continued

State	Full	Partiala	Noneb
Alabama			X
Alaska			X
Arizona		X	
Arkansas			X
California	X		
Colorado		X	
Connecticut	X		
Delaware			X
District of Columbia			X
Florida		X	
Georgia			X
Hawaii			X
Idaho		X	
Illinois		X	
Indiana	X		
Iowa	X		
Kansas			X
Kentucky		X	
Louisiana		X	
Maine	X		
Maryland			X
Massachusetts	X		
Michigan	X		
Minnesota	X		
Mississippi			X
Missouri		X	
Montana		X	
Nebraska		X	
Nevada			X
New Hampshire			X
New Jersey	X		

New Mexico	X		
New York	X		
North Carolina		X	
North Dakota	X		
Ohio		X	
Oklahoma			X
Oregon		X	
Pennsylvania	X		
Rhode Island		X	
South Carolina			X
South Dakota		X	
Tennessee			X
Texas			X
Utah		X	
Vermont		X	
Virginia		X	
Washington	X		
West Virginia			X
Wisconsin	X		
Wyoming			X

a States do not cover particular services (preventive, diagnostic, restorative, or more complex), or they impose other limitations on coverage, such as a \$475 annual ceiling.

b None or emergency services only.

Source: GAO survey of state Medicaid and SCHIP agencies, Jan. 2000.

Table 8: Percentage of Medicaid Fee-for-Service Recipients Who Made a Dental Visit in the Preceding Year

State	Children	Adults
Weighted average	33.5%	29.0%
Alabama	29.1	a
Alaska	45.1	a
Arkansas	36.8	a
California	31.8	34.5
Colorado	32.4	5.6
Delaware	21.8	a
Florida	33.7	11.5
Georgia	36.2	a
Indiana	26.0	24.2
Iowa	47.9	45.7
Kansas	38.9	a
Kentucky	34.3	23.1
Maine	41.4	10.0
Michigan	39.4	30.6
Mississippi	32.0	a
Missouri	27.1	25.7
Montana	35.8	35.4
New Hampshire	56.1	a
New Jersey	33.8	28.2
North Dakota	37.2	35.3
Pennsylvania	38.4	22.6
Rhode Island	28.6	26.6
Utah	30.7	34.8
Vermont	58.3	42.7
Washington	35.0	31.9
Wisconsin	26.5	32.6
Wyoming	40.1	a

a State does not provide dental coverage for adults or provides only emergency care.

Source: SMRF, HCFA, 1995.

Comments From the Department of Health and Human Services

(101888)

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1. For example, by law, the states must provide Medicaid eligibility to pregnant women, to infants, and to children up to age 6 whose family income is up to 133 percent of the federal poverty level and children aged 6 to 15 whose family income is up to 100 percent of the federal poverty level. Many adults do not qualify for Medicaid unless they are aged, blind, or disabled.

2. Under Medicaid, the federal government will match a state's contribution from 50 to 77 percent in fiscal year 2000, depending on the state's average income level. Under SCHIP, the states are eligible for an enhanced federal matching share of 65 to 84 percent. SCHIP allows states with Medicaid incomes that already approach or exceed 200 percent of the federal poverty level to expand eligibility to up to 50 percentage points above their existing Medicaid eligibility standards.

3. Formerly the Agency for Health Care Policy and Research (AHCPR).

4. A National Institute of Dental Research study of 1989 NHIS data found that children missed about 52 million school hours (more than 8 million school days) and adults missed more than 20 million work days because of dental treatment or problems in 1989. However, missed days from dental problems alone cannot be disaggregated from the total. More current estimates are not available

5. Interagency Council on the Homeless, Homelessness: Programs and the People They Serve (Dec. 1999)

6. HCFA's State Medicaid Resource File contains Medicaid fee-for-service information on eligibility, billing claims, and utilization for states that participate in the Medicaid Statistical Information System. Billing data are limited to the extent that they do not provide information on provided services for which no reimbursement was sought. This analysis does not include information on children who may have made a dental visit under a managed care plan, because such data are not available.

7. Of the 27 states that submitted billing data to HCFA in 1995, 9 did not cover adult dental services or covered only emergency services. Our analysis was limited to adults who were enrolled in Medicaid for a full year and who presumably had no other source of insurance.

8. National data from AHRQ's survey cannot be analyzed state by state. Instead, we used CDC's state-based BRFSS. Because the two surveys differ in their purpose, survey questions, and protocols, they yield somewhat different results, but important trends and disparities remain. Of note, MEPS gathers income and family size data that can be expressed as a percentage of the federal poverty level. BRFSS gathers income data only in broad categories that cannot be correlated with federal poverty levels.

9. See Mark D. Macek and others, "A Comparison of Dental Utilization Estimates From Three National Surveys," abstract, Association for Health Services Research, Washington D.C., June 28, 1999.

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