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Health Policy Brief

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Despite Insurance, the Poorest Adults Have the Worst Access to Dental Care

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SUMMARY: Oral health is critical for overall health and well-being, yet it is not considered an essential health benefit for adults under the Patient Protection and Affordable Care Act. Long-standing income disparities in oral health have been documented and are linked to lower rates of dental insurance and subsequent limited access to oral health care. We examined pooled data from the 2017 and 2018 California Health Interview Surveys to assess whether there were income and dental insurance disparities among California adults, and, if so, whether such disparities included access to timely dental care. We found that low-income California adults were less likely to have had timely dental visits, more likely to have had visits for dental problems, and less likely to have had private dental insurance than their higher-income counterparts. We also found that dental insurance alleviated some, but not all, income disparities in access. These findings highlight the importance of considering dental health as an essential health benefit and of ensuring parity in dental benefits, among other potential policy solutions for reducing disparities in dental coverage and access.

"Dental services are not an essential health benefit under the ACA and are not covered by public programs such as Medicare."

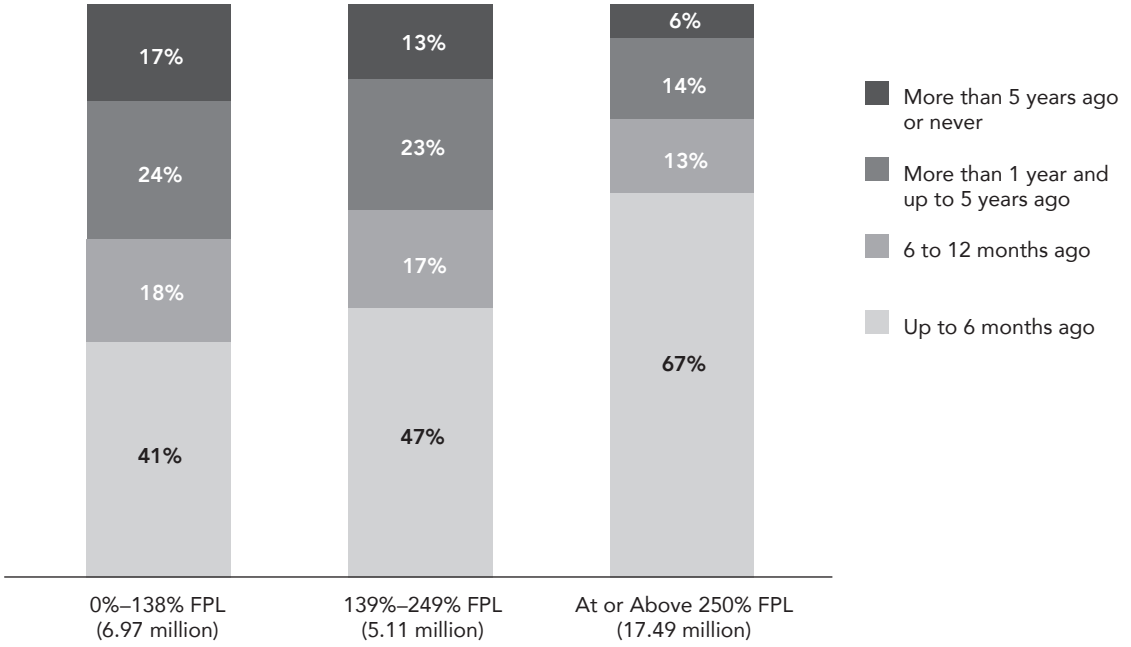
Oral health is an integral component of overall health.[1] Evidence indicates that oral health depends on timely care that includes oral health education, preventive services, and early detection and treatment of dental problems.[1] However, evidence also indicates that low-income adults have poorer oral health, which is potentially linked to lack of dental insurance.[2]

Like health insurance, dental insurance promotes access to care by reducing financial barriers to access.[3] However, dental insurance is different from health insurance in several respects. For one thing, private dental insurance is offered less frequently than health insurance by employers. Without premium sharing from employers, dental insurance premiums are less affordable to lower-income populations. In addition, dental services are not considered an essential health benefit under the Patient Protection and Affordable Care Act and are not covered by public programs such as Medicare. Adult dental benefits are optional for Medicaid (Medi-Cal in California), and California is one of 35 states that include this benefit.[4] Most dental insurance policies have an annual cap on benefit amounts, as well as restrictions on coverage of some services.[5,6] Medi-Cal has lower provider reimbursement levels and a lower rate of provider participation than private dental insurance.[7] Private insurance may also have high levels of cost sharing on specific services, which may contribute to reduced dental visits.[8]

Access to dental care is measured by visits to dental providers to receive preventive care and dental treatment. Healthy People 2020 set the target for this access indicator as at least one dental visit per year for 49% of the population by 2020.[9] The frequency of visits varies by

Exhibit 1

Timeliness of Dental Visits by Federal Poverty Level (FPL), Adults Ages 18 and Older, California, 2017–2018



Sources: 2017 and 2018 California Health Interview Surveys

"Our aim was to assess whether income disparities in access to dental care exist, and what potential role dental insurance might have in addressing these disparities."

dentist recommendations, which are based on the oral health of individuals. Most dental insurance policies and Medi-Cal cover up to two preventive visits per year.

This policy brief examines timeliness of and reasons for dental visits among California adults by income and insurance coverage. We pooled data from the 2017 and 2018 California Health Interview Surveys (CHIS) to obtain the most recent available data on oral health access for California adults. Our aim was to assess whether income disparities in access to dental care exist among California adults, and, if such disparities exist, what potential role dental insurance might have in addressing these disparities.

We used the federal poverty level (FPL) to measure income, identifying California adults with incomes at or below 138% FPL ($17,237 for a single person and $35,535 for a household of four) as those whose incomes were lowest and were consistent with Medi-Cal eligibility criteria.

Low-Income Californians Have Less Timely Dental Visits Than Higher-Income Individuals

There is no single requirement for frequency of dental visits, as the need for care is highly dependent on individual risk factors. However, the American Dental Association recommends a minimum of one annual visit, and most survey data examine this frequency.[10] CHIS respondents reported on how long it had been since they had had a dental visit, which allowed us to examine both variations in annual visits and the time intervals between visits. We found that these indicators varied by income (Exhibit 1). Among low-income adults (0%–138% FPL), we found that 41% had had a dental visit less than six months ago, and 18% had had a visit 6–12 months ago. Combined, 59% of low-income adults (data not shown) had visited a dentist in the last year. In contrast, 67% of those with incomes above 250% FPL ($31,225 for a single person and $64,375 for a household of four) had had a visit less than six months ago, and 13% had

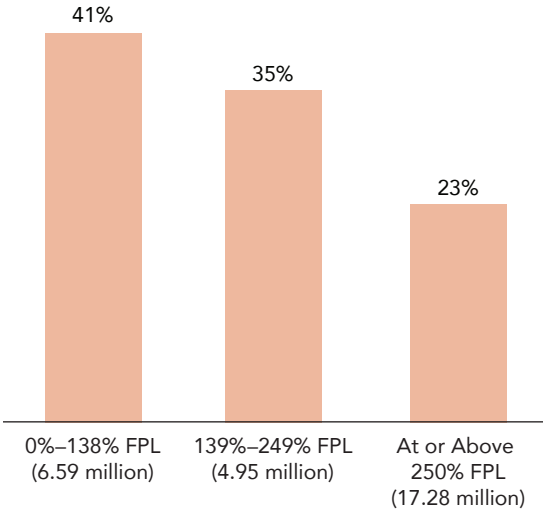
had a visit 6–12 months ago. Combined, 80% of adults with the highest incomes had had a dental visit last year.

Low-Income Californians Visit Dentists More Frequently Than Higher-Income Adults for Dental Problems

CHIS respondents were asked whether their last dental visit was for preventive care, a specific problem, or both. We examined whether low-income adults (0%–138% FPL) had visited dentists for specific problems (including those who had visited for both preventive and specific problems) at a different rate than that of higher-income adults. We found that 41% of low-income adults had visited a dentist for specific problems, compared to 23% of adults with incomes at or above 250% FPL (Exhibit 2).

Exhibit 2

Last Dental Visit for Specific Problem by Federal Poverty Level (FPL), Adults Ages 18 and Older, California, 2017–2018



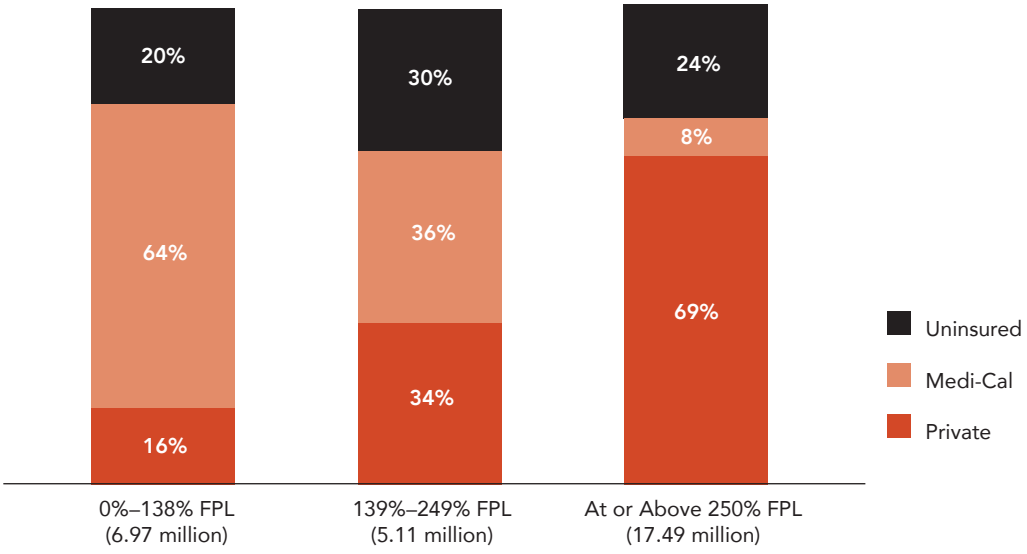
Sources: 2017 and 2018 California Health Interview Surveys

Medi-Cal Is the Dominant Form of Dental Coverage Among Low-Income Adults

We identified adults with private dental insurance, Medi-Cal, and no dental insurance and examined types of coverage reported by income. Sixteen percent of low-income adults (0%–138% FPL) had private dental insurance, and 64% had Medi-Cal (Exhibit 3). In contrast, 69% of those with incomes at or above 250% FPL had private dental insurance, and 8% had Medi-Cal (a small share of higher-income populations received Medi-Cal under specific circumstances, including high medical expenses). Data also showed that a smaller proportion of low-income adults (20%) had no dental insurance compared to those with incomes at or above 250% FPL (24%).

Exhibit 3

Type of Dental Insurance by Federal Poverty Level (FPL), Adults Ages 18 and Older, California, 2017–2018

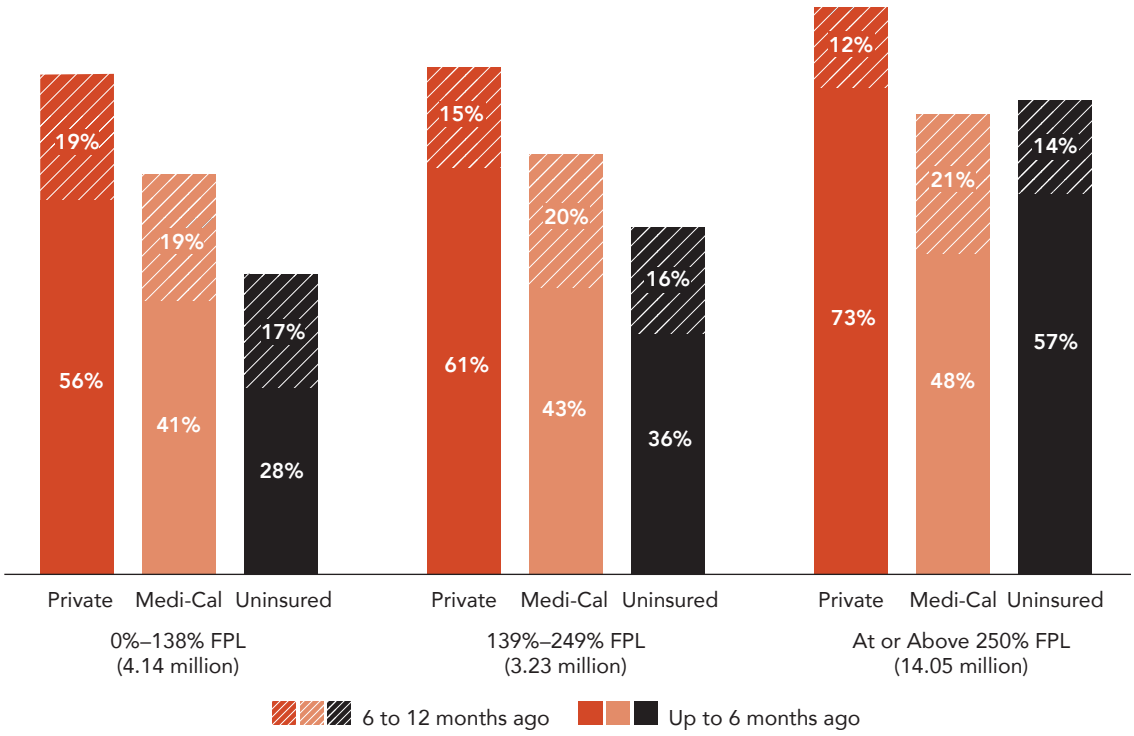


Sources: 2017 and 2018 California Health Interview Surveys

Note: Private dental insurance may include a small proportion with military or other publicly funded coverage.

Exhibit 4

Timeliness of Dental Visits by Dental Insurance and Federal Poverty Level (FPL), Adults Ages 18 and Older, California, 2017–2018



Sources: 2017 and 2018 California Health Interview Surveys

Note: Private dental insurance may include a small proportion with military or other publicly funded coverage.

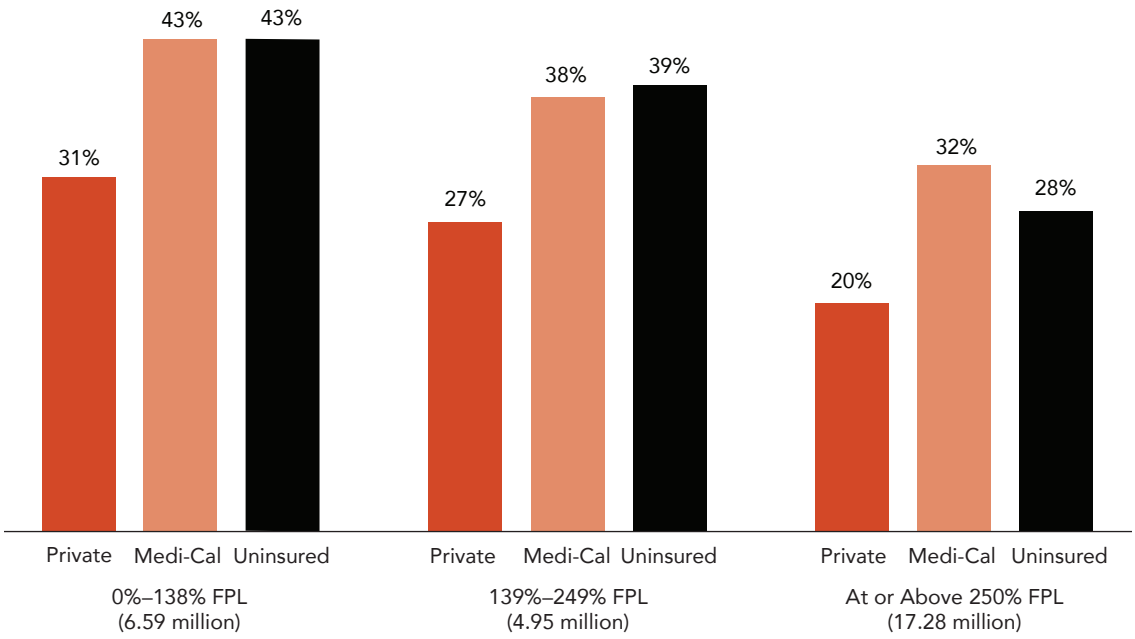
"Having a higher income was significantly associated with more visits … for both privately insured and uninsured adults."

Dental Insurance Improves Timeliness of Dental Visits, but Income Disparities Remain

When we examined the joint relationship of type of insurance coverage with timeliness of visits by income, we found that having a higher income was significantly associated with more visits within the past six months for both privately insured and uninsured adults (Exhibit 4). Among privately insured adults, 56% of low-income adults (0%–138% FPL) had had a visit within the past six months, compared to 73% of those with incomes at or above 250% FPL. Among uninsured adults, 28% of low-income adults had had a dental visit within the past six months, compared to 57% of those with incomes at or above 250% FPL. Among adults with Medi-Cal coverage, however, the timeliness of dental visits did not significantly increase by income.

Last Dental Visit for Specific Problem by Federal Poverty Level (FPL) and Dental Insurance, Adults Ages 18 and Older, California, 2017–2018

Exhibit 5



Sources: 2017 and 2018 California Health Interview Surveys

Note: Private dental insurance may include a small proportion with military or other publicly funded coverage.

Dental Visits for Specific Problems Are Least Common Among Privately Insured Adults, but Income Disparities Persist

We analyzed the data to determine whether rates of dental visits for a specific problem varied by type of dental insurance and income (Exhibit 5). Overall rates for visits due to a specific problem declined significantly for high-income individuals, irrespective of type of insurance. However, results also indicated that privately insured adults in all income groups visited dentists for a specific problem significantly less often than adults who had Medi-Cal or who were uninsured. These rates also varied by income. Among low-income adults (0%–138% FPL), 31% of those who were privately insured reported having visited a dentist for a specific problem, compared to 43% of the Medi-Cal and uninsured groups. Among those with incomes at or above 250% FPL, these rates were lower for those with private insurance (20%) or Medi-Cal (32%) and those who were uninsured (28%).

Implications and Policy Recommendations

We found that a higher percentage of California adults had had a dental visit in the last year than the Healthy People 2020 target of 49%. However, we found income disparities in timeliness of visits, with low-income adults more likely than high-income adults to have had a visit for a dental problem. Furthermore, we found that among those who were uninsured, low-income adults (0%–138% FPL) had the lowest rates of dental visits compared to their higher-

"Low-income adults are more likely to have had a visit for a dental problem."

"Low-income adults have less access to dental services for preventive care and early diagnosis of problems."

income counterparts. Also, we found that although most low-income adults had dental insurance because of enrollment in Medi-Cal, this advantage did not translate into better or more timely access to dental visits for this group compared to those with incomes at or above 250% FPL. Similarly, Medi-Cal coverage did not reduce the likelihood of dental visits for specific problems for low-income adults. Our findings were consistent with other studies that found more public dental coverage, infrequent dental check-ups, fewer dental visits, and higher unmet need for dental treatment among low-income adults compared to higher-income populations.[11, 12]

Collectively, our findings imply that low-income adults (0%–138% FPL) have less access to dental services for preventive care and early diagnosis of problems, which in turn leads to missed opportunities to promote better oral health among this population. Policies are needed that promote the availability of affordable dental insurance for adults. Such policies should involve inclusion of dental services as an essential health benefit, regulation of premiums, standardization of dental benefits and cost sharing, and parity between dental and medical benefits.

Policies are also needed to address the limited role of Medi-Cal in reducing income disparities in access to dental services. In addition, policies should be established that promote higher reimbursement rates for dental services, along with financial and nonfinancial incentives to encourage better participation of dentists in Medi-Cal. Financial incentives have been used successfully by Medi-Cal to promote access to dental care of children.[13] California Proposition 56 provided supplemental payments for several dental services under Medi-Cal during fiscal years 2017–18 and 2018–19. However, the continuation of these payments is in question due to the financial impact of COVID-19 on the state budget. The data in this brief were unlikely to have captured the impact of these payments on access to dental care among Medi-Cal beneficiaries.

The impact of COVID-19 is likely to include significant changes in dental coverage associated with loss of employment-based insurance. The economic recession associated with the virus is also likely to lead to cutbacks in coverage of adult dental care, which is an optional Medi-Cal benefit. These changes are likely to exacerbate the income disparities highlighted in this brief.

Data Source and Methods

We pooled 2017 and 2018 California Health Interview Survey (CHIS) data for these analyses.

Income was measured based on the total annual income of a household divided by the number of individuals in the household and reported as a percentage of the federal poverty level. We considered those who had had Medi-Cal insurance at any time during the past year to have had dental insurance, regardless of their response to the question on having dental insurance. Among the remainder of respondents, we identified those who had had dental insurance and those who had lacked any dental insurance. Some Medi-Cal beneficiaries—particularly those whose income was above 138% FPL—may have had limited-scope Medi-Cal, although this data may be underreported.

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Funder Information

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Endnotes

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CHIS california health interview survey

The California Health Interview Survey (CHIS) covers a wide array of health-related topics, including health insurance coverage, health status and behaviors, and access to health care. It is based on interviews conducted continuously throughout the year with respondents from more than 20,000 California households.

CHIS is a collaboration between the UCLA Center for Health Policy Research, California Department of Public Health, California Department of Health Care Services, and the Public Health Institute. For more information about CHIS, please visit ***chis.ucla.edu***.

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