

Putting Teeth Into Health Care Reform



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INTRODUCTION

Despite consistent reports of the poor oral health of Californians, oral health/dental coverage has been largely absent from the current health care reform discussion. Yet, good oral health is a fundamental part of overall health and function. Oral health not only impacts overall physical health, but also reduces the risk and severity of other systemic conditions and diseases. Maintaining good oral health for all Californians should be a top priority, particularly given that cost-effective preventive measures have the ability to reduce the prevalence of dental disease, leading to cost savings to both consumers and the broader health care system. This policy brief focuses on the importance of including oral health in health care reform efforts, the extent of current dental coverage, barriers to utilization and policy considerations for improving the oral health of all Californians.

IMPORTANCE OF DENTAL COVERAGE TO PHYSICAL HEALTH

Oral Health Contributes to Overall Physical Health and Vice Versa

Extensive research has demonstrated that oral health is integral to maintaining optimal physical health throughout life. When it comes to oral health, an integrated approach to prevention, early detection and management is key. Safe and effective oral disease prevention measures exist that result in significant improvements in oral health at the individual and community levels (e.g., dental sealants and fluoride varnishes for children, fluoridation of water systems). Despite progress and advances in the field, oral health often takes a backseat priority to other health conditions, even though in some cases good oral health demonstrably reduces the risk, prevalence and severity of other associated conditions/diseases, such as diabetes, cardiovascular disease, respiratory diseases and adverse pregnancy outcomes.¹

An abundance of health research over the last few decades demonstrates the adverse effects of poor oral health. Some of the immediate short-term consequences include pain and discomfort, which can interfere with the functions of daily living, such as sleeping, learning in school, and functioning on

the job, often resulting in missed school and work days.¹ According to the Surgeon General's groundbreaking 2000 report on oral health in the U.S., it is estimated that children lost over 50 million hours from school and adults 160 million hours from work annually from dental illness and visits. Longer-term consequences of poor oral health usually involve costly restorative treatment of dental diseases that in a majority of cases could have been prevented or minimized with preventive care and appropriate oral health habits.¹

Poor oral health is also linked to and worsens other health problems, and can also be a manifestation of other health conditions/diseases. A growing number of scientific studies have found associations between oral health and heart disease, stroke, respiratory disease and diabetes. Oral health and overall health are also linked to a number of common health risk factors, such as alcohol and tobacco use and poor dietary habits.^{1,2,3}

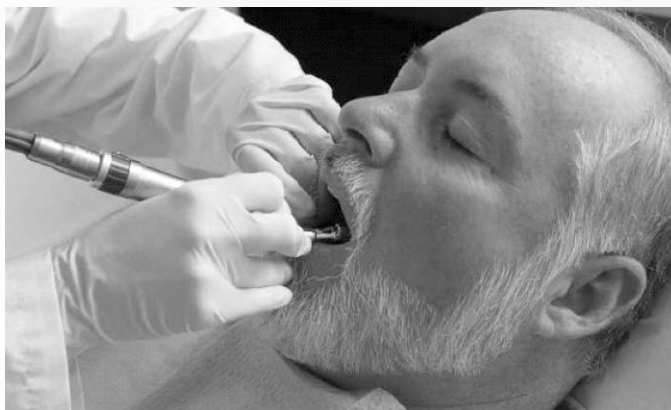
Evidence is mounting that dental care improves physical health and lowers costs. Steadily, insurance plans are not only recognizing the link between oral and overall health, but are also increasing to the availability of oral health care as a deliberate strategy to reduce overall medical care costs. For example, Aetna's Dental/Medical Integration program (launched in 2007) provides enhanced dental benefits to members with targeted health conditions that are impacted by oral disease (i.e., pregnancy, diabetes, heart disease and stroke). Aetna's expanded benefit and outreach program was created in direct response to scientific evidence that demonstrated that early and preventive dental care not only improves oral health status but also lowers the risk and severity of associated health conditions.⁴ More promisingly, Aetna also discovered that increasing access to oral health care for patients with diabetes, cardiovascular disease and cerebrovascular disease reduced overall medical care costs by as much as 16 percent (Table 1). These cost savings reflect the dual benefits of periodontal treatment – improved health outcomes with concomitant savings in the overall health care system. Similarly, Cigna and Delta Dental offer enhanced dental benefits to members with targeted health conditions known to benefit from improved oral health.

Table 1. Cost savings from providing periodontal treatment
Aetna-Columbia University study of 144,000 insured ⁵

History of	Reduced Medical Costs
Diabetes	9%
Coronary Artery Disease	16%
Cerebrovascular Disease	11%

As periodontal infection is also a possible risk factor for preterm and low birth weight deliveries, it has been estimated that by eliminating periodontal infections, approximately 45,500 preterm low birth-weight newborns a year could be avoided nationally, with a concomitant decrease in neonatal intensive care unit costs of \$22,000 per baby, or almost \$1 billion.⁶ Based on an extrapolation of this analysis, Medi-Cal estimated in 2004 that \$29.2 million per year in neonatal infant care costs attributable to periodontal disease in pregnant women could be saved by providing periodontal treatment to Medi-Cal enrolled women during their pregnancy, and this benefit is now available to virtually all pregnant Medi-Cal beneficiaries.

A further indication of the cost savings attributable to providing access to dental services was shown when Maryland eliminated Medicaid reimbursement to dentists for treatment of adults with dental emergencies in 1993. Review of those cuts in dental coverage found that there were subsequent increases in medical care costs and that the rate of emergency room visits for dental problems rose by 12 percent.⁷



There are many tragic situations where major trauma, and even death, have resulted from the lack of access to dental services.

- *Recently, Deamonte Driver, a 12-year-old boy from Maryland died from complications of a dental infection and his inability to find a dental provider. Had he had a dental home with access to early preventive care and screenings he might be alive today and “rather than a quarter million dollar bill to Maryland Medicaid for neurosurgery, he could have been treated with a sealant, a filling, or, if necessary, an extraction – any one of which would cost the state less than \$150.” ⁸*
- *A young autistic California woman who was nonverbal began to act out and hit other residents of her community residential care facility. She was admitted to a locked psychiatric facility at a cost of \$150,000 per year to the State of California. Fortunately, it was eventually discovered she had dental problems. Once her dental problems were treated, her acting out behaviors ceased and she was able to return to her community.⁹*
- *In Louisiana in 2003, a \$70 extraction would have saved an elderly patient 15 days in the hospital, including two days in an intensive care unit, and a \$35,000 medical bill.¹⁰*

Who Suffers Most? Disparities in Oral Health in California

Various factors influence oral health status and healthy behaviors. These include: employment (which is a strong predictor of having private dental insurance), age, cultural variables, and education/income levels.¹¹ In 2000, the California Dental Access Project released a comprehensive report detailing the state of oral health care in California. This report concluded that oral disease in California is caused by a lack of preventive oral health care, particularly to underserved populations. This problem is further compounded by limited access to affordable dental coverage and care in the private sector and an insufficient dental safety net structure that can adequately meet the dental needs of uninsured individuals.² A preliminary 2007 report from the Centers for Disease Control and Prevention showed that while most Americans' oral health has improved since the late 1980s, disparities persist, e.g., utilization of dental services declined among adults and caries prevalence in primary teeth increased for 2-5-year-olds.¹² Hence it is the children, poor, elderly, those who lack adequate coverage and those who experience economic, cultural, physical, geographic, or psychosocial barriers or simple lack of information, who suffer the most from disparities in oral health and in particular in access to dental care.

TABLE 2:
California populations that disproportionately experience barriers in accessing routine dental care: 2, 13, 14, 15, 16, 17, 18

- *Communities of color*
- *Children*
- *Seniors*
- *Rural residents*
- *Low-income populations*
- *Limited-English proficient (LEP) populations*
- *Persons with disabilities or major medical conditions*
- *Persons without dental insurance*

Why Coverage Matters - Dental Coverage and Benefits to Health

Dental coverage links individuals to a source of regular dental care. Research indicates that a child, adult or senior with dental coverage is significantly more likely to seek and use regular dental care than their uninsured counterparts. Studies have also shown that private dental insurance is associated with improved clinical oral health status among the insured.^{11,19,20,21} Hence a loss of coverage could result in declines in oral health status. Children who have dental coverage, regardless of whether the coverage is from public programs (e.g., Medi-Cal, Healthy Families) or from private insurance, show more regular use of preventive care than children without dental insurance.²² Coverage and the use of preventive care not only improves the health of the individual but also results in cost savings that are passed along to consumers and the health system. The California Association of Dental Plans (CADP) cites a study by the Institute of Medicine that found that routine dental care led to substantial cost savings to patients (approximately \$4 billion annually) by reducing the incidence of dental diseases.²³

CURRENT STATUS OF DENTAL COVERAGE

Who is Covered?

In 2006, the National Association of Dental Plans estimated that nearly 163 million Americans are covered by some form of dental benefit through employer-sponsored group plans or other group or individual plans. This represents about 55 percent of the population of the United States.²⁴ Other national data indicate that most persons with private dental insurance come from middle- to high-income families.²⁰ While less than half of the U.S. population has private dental insurance, this insured segment of the population makes up nearly two-thirds of dental patients in the average dental office.²⁵ Among seniors, approximately 20 percent have private dental coverage.²⁶ Residents in urban areas are more likely to have dental coverage than residents living in rural areas.^{14,15}

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CURRENT STATUS OF DENTAL COVERAGE

Who is Covered? *continued*

California residents are far more likely to have medical insurance than dental insurance, and nearly one in three Californians lacks dental coverage. According to data from the California Health Interview Survey (CHIS) in 2003, those who are more likely to have dental coverage include: higher income individuals, those who work full-time, those who work for larger employers, children (due to Medi-Cal and Healthy Families coverage) and African-American, Asian and White Californians.²⁷ [See Table 3.]

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Source: California Health Interview Survey (CHIS) Data - 2003

Continued on next page

TABLE 3: Dental Coverage and Medical Coverage Rates in California				
	2003			
	Dental coverage		Medical coverage	
	Insured	Uninsured	Insured	Uninsured
Total CA Population	69.4%	30.6%	86.0%	14.0%
Income				
0-199% FPL	63.8%	36.2%	75.1%	24.9%
200-299% FPL	64.2%	35.8%	85.2%	14.8%
300%+ FPL	75.2%	24.8%	94.5%	5.5%
Adult employment status				
>20 hours week	69.9%	30.1%	83.8%	16.2%
<20 hours week	60.0%	40.0%	82.2%	17.8%
Unemployed	58.2%	41.8%	82.8%	17.2%
Business/company size (for employed)				
<10 employees	44.4%	55.6%	71.9%	28.1%
10-50 employees	55.4%	44.6%	74.8%	25.2%
51-99 employees	66.8%	33.2%	83.5%	16.5%
100-999 employees	75.1%	24.9%	85.6%	14.4%
1,000 or more employees	86.8%	13.2%	92.7%	7.3%
Ethnicity				
Latino	64.1%	35.9%	73.6%	26.4%
Asian	72.4%	27.6%	88.6%	11.4%
African American	80.7%	19.3%	89.6%	10.4%
White	70.4%	29.6%	92.5%	7.5%
Age				
0-18	81.8%	18.2%	92.9%	7.1%
19-64	66.4%	33.6%	80.6%	19.4%
65+	54.7%	45.3%	99.4%	0.6%

Why Coverage Matters - Dental Coverage and Benefits to Health *Continued*

of preventive care than children without dental insurance.²² Coverage and the use of preventive care not only improves the health of the individual but also results in cost savings that are passed along to consumers and the health system. The California Association of Dental Plans (CADP) cites a study by the Institute of Medicine that found that routine dental care led to substantial cost savings to patients (approximately \$4 billion annually) by reducing the incidence of dental diseases.²³

Availability and Scope of Dental Coverage in the Market

Most individuals with dental coverage obtain it through their employers, typically larger companies or public sector institutions. In addition, many low-income California children and families are eligible to receive dental coverage through the state's public Medi-Cal and Healthy Families programs. Under Medi-Cal, low-income children and adults receive dental coverage primarily through Delta Dental under a program called Denti-Cal. Low-income children with Healthy Families coverage receive dental coverage through competitive state contracts with five dental plans. Several California counties also offer dental coverage to eligible low-income children through local children's health initiatives/Healthy Kids programs, Kaiser Child Health Plan, and CalKids. Lastly, in terms of other publicly financed coverage programs, Medicare does not provide seniors with routine dental care and only provides very limited coverage for dental-related procedures related to other hospital procedures.

Cost Of Dental Coverage

Dental care expenditures accounted for 5.2 percent of national personal health care expenditures and 15.3 percent of all out-of-pocket payments in the U.S in 2005.²⁸ Private dental coverage accounted for nearly half (49.8%) of total dental care expenditures, while the remainder was paid out-of-pocket by consumers (44.2%) and by government (6.0%).²⁹

The cost of dental coverage varies dramatically depending upon several factors, such as type of plan (individual versus group), scope of benefits, cost sharing, waiting periods for certain services, coverage maximums, geographic area and the panel of participating dentists. One benchmark of dental coverage rates in California are those negotiated by the federal Office of Personnel Management (OPM) pursuant to the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 which required OPM to establish arrangements under which supplemental dental and vision benefits will be made available to federal employees, retirees, and their dependents. In California, total dental insurance costs for individual employees enrolled in private dental plans range from approximately \$20 to \$40 a month (\$240 to \$480 annually). For enrolled



couples, dental insurance costs double to \$40 to \$80 a month (\$480 to \$960 annually), and family coverage is approximately triple the cost of individual coverage at \$60 to \$120 a month (\$720 to \$1,440 annually). Most of these plans, however, have annual maximum benefits of \$1200 per individual, and large co-payments for non-preventive services. For example, to be eligible to receive the same periodontal treatment benefits available to pregnant Medi-Cal beneficiaries, federal employees would have co-payments of 50-65 percent of the treatment cost, depending on the plan. Orthodontic benefits are only available after a 24-month waiting period.

As stated earlier, prevention and early detection are vital measures that not only improve oral health outcomes but also result in cost savings. The earlier the provision of preventive services begins, the less expensive are subsequent treatment costs.³⁰

Utilization Of Dental Coverage

The use of routine dental care has grown in the last few decades, with preventive care increasingly being utilized over restorative care. Utilization trends show that individuals with coverage are more likely to have visited a dentist than those without coverage. Additionally, the privately insured are more likely to receive dental care than the publicly insured.²⁵

Traditionally cited factors that influence utilization of dental care include income, education level and dental insurance status, though numerous studies also demonstrate that cultural factors strongly influence a person's use of dental care when controlling for other indicators. Low-income populations and communities of color have lower rates of dental care utilization than higher income and Anglo populations, which contributes to oral health disparities.³¹ In 1999, Latinos in particular had the lowest level of dental visits and rates of private dental coverage in comparison with other racial/ethnic groups.²⁵

Affordability of coverage and care also impacts utilization rates, as evidenced by a RAND controlled experiment that showed that making care more affordable improved access to dental care and led to improvements in oral health.^{32,33}

Denti-cal Coverage Fails To Provide Adequate Access To Dental Care

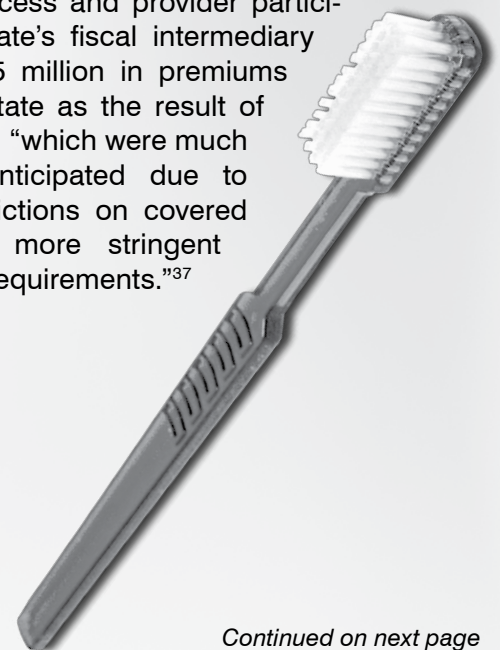
This difference in utilization between the privately and publicly insured can be partially attributed to access issues in public programs, as detailed in Table 4 (displayed on page 7).^{34,35,36} These barriers include low provider participation, low reimbursement rates and other administrative challenges, as well as lower patient awareness of the benefits of routine preventive dental care. Families and advocates throughout the State, both in rural and urban areas, have a very difficult time finding dentists accepting Medi-Cal, particularly for young children and those who are not English language proficient. This is especially true for specialty care such as endodontics, periodontics or tooth replacement.

Denti-Cal reimbursement rates are so low that most dentists refuse to accept the coverage. Table 4 compares Denti-Cal reimbursement rates ("Denti-Cal Rate") with the 50th percentile fees ("CA 50th

Percentile") and the 75th percentile fees ("CA 75th Percentile") of California general dentists for 15 common children's procedures. The 50th percentile is the same as the median fee, and means that half the general dentists in the state charge this amount or less. The 75th percentile means that three-fourths of the general dentists charge this amount or less. The right column ("Denti-Cal Rate as Percentile") shows the Denti-Cal fee as a percentile of what general dentists charge for that procedure. As can be seen in this table, for 12 of the 15 most common children's procedures, not more than 1 percent of dentists' claims for the procedures were at the Denti-Cal fee, while 99 percent of dentists' claims for these

procedures were for a greater amount. It should be noted that the percentiles shown in this table are based on 2003 data in the American Dental Association's national claims database, and can be expected to have increased since then, while the Denti-Cal rates have remained the same.

Denti-Cal's portion of the State Medi-Cal budget is far less than national spending on dental services. In 2005, Denti-Cal expenditures represented only 2.05 percent of all Medi-Cal expenditures, which can be compared to the national spending on dental services as a proportion of spending on all personal health services which, as noted above, was 5.2 percent in 2005.²⁹ Yet, despite the perennial underfunding of the Denti-Cal program and its inadequate access and provider participation, the State's fiscal intermediary returned \$63.5 million in premiums back to the State as the result of premium costs "which were much lower than anticipated due to statutory restrictions on covered benefits and more stringent authorization requirements."³⁷



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TABLE 4. Denti-Cal Rates vs. General Practice Rates, Selected Procedures

Procedure Code	Procedure Description	Denti-Cal Rate	CA 50th Percentile*	CA 75th Percentile*	Denti-Cal Rate as Percentile*
Diagnostic					
D0120	Periodic Oral Exam	\$15.00	\$35.00	\$43.00	1st
D0150	Comprehensive Oral Exam	\$25.00	\$48.00	\$56.00	3rd
D0210	Complete X-rays, with Bitewings	\$45.00	\$92.00	\$102.00	<1st
D0272	Bitewing X-rays - 2 Films	\$10.00	\$35.00	\$142.00	<1st
D0330	Panoramic X-ray Film	\$25.00	\$78.00	\$85.00	<1st
Preventive					
D1120	Prophylaxis (cleaning)	\$30.00	\$78.00	\$65.00	<1st
D1203	Topical Fluoride (excluding cleaning)	NA	NA	NA	NA
D1351	Dental Sealant	\$22.00	\$42.00	\$50.00	< 1st
Restorative					
D2150	Amalgam, 2 Surfaces, Permanent Tooth	\$48.00	\$107.00	\$122.00	< 1st
D2331	Resin Composite, 2 Surfaces, Anterior Tooth	\$55.00	\$139.00	\$160.00	< 1st
D2751	Crown, Porcelain Fused to Base Metal	\$340.00	\$730.00	\$775.00	< 1st
D2930	Prefabricated Steel Crown, Primary Tooth	\$75.00	\$183.00	\$203.00	< 1st
Endodontics					
D3220	Removal of Tooth Pulp	\$71.00	\$110.00	\$130.00	6th
D3310	Anterior Endodontic Therapy	\$215.00	\$500.00	\$650.00	< 1st
Oral Surgery					
D7140	Extraction, Single Tooth	\$45.00	\$100.00	\$115.00	< 1st

* Percentile refers to the percentage of dentists whose fees are at or below the amount shown. For example, for Procedure D0120 (Periodic Oral Exam), 50 percent of California dentists charge \$35 or less, 75% of dentists charge \$43 or less, and 1% of dentists charge the Denti-Cal fee (\$15) or less.³⁸

HEALTH CARE REFORM AND DENTAL COVERAGE: POLICY CONSIDERATIONS

Research has continually shown that individuals with dental coverage are more likely to seek and use routine dental care, resulting in improved oral health and the reduction of preventable dental diseases. A focus on prevention also results in savings to consumers and the health care system over the long-term by avoiding more costly treatment. Yet our health coverage and delivery systems are currently irrationally structured on the basis of body parts. While we would be appalled



at excluding limbs and organs from health care coverage, we accept most casually the exclusion of the entire human mouth. No one would question treatment of an abscess on an arm, a leg, even a face. But if that abscess happens to be in the mouth, perhaps inches from the brain, it's a "dental problem" that is not a covered benefit for 10.6 million Californians.

Given the current debate on health coverage reform, it is critical for policy makers to include dental coverage and meaningful access to dental care as an essential element of any coverage option. The current health care reform proposals do not adequately provide for the inclusion of dental coverage as part of basic health care coverage. To the extent that there is an expansion of coverage in Medi-Cal and Healthy Families (mostly for children), dental coverage is included. However, coverage in these programs does not necessarily equate to access to dental services since there is historically low provider participation and patient utilization. For private coverage expansions, none of the health reform proposals, except for the "single-payer" proposal, has dental coverage included as a mandatory basic benefit. At best, it is an optional coverage at individual cost.

Based on research and dialogue with stakeholders and health experts across the state, the following are essential objectives that should be considered in the health care reform debate.

Essential Objectives

1. Integrate dental and medical coverage and care.

Oral health impacts overall health, and vice versa; therefore dental coverage should be an essential component of any health benefits package under consideration. In excluding oral health coverage as a required benefit of comprehensive coverage, it is implied that oral health is optional and less important than that of other parts of the body.

By including dental coverage as part of a basic benefit package, dental care will be made more accessible and affordable to all Californians, particularly for underserved populations that disproportionately experience disparities in oral health and access to care.

Integration of dental and medical care at the coverage level can also foster integration and a more integrated view of oral and overall health at the practice level. Oral health screenings can be incorporated into regular medical visits and healthy oral health habits reinforced by physicians. Similarly, dental professionals are often able to detect systemic diseases as a result of seeing many asymptomatic patients before a physician does.

2. Provide dental care benefits comparable to those provided for medical care.

Dental care benefits should mirror medical care benefits – if a benefits package offers comprehensive medical care, comprehensive dental care should also be included. Additionally, coverage reform proposals should not negatively impact the scope of coverage for Californians who already receive comprehensive benefits through private or public insurance.

3. Ensure that dental coverage in public programs (i.e., Medi-Cal and Healthy Families) provides patients with meaningful access to dental care.

Current barriers in public programs, such as low provider reimbursement rates, complicated billing processes, and the perception of excessive rejection of claims result in very low provider participation. These barriers make it difficult for even insured low-income individuals and families to access routine dental care. While providing comprehensive dental coverage is a meaningful

first step to improving access, improvements in public programs need to be implemented to provide meaningful access to dental care.

4. Combine oral health promotion and dental disease prevention with coverage reform.

While any expansion in dental coverage will likely lead to improvements in access to dental care, it is only one part of the solution. Because other factors also strongly influence oral health behaviors and access to care, health reforms also need to include consumer education. Oral health promotion is important in order to reinforce healthy habits and educate consumers on the importance of regular dental care, particularly with young children, parents and pregnant women.

5. Ensure the health care system has an adequate infrastructure to provide expanded dental coverage to more Californians.


There are many challenges to the dental care delivery system that need to be addressed for coverage to be meaningful. Investments in the capacity of federally qualified health centers to provide dental services would expand access. “Pipeline” programs to increase the number of dentists, particularly from underserved ethnic and cultural minorities, would expand the current workforce. And adequate provider reimbursement by public programs would allow practitioners to see more patients with dental coverage. Lastly, an adequate dental public health infrastructure that promotes and supports population-based interventions such as fluoridation, school-based prevention programs and clinics, is essential to the improvement of oral health.

6. Improve the collection of data on dental coverage.

Basic information on dental coverage, including source of coverage, benefits, co-pays and deductibles, duration of coverage is far less available compared to data on medical coverage. For instance, the California Health Interview Survey asks only one question on dental insurance, while a multitude of questions are asked about medical coverage. To gain a further understanding of the benefits of dental coverage to individuals and to the entire health care systems, further research is necessary.

CONCLUSION

The health care reform debate provides opportunities to ensure that access to health care includes access to good oral health care. Dental care not only improves oral health, but also improves general health and reduces disease. Dental coverage for preventive and restorative care is a critical component of health care and will both provide improved health and save money in the long term. The issue can no longer be ignored in policy discussions.



- ¹ U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
- ² Mertz, E., Manuel-Barkin, C., Isman, B., et al. (2000). Improving Oral Health Care Systems in California. Report of the California Dental Access Project at the UCSF Center for the Health Professions.
- ³ Roan, S. (2007). Gum Disease Can Inflict Damage Elsewhere. Los Angeles Times article accessed on 5/03/07 from www.latimes.com.
- ⁴ Aetna (2006). Aetna Launches Dental/Medical Integration Program That Includes Specialized Pregnancy Benefits. Press release accessed on 5/08/07 from http://www.aetna.com/news/2006/pr_20061030a.htm.
- ⁵ Conicella ML. Aetna dental weighs in on oral-systemic medicine. *Grand Rounds in Oral-Systemic Medicine* 2007; 2(1):41-42. Available at <http://www.grandrounds-digital.com/grandrounds/200702>.
- ⁶ Offenbacher, S., Katz, V., Fertik, G., et al. Periodontal infection as a possible risk factor for preterm low birth weight. *Journal of Periodontology* 1996, 67(Special Supplement #10):1103-1113.
- ⁷ Cohen, L.A., Manski, R.J., et al. Dental visits to hospital emergency departments by adults receiving Medicaid: Assessing their use. *Journal of the American Dental Association* 133(6):715-24, 2002.
- ⁸ Testimony of Burton L. Edelstein, DDS, MPH, Board Chair, Children's Dental Health Project, Washington, DC, Professor of Dentistry and Health Policy, Columbia University, March 27, 2007, US House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, Hearing on "Insuring Bright Futures: Improving Access to Dental Care and Providing a Healthy Start for Children".
- ⁹ Glassman, P., Folse, G. Financing oral health services for people with special needs: projecting national expenditures. *Journal of the California Dental Association* 2005; 33(9):731-740.
- ¹⁰ Folse, G.J., Oral Health Shame: A call to action. *The Exceptional Parent* 2005; 35(7):63.
- ¹¹ Stancil, T.R., Li, C.H. Hyman, J.J., et al. (2005). Dental Insurance and Clinical Dental Outcomes in NHANES III. *Journal of Public Health Dentistry*, 65(4), 189-95.
- ¹² Dye, B.A., Tan, S., Smith, V. Lewis, B.G., Barket, L.K., Thornton-Evans, G. et al. (2007). Trends in Oral Health Status: United States, 1988-1994 and 1999-2004. National Center for Health Statistics. *Vital Health Statistics* 11(248).
- ¹³ Garcia, R.I. (2005). Addressing Oral Health Disparities in Diverse Populations. *Journal of the American Dental Association*, 136, 1210-1212.
- ¹⁴ Vargas, C.M., Dye, B.A. and Hayes, K.L., (2002). Oral Health Status of Rural Adults in the U.S. *Journal of the American Dental Association*, 133, 1672-1681.
- ¹⁵ Liu, J., Probst, J.C., Martin, A.B., et al. (2007). Disparities in Dental Insurance Coverage and Dental Care Among U.S. Children: The National Survey of Children's Health. *Pediatrics*, 119, S12-S21.
- ¹⁶ Newacheck, P.W., Hughes, D.C., Hung, Y.Y., Wong, S. and Stoddard, J.J. (2000). The unmet Health Needs of America's Children. *Pediatrics*, 105(4), 989-997.
- ¹⁷ Oral Health America (2003). A State of Decay: The Oral health of Older Americans. Report for the Oral Health America Special Grading Project.
- ¹⁸ Centers for Disease Control (2006). Oral Health for Older Americans. Accessed on 4/15/07 from <http://www.cdc.gov/Oral-Health/factsheets/adult-older.htm>.
- ¹⁹ Eklund, S.A. (2001). The Impact of Insurance on Oral Health. *The Journal of the American College of Dentists*, 68(2), 8-11.
- ²⁰ Manski, R. J., Macek, M.S. and Moeller, J.F. (2002). Private Dental Coverage: Who Has It and How Does It Influence Dental Visits and Expenditures? *Journal of the American Dental Association*, 133, 1551-1559.
- ²¹ Manski, R.J., Edelstein, B.L. and Moeller, J.F. (2001). The Impact of Insurance Coverage on Children's Dental Visits and Expenditures, 1996. *Journal of the American Dental Association*, 132, 1137-1145.
- ²² Lewis, C., Mouradian, W. Slayton, R. and Williams, A. (2007). Dental insurance and its Impact on Preventive Dental Care Visits for U.S. Children. *Journal of the American Dental Association*, 138, 369-380.
- ²³ California Association of Dental Plans (2005). Dental Is Different: Dental Benefits Improve Oral Health. Accessed on 5/07/07 from <http://www.caldentalplans.org/different/dental1.html>.
- ²⁴ 2006 NADP/DDPA Joint Dental Benefits Report: Enrollment, www.nadp.org, accessed on 5/22/07.
- ²⁵ Wall, T.P. and Brown, L.J. (2003). Recent Trends in Dental Visits and Private Dental Insurance, 1989 and 1999. *Journal of the American Dental Association*, 134, 621-627.
- ²⁶ Manski, R.J., Goodman, H.S., Reid, B.C. and Macek, M.D. (2004). Dental Insurance Visits and Expenditures Among Older Adults. *American Journal of Public Health*, 94(5), 759-764.
- ²⁷ California Health Interview Survey 2003 data. UCLA Center for Health Policy Research. Data accessed on 4/25/07 from www.askchis.org.
- ²⁸ Smith, C., Cowan, C., Catlin, A et al. (2007) National Health Spending In 2005: The Slowdown Continues. *Health Affairs*, 26(1):142-153.
- ²⁹ 2005 National health expenditure data. Data accessed on 5/22/07 from www.cms.hhs.gov/NationalHealthExpendData/downloads/dsm-05.pdf.
- ³⁰ Savage MF, Lee JY, Kotch JB et al.. Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs *Pediatrics* 2004, 114(4):418-423
- ³¹ Manski, R.J. and Magder, L.S. (1998). Demographic and Socioeconomic Predictors of Dental Care Utilization. *Journal of the American Dental Association*, 129, 195-200.
- ³² Tomar, S.L., Azevedo, A.B. and Lawson, R. (1998). Adult Dental Visits in California: Successes and Challenges. *Journal of public health dentistry*, 58(4), 275-80.
- ³³ Oral Health America (2003). Keep America Smiling: Oral Health in America. Report for the Oral Health America National Grading Project.
- ³⁴ Sweet, M. Diamiano, P., Rivera, E., Raymond, K. and Heller, K. (2005). A Comparison of Dental Services Received by Medicaid and Privately Insured Adult Populations. *Journal of the American Dental Association*, 136, 93-100.
- ³⁵ Eklund, S.A., Pittman, J.L. and Clark, S.J. (2003). Michigan Medicaid's Healthy Kids Dental Program: An Assessment of the First 12 Months. *Journal of the American Dental Association*, 134, 1509-1515.
- ³⁶ Jones, J. (2002) Denti-Cal Denied: Consumers' Experiences Accessing Dental Services in California's Medi-Cal Program. Health Consumer Alliance and Health Rights Hotline.
- ³⁷ California Governor's Budget 2007-2008 Revised Budget Summary (2007) accessed 5/25/07 from <http://www.ebudget.ca.gov/Revised/BudgetSummary/HHS/26649383.html>.
- ³⁸ American Dental Association (2005) State Innovations to Improve Dental Access for Low-Income Children: A Compendium Update. Accessed on 5/25/07 from <http://www.prnewswire.com/mnr/ada/20973/#>.

Dental Health Foundation

For the past twenty years the Dental Health Foundation (DHF) has been one of the few organizations in the country dedicated to the vision of “**oral health for all.**”

Our mission is to build and work through community partnerships to promote oral health for all by:

- *Providing leadership in advocacy, education and public policy development*
- *Promoting community-based prevention strategies*
- *Improving access to and the quality of oral health services*
- *Encouraging the integration of oral health and total health*

California Primary Care Association

California Primary Care Association (CPCA) is the statewide leader and recognized voice of California’s community clinics and health centers and their patients. CPCA’s member clinics provide high quality medical, dental and mental health services, children’s day care, and early intervention programs for low-income, uninsured and underserved Californians, who might otherwise not have access to health care. The more than 650 community clinics and health centers that CPCA represents share a common mission to serve all who walk through their doors, regardless of ability to pay. The mission of CPCA is to strengthen its member community clinics and health centers and networks through advocacy, education, and services in order to improve the health status of their communities.

Oral Health Access Council

In 2001, California Primary Care Association (CPCA) and the Dental Health Foundation (DHF) together launched the Oral Health Access Council (OHAC), a major campaign aimed at solving California’s oral disease epidemic. OHAC is a multi-lateral, non-partisan effort whose mission is to improve the oral health of the California’s underserved and vulnerable populations. With a membership of over 44 organizations representing a diversity of oral health stakeholders, OHAC has become California’s most broad-based and unified voice for oral health.

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