

**COMMITTEE ON HEALTH,  
EDUCATION, LABOR AND PENSIONS**

**SUBCOMMITTEE ON PRIMARY  
HEALTH AND AGING**

**Dental Crisis in America:  
The Need to Expand Access**

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**Testimony of  
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Senator Sanders, Senator Paul, and Members of the Subcommittee. Good Morning.

I am Dr. Burton Edelstein, professor of dentistry and health policy at Columbia University and Founding President of the Children's Dental Health Project (CDHP), a DC-based independent non-profit organization committed to eliminating disparities and achieving equity in oral health.

In these professional roles and in my role as a Commissioner of the Medicaid and CHIP Payment and Access Commission, I seek to objectively analyze and understand the oral health disparities, the dental care disparities, and the consequences of these disparities that your Hearing today addresses. I thank you for your concern over what Surgeon General Satcher described as a "hidden epidemic" of oral disease and what Healthy People 2020 has identified as a "leading health indicator" for the Nation.

According to Healthy People 2020 (<http://healthypeople.gov/2020/LHI/oralHealth.aspx>) there are ongoing, impactful, and addressable oral health disparities at all ages that require the nation's attention in order for the US population to enjoy better oral health and associated general health. Among these are:

- population-wide inadequate use of dental services with fewer than half of all Americans obtaining dental care in a year.
- disparities in dental care by race, ethnicity, income, educational attainment, and disability status.
- disparities in dental care by insurance-coverage with more privately-insured people than publicly-insured or uninsured obtaining care in a year.
- disparities in dental care by place with people living in cities and suburbs having more care than those in rural areas.

In and of themselves, these disparities would not be of concern to Congress were it not that people with characteristics associated with these disparities—minority status, low income and education, disability, public insurance or no insurance, and rural residence—also have higher rates of oral diseases and that oral diseases are impactful on people's ability to, in the words of Healthy People 2020, "speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions." Oral diseases cited by Healthy People 2020 include dental caries, periodontal disease, congenital malformations like cleft lip and palate, oral and facial pain disorders, and oral and pharyngeal cancers. Importantly, most of these conditions and their significant consequences in pain and dysfunction are preventable and prevention requires use of dental services.

The Medicaid and CHIP Payment and Access Commission employs a schema to understand and investigate access to health care. This model has two parts: (1)

the availability of services to answer the question, “Are healthcare facilities and providers available?” and (2) the use of services to answer the question, “Do people use services when they are available?” This formulation recognizes the complexity of understanding access issues like dental care because it incorporates both concerns about providers of health care and concerns about consumers of health care.

The issues surrounding access to healthcare are many and complex, including myriad considerations of workforce—its adequacy, competency, makeup, distribution, and integration; delivery systems—both safety net and private; and coverage and financing—employer sponsored, individual market, Medicare, Medicaid, and CHIP. These are as true for dental care as other health services. I wish to focus particularly on coverage issues today as coverage is a significant driver of access and contributes to shaping workforce and delivery systems. Coverage issues apply equally to care accessed in the private sector as in the safety net, including the growing network of federally qualified health centers (FQHCs) that offer dental services.

Medical and dental coverage are inherently different in design, availability, and use. Nonetheless, dental coverage is an overwhelmingly significant component of access to care, particularly for Americans of modest or low incomes. I cannot stress enough that Congress, in its decisions about coverage, has only very recently recognized that dental services are essential to basic, primary, health care – and then only for children.

The record is clear that Congress considers dental care to be an “optional” service for adults. For adults, it is missing in Medicare, largely absent in Medicaid, and unaddressed in health reform.

- As a result of the Medicare exclusion of dental coverage, millions of baby boomers will be moving out of employer-sponsored dental coverage that they have enjoyed for decades and into no dental coverage at all. Unlike many of their predecessors, they have benefited from dental care and have retained their teeth. They will need ongoing and regular basic primary dental care which is increasingly priced out of reach for the uninsured.
- As a result of Congress determining in Medicaid that dental care is “optional”, it is up to the states to elect adult dental coverage. According to tracking data from the American Dental Association, in 2009 23 states limited their coverage only to emergency relief of pain and infection (n=16) or offered no dental coverage at all (n=7). Since that time, additional states have cut adult dental programs as a cost savings measure. The outcome is that pregnant women, the disabled, those in long-term care, and other very vulnerable individuals that rely on Medicaid for their medical care have very limited access, if any, to dental care.

- Now as states set up coverage expansion through health reform, Congress has obligated them to cover only pediatric dental care, again ignoring the importance of oral health to adults, including the most vulnerable.

This consistent record of exclusion is equivalent to arbitrarily excluding a limb, an organ, or an essential biological function from health coverage. It inherently suggests that dental care is not primary care, not essential care, and something that people can do without.

In sharp contrast to Congress' approach to adults, it has increasingly recognized the importance of dental care for children. I applaud Congress for its passage of historic policies that not only assure that children have extensive access to coverage but that go further by addressing prevention, public education, workforce, training, early intervention, research, quality, and accountability. It is my sincere hope that your Subcommittee's work serves to further catalyze Congress—as well as the state and federal governments—in assuring that oral health provisions in existing law (e.g. the Safety Net Improvement Act of 2002, the Children's Health Insurance Program Reauthorization Act of 2009, and the Affordable Care Act of 2010) are moved from Congressional intent to meaningful care for America's children.

Since the original enactment of S-CHIP in 1997, our Country has made meaningful strides in ensuring that oral health is attended to for children in federal health programs. Head Start and WIC are attending to children's oral health. Multiple federal agencies have active pediatric oral health initiatives. Countless reports, including many by the Government Accountability Office at Congressional request and others by the Institute of Medicine have been published. A number of Congressional hearings have been held, dozens of bills introduced, and key legislation enacted. Many states have similarly undertaken notable oral health initiatives.

Sadly, the catalytic tragic event that awakened many policymakers to the seriousness of poor oral health was the death of 12-year-old Deamonte Driver five years ago this week. In fact, the day Deamonte's death was reported in the Washington Post, the Children's Dental Health Project was attending a long scheduled meeting with the Senate Finance Committee. The purpose of our meeting was to ask the Committee to support inclusion of a mandatory dental benefit in the CHIP reauthorization. Our efforts to date had not resonated but that morning, the tragedy of this child's death transformed our conversations with policymakers forever. It became painfully clear what had long been known and well documented but not fully recognized in policy: that oral health is essential to overall health and that poor oral health has significant and yes, sometimes tragic, consequences on our health and well-being.

Just a few weeks after that conversation, the Senate Finance Committee accepted a bipartisan amendment to add a dental benefit to the reauthorization of CHIP. Today, all fifty states are required to offer dental benefits to children enrolled in Medicaid and CHIP and states are now planning the provision of dental care for children through their Exchanges. The question now is, what needs to be done to make these provisions real for families across the country?

At this point, it is critical that the provisions of CHIPRA and ACA are implemented effectively and that states have the appropriate guidance and flexibility to create a coordinated health care system that truly incorporates oral health care. Continued Congressional interest and oversight is required to ensure that these laws' common sense provisions are maximally implemented as, together, they inform the public about risks for oral disease in children, provide targeted and timely information to new parents, advance the science of disease management, enhance training for dentists and dental hygienists, promote accountability through disease surveillance, and encourage the piloting of creative new workforce models including a new paraprofessional concept built on principles of social work—the Community Dental Health Coordinator, as proposed by the American Dental Association.

Let me highlight two of these many opportunities that focus on advancing oral health through cost-effective prevention:

- ACA establishes a National Oral Health Literacy Campaign that can raise public awareness about prevention and encourage appropriate use of dental services. Recognizing current budget constraints, we encourage that this campaign, authorized at \$100 million dollars, be initiated with a \$5 million dollar investment in Federal Fiscal Year 2013.
- The CDC is primed to address the very high rates of ordinary tooth decay in America's youngest children. CDC reports that more than 1-in-10 two year olds, 2-in-10 three year olds, 3-in-10 four year olds, and 4-in-10 five year olds has visible cavities and that three-quarters of affected children are in need of dental repair. The Surgeon General reports that these rates are five-times greater than childhood asthma, the next most prevalent chronic disease of U.S. children. Because prevention is cost savings and improves quality of life, we encourage support for \$8 million dollars in expanded funding in FY 13 to support CDC demonstrations of early childhood caries prevention and management.

Arguably, the most important of CHIPRA and ACA dental provisions are the requirements that states cover pediatric oral health care. Regulatory guidance is needed to assure that dental coverage established by CHIPRA meets covered children's needs and that the CHIPRA dental benefit can serve well as a benchmark for the pediatric dental benefit in ACA. ACA appropriately establishes pediatric dental care among the 10 Essential Health Benefits that must be covered. As you are well aware, however, there is a heated debate at both the

federal and state levels about how these benefits should be defined, how they will be accessed in the state Exchanges, and how consumer protections will apply. Because these critical issues are particularly nuanced for dental coverage, it is important that the details be attended to with care. I urge you to look closely at these technical issues as their resolution will determine how meaningful the dental benefit will be to children and their families and how they will contribute to access.

To address the problem of inequitable access through coverage reform, it is critical that every dental plan certified by the state or Federal Exchanges requires the same substantive level of consumer protections. Whether dental coverage is obtained through a qualified health plan or a limited-benefit stand-alone dental plan, consumers need to be assured of choice, affordability, network adequacy, and quality. Exemption of these requirements for dental plans but not qualified health plans would be at the expense of children and their parents.

Congressional intention needs to be clearly communicated to state legislatures and Exchange Boards as they establish their own policies. An amendment by Senator Stabenow adopted by the Senate Finance Committee clarified that intention. It stated that "...standalone dental plans must ... comply with any relevant consumer protections required for participation in the Exchange." This language was reiterated in a September 22, 2011 colloquy with Senators Baucus and Bingaman when Senator Stabenow stated, "I intended for standalone dental plans to fully comply with the same level of relevant consumer protections that are required of qualified health plans with respect to this essential benefit."

The dental benefits created by CHIPRA and ACA must also be designed to respect differences among our nation's children in their level of risk for tooth decay. We encourage federal and state policymakers to adopt best practices in coverage and care as suggested by the American Academy of Pediatric Dentistry (AAPD). AAPD calls for "risk-based" care that provides the most intensive clinical care to children with the greatest level of disease and risk for ongoing disease. A pediatric-only dental benefit should follow AAPD's guidance and thereby promote allocation of care according to individual children's needs. By preventing dental disease at an early age and managing the disease as a chronic condition when it does occur, we can significantly reduce the cost of care and improve the quality of life for our children while setting them on a path toward lifetime oral health.

Many of you and your colleagues have a long history of extraordinary leadership in the Congress on health issues. On behalf of children who do have coverage through your actions, advocates and families now look to you for follow through on CHIPRA and ACA that will assure full implementation of the oral health provisions. Doing so will save money, improve patient experience, and improve the nation's oral health. There is much yet to be done and we look forward to working with you to reach the goal of equitable oral health and dental care for all.

That concludes my testimony. I am happy to answer any questions you may have.

Thank you.