

Measuring What Matters

Access to Dental Care in Oregon

Marko Vujicic, PhD
Chief Economist & Vice President
Health Policy Institute
American Dental Association

The ADA Health Policy Institute

HSR Health Services Research

The Impact of Medicaid Reform on Children's Dental Care Utilization in Connecticut, Maryland, and Texas

Kamyar Nasseh and Marko Vujicic

Objective. To measure the impact of Medicaid reforms, in particular on Medicaid dental fees in Connecticut, Maryland, and Texas, on access to dental care among Medicaid-eligible children.

Data. 2007 and 2011–2012 National Survey of Children's Health.

Study Design. We measure the Principal P group of eligible child-eligible Conclusion has a significant-eligible Key Word

It becomes first birth of pediatric access Medicare S multiple of providers t

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HEALTH ECONOMICS
Health Econ (2016)
Published online in Wiley Online Library (wileyonlinelibrary.com). DOI: 10.1002/hec.3316

HEALTH ECONOMICS LETTER

THE RELATIONSHIP BETWEEN PERIODONTAL INTERVENTIONS AND HEALTHCARE COSTS AND UTILIZATION. EVIDENCE FROM AN INTEGRATED DENTAL, MEDICAL, AND PHARMACY COMMERCIAL CLAIMS DATABASE

KAMYAR NASSEH^{1*}, MARKO VUJICIC² and MICHAEL GLICK³

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²University of Buffalo, The State University of New York, Buffalo, NY, USA

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ABSTRACT

to poor glycemic control among individuals with type 2 diabetes. Using integrated claims from Tavon MarketScan Research Databases, we implement inverse probability to estimate a relationship between a periodontal intervention and healthcare costs. Newly diagnosed with type 2 diabetes, we find that a periodontal intervention is associated with \$1,999, lower total medical costs excluding pharmacy costs (–\$1577), and lower total (–\$408). © 2016 The Authors. Health Economics Published by John Wiley & Sons

BRIEF REPORT

The Effect of the Affordable Care Act's Expanded Coverage Policy on Access to Dental Care

Marko Vujicic, PhD, Cassandra Yarborough, MPP, and Kamyar Nasseh, PhD

Objective. The Affordable Care Act included a dependent policy that extends parents' or guardians' health insurance to children aged 19–25. This policy does not apply directly to private health plans. However, for various reasons it could still have an "spillover" effect if employers voluntarily expand dental coverage in conjunction with medical coverage.

Methods. To assess the effect of the Affordable Care Act's dependent coverage policy on private dental benefits coverage, we

America's oral health is an important concern to policy makers, and new links between oral body health are continually being discovered.¹ dental care and oral disease prevention are the most critical drivers of oral health, and evidence indicates that investing in these drivers may avert future serious whole body health care needs and costs.^{2,3} At the same time adults' access to dental care has fallen steadily since the early 2000s, largely be-

HSR Health Services Research

Early Impact of the Affordable Care Act's Medicaid Expansion on Dental Care Use

Kamyar Nasseh and Marko Vujicic

To examine the impact of the Affordable Care Act on dental care use by adults ages 21–64 in 2014.

0–2014 Gallup-Healthways Wellbeing Index Survey.

sign. Among poor adults with income at or below 138% of the Federal Pov-

ORIGINAL ARTICLES

THE JOURNAL OF PEDIATRICS • www.jpeds.com

Estimating Premium and Out-of-Pocket Outlays Under All Child Dental Coverage Options in the Federally Facilitated Marketplace

Marko Vujicic, PhD, and Cassandra Yarborough, MPP

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a premium and out-of-pocket costs for child dental care services under various dental options within the federally facilitated marketplace.

Estimated premium and out-of-pocket costs for child dental care services for 12 patient population age and spending. We did this for 1039 medical plans that include child dental plans that do not include child dental coverage, and 583 stand-alone dental plans for analysis is based on plan data from the Center for Consumer Information and Insurance Oversight.

Expected total financial outlays for child dental care services were lower under dental coverage within a medical plan compared with the alternative of a stand-alone dental plan. The average expected out-of-pocket spending varied significantly for our 12 patient profiles. On high users of dental care, for example, have lower expected out-of-pocket costs under dental coverage. For the vast majority of other age groups and dental care use profiles, the reverse holds true that embedding dental coverage within medical plans, on average, results in lower or child beneficiaries. Although our results are specific to the federally facilitated marketplace for both state-based marketplaces and the general private health insurance market, (J Pediatr 2016; ■■■■■■■■).

most common chronic disease among children in the US.¹ Routine dental care is important in oral health. Child dental care coverage is mandatory in Medicaid and the Children's Health Insurance of 10 essential health benefits under the Affordable Care Act (ACA). Still, disparities in dental insurance coverage have been a challenge. Private dental coverage traditionally has been medical coverage through stand-alone dental plans (SADPs). The ACA maintained this separation to cover dental care for children if SADPs are available for purchase in the health insurance marketplace. For the vast majority of other age groups and dental care use profiles, the reverse holds true that embedding dental coverage within medical plans, on average, results in lower or child beneficiaries. Although our results are specific to the federally facilitated marketplace for both state-based marketplaces and the general private health insurance market, (J Pediatr 2016; ■■■■■■■■).

ing through a separate plan also has implications for consumer financial protection. Several premium out-of-pocket spending, including premium subsidies, annual out-of-pocket maximums, and copayments on plans. Many of these provisions do not apply to SADPs. For example, when dental coverage plan, premium subsidies partly offset the cost of dental coverage. When dental coverage is however, often it is not eligible for premium subsidies. In contrast, SADPs might be more effective out-of-pocket spending on dental care because they have dental-only provisions. For example, medical coverage might use a single medical/dental deductibles, have a dental-only deductible. Depending on are exempt from the common medical/dental deductibles impact on out-of-pocket dental care spending.

95% of medical plans with embedded dental and federal marketplaces use a single medical/dental

From the Health Policy Institute, American Dental Association, Chicago, IL (Nasseh); and the Health Policy Institute, American Dental Association, Chicago, IL (Vujicic). The authors do not necessarily reflect those of the American Dental Association, and Tavon Health Research or any of its officers or employees in this article. The authors declare no conflicts of interest.
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Information and Insurance Oversight
Marketplace
Plan

FLA 5.4.0 DTD ■ WJPHS8000 proof ■ December 15, 2016

The NEW ENGLAND JOURNAL of MEDICINE

Perspect

Health Reform in Massachusetts Increased Adult Dental Care Use, Particularly Among The Poor

By Kamyar Nasseh and Marko Vujicic

Health Reform in Massachusetts increased adult dental care use, particularly among the poor. The study found that dental care use increased among all age groups, but the increase was largest among low-income adults. This finding suggests that Medicaid expansion may be an important way to improve dental care access for vulnerable populations.

Are We in a Medical Education Bubble Market?

David A. Asch, M.D., M.B.A., Sean Nicholson, Ph.D., and Marko Vujicic, Ph.D.

In November 1636, the prices of tulip bulbs in the Dutch market rose rapidly from their normal level to the point where a single bulb might sell for 10 times the annual earnings of a typical worker. Just

as quickly, in May 1637, tulip-bulb prices returned to their previous levels. The causes of this dramatic rise and fall remain in dispute. The event occurred during the Dutch Golden Age, when stock exchanges, central banking, and many of the fundamental structures that govern contemporary capital markets and the approaches deployed by M&As today were developed. One modern economic analysis suggests that the precipitous decline in tulip-bulb prices resulted from a February 1637 change in the way that futures contracts were enforced, which immediately reduced the value of those contracts by 97%, but this

rose until 200 rapidly fell, and, in which stocks rose to plummeted. If some new asset value appear are stuck will paid too much longer unless caught without music spots, by lowers at most as some point left standing, usually receive spect – not coming.

Are we in medical education bubble market? One modern economic analysis suggests that the precipitous decline in tulip-bulb prices resulted from a February 1637 change in the way that futures contracts were enforced, which immediately reduced the value of those contracts by 97%, but this

ABSTRACT States frequently expand or limit dental benefits for adults covered by Medicaid. As part of statewide health reform in 2006, Massachusetts expanded dental benefits to all adults ages 19–64 whose annual income was at or below 100 percent of the federal poverty level. We examined the impact of this reform and found that it led to an increase in dental care use among the Massachusetts adult population, driven by gains among poor adults. Compared to the prereform period, dental care use increased by 2.9 percentage points among all nonelderly adults in Massachusetts, relative to all nonelderly adults in eight control states. For poor Massachusetts adults, the effect was larger—an eleven-percentage-point increase in dental care use above the increase among the state's nonpoor residents. The Massachusetts experience provides evidence that providing dental benefits to poor adults through Medicaid can improve dental care access and use. Our results imply that the lack of expanded dental coverage for low-income adults under the Affordable Care Act is a missed opportunity to improve access to oral care.

Routine dental care is an important component of oral and general health.¹ As of 2010 gum disease affected nearly half of US adults.² Although the relationship is not well understood, gum disease is linked to chronic diseases such as cardiovascular disease and diabetes.^{3,4} Improved oral health has also been shown to have a positive effect on employment and wages.⁵ Poor adults, with poor defined here as having self-reported household incomes at or below 100 percent of the federal poverty level, tend to face significant barriers to dental care.⁶ Dental care use decreased as the national level among poor adults from 2000 to 2010, in part as a result of Medicaid policies toward dental benefits for adults.⁷ States are obligated to provide dental benefits for poor children through Medicaid or the Children's Health Insurance Program, but providing dental benefits for

Medicaid-eligible adults is optional.⁸ In the past decade several states have scaled back dental benefits for such adults.⁹ For example, Missouri eliminated all adult dental Medicaid benefits in 2005, and California went from full dental Medicaid coverage to no coverage in July 2009. Washington State went from full adult dental Medicaid benefits in 2002 to limited coverage in 2003, reinstated full dental coverage in 2007, and ultimately eliminated all adult dental benefits in 2010.¹⁰ Several studies have analyzed the impact of expanding or eliminating dental benefits for adults covered by Medicaid. A national analysis showed that the expansion of Medicaid to include adult dental benefits resulted in a seven- to ten-percentage-point increase in the likelihood of a dental visit among adults with less than \$10,000 in annual household income.¹¹ After California eliminated adult Medicaid dental benefits in July 2009, the percentage of adult

ORAL HEALTH COST & USE

By Marko Vujicic, Thomas Buchmueller, and Rachel Klein

Dental Care Presents The Highest Level Of Financial Barriers, Compared To Other Types Of Health Care Services

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Thomas Buchmueller is the Walter D. Hildegarde and Professor of Risk Management and Insurance in the Ross School of Business, University of Michigan, in Ann Arbor.

Rachel Klein was director of organizational strategy for Families USA, in Washington, DC, at the time of this writing.

ABSTRACT The Affordable Care Act is improving access to and the affordability of a wide range of health care services. While dental care for children is part of the law's essential health benefits and state Medicaid programs must cover it, coverage of dental care for adults is not guaranteed. As a result, even with the recent health insurance expansion, many Americans face financial barriers to receiving dental care that lead to unmet oral health needs. Using data from the 2014 National Health Interview Survey, we analyzed financial barriers to a wide range of health care services. We found that irrespective of age, income level, and type of insurance, more people reported financial barriers to receiving dental care, compared to any other type of health care. We discuss policy options to address financial barriers to dental care, particularly for adults.

The Affordable Care Act (ACA) is having a significant impact on the US health care system. Early evidence shows that the number of Americans without health insurance has declined and access to health care services has improved.¹ However, the percentage of Americans without dental insurance has always been higher than the percentage without health insurance, and there are large differences in dental coverage rates between children and adults. In 2013, 12 percent of children and 23 percent of nonelderly adults had no dental insurance, compared to 6 percent of children and 20 percent of nonelderly adults who lacked health insurance.^{2,3}

The higher rate of dental coverage for children, compared to nonelderly adults and seniors, is partly explained by the fact that dental services are a mandatory benefit within Medicaid for children. For child Medicaid beneficiaries, dental services are part of a comprehensive set of benefits provided through the Early and Periodic Screening, Diagnosis, and Treatment Program. Under the program, dental services for children must primarily include: relief of pain and infections, restoration of teeth, [and] maintenance of dental health, and all services must be provided if determined medically necessary.⁴ In contrast, dental care for adults is not covered by Medicare and is an optional benefit in Medicaid, with no minimum standards. According to the most recent data available, over eight million adults are enrolled in Medicaid in the twenty-two states whose Medicaid programs do not provide adult dental benefits beyond emergency services.⁵

The ACA's essential health benefits package perpetuates the long-standing division between dental and other health care services by excluding dental coverage for adults. It requires dental coverage for children, although implementing these provisions has posed challenges. For example, because dental benefits are offered primarily as stand-alone products, not as part of a medical plan, the purchase of dental benefits cannot be enforced, and dental benefits are excluded from premium tax credit calculations.⁶ Even though the ACA does not have specific provisions that address adult dental care, it is likely that the law has modestly increased dental coverage through two channels. First, one provi-

The ADA Health Policy Institute



Health » Diet + Fitness | Living Well | Parenting + Family

Stopped flossing? Teeth still vital to overall health

By Susan Scutti and Carina Storms, CNN
Updated 3:46 PM ET, Wed August 3, 2016

Story highlights

Periodontal disease could complicate the management of diabetes and heart disease

One-third of adults in the United States have no dental coverage

Studies show dental insurance provides improvements in overall health and cost savings

(CNN) — Your teeth are more than just something to chew and smile with. Research is increasingly showing that they can have an effect on your overall health.

Many Americans think their poor oral health is holding them back. In a 2015 survey by the American Dental Association, 20% of low-income adults said their mouths and teeth were in bad condition, and 20% of all adults said their unhealthy mouths caused them anxiety, according to Marko Vujcic, chief economist for the

FOX NEWS

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The main reason people avoid the dentist isn't fear

The biggest reason people skip out on going to the dentist isn't fear or inconvenience; it's cost, KIDY reports. A study published this month in *Health Affairs* found people are more likely to forego dental health because of cost than any other type of health care.

In fact, cost is the main reason for not seeing a dentist even among people who have private dental insurance. Study author Marko Vujcic points to maximum benefit limits and high co-pays in most dental coverage as the culprit.

"Anything beyond checkups, like getting a cavity filled or a root canal and a crown, you're looking right away at 20% to 50% coinsurance," he says.



Education Doesn't Solve the Gender Pay Gap

For women in professions that require advanced degrees, such as dentists and physicians, discrepancies in pay are becoming harder to explain.

BOURREE LAM | 3:44 PM ET | BUSINESS

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Forbes

Why Some Millennials Aren't Smiling: Bad Teeth Hinder 28% In Job Search



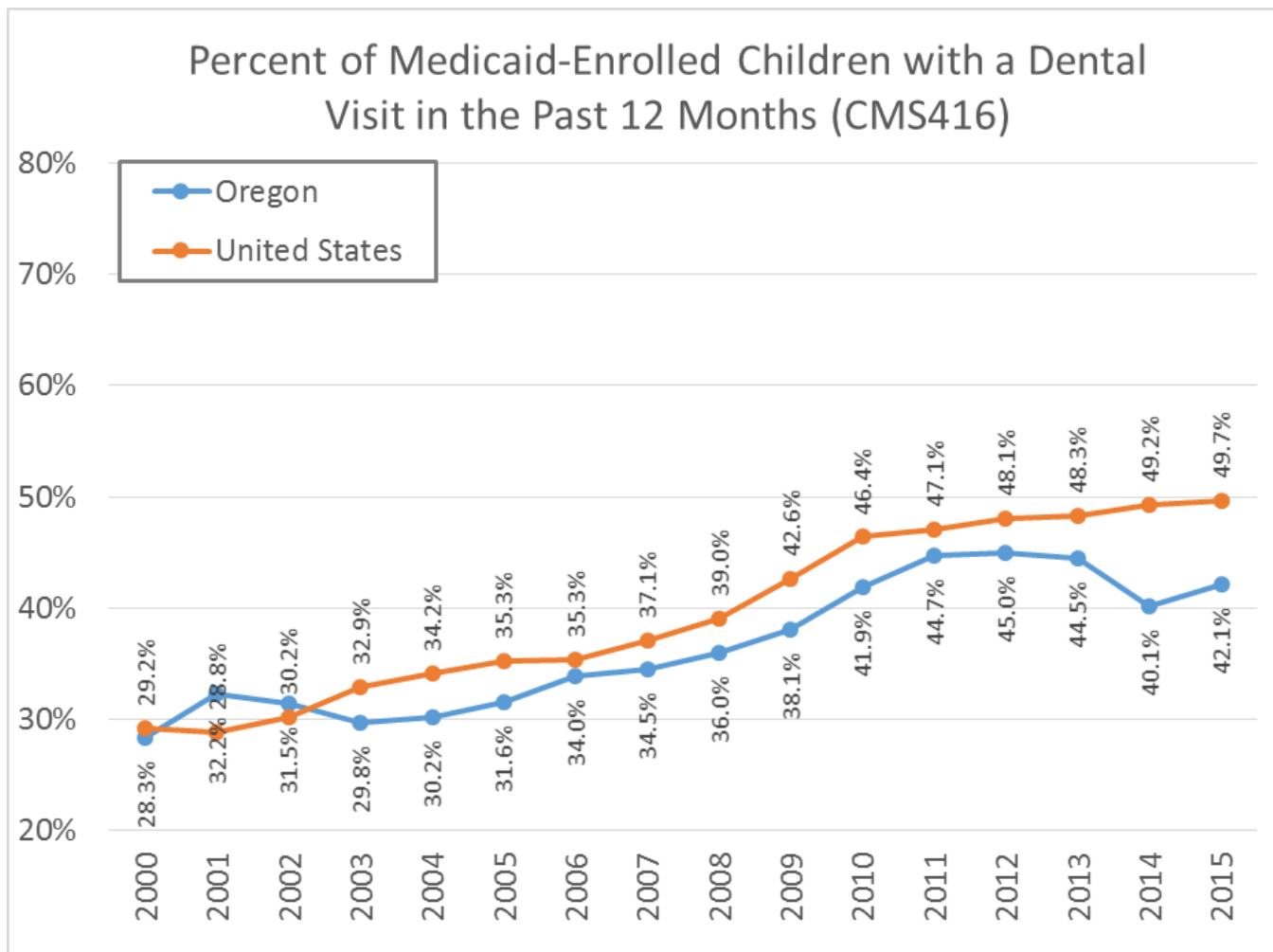
If some millennials aren't smiling, there's good reason. A recent study by the American Dental Association's (ADA's) research arm found they're in a world of hurt – from tooth pain and anxiety about the poor condition of their teeth.

Decaying teeth and gum problems make one in three young adults aged 18 to 34 (33%) reluctant to smile, the ADA found. About one in five have cut back on socializing as a result of dental problems. And 28% say the appearance of their teeth and mouth undermines their ability to interview for a job.

Today

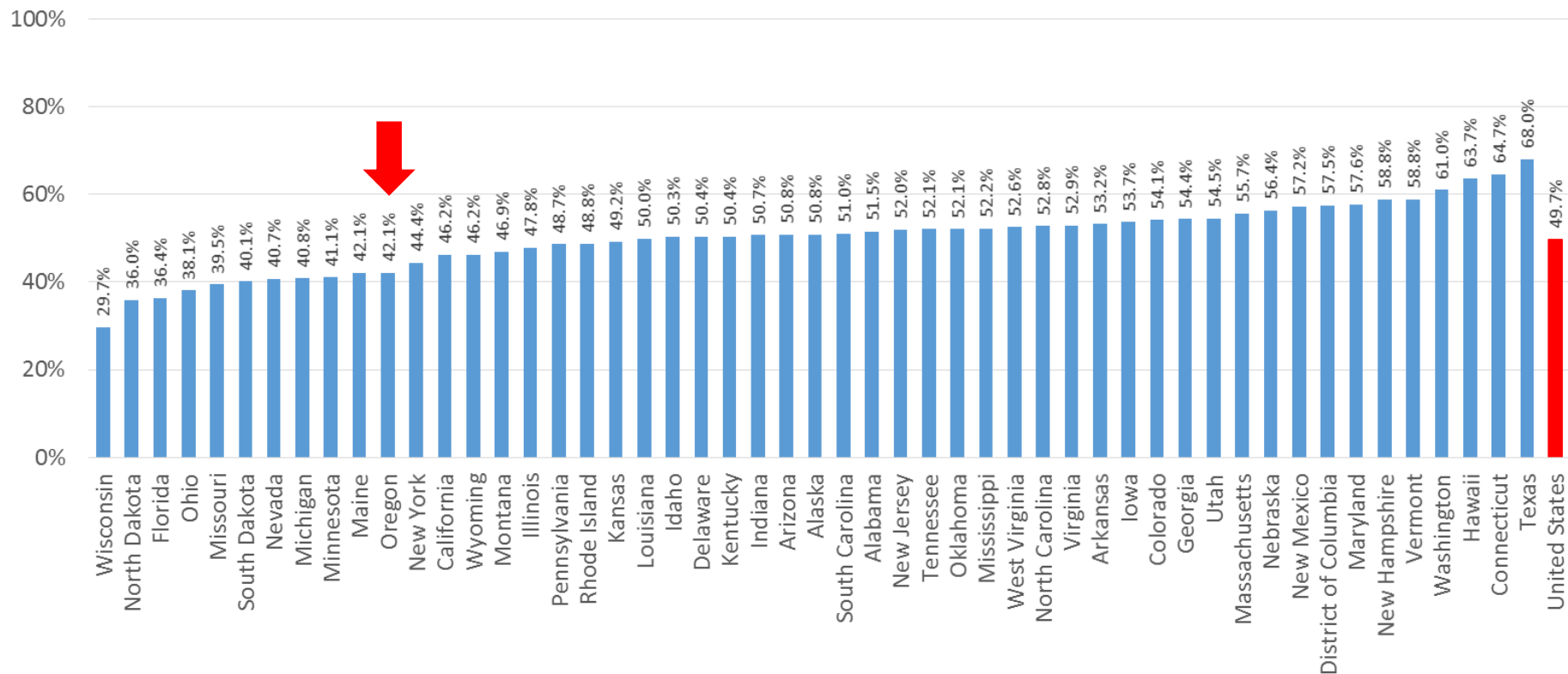
1. Review key oral health outcomes in Oregon compared to other states
2. Present new analysis on access to dental care in Oregon
3. Give you my takeaways on where policy makers should be putting more focus

Dental Care Use



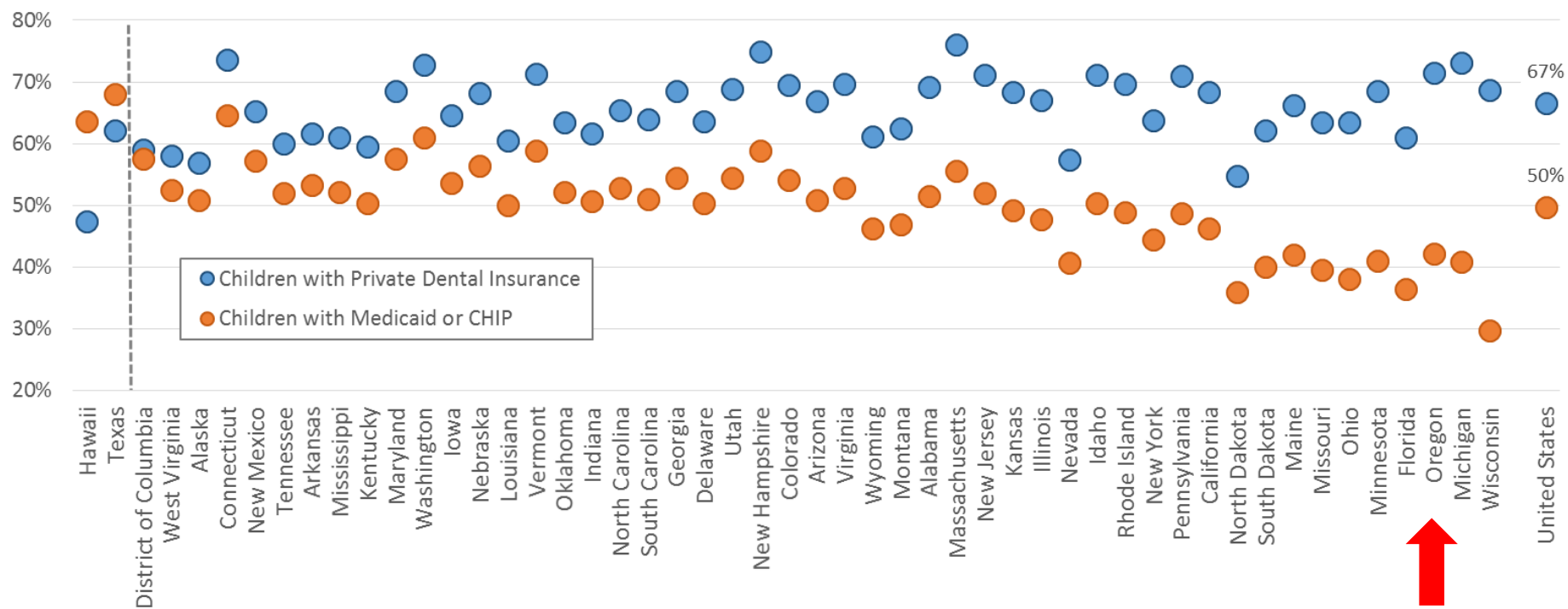
Dental Care Use

Percent of Medicaid- or CHIP-Enrolled Children With a Dental Visit in the Past 12 Months, 2015 (from CMS416)



Dental Care Use

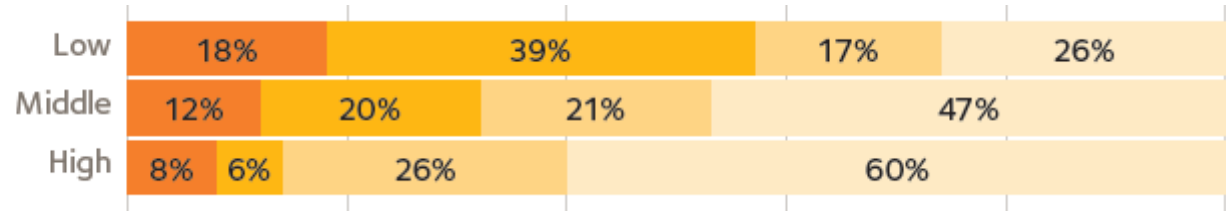
Percent of Children With a Dental Visit in the Past 12 Months, 2015



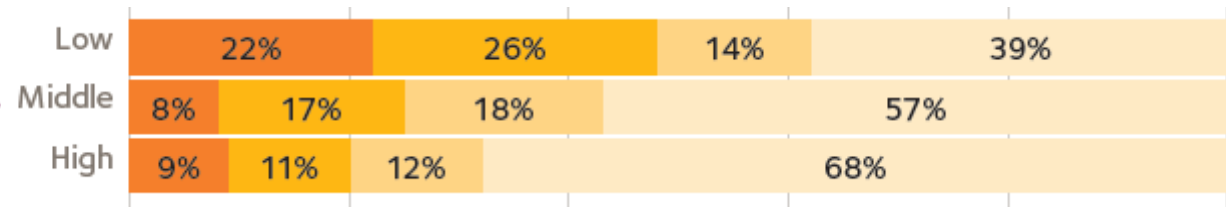
Oral Health & Well-Being for Adults

■ VERY OFTEN
 ■ OCCASIONALLY
 ■ RARELY
 ■ NEVER

DIFFICULTY BITING/CHEWING



AVOID SMILING

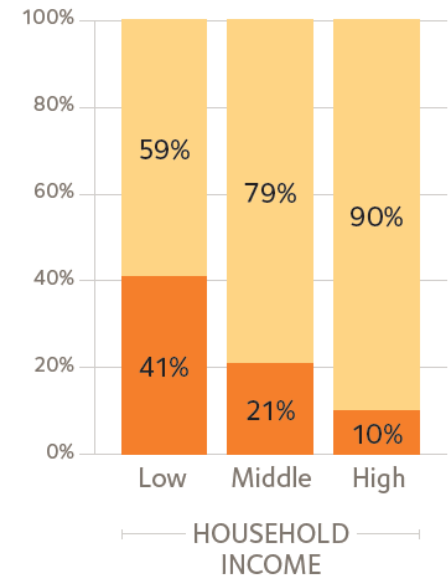
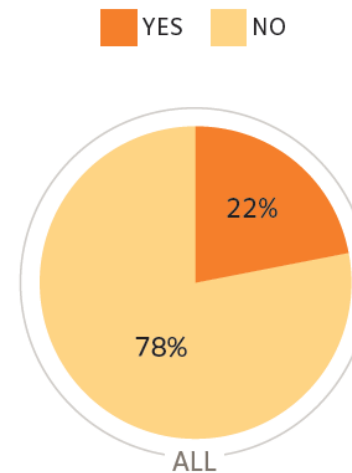


Oral Health & Well-Being for Adults



33% of low income adults reduce participation in social activities due to the condition of their mouth and teeth.

Appearance of Mouth and Teeth Affects Ability to Interview for a Job

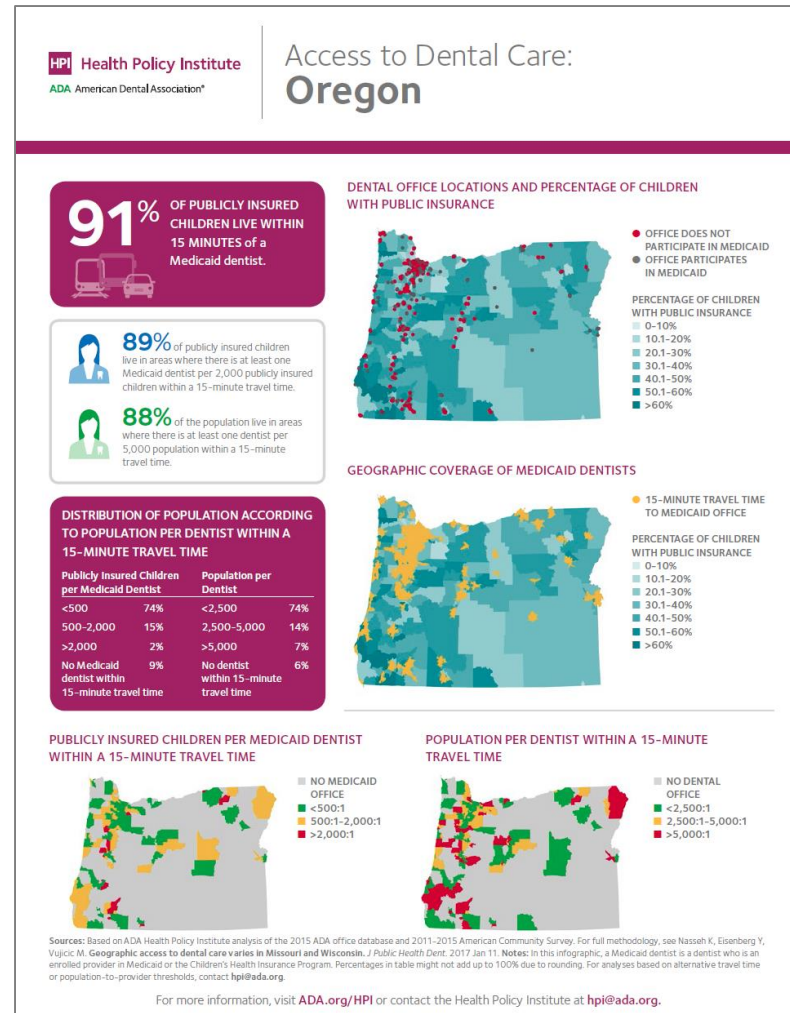
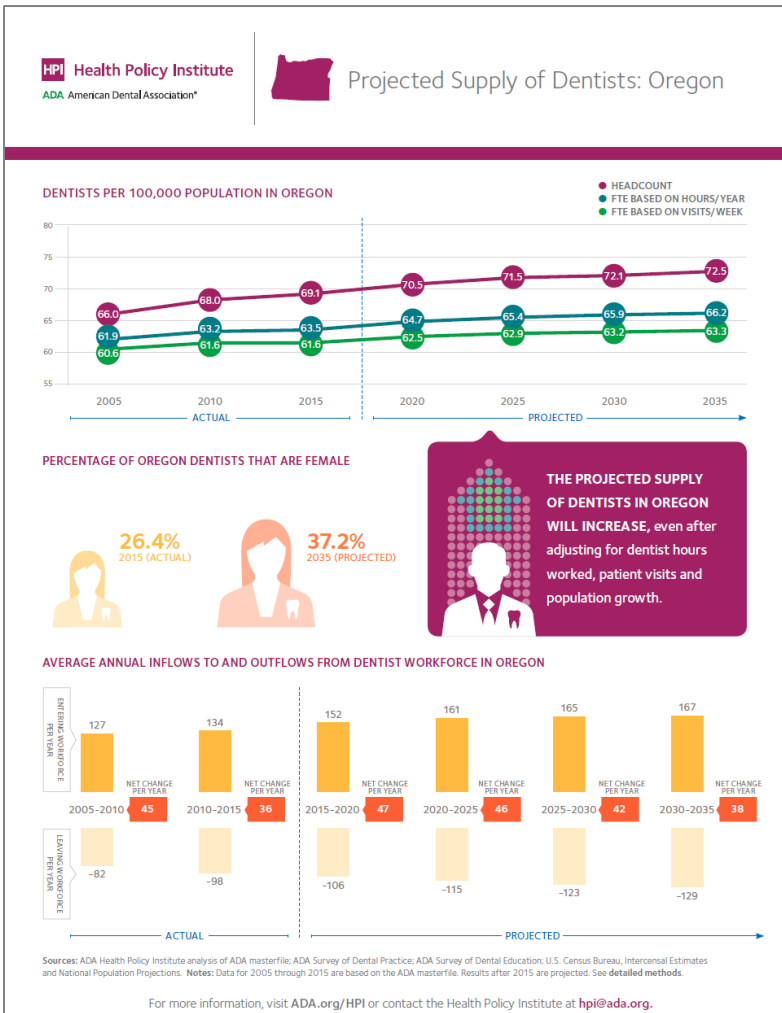


Barriers to Dental Care for Adults

Reasons for Not Visiting the Dentist More Frequently,
Among Those Without a Visit in the Last 12 Months



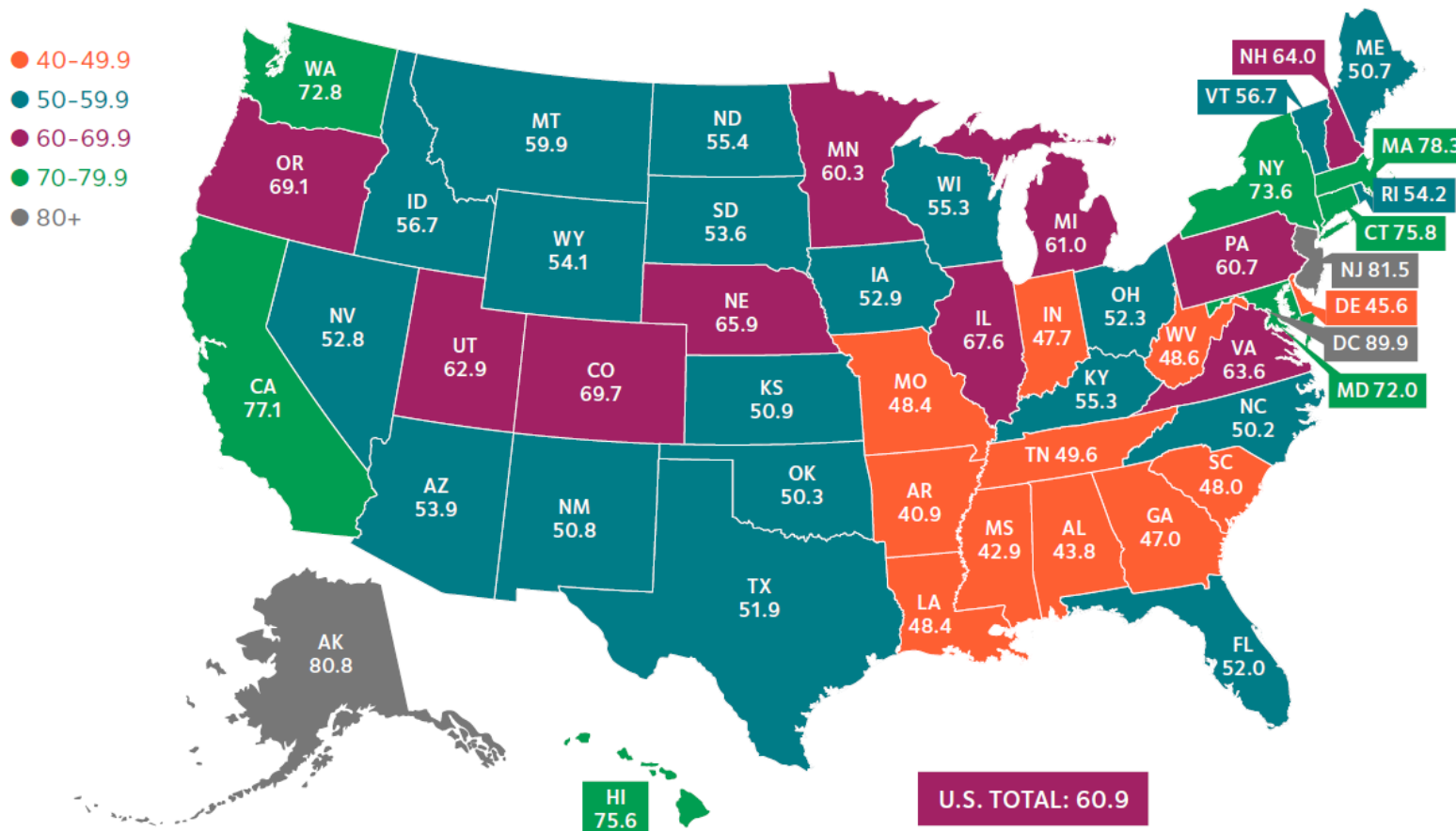
New Data-Driven Insights



Supply of Dentists

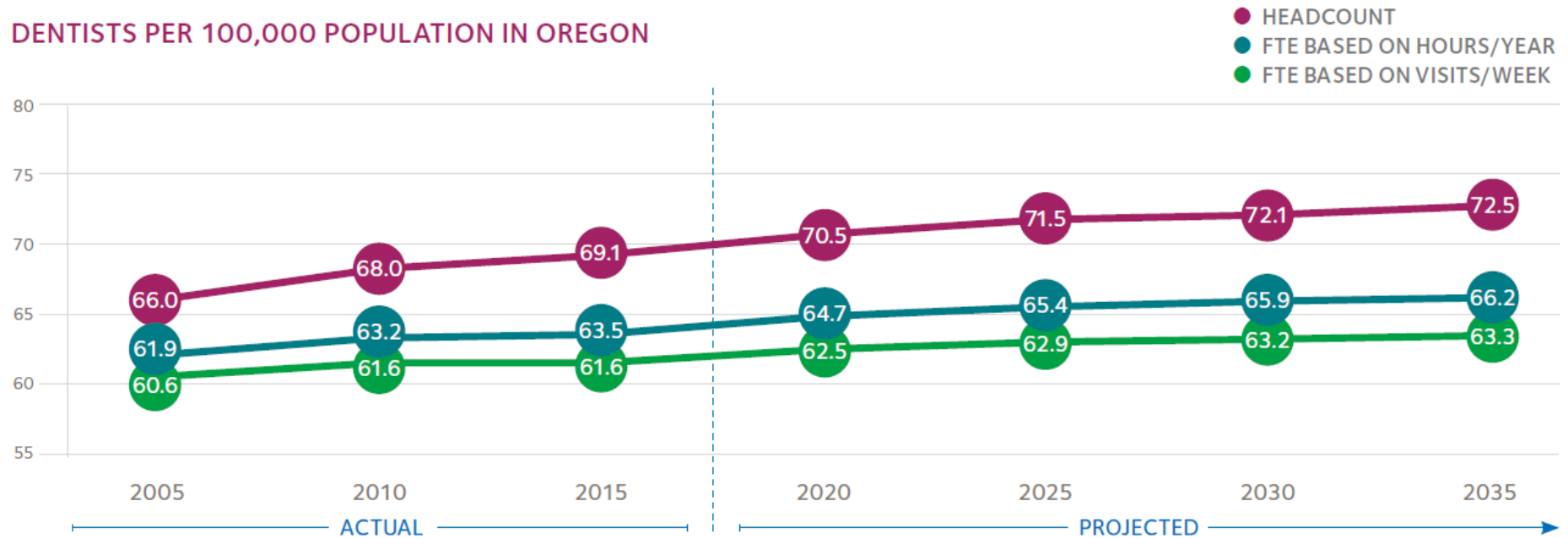
DENTIST-TO-POPULATION RATIOS VARY ACROSS STATES

The number of dentists per 100,000 population in the United States was 60.9 in 2015 and varied across states. The District of Columbia (89.9), New Jersey (81.5) and Alaska (80.8) had the highest ratios in the nation.



Supply of Dentists

DENTISTS PER 100,000 POPULATION IN OREGON



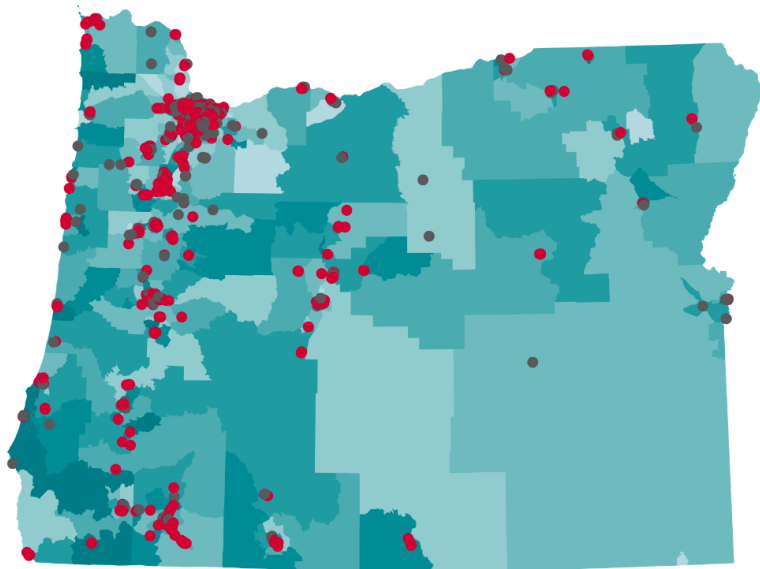
Geographic Access

Dental Offices

- Office Does Not Participate in Medicaid
- Office Participates in Medicaid

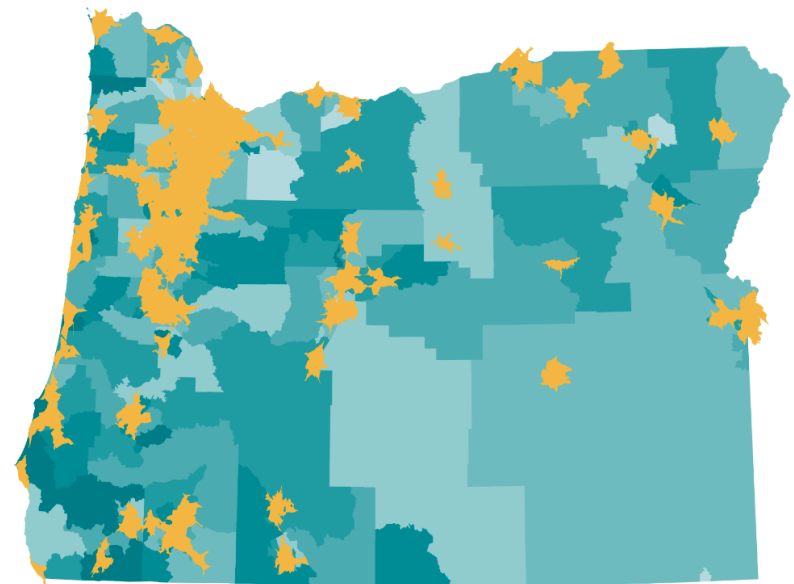
Percentage of Children with Public Insurance

- 0-10%
- 10.1-20%
- 20.1-30%
- 30.1-40%
- 40.1-50%
- 50.1-60%
- >60%



15 Minute Travel Time to Medicaid Office Percentage of Children with Public Insurance

- 0-10%
- 10.1-20%
- 20.1-30%
- 30.1-40%
- 40.1-50%
- 50.1-60%
- >60%



Geographic Access

91%

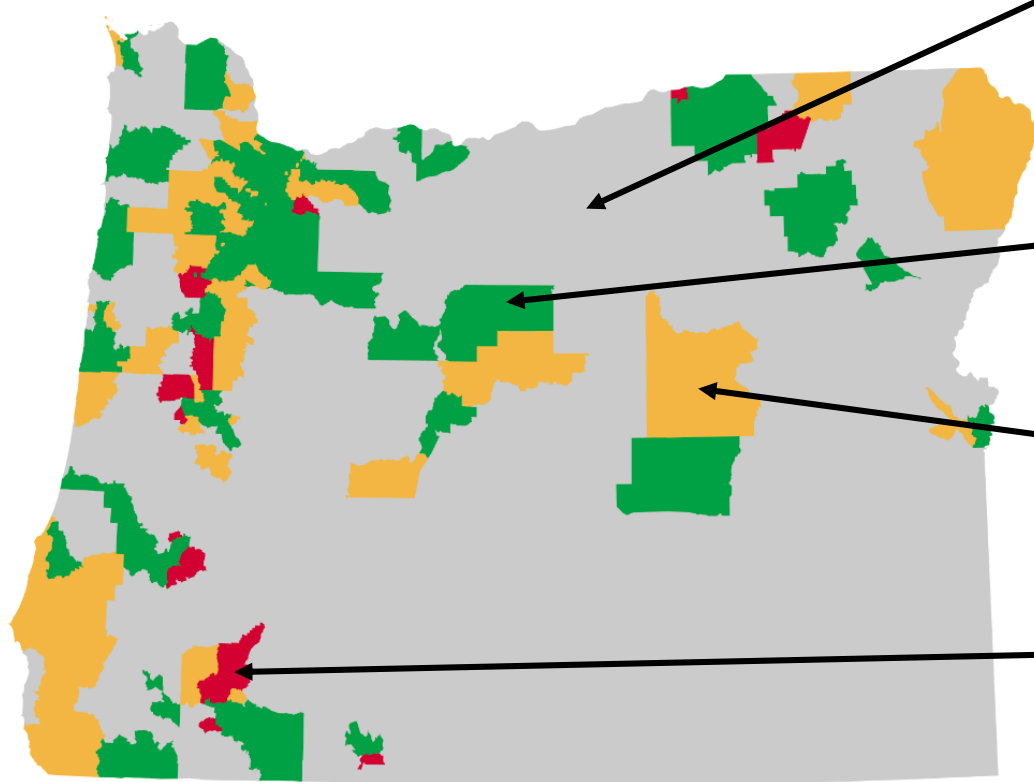
OF PUBLICLY INSURED
CHILDREN LIVE WITHIN
15 MINUTES of a
Medicaid dentist.



Geographic Access

Publicly Insured Children Per Medicaid Dentist Within a 15-Minute Boundary

- No Medicaid Office
- <500:1
- 500:1-2000:1
- >2000:1



9% of publicly insured children do not have a Medicaid or CHIP dentist within a 15 minute travel time

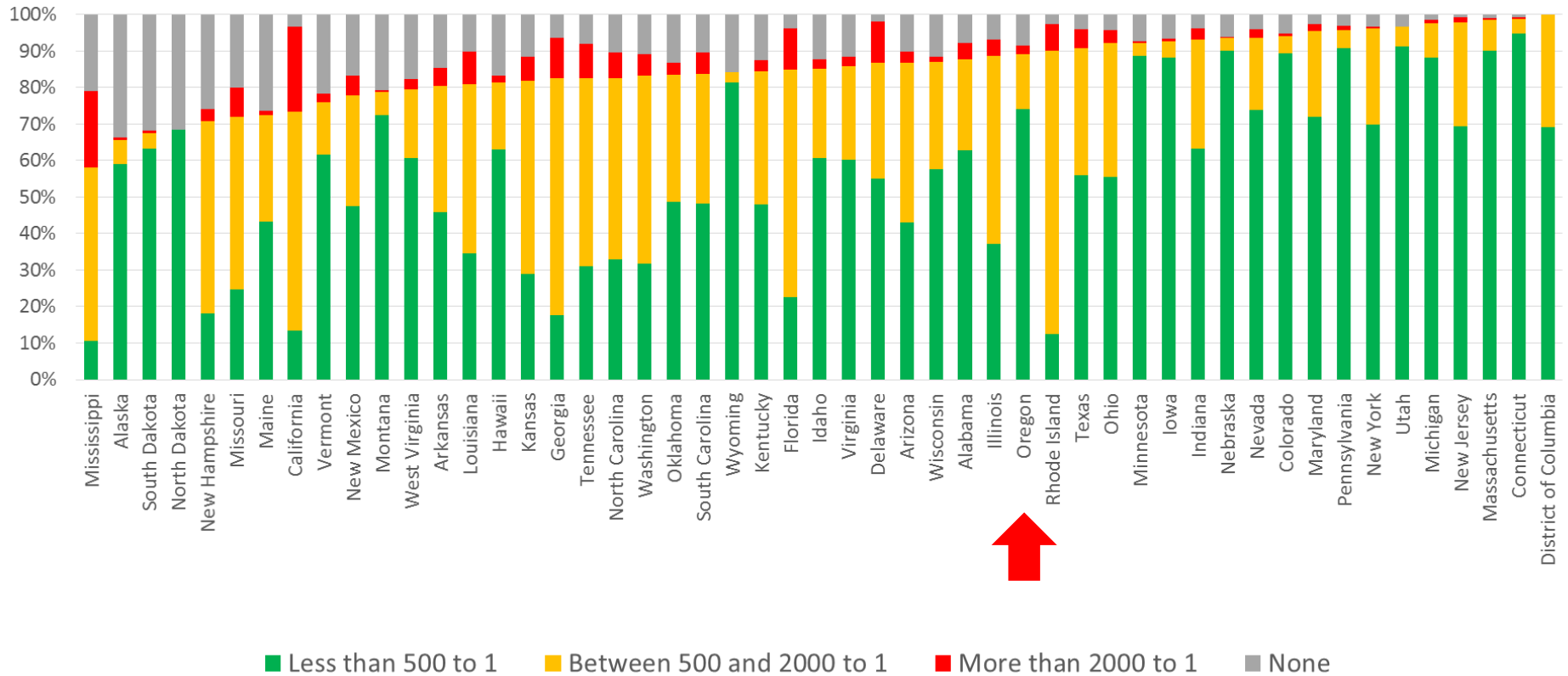
74% of publicly insured children live in areas with more than one Medicaid or CHIP dentist within a 15 minute travel time for every 500 publicly insured children

15% of publicly insured children live in areas with one Medicaid or CHIP dentist within a 15 minute travel time for every 500 to 2,000 publicly insured children

2% of publicly insured children live in areas with less than one Medicaid or CHIP dentist within a 15 minute travel time for every 2,000 publicly insured children

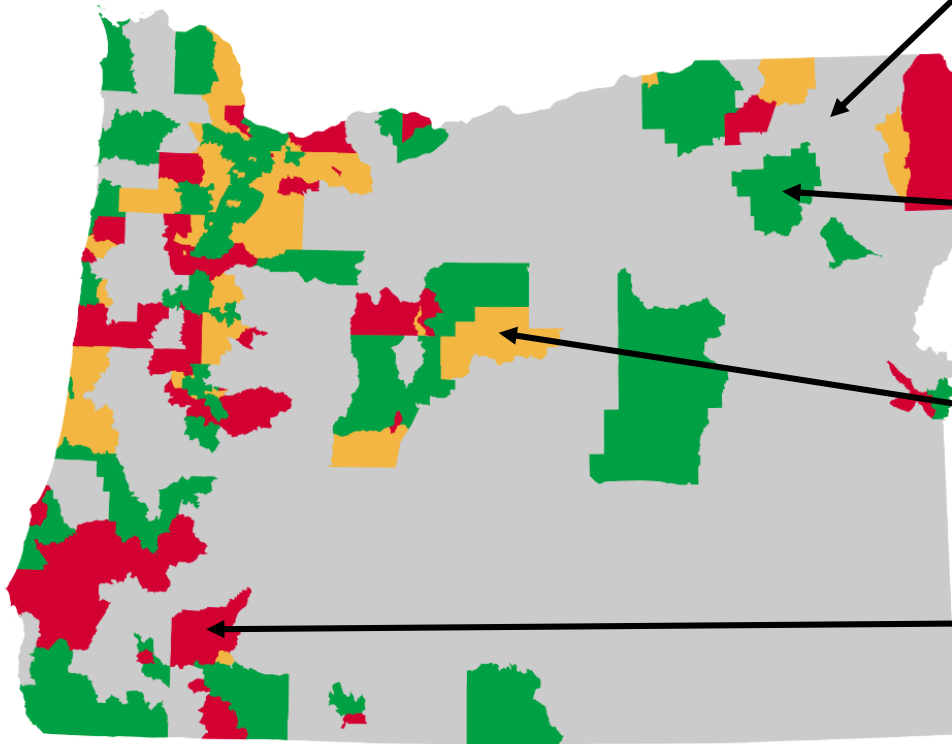
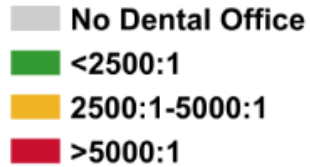
Geographic Access

Breakdown of Publicly Insured Children per Medicaid or CHIP Dentist Within 15 Minute Travel Time



Geographic Access

Population Per Dentist Within a 15-Minute Boundary



6% of the population do not have a dentist within a 15 minute travel time

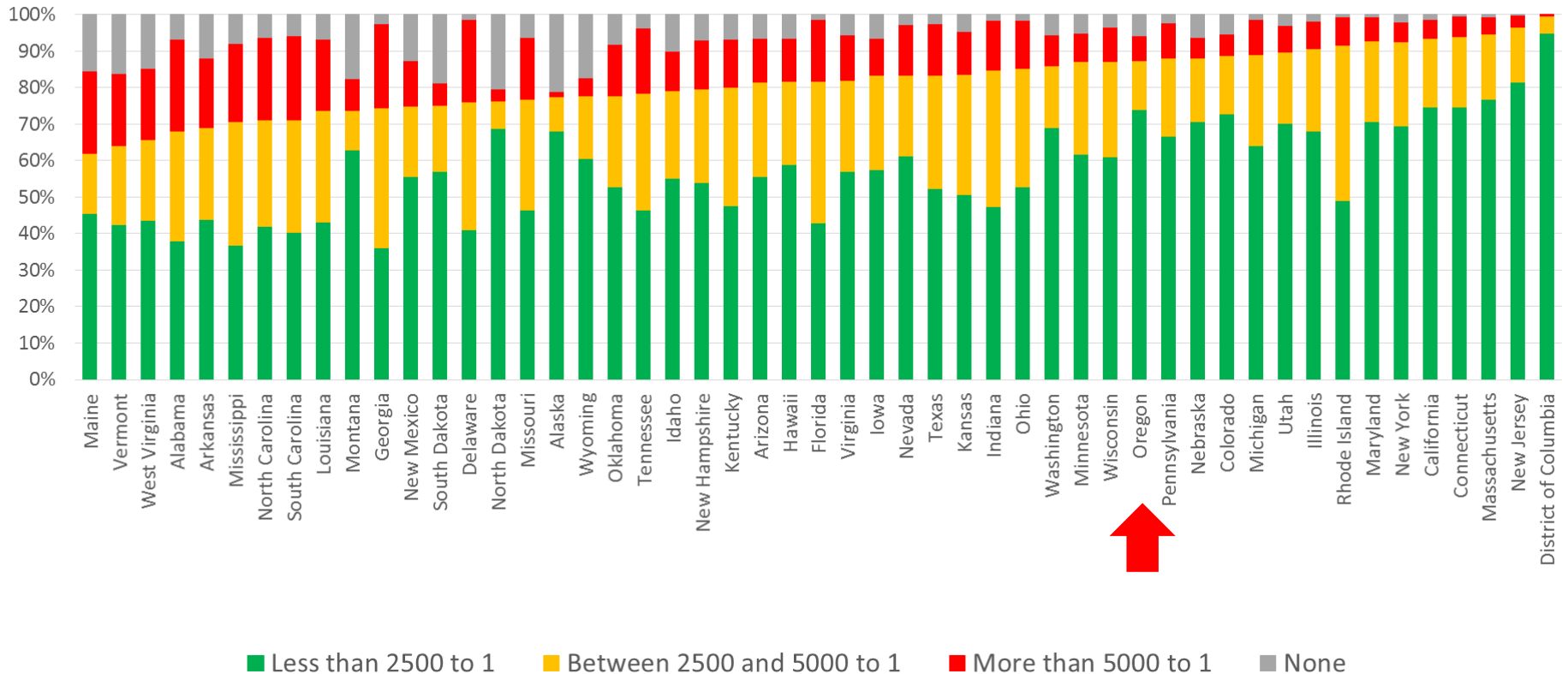
74% of the population live in areas with more than one dentist within a 15 minute travel time for every 2,500 people

14% of the population live in areas with one dentist within a 15 minute travel time for every 2,500 to 5,000 people

7% of the population live in areas with less than one dentist within a 15 minute travel time for every 5,000 people

Geographic Access

Breakdown of Population per Dentist Within 15 Minute Travel Time



Reimbursement in Medicaid

HPI Health Policy Institute

ADA American Dental Association*

Research Brief

Medicaid Fee-For-Service Reimbursement Rates for Child and Adult Dental Care Services for all States, 2016

Authors: Niodita Gupta, M.D., M.P.H., Ph.D.; Cassandra Yarbrough, M.P.P.; Marko Vujicic, Ph.D.; Andrew Blatz, M.S.; Brittany Harrison, M.A.

Key Messages

- Wisconsin, Washington and California had the lowest Medicaid reimbursement rates for both adult and child dental care services among states that provide dental services via fee-for-service.
- There is considerable variation across states in Medicaid fee-for-service reimbursement rates.

Introduction

Low-income children and adults are subject to different dental safety nets. States are required to provide dental benefits to children, who are covered by Medicaid and the Children's Health Insurance Program (CHIP), but providing adult dental benefits is optional.¹ Increased enrollment in Medicaid and CHIP led to a historic low of 11 percent of children lacking dental benefits in 2014, the most recent year data are available.² There has also been a steady increase in dental care utilization among children enrolled in Medicaid and CHIP over the past fifteen years.³ Low-income adults have not experienced similar gains. In 2014, the latest year for which we have data since Medicaid expansion under the Affordable Care Act, 54 percent of Medicaid-enrolled adults lived in states that provide adult dental benefits in their Medicaid programs.² However, 35.2 percent of adults in the U.S. do not have any form of dental coverage.²

A key issue for Medicaid is having a sufficient number of providers willing to participate. Research shows that a variety of factors limit the number of dentists that accept Medicaid, including high rates of cancelled appointments among Medicaid enrollees, low

The Health Policy Institute (HPI) is a thought leader and trusted source for policy knowledge on critical issues affecting the U.S. dental care system. HPI strives to generate, synthesize, and disseminate innovative research for policy makers, oral health advocates, and dental care providers.

Who We Are

HPI's interdisciplinary team of health economists, statisticians, and analysts has extensive expertise in health systems policy research. HPI staff routinely collaborates with researchers in academia and policy think tanks.

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April 2017

HPI Health Policy Institute
ADA American Dental Association*

Medicaid Fee-for-Service (FFS) Reimbursement and Provider Participation for Dentists and Physicians in Every State

REIMBURSEMENT AND PROVIDER PARTICIPATION IN MEDICAID FOR DENTISTS IN EVERY STATE



REIMBURSEMENT AND PROVIDER PARTICIPATION IN MEDICAID FOR PHYSICIANS IN EVERY STATE



PERCENTAGE OF PROVIDERS PARTICIPATING IN MEDICAID

37.5% DENTISTS 68.9% PHYSICIANS

MEDICAID FFS REIMBURSEMENT AS A PERCENTAGE OF PRIVATE INSURANCE REIMBURSEMENT

61.8% DENTISTS 60.1% PHYSICIANS

Source: Medicaid reimbursement for dentists is calculated from here. Medicaid reimbursement for physicians is calculated from here and here. Medicaid participation for dentists can be found here and for physicians here. Note: While fee-for-service (FFS) reimbursement rates are an important policy lever within Medicaid, they may not be representative of actual payment rates to providers in all states, depending on the extent of managed care programs. However, excluding managed care states based on classification found here does not change main conclusions. Analysis for dentists is based on reimbursement and participation in Medicaid for child dental care services. Physician participation is for office-based physicians and reimbursement is for primary care services. Data are for 2016 except for physician participation in Medicaid, which is for 2013. However, analysis suggests physician participation has not changed substantively since then.

Reimbursement in Medicaid

Figure 1: Medicaid Fee-For-Service Reimbursement as a Percentage of Fees Charged by Dentists, Child Dental Services, 2016

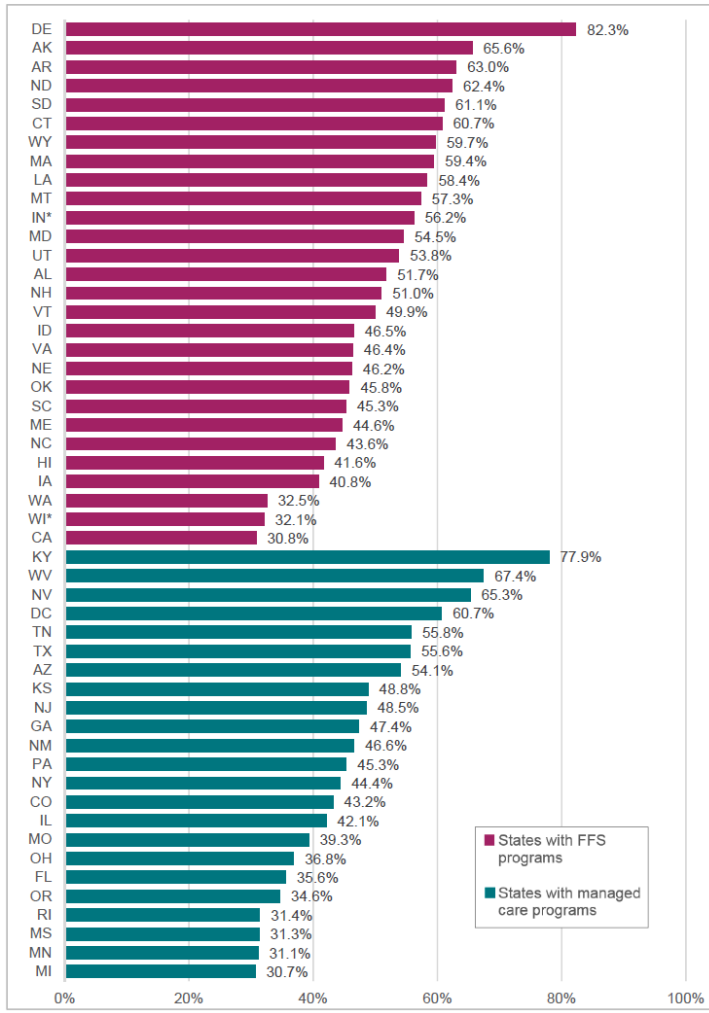
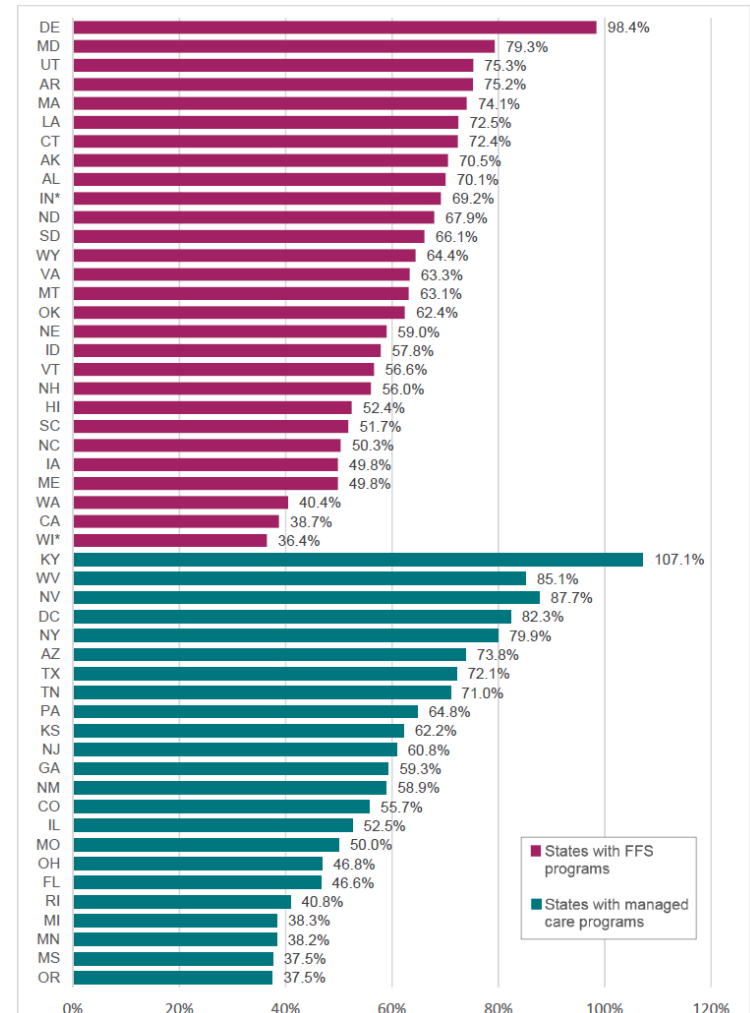


Figure 2: Medicaid Fee-For-Service Reimbursement as a Percentage of Private Dental Insurance Reimbursement, Child Dental Services, 2016



Reimbursement in Medicaid

Figure 4: Medicaid Fee-For-Service Reimbursement as a Percentage of Fees Charged by Dentists, Adult Dental Services, 2016

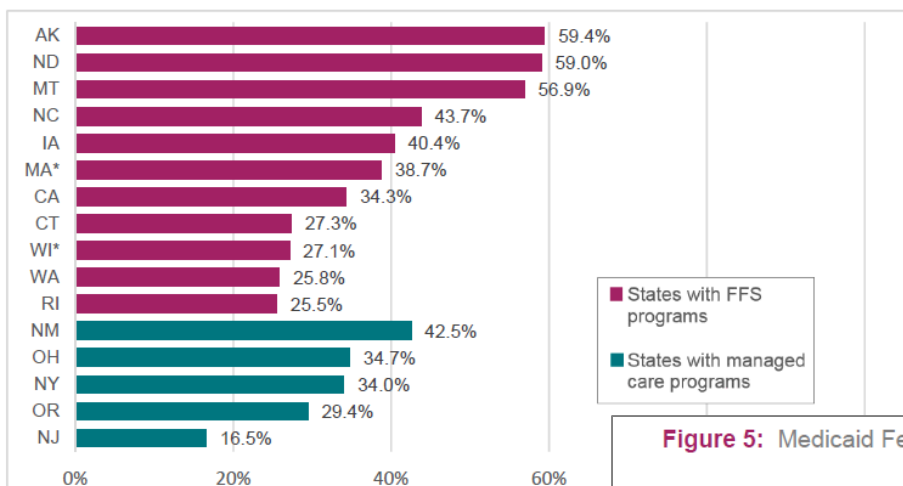
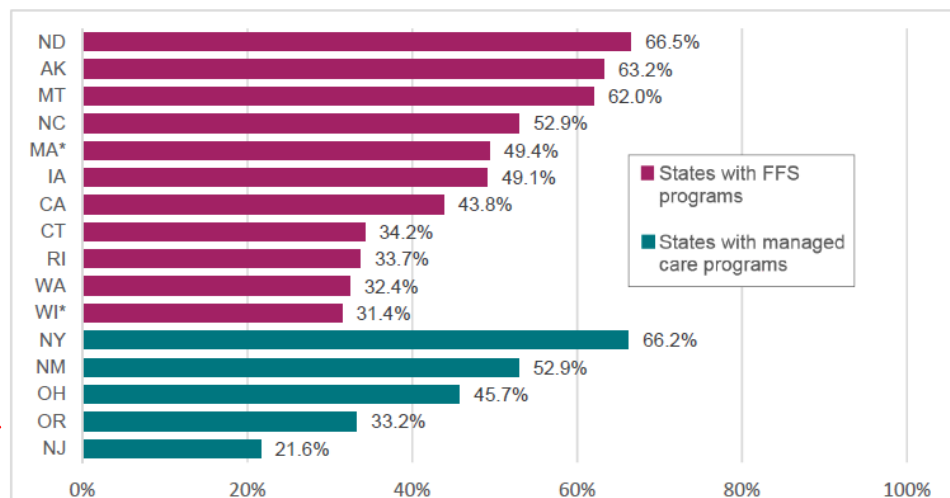
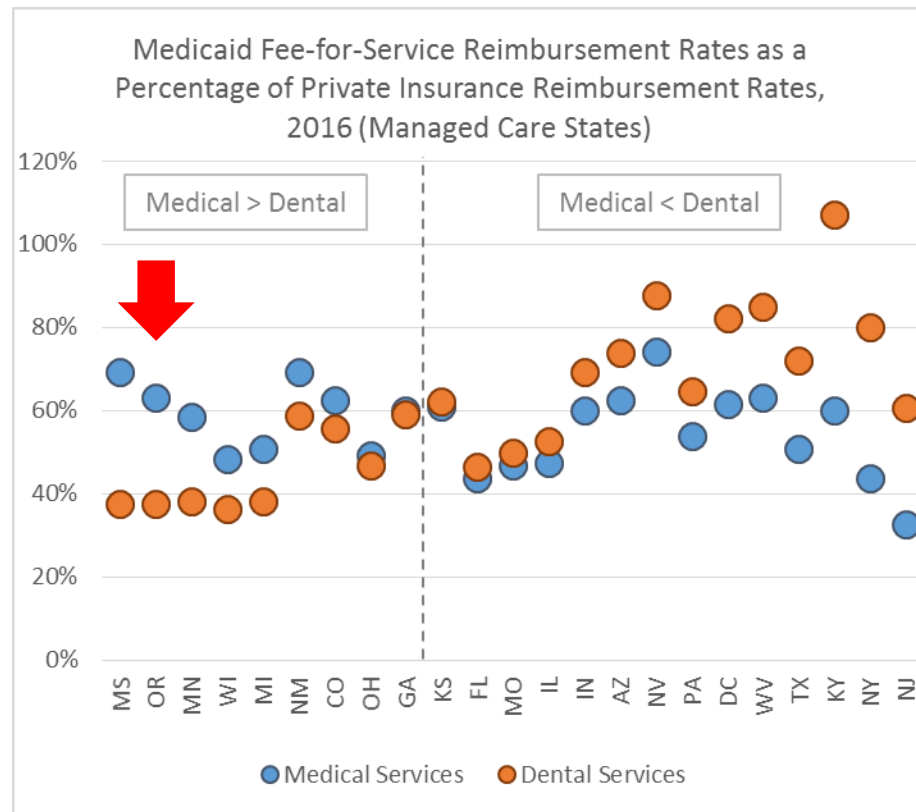
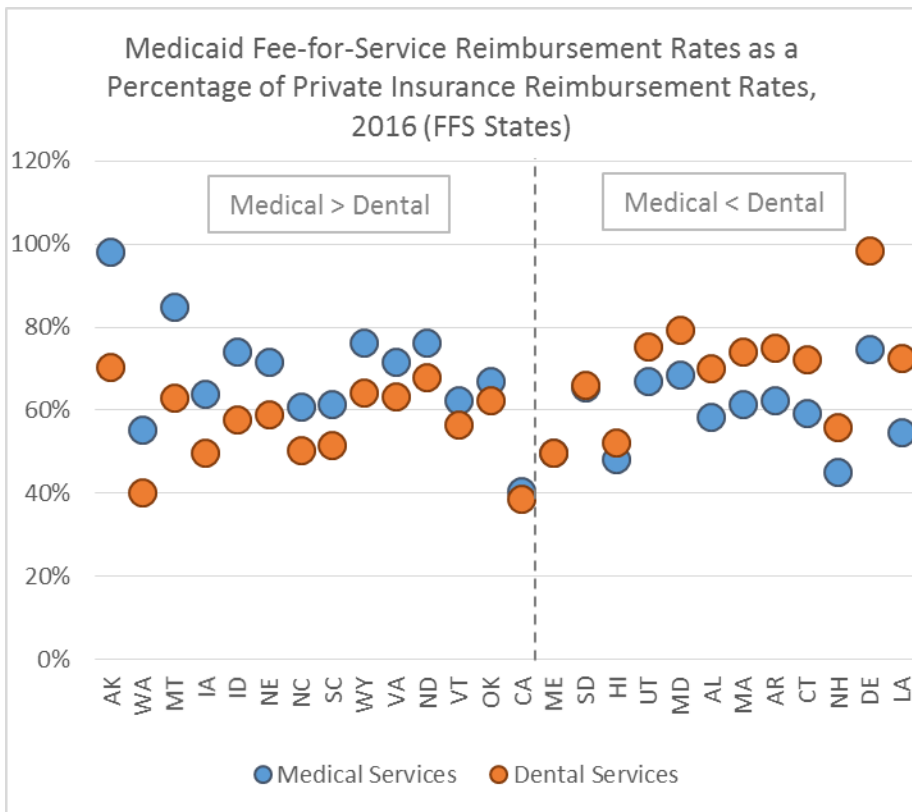


Figure 5: Medicaid Fee-For-Service Reimbursement as a Percentage of Private Dental Insurance Reimbursement, Adult Dental Services, 2016



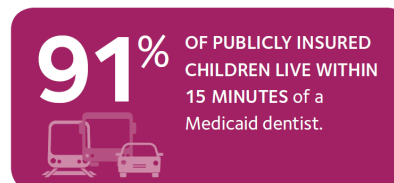
Reimbursement in Medicaid



Key Takeaways

What We Learned...

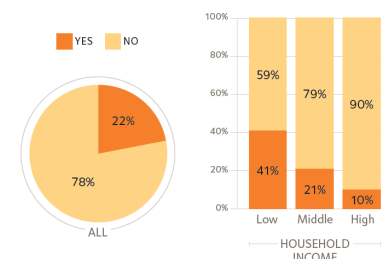
- Geographic coverage of dental care providers is quite extensive
- The supply of dentists is expected to grow steadily in the coming years
- Dental care use is low among publicly insured children
- Main barriers to dental care among adults relate to cost and fear, not lack of providers



What This Means...

- Need to focus less on “supply” interventions, more on “navigation” interventions (e.g. connecting members to a dental home, nudging diabetics into routine dental care)
- Need to re-examine adult dental benefit design so that it focuses much more on oral health outcomes
- Need to accelerate innovations in payment and care delivery models that focus on outcomes

Appearance of Mouth and Teeth Affects Ability to Interview for a Job



Thank You!

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