

THE STATE OF LITTLE TEETH

SECOND EDITION



AMERICA'S PEDIATRIC DENTISTS
THE BIG AUTHORITY on little teeth®





Executive Summary

The second edition of the “State of Little Teeth Report,” published by the American Academy of Pediatric Dentistry (AAPD), draws on the latest scientific research and best available expertise to examine the U.S. public health crisis of tooth decay among today’s children. In addition to examining the problems and causes of dental diseases, this report also explores an array of viable remedies by pediatric dentists, parents and our nation’s leaders. Here is a snapshot of the tooth decay epidemic, its challenges and potential solutions:

- Although the prevalence of tooth decay has decreased, nearly one in five children under the age of 5 has experienced dental decay.
- Nearly half of children aged 6–11 in the U.S. population are affected by tooth decay, along with more than half of those aged 12–19.
- Dental decay is not an equal opportunity disease. Children living in poverty are twice as likely to suffer tooth decay, and their dental diseases are more than twice as likely to go untreated as their more affluent peers.
- The 15 million children in the U.S. with special health care needs face acute unmet needs for dental care. Although virtually every pediatric dentist provides services to this population, transitioning from pediatric to general dental practices as these patients enter adulthood, remains a significant access challenge.
- Tooth decay compromises the health, development, and quality of life of children, affecting such factors as eating, sleeping, self-esteem, speech development and school performance.
- The AAPD, American Dental Association, and American Academy of Pediatrics all endorse the importance of a dental visit on or before the first birthday.
- The early dental visit, combined with good dental habits and dietary practices, can slow or even reverse the decay process in children.
- Early dental visits, along with prevention, make dental care safer, more comfortable and more affordable. Treatment of severe tooth decay can cost \$10,000 per child and up to \$25,000 in severe cases, especially if the child needs to be hospitalized and treated under general anesthesia.
- An AAPD national survey revealed nearly three quarters of U.S. parents do not take their child to the dentist by the first birthday, partially due to a lack of understanding of the importance of an early dental visit among parents, caregivers and medical professionals.
- Thanks to expanded dental benefits coverage for children, primarily through Medicaid and the Children’s Health Insurance Program (CHIP), 2016 marked the first year a majority of publicly insured children visited a dentist, thus narrowing the gap in dental care utilization between publicly and privately insured children.
- The number of practicing dentists and pediatric dentists is projected to continue to increase through 2030, outpacing the projected growth of the child population.
- A community may have an ample supply of dentists, but not enough dentists willing to treat young or financially distressed patients. Over 70 percent of pediatric dentists and 38 percent of general dentists accept Medicaid. Further, Medicaid patients represented one third of the average caseload of pediatric dentists in 2016, up from one quarter in 2011.

- Children are best served by protecting the financial support of dental Medicaid, which will encourage access to care through current providers already prepared to serve. Another solution is addressing barriers like transportation and language that may prevent patients from visiting a dentist.
- Medicaid and dentistry are working together to find innovative approaches to encourage participation by dentists, utilization by families, and a focus on prevention rather than treatment of disease.
- One child harmed during dental treatment is one too many. The AAPD has adopted a position of zero events of preventable harm to children—a perfect safety record—as a universal goal.
- Pediatric dentists actively advocate for children in their communities, at the state level, and the national level. For example, they lead efforts to protect water fluoridation, serve young children through organizations like Head Start, promote public health activities, and testify to legislatures on bills affecting access to dental care.

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Introduction

Though the prevalence has decreased over time, tooth decay is the most common chronic disease of childhood and remains an epidemic among our nation’s children. Research shows that it can cause lasting harm to a child’s oral and general health, potentially having serious influence on social and intellectual development. Children from low-income and minority families are particularly vulnerable to dental disease, as are children with special health care needs. Yet tooth decay is almost entirely preventable. Even though more children are visiting the dentist than ever before, many children still lack access to pediatric dental services.

The second edition of the “State of Little Teeth Report” draws on the latest scientific research and best available expertise to examine the public health crisis of tooth decay among children in the U.S. In addition to examining the problems and their causes, this report also explores a variety of solutions on the part of pediatric dentists, parents, and our nation’s leaders. We hope this report provides the basis for a meaningful discussion about the challenges facing the oral health of our children and what we can do about them.



I. The Epidemic of Caries In Our Youngest Children

Tooth decay in young children continues to be a concern in the U.S. and around the world. The latest data showed nearly one in five U.S. children under the age of five had experienced dental caries in 2015–2016. Tooth decay continues to have an even greater impact on minorities and children from financially disadvantaged families. This public health crisis poses an immediate and long-term threat, not just to the teeth of young children, but to their overall health and development.

Caries (derived from the Latin word for crumbling) is commonly referred to as cavities or tooth decay. It is a chronic, infectious disease resulting from the interaction of sugars, bacteria and tooth enamel. The bacteria metabolize sugars to produce acid which, over time, demineralizes tooth structure. The earlier children are exposed to these bacteria, the greater the risk of developing caries. Infected infants are far more likely to develop immediate and long-term oral health issues than infants who are not infected.³ The infection results from exposure to bacteria through contact with saliva, often from the parent or primary caregiver, but sometimes from other caregivers or playmates.³ Caries among young children, or early childhood caries (ECC), is a particularly rapid form of tooth decay.

ECC was once called baby bottle tooth decay, since a common cause of the disease is putting children to bed with a bottle of juice or milk. Children given

STATE OF LITTLE TEETH – FIGURE 1
Total and Untreated Caries Throughout Childhood



Fleming E, Afful J. Prevalence of Total and Untreated Dental Caries Among Youth: United States, 2015-2016. NCHS Data Brief: 2018;(307):1-8.

bottles of juice, milk or formula to drink during the day or overnight are prone to developing ECC. The sugar content in these beverages pools around the upper front teeth and mixes with caries-producing bacteria, leading to rapidly progressing tooth destruction. Other factors that put children at risk for caries include frequent consumption of sugary drinks and snacks, lack of dental hygiene, lack of fluoridation, chronic illness, enamel defects, and certain medications.⁴

Based on recent data, 18 percent of children ages 2–5 and 45 percent of children ages 6–11 in the U.S. population are affected by tooth decay. The issue is not just that many kids have caries—it’s also that many kids have untreated caries. In 2015–2016, 9 percent of children aged 2–5 had untreated tooth decay in primary teeth. Untreated caries rates were nearly twice as high for children aged 6–11.¹ (See Figure 1.) Due to the aggressive nature of ECC, cavities can develop quickly and, when left untreated, decay can work deep into the tooth’s nerve tissue, causing infections that may result in a medical emergency requiring hospitalization. The longer ECC remains untreated, the worse the condition gets, making it more difficult to treat. Often the treatment required is extraction, rather than repair, of the decayed teeth. These more complicated procedures are more expensive, and a smaller number of clinicians perform them. In other words, as treatment is delayed, the problem becomes more serious and difficult to treat, and access and cost issues multiply.

Dental decay is not an equal opportunity disease. Children living in poverty are more likely to have caries—and to have the condition left untreated.

The Most Risk for the Most Vulnerable Children

Few population groups are more vulnerable to oral disease and its consequences than young children, who depend on others and have trouble communicating their needs. Although children represent 23 percent of the overall population, they represent 33 percent of the population living in poverty. Non-Hispanic black and Hispanic children are almost 3 times more likely to live in poverty than white children.

Poverty has an especially strong correlation with childhood caries.¹⁴ Children aged 2–9 living in poverty are twice as likely to suffer tooth decay as their more affluent peers. In addition, their disease is more than twice as likely to go untreated (37 percent of poor versus 17 percent of non-poor).⁴ In 2014–2015, the prevalence of total dental caries went up as family income levels went down, from 52 percent for youth aged 2–19 from families living below the federal poverty level to 34 percent for youth from families with income levels greater than 300 percent of the federal poverty level.¹

Poor diet and lack of education play a part in these disparities. For instance, young children who consume a diet high in sugar, are of low socioeconomic status and whose mothers have a low education level are more likely to have ECC than those who do not have these combined characteristics. Emergency dental care expenditures are consistently higher among children of low-literacy caregivers than other children. In effect, children seen in the emergency room for caries-related dental pain are predominantly minority children from low-income families.

A key reason low-income and minority children have more oral health problems than their peers is that they are less likely to see a dentist. Though the number of children seeing a dentist has increased over the past years, visits continue to be influenced by financial standing. The most significant impact is currently seen among adolescents. Between ages 12 and 17, the percentage with a dental visit in the past year was lower among those living in poverty (81 percent) and in families with incomes of 100 percent to 199 percent of the poverty level (84 percent), compared with adolescents in families with incomes of 200 percent or more of the poverty level (92 percent).

Dental Disparities Exist Throughout Childhood

The foundation of adult oral health is established during the preschool years, when a child develops dental health patterns and corresponding caries risk. Early prevention is the key to a positive attitude about oral health in later years.

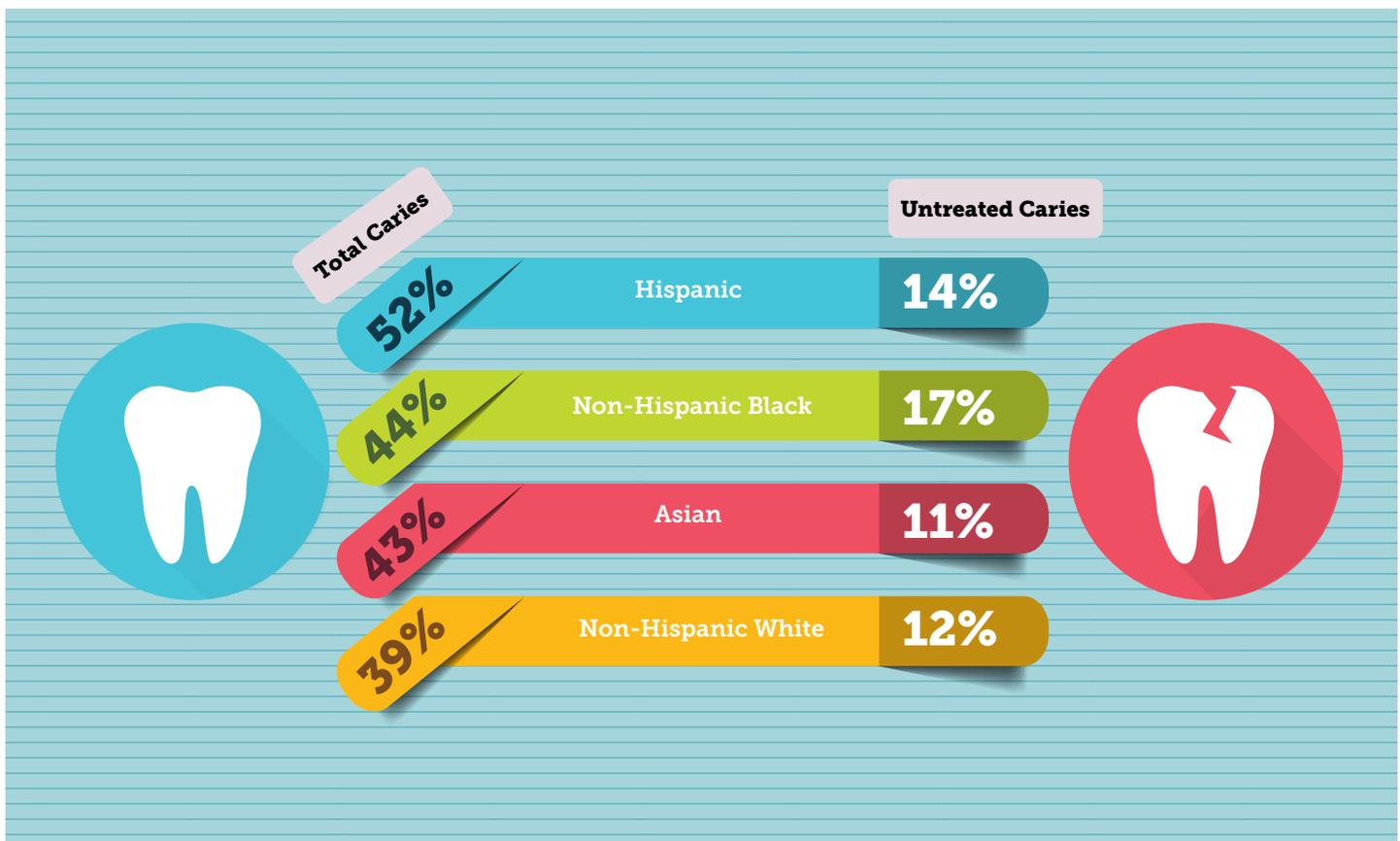
Dental caries is a disease that worsens throughout childhood. Data has shown that 21 percent of U.S. children aged

6–11 had dental caries in permanent teeth. Within this group of school-age children, dental caries among children aged 9–11 (29 percent) was twice as high as that of children aged 6–8 (14 percent).¹

In the face of the decreasing overall caries rate, adolescents and teens have the highest prevalence of dental caries among all age groups. Among youth aged 12–19, 54 percent had experienced dental caries in permanent teeth.¹ During adolescence, increased intake of sugars and carbohydrates, as well as inattention to oral hygiene procedures, can lead to an increase in caries.

Disparities in dental disease exist based on race and ethnicity as well. Among youth aged 2–19 years, the prevalence of total dental caries was highest for Hispanic youth (52 percent) compared with Non-Hispanic black (44 percent), Asian (43 percent), and Non-Hispanic white youth (39 percent). The prevalence of untreated dental caries was highest among Non-Hispanic black children (17 percent) compared with Hispanic (14 percent), Non-Hispanic white (12 percent), and Asian children (11 percent).¹

STATE OF LITTLE TEETH – FIGURE 2
Total Untreated Caries by Race and Ethnicity



Fleming E, Afful J. Prevalence of Total and Untreated Dental Caries Among Youth: United States, 2015-2016. NCHS Data Brief. 2018;(307):1-8.

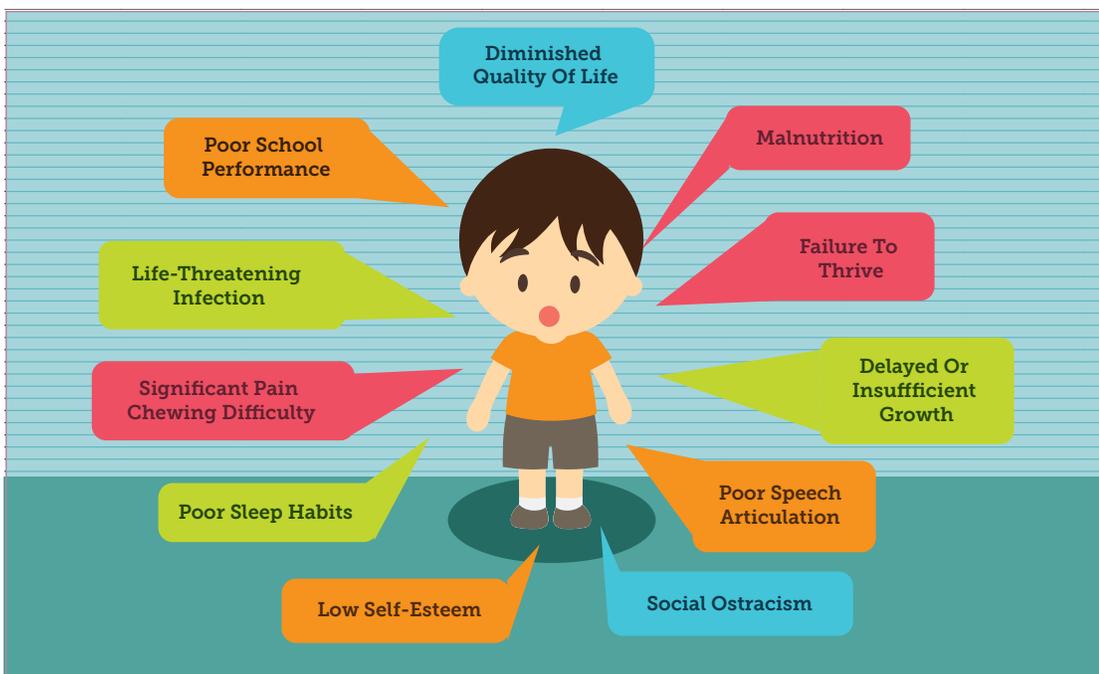
II. The Impact of Caries on Quality of Life



Caries compromises the health, development, and quality of life of children both in the short run and over the long term. Caries makes children more vulnerable to various infections in other parts of their body, such as the ears, sinuses and the brain, and could have a harmful long-term impact not only on their oral health, but also on their overall health.

Caries left untreated can result in:^{3, 23, 24, 25, 26, 27, 28, 29, 30, 31}

STATE OF LITTLE TEETH – FIGURE 3
ECC Left Untreated



Health Impact

ECC puts children at elevated risk for oral health problems throughout their lifetimes. For instance, if the tooth becomes infected and the nerve dies, the subsequent abscess can potentially damage permanent teeth. Also, if baby teeth are lost early, the child's permanent teeth are more likely to erupt out of proper position or to be delayed in eruption, subjecting the child to years of crooked teeth or orthodontic treatment.³³ Additionally, undetected and untreated tooth decay can lead to infection, loss of teeth, and expensive emergency and restorative interventions. In extreme cases, ECC can be life threatening and lead to serious disability.^{24,28,31}

The mouth is the gateway to a person's overall health, and children with tooth decay are prone to repeated infections in their ears and in their sinuses.^{21,22} Painful teeth keep children from getting enough sleep, interfering with overall health and development.¹⁴ As the child grows older, an unhealthy mouth can be associated with obesity, diabetes and even heart disease.^{4,34}

About one in 10 children with ECC suffers pain from the disease, making chewing food painful enough to keep them from eating properly and getting adequate nutrition.¹⁴ The result can be a failure to thrive, or reduced growth and weight, due to insufficient consumption of nutritious food.²¹ A cross-sectional study of children aged 1–3 found that children with untreated dental disease in advanced stages are more likely to have a poorer quality of life than their peers, including more difficulty eating and drinking.¹⁰ Evidence suggests that young children with severe caries may be more likely than their peers to satisfy one of the criteria for failure to thrive by weighing less than 80 percent of their age-adjusted ideal weight.³⁶ If they receive dental rehabilitation, children may experience an increase in growth rate and overall health.³⁷

“Evidence increasingly suggests that to be successful in preventing caries, we must begin within the first years of life. If appropriate preventive measures are applied early—in infancy—it may be possible to raise a cavity-free child.”

Paul Casamassimo, D.D.S., M.S., Chief Policy Officer, American Academy of Pediatric Dentistry

Difficulties of Dental Pain

Treating dental pain is as important as it is difficult and complex. Pain is hard to measure due to its subjectivity. Children may not have the language skills to communicate the level of pain they are feeling, making pain assessment dependent upon parent reports or pain scale indicators.³⁸ As a result, it’s possible to undertreat or overtreat pain, each carrying its own set of health risks. In some populations with access to care issues, children may suffer for weeks in pain before families are successful at finding a resolution.³⁹

In addition to the unnecessary suffering a child endures, failure to adequately treat dental pain has repercussions that may persist well into adulthood. Medical studies of pain in children suggest that inadequate management of pain results in lower pain thresholds and sensitization to pain in the future.^{40,41} Pain treatments may also pose certain risks. Some providers are worried about giving the child too high a dose of pain medication, or they are hesitant to prescribe opioid painkillers due to fears of addiction.⁴²

Other children with advanced disease may require repeated rounds of antibiotics, which contributes to an increased risk for drug resistance and allergic reactions.⁴³

Even commonplace drugs such as acetaminophen can harm children’s health and endanger their lives. (Over-the-counter brand name medicines that contain acetaminophen include Tylenol, PediaCare and Triaminic.) In the U.S., acetaminophen toxicity is the most frequent cause of acute hepatic failure and is the second most frequent cause of liver failure requiring transplantation.^{44,45}

The vast majority of acetaminophen-related liver injuries reported in children were caused by medication errors due to improper measuring devices, dosing at the wrong concentration, or lack of dosing information for children under age two.⁴⁶ Accordingly, pediatric dentists follow AAPD clinical recommendations to protect patients from a potential overdose of pain medication.

Social Impact

The pain from tooth decay may hinder many young children from speaking, playing, going to school or paying attention in class. Discolored, damaged or missing teeth may hurt children’s self-esteem and social development by making them afraid to smile or subjecting them to teasing and social ostracism.⁴ Children with oral health issues are less friendly and more likely to feel worthless, shy, or unhappy than those who do not have oral health problems.⁴⁷

Children with poor oral health are more likely to miss school and are less likely to do all required homework.^{48,49} In the U.S., over 34 million school hours are lost each year due to dental problems. Children with poor oral health are nearly three times more likely to miss school as a result of dental pain and more likely to have lower school performance.⁵⁰ Given that poor and minority children are especially subject to untreated tooth decay, these social and quality-of-life repercussions pose yet another barrier to achieving success in life.

Children in the U.S. miss over 34 million school hours each year due to dental problems.

Economic Impact

ECC not only exacts a toll on children, but it can also affect the financial well-being of families, communities, and public insurance programs. For example, treatment of severe ECC can cost \$10,000 per child and can go up to \$25,000 in severe cases, especially if the child needs to be hospitalized and treated under general anesthesia.^{51,52}

Medicine offers numerous examples of the cost effectiveness of early prevention. For example, folic acid supplementation during pregnancy helps prevent birth defects of the brain and spinal cord such as spina bifida. It is estimated that for every dollar spent on prenatal care, the health care system saves between \$2.57 and \$3.38 on the medical cost of care to low-birth-weight babies.^{53,54}

Similarly, early intervention has great potential to reduce overall costs associated with dental treatment in preschool children. Because untreated dental disease increases in severity over time, it often necessitates more extensive and costly treatment delivered in ambulatory or hospital settings.⁵⁵

Several studies have examined the cost-effectiveness of early dental visits. The seminal study from North Carolina examined the effects of early visits on subsequent utilization and costs of dental services among preschool-aged children.⁵⁶ The average costs for children with an age one visit was \$300 less than those who waited until age three. Two subsequent studies of children in Wisconsin and Michigan failed to find a relationship between an early dentist visit and total dental costs.^{57,58} However, unlike the North Carolina study, neither of these investigations included hospital, emergency room, or other medical-related costs associated with the treatment of dental disease in young children. A disproportionate share of costs for dental treatment of children under age five is for emergency room or hospital visits that are realized in medical costs.⁵⁶

The cost-effectiveness of early dental visits is supported by several follow-up studies. Preventive dental visits before the age of five significantly reduce non-preventive dental visits and expenses associated with non-preventive services.⁵⁹ Additionally, after eight years of follow up, children who had their first dental visit before the age of four spent an average of \$360 less on dental treatment than those who did not.⁶⁰ A 2014 systematic review examined the importance of preventive dental visits from a young age. The review concluded that although there are costs associated with preventive services, early preventive dental visits may be associated with reduced restorative dental care visits and related expenses during the first years of life.⁶¹

Beyond the savings on restorative dental care provided in an office or hospital setting, the prevention of dental disease has the potential to save millions of dollars each year on dental-related emergency room visits and hospital-

izations. A study of Iowa Medicaid children under age six treated for early childhood caries in the hospital or ambulatory care setting indicated that fewer than five percent of those receiving dental care consumed 25–45 percent of the dental resources.⁵⁵ A similar study from Washington State concluded that 19 percent of their pediatric dental emergencies were related to early childhood caries, and of those, over half were children under 3.5 years. In a survey of hospital-based emergency department visits of children due to dental conditions, more than 200,000 occurred each year with an average cost per visit of \$564 and a total charge across the U.S. of over \$100 million.⁶² These studies emphasize that early prevention can translate into significant cost-savings for restorative and emergency dental care, especially for those families at or below the poverty level where caries rates are dramatically higher in children three years and younger.

“For parents who think postponing the first dental visit will help their budget, the opposite is more likely. Children who had their first appointment after age four had \$1,054 of dental treatments, while children who had their first appointment before age four had \$694 of dental treatments during eight years of follow-up.”

Arthur J. Nowak, D.M.D., M.A., professor emeritus of pediatric dentistry and pediatrics, University of Iowa Colleges of Medicine and Dentistry

Caries affects the quality of life for children. The potential health, social and economic benefits to the child who has experienced early dental visits are significant. The early visit to the dentist improves the oral health of the child by assessing and treating oral health, including caries, thereby reducing the child’s future risk of dental disease and enhancing oral health throughout childhood. In addition to the caries assessment, the dentist will address any growth and development issues that may be specific to a particular child, such as delayed eruption of teeth or rare structural abnormalities or habits that may predict future dental treatment needs.⁶³



III. Children Visit Dentists Too Late

Delays In First Dental Visit

Because children are not seeing the dentist early enough, a preventable disease like caries remains a significant threat to the health, welfare and future of the youngest members of our society. Why do so few children see the dentist in their first year of life? A key reason is a lack of understanding of the importance of the early dental visit among parents, caregivers and medical professionals.

Tooth decay can be difficult to diagnose in infants and toddlers, since it often starts with a dull ache that may be mistaken for teething. Frequently, parents don't realize their child has caries until the pain becomes acute or the teeth break. Much pain and damage could be avoided if the child visits the dentist earlier.

Baby teeth are vulnerable to tooth decay from their very first appearance, occurring on average between the ages of six and 12 months. That's why the first examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age.^{28,64} In fact, most major dental and pediatric organizations, including the American Dental Association, the American Academy of Pediatrics, the Academy of General Dentistry and the AAPD, are on record supporting the importance of a dental visit on or before the first birthday.^{28,63,65,66}

Aside from diagnosing the child's oral health, the early visit is an important opportunity for dental providers to discuss with caregivers the importance of establishing good dental habits and dietary practices. If established early in the child's life, these practices can have a significant impact on the child's future oral health. Waiting until the child is older—even if only to the age of two or three—can have an adverse impact on oral health as well as family finances.⁶⁷

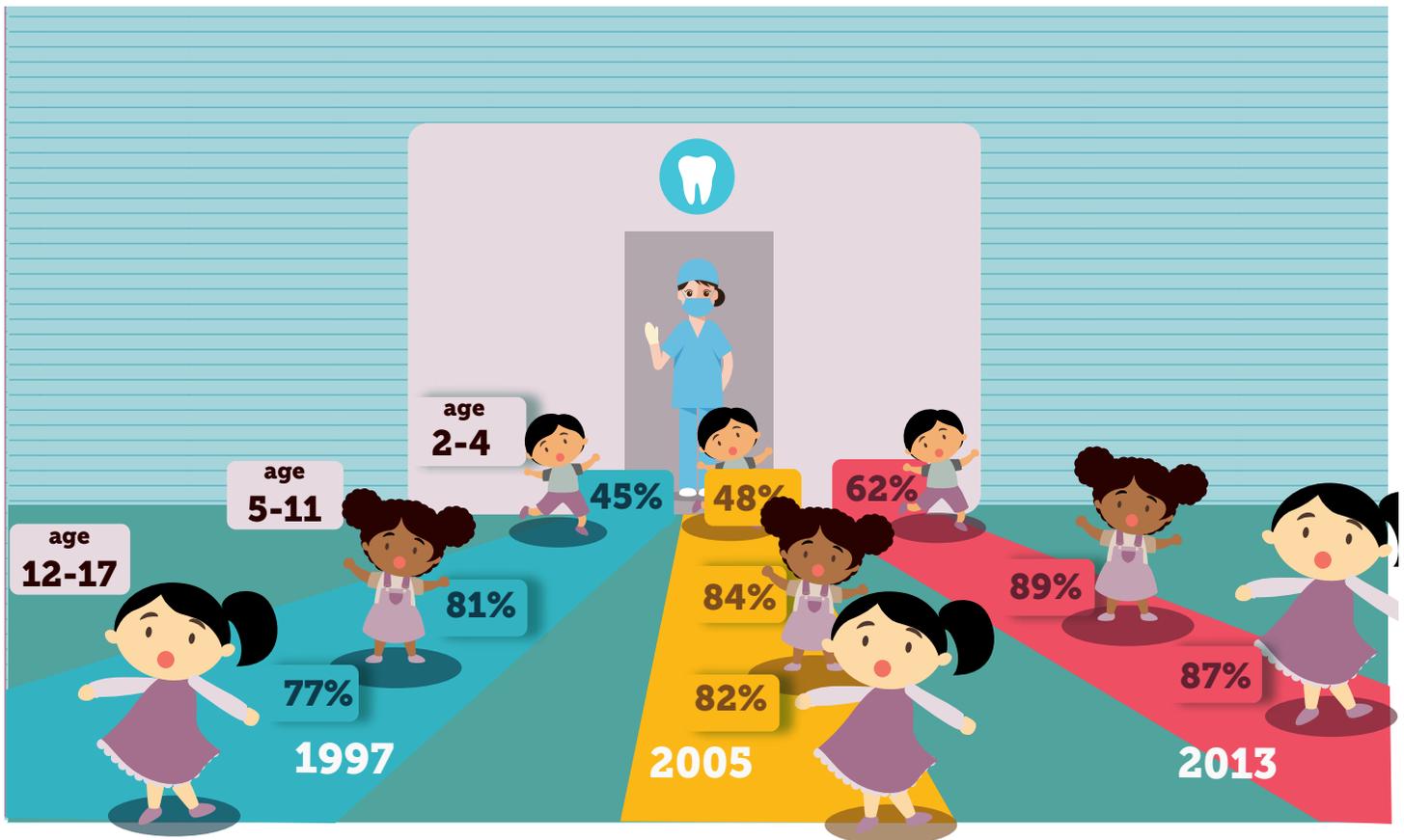
The AAPD, American Academy of Pediatrics, American Dental Association and Academy of General Dentistry recommend a first dental visit by the first birthday or when the first tooth comes in.

Parents and Providers Play Vital Roles

More than eight in 10 parents and caregivers surveyed know their child's oral health is important before the permanent teeth come in.⁶⁸ This awareness is partly reflected in the rising rate children are seeing the dentist. Between 1997 and 2013, children with a dental visit in the past year increased by:

- Seventeen percent among children ages 2–4,
- Eight percent among children ages 5–11, and
- Ten percent among adolescents ages 12–17.¹⁸

STATE OF LITTLE TEETH – FIGURE 4
Dental Visits Have Increased for All Ages Since 1997



Federal Interagency Forum on Child and Family Statistics. *America's Children: Key National Indicators of Well-Being, 2017*. ChildStats.gov. Washington, D.C.: U.S. Government Printing Office; 2017:23-25.

Parents play a critical role in the oral health of their children, not only in making dental appointments, but in providing the information, guidance and encouragement needed for a healthy dental lifestyle.⁶⁹ Good home care habits and healthy teeth in children are associated with positive attitudes about oral health held by their mothers.

In fact, parents' beliefs in their ability to control their children's tooth brushing and snacking significantly predict the establishment of favorable oral health habits.⁷¹

Despite a growing awareness of the importance of children's oral health, many parents do not follow good dental practices with their children, often because of a lack of understanding or perceived need for protecting their child's oral health.^{72,73,74,75} A national poll of parents of at least one child aged five or younger found one in six of those parents who did not receive advice from a health provider thought children shouldn't visit a dentist until age four.⁷⁶ A national survey conducted by the AAPD reveals nearly three quarters (74 percent) of U.S. parents do not take their child to the dentist by their first birthday, although millennial parents are more likely to take their child to the dentist by

age one than any other generation and are more likely to supervise their child's brushing habits.⁷⁷ Additionally, while 96 percent of parents say oral health is important to their family, many do not think toothaches are a serious ailment.

One third of parents (31 percent) rank toothaches as the least serious ailment compared to tummy aches, earaches, headaches and sore throats.

Even when parents and caregivers recognize the importance of their child's oral health and the various practices that support that health, they don't always follow through. Nearly eight out of 10 parents and caregivers report they engage in practices they know are bad for their children's teeth.⁶⁸ For example:

- Seventy-eight percent agree that juice is not a healthy drink for their kids' teeth, but 34 percent frequently serve juice to their children.
- Eighty-five percent of parents and caregivers agree it is not okay to put their child or children to bed with a bottle of milk or juice, but 20 percent do so anyway.
- Ninety-one percent agree that poor diets can harm tooth development, but more than half (57 percent) of parents and caregivers surveyed allow their children to snack multiple times a day.

The lack of understanding of the importance of caring for teeth at an early age and establishing a Dental Home is not restricted to parents—it is still too common among providers in the health care community.⁷⁸ Despite the recommendation from their own professional societies that children see a dentist around age one, a majority of primary care providers do not pass this recommendation on to their patients.^{28,79,80,}

ODDS NOT GOOD FOR DELAYED FIRST VISIT

Research from the AAPD supports the vital importance of early dental visits to protect children's oral health. The study, conducted with over 2,000 infants at Nationwide Children's Hospital in Columbus, Ohio, produced a predictive model that suggested the odds of a child having tooth decay at the first dental visit more than doubles for every year of increased age.⁸¹ For example, a child who has a first dental visit at age five would have nearly 20 times the odds of having cavities than a child who has a first dental visit at age one.

The study suggested that, starting at the 18-month well-child visits, four variables from earlier well-child visits could help medical providers assess the risk of future or present caries in our study population, even if tooth decay was not readily apparent. The variables were:

- Age of the child
- Duration of breastfeeding (past age one)
- No-show rate (such as broken appointments, etc.)
- Preferred spoken language

The use of this type of risk modeling to predict early childhood caries represents a new analytical approach to caries assessment and treatment decision-making. The next steps are testing the model in additional child populations and medical settings, as well as exploring the application of predictive models in clinical settings.



IV. Every Child Deserves a Dental Home



Pediatric Dental Providers Can Help Address the Threat of ECC

The early dental visit, combined with good dental habits and dietary practices, can slow or even reverse the caries process in children. The goals of an early visit are to establish a Dental Home for the infant, introduce healthy habits, and prevent ECC.³³ In children at increased risk of poor oral health, early intervention and prompt referral to a dentist is cost-effective and can improve a child's overall quality of life.

Dental Home

While it is difficult to overestimate the importance of the early visit to the dentist, it is equally important that the visit is not a one-time or rare event. A child's oral health greatly depends on regular visits to the dentist. Since choosing a dentist is too important a decision to do in a hurry or an emergency situation, parents are urged to find their child a Dental Home *before* there is a dental problem.

A Dental Home is defined as the ongoing relationship between the dentist and the patient in which all aspects of oral health care are delivered in a comprehensive, continuously accessible, coordinated and family-centered way. Such care takes into consideration the patient's age, developmental status, and psychosocial well-being, as well as family situation and preferences. A Dental Home provides a network of health professionals specializing in everything from preventive oral care and education to the advanced care required to treat emergencies.

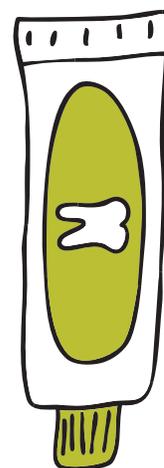
To find a pediatric dentist in your area, visit the American Academy of Pediatric Dentistry's website at aapd.org or mychildrensteeth.org.

SILVER DIAMINE FLUORIDE: NEWEST ADDITION TO THE TREATMENT TOOLBOX

Silver diamine fluoride (SDF) is recommended for treating active cavities in child and adolescent patients, including those with special health care needs, by the 2017 AAPD evidence-based clinical guideline.⁸² SDF is a minimally invasive, low-cost treatment that dentists paint on teeth to painlessly treat cavities. According to the systematic review of research, SDF has a history of being very safe, with no reports of significant adverse effects. Clinical studies, although limited, indicate that SDF is effective in 70 – 80 percent of treated teeth. The most notable drawback is that SDF turns cavities black. This color change is permanent and noticeable, especially on the front teeth. (As a parent, ask to see before-and-after pictures of teeth treated with SDF when making the treatment decision.)

Why would a dentist recommend SDF instead of a filling? Because sometimes fixing cavities immediately is not possible, for instance, when a child has special health care needs, is sick, or is too young to cope with the treatment. Treating cavities in young children often involves sedation or general anesthesia, both of which pose potential health risks. In addition, the cost of treating cavities in young children can be disproportionately high.

Topical silver products, including SDF, have been used in Japan for over 40 years to arrest cavities and reduce tooth hypersensitivity. Many other countries, such as Australia and China, have had similar success with SDF during the past decade. SDF is most effective as part of an ongoing decay management plan preceded by consultation with the patient and/or parent. Teeth treated with SDF need to be checked by a dentist at least every six months and SDF may need to be re-applied twice a year to have a sustained effect. While SDF can slow or arrest the decay process, it doesn't fix the damage already done. As soon as practicable, the tooth must still be restored by the child's dentist.



Children with Special Health Care Needs

More than 15 million children, representing nearly 20 percent of the U.S. population under age 18, have special health care needs. Moreover, the number of children with activity limitations has more than tripled over the last four decades.⁸⁵ This growing population is at high risk for developing oral disease, and untreated tooth decay can exacerbate other health conditions.⁸⁶ Access to dental care has been nationally recognized as a critical unmet necessity for children with special health care needs. Children with special health care needs have more dental problems and more untreated dental disease, especially those who are uninsured, financially disadvantaged, or have greater limitations due to their underlying disabilities.⁸⁷

Only one in four general dentists reported having hands-on experience with patients with special health care needs in dental school. Approximately 10 percent of general dentists provide care to children with special health care needs.⁸⁸ In comparison, virtually every pediatric dentist (99 percent) provides services to patients with special health care needs. On average, special needs patients represent 12 percent of the caseload of a pediatric dental practice.⁸⁹

Why are pediatric dentists the providers of choice for the oral health care of children with special health care needs? Pediatric dental residencies require hospital-based advanced training and service programs on the care of children with special health care needs. In addition to their training, pediatric dentists remain the main source of care because of use of advanced behavior guidance techniques, hospital affiliations, experience in treating patients with uncontrolled movement, and the specialty's dedication to their patients. Further, the high percentage of pediatric dentists who accept public insurance plans is an essential part of access to care for many patients with special health care needs.

Pediatric dentists often retain special needs patients into adulthood due to the relationship that they have built with them. The transition of patients with special health care needs from pediatric to general dental practices remains challenging; the major barrier is the availability of general dentists.⁹⁰ As a result, many community- and home-based adults remain in the care of pediatric dentists. Without significant changes in dental education, appropriate health support services, and funding for dental care in public sector programs, pediatric dentists will retain the primary care responsibility for persons with special health care needs of all ages.





V. Secure a Dental Home for Your Child

The benefits of early visits and the Dental Home are not available to those who cannot find a dentist. Access to pediatric dental care involves a host of factors including the support of public insurance programs such as Medicaid and Children's Health Insurance Program (CHIP), the willingness of general dentists to treat children, and the availability of pediatric dentists.

Dental Visits on the Rise

Nearly five in 10 children (birth to age 20) had a dental visit in 2015, an increase from four in 10 children in 1996.⁹¹ Although the likelihood of a visit rose for virtually all child populations, it continues to vary by age, income and ethnicity. For example, fewer than three in 10 children under age six visited a dentist within a given year, while six in 10 children ages 6–12 had a dental visit. Children from lower income families were less likely to have a dental visit than those from higher incomes (28 vs 56 percent). Hispanic and non-Hispanic black families were less likely to see a dentist than non-Hispanic whites (33, 30 and 49 percent respectively).⁹¹

STATE OF LITTLE TEETH – FIGURE 5
Dental Visits within a Given Year for Different Age Groups



Manski Rj and Rohde F. Research Findings No. 38. Dental Services: Use, Expenses, Source of Payment, Coverage and Procedure Type, 1996–2015. Rockville, MD: Agency for Healthcare Research and Quality. November 2017.

Influence of Insurance

Dental benefits coverage is a strong, consistent predictor of access to a continuous source of oral health care.⁴ Approximately 88 percent of children (birth to age 20) had dental coverage in 2015, increasing from 73 percent in 1996.

More children than ever are visiting the dentist. The greatest growth comes from low-income children, thanks to expanded dental benefits coverage, primarily through Medicaid and CHIP. Dental care utilization among children covered by public insurance increased from 35 percent in 2005 to 50.4 percent in 2016, thus narrowing the gap in dental care utilization between Medicaid-enrolled and privately insured children.⁹²

Regardless of dental insurance type, having insurance is found to be positively correlated with the use of dental services, and children with insurance have less unmet dental need.⁴ Though the number of insured children increased by 18 percent from 1997 to 2014, there are still children left without the security blanket of insurance coverage.⁹¹ Our most vulnerable children are not receiving the oral care they need.

Dental Homes with General Dentists

Many families experience problems finding a dentist who will see their child. In a study of mothers of Medicaid-enrolled children in Washington State, more than 60 percent had no regular dentist or regular source of dental care for their children.⁹³

The supply of dentists is growing. In 2017, there were 156,992 general dentists in the U.S., up from 141,217 in 2007.⁹⁴ The number of practicing dentists is projected to increase through at least 2035, outpacing the projected growth of the general population. However, there still may be an insufficient number of dentists compared to the need or demand for dental care among disadvantaged populations, particularly children in low-income families. A community may have an ample supply of dentists, but not enough dentists willing to treat Medicaid patients seeking care. According to the 2017 ADA Survey of Dental Practice, only 38 percent of general dentists reported seeing children with Medicaid. On average, patients covered by public insurance make up less than 9 percent of a general dental practice.⁹⁶

CHOOSE THE RIGHT DENTIST FOR YOUR CHILD

- Does the dentist have special training or interest in treating children?
- Is the dental office set up for children? For example, does it offer toys, books, games and child-sized furniture?
- How does the dental office manage emergencies?
- Is the office conveniently located to your home, work or child's school?
- Does the practice accept your dental benefits plan?
- Was your child seen promptly?
- Were you asked for a complete medical and dental history for your child?
- Did the dentist or staff talk to your child, encouraging involvement in the visit and oral health?
- Were you informed about your child's tooth development, the causes and prevention of dental disease, and appropriate dental care at home?
- Were your questions treated with concern and respect?
- Was the visit positive for your child?

In addition to a low participation level in Medicaid, many general dentists are unwilling or unable to treat young children; the visits require unique skills.⁹⁷ While most general dentists report treating children, few provide care for children aged three or younger.⁹⁸ According to a survey of dentists affiliated with Medicaid managed care in New York City, the majority (94 percent) were general dentists, but less than half (47 percent) reported a willingness to see children aged 0–2 years.⁹⁹ Results from a national survey showed 91 percent of the general dentists surveyed treated children, but patients younger than four years of age, with high levels of caries, or whose care is funded by Medicaid were represented in very low numbers.¹⁰⁰ For example, 73 percent of respondents did not treat children ages 6–18 months, and 28 percent did not treat children ages 19 months–3 years. These data indicate that groups of children have difficulty finding dental care in the general practice community, contributing to the problem of access for the children who need it most.

Dental Homes with Pediatric Dentists

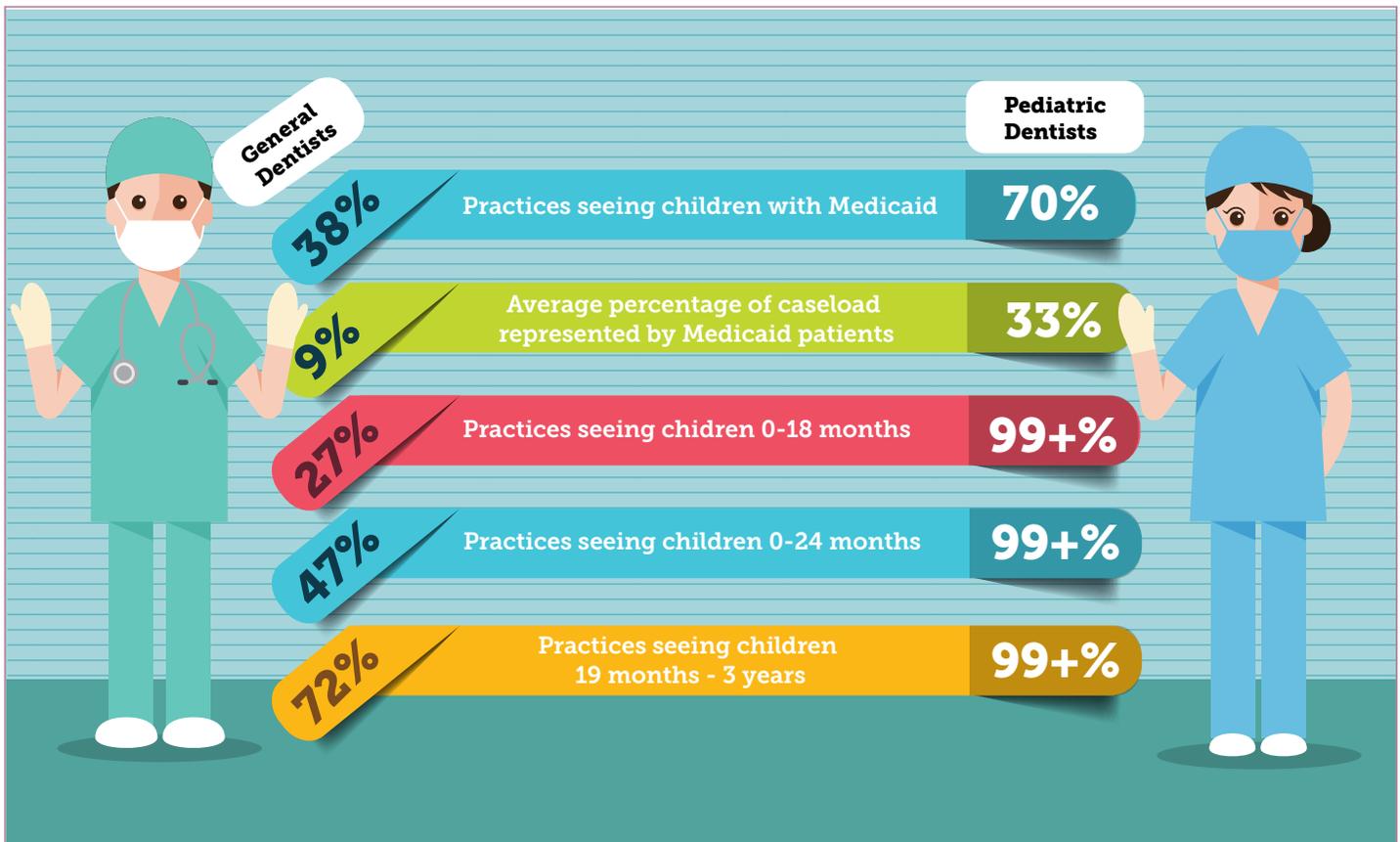
The supply of pediatric dentists is growing at a more accelerated pace than that of general dentists. Pediatric dentistry, the only ADA-recognized dental specialty that is age-defined and emphasizes clinical competencies to care for children, was represented by 7,778 practitioners in 2017, up from 5,107 in 2007.⁹⁴ The AAPD has worked for more than 15 years to increase the supply of pediatric dentists, seeing the number of first-year pediatric residency positions grow from 316 in 2006–2007 to 457 in 2016–2017.¹⁰¹

A comprehensive workforce study on the supply and demand for pediatric dentistry projected that the number of pediatric dentists in the U.S. will continue to grow. In 2016, about nine pediatric dentists per 100,000 children were practicing in the U.S. If the graduation of new pediatric dentists continues at the current rate, the number of practicing pediatric dentists is projected to increase about 60 percent by 2030, equal to about 14 per 100,000 children.¹⁰²

Equally relevant to access to care for underserved child populations is the high proportion (70 percent) of pediatric dentists who see patients covered by Medicaid.⁸⁹ Further, Medicaid patients represent 33 percent of the average caseload of pediatric dentists in 2016, up from 26 percent in 2011. With an average of 5,120 active patients per pediatric dentist per year, pediatric dentists care for 13.4 million children with Medicaid each year.

The professional education of a pediatric dentist includes two to three years of specialized training and experience after becoming a dentist, emphasizing growth and development, special health care needs, and advanced treatment techniques in hospital settings. Pediatric dentists limit their practices to treating children and are prepared to allay children’s fears, treat special needs children, and create a kid-friendly environment.⁹ The specialty is becoming even more important as advances in medicine and dentistry increase the life expectancy of children with chronic diseases and congenital problems.

STATE OF LITTLE TEETH – FIGURE 6
Dentists Who See Medicaid and Very Young Patients



Source: American Academy of Pediatric Dentistry, 2017; American Dental Association, 2016.

Pediatric dentists are the “pediatricians of dentistry” with two or more years of specialized education beyond dental school in children’s unique oral health needs.

Access to Care Through a Team Approach

Every child deserves a Dental Home providing the highest quality of oral health care possible, including emergency care and continuity of care (being seen by the same dental professionals for comprehensive dental services). According to the AAPD Patient’s Bill of Rights, every patient has the right to:¹⁰³

- A Dental Home that provides comprehensive, considerate, and respectful care;
- Oral health diagnoses made by a dentist; and
- The choice of a pediatric dentist as a primary oral health care provider.

The best way to provide access to care for children is a Dental Home utilizing a team approach under the direct supervision (physical presence) of a dentist. Efficiency and cost-effectiveness can be accomplished through dental practice regulations expanding the functions (additional patient treatments and services) of dental hygienists and assistants, with additional required education provided by currently existing and funded dental hygiene and dental assistant schools.

Some state legislatures are considering bills that would allow the unsupervised provision of irreversible dental procedures by non-dentist providers such as dental therapists. The expectation is to expand access to dental care in remote and underserved populations. The AAPD strongly believes that there is no clinical or ethical justification for children to receive lesser care simply because they live in a rural area, come from a low-income family, or cope with more severe oral health needs. Oral health services to our nation’s highest-risk children should not be provided by non-dentists with less education and experience. No evidence-based research supports the safety, efficiency, effectiveness and sustainability of such an approach. In fact, a systematic review, including outcome comparisons of populations treated within different models of dental care, concluded that dental therapists did not reduce the development of dental caries or overall disease burden for patients.¹⁰⁴

Adding the educational and administrative costs of another dental provider to already financially-strapped state budgets is not the best way to make real improvements, particularly when 90 percent of publicly insured children live within 15 minutes of a Medicaid dentist.⁹⁶ Children are better served by protecting the financial support of state dental Medicaid, encouraging access to providers educated within existing and already funded programs, removing barriers like transportation and language that may prevent patients from visiting a dentist, and expanding loan repayment assistance programs that have the proven result of placing dentists in designated Health Professional Shortage Areas.





VI. Medicaid Solutions for Dental Disparities

More Reimbursement and Less Red Tape

The Medicaid program provides access to oral health care for our most vulnerable children. Low or reduced reimbursement rates threaten the availability of necessary dental care and, as a result, the oral health of children. Reasonable, market-based reimbursement rates foster participation by dentists and dental care utilization by patients, thus reducing unmet dental needs and disparities in children's oral health.^{105,106} For example, Connecticut, Maryland and Texas all substantially increased their provider reimbursement rates to be closer to market rates. In each case, access to care and dental care use by Medicaid-eligible children significantly increased.^{107,108}

Higher reimbursement rates make it more feasible for dental professionals to participate in Medicaid, but administrative challenges such as provider credentialing, program administration, and claims processing all impose significant barriers to provider participation. The most successful states didn't just raise reimbursement rates. They also made administrative changes that streamlined credentialing and simplified claims processing to improve provider participation and ultimately increase access to care.¹⁰⁹ Some states moved from paper to electronic billing, or multiple forms to a single form.¹¹⁰ Other states carved dental coverage out of medical managed care plans, simplifying communication for providers with a single dental program manager rather than multiple managed care plans.¹¹⁰

Moreover, some states boosted the demand side of utilization by emphasizing family education and case management. (Case management assists Medicaid families to successfully get care, such as finding transportation or childcare, helping with insurance paperwork, or arranging visits with physicians or other health professionals.) Providers often cite high rates of failed appointments or no-shows among the Medicaid population as reasons they do not participate, so an emphasis on case management allows Medicaid programs to work with both providers and patients to encourage the fulfillment of needed oral health services.¹¹⁰

Medicaid Success Story: Maryland's Medicaid program increased dental reimbursement, carved dental services out of managed care, increased the dental provider network, and created a missed appointment tracker. The result: One of the largest increases in dental care use among Medicaid-enrolled children of any state.¹⁰⁹

Medicaid Innovations for a Lifetime of Health

New Approaches to Alleviate Disease. The model for managing ECC is dramatically shifting. In particular, chronic disease management programs in pediatric dentistry offer new ways to mitigate disease. The basic principle is to promote patient self-care through a combination of patient, family, and community level strategies.¹¹¹ In most cases, the dentist's role features case management, but can include chemotherapeutic, non-surgical care to control disease before restoring form, function, and esthetics.¹¹¹ For example, silver diamine fluoride offers an opportunity for cost savings, particularly if used in a chronic disease management program to prevent more expensive procedures from being needed.¹¹²

New Programs to Encourage Provider Enrollment. Multiple professional organizations recommend a child's first dental visit should occur at age one, yet the utilization of dental services at this age is strikingly low.⁹¹ Slightly more than half (54 percent) of children between the ages of two and five are offered advice from a physician or other health provider about the need for regular dental visits.¹¹³ As a way to improve access to oral health services at this age, many states have turned to Medicaid-enrolled physicians to deliver preventive oral health services such as caries risk assessments, fluoride varnish and referral to a Dental Home for young children. The success of the Into the Mouths of Babes medical provider training program in North Carolina is a great example of a public health campaign that increased access to oral health services and reduced dental disparities.¹¹⁴

Other states have changed the payment structure of early childhood visits to encourage enrollment and utilization. For example, the Texas First Dental Home project targets children aged six months to three years and pays a bundled payment for these services rather than a traditional fee-for-service payment.¹¹⁵

New Programs to Encourage Innovation. The current health care reform environment has primed Medicaid programs to innovate provider reimbursement to emphasize prevention and health maintenance rather than disease treatment. For example, California now offers incentives to dental offices for increasing rates of prevention under their state Medicaid waiver. Under this program, the larger the increase in prevention a practice demonstrates, the larger the incentive they receive.¹¹⁶

Oregon is using Coordinated Care Organizations to innovate its Medicaid program and integrate oral health into medical settings as one way to improve the oral health of children.¹¹⁷ Each organization receives a per-member-per month global payment for its covered populations. Each then has flexibility to choose its preferred methods of reimbursement to providers ranging from fee-for-service to salary to alternative payments, such as pay for performance or bonuses for achieving quality metrics. Thus, some of the payment approaches rely on performance and quality measurements, and emphasize prevention of disease.





VII. Commitment to Patient Well-Being: Strong Standards and Safety Records

Since 1991, the AAPD has set the bar for quality pediatric oral health care by developing clinical recommendations related to both the oral and overall health of children. Whether tracking research, generating evidence-based clinical guidelines, or offering comprehensive continuing education for general dentists and specialists, the AAPD has been the leader in disseminating clinical recommendations for safe, effective care of children to professional, governmental, and consumer organizations.

Bringing Today's Science to the Care of Children

The AAPD Reference Manual is the archive, policy tool and essential guide for the best practices in oral care of children. Its first edition in 1991 listed 34 policies and guidelines. Changing science and broadened awareness of the range of pediatric oral health issues have expanded the manual, and today's edition has 81 policies, guidelines and best practices, plus resources on pediatric oral health. The dynamic process is exemplified by the recent rapid development of sound practice guidelines on SDF. Evidence-based guidelines will help translate the latest science on emerging techniques such as SDF, as well as other new methods and materials coming in the future of care for children.

The Reference Manual is a living document, revised every year by experts who research and practice state-of-the-art care based on sound clinical science. It is used by pediatric dentists, general dentists, pediatricians and allied health professionals. In effect, while a second opinion offers the expert opinion of one doctor, the Reference Manual offers the expert opinions—backed by the latest evidence—of thousands of doctors.

“The designation of ‘The Big Authority on Little Teeth’ clearly communicates the AAPD’s role as a primary source of leading-edge pediatric oral health information based on sound scientific evidence.”

Dr. John S. Rutkauskas, CEO, AAPD

Taking Action on Safety Issues

The issue of sedation safety in pediatric dentistry is perhaps the most visible sign of the intersection of advocacy for patient safety and pediatric dental practice, but in truth, is just a small part of the latest efforts of the AAPD to advocate for children. The AAPD has adopted a zero-event posture with no preventable harm to children as a universal goal—one child harmed is one child too many. The strategic plan for safety is to apply the diverse resources of the AAPD in aiding dentists to create a culture of safety for both patients and providers in the dental setting, accomplished by building and incorporating systems of safety into all aspects of the delivery of oral health care.

Efforts already address this lofty and long-term objective. In 2017, the AAPD established a standing Safety Committee to investigate and make recommendations related to the safe provision of dental care to children. Initiatives to enhance the safety of children in a pediatric dental office include:

- Create a research hub on potential risk areas in pediatric dental practice, like toy safety, infection control, and long-term effects of irradiation;
- Extend additional support to the AAPD’s ongoing program of continuing education for pediatric and general dentists and staff;
- Develop a mechanism to report adverse events through state dental boards; and
- Establish a national clearinghouse to record reports of adverse events.

SAFETY OF SEDATION AND ANESTHESIA

- The Guidelines of the American Academy of Pediatric Dentistry, co-endorsed by the American Academy of Pediatrics, reflect the highest safety measures for children undergoing sedation and anesthesia.
- Dental sedation and anesthesia are very safe, as shown by solid science and clinical experience.
- Effective sedative and anesthetic techniques have allowed thousands of children to undergo dental treatments safely; without these techniques, treatment might not be possible.
- Dental sedation and anesthesia are most often recommended for children with extensive dental needs who cannot otherwise tolerate the treatment required to restore their oral health.
- General anesthesia and deep sedation are not without risk, particularly in children younger than three. These treatment options should only be used when the risk of the dental condition or disease outweighs the benefits of less extensive treatment alternatives to slow or stop the progression of tooth decay.
- It is paramount that every health provider discuss the risks and benefits of anesthesia with parents when there is a need for treatment involving anesthesia services.
- If parents are not satisfied with a pediatric dentist’s explanation of dental conditions, treatment options, or answers to their questions, they should consult with another pediatric dentist.
- Although pediatric dentists have an excellent safety record in treating children, even one child suffering a negative outcome is one too many. That’s why the AAPD continues to improve safeguards for the well-being, dental health and appropriate dental treatment of children.

*American Academy of Pediatric Dentistry. Best practice on monitoring and management of pediatric patients before, during, and after sedation for diagnostic and therapeutic procedures. *Pediatr Dent* 2018;40(6):287-316.*



VIII. Ongoing Advocacy for Children in the Community and the Nation

You will find pediatric dentists actively leading the way in public health programs and organizations to improve children's oral health in their communities, at the state level, and the national level. In local communities, pediatric dentists are championing efforts to promote water fluoridation, helping organizations like Head Start and other programs that aid young children, and serving on local health department boards to advance dental public health activities. You will find them volunteering for Give Kids a Smile Day, Missions of Mercy, and other projects that increase access to care for children in their community.

Pediatric dentists are trained advocates for children. It is a natural fit for pediatric dentists to be called upon by state dental associations to testify in front of legislatures on bills affecting access to dental care, to work with state boards of dentistry on dental safety measures such as sedation, and advocate for children's needs on state Medicaid advisory committees.

On a national level, pediatric dentists give their time to speak out to organizations that can influence children's oral health issues such as the American Dental Association, the American Academy of Pediatrics, the Medicaid-Medicare-CHIP Services Dental Association, and Head Start. They are continuously working to assure that dental benefits are available for all children. Each spring, hundreds of pediatric dentists visit our nation's capital to discuss with lawmakers the importance of pediatric dentistry to the health and well-being of children. Simply put, pediatric dentists speak on behalf of children.

Conclusion

While we have advanced in the battle of tooth decay, there is still much to do. Nearly half of children in the U.S. are affected by tooth decay, and an inordinate amount of the disease goes untreated. These unfortunate conditions are especially acute for financially-disadvantaged children, compromising not just their oral health, but overall health and quality of life.

The tooth decay epidemic can be at least partially remedied by earlier and regularly scheduled dental visits for more children, achieved through advocacy by pediatric dentistry, collaboration with primary care medical providers, education for parents, and removal of such barriers as transportation and language that prevent patients from visiting a dentist. We have increased the number of pediatric dentists, the majority of whom treat Medicaid patients as a sizable part of their practices. Continued expansion and increased support for public insurance programs, primarily through Medicaid and CHIP, will protect the increase in dental visits by children most susceptible to dental disease. As a result of these efforts, more children can enjoy a lifetime of better oral health.

Affordable Care Act: Coverage and Uncertainty

Overview

The Affordable Care Act (ACA) marked a potential advance for children’s oral health by making dental insurance available to millions of uninsured children. In a significant indication of the importance of oral to overall health, pediatric dental services were designated as one of the 10 essential health benefits that all plans in the individual and small-group markets must offer. Specifically, the ACA required dental benefits to be offered for everyone under age 19 through individual and small employer plans, whether or not the plans are sold within or outside state health insurance exchanges. States chose between two model benefit plan options—the CHIP benefit package or a benefit package modeled after the Federal Employees Dental and Vision Insurance Program (FEDVIP), Pediatric dental coverage could be offered via a stand-alone dental plan (SADP) or as part of an overall health insurance plan (embedded plan).^{118,119}

While challenges remain in the law and regulations, one major outcome of the ACA has been an increase in dental-insured children. In 2015:

- Fifty-one percent children had private/commercial coverage,
- Thirty-nine percent had coverage through Medicaid or CHIP, and
- Ten percent had no form of dental benefits—the lowest level ever.

However, types of coverage vary, and many families still had a hard time finding dental providers or paying for dental benefits for their children due to the structure of insurance plans. Further, necessary legislative changes to the ACA to improve pediatric oral health coverage have remained elusive, due to deep political disagreement over whether to amend the ACA to make it work better or to repeal it altogether.

Health insurance options vary; not all plans are created equal. Parents should ask key questions to selecting the right health insurance plan and dental benefits for their family.

- How much will my deductibles, out-of-pocket maximums and co-pays cost?
- Does the plan’s network include pediatric dentists near my home or children’s school?
- Based on my benefit level, how much will my premium costs be?

The key to understanding a dental benefit plan’s design is recognizing that most oral disease, especially in children, is largely preventable. Unlike the traditional utilization of health insurance as a benefit to be used infrequently as a way of paying the very high cost of unpredictable illness, accident or disease, a dental benefit plan is intended to be accessed regularly for preventive services to positively affect oral health.

ACA Challenges

In practice, ACA pediatric oral health coverage has veered significantly from typical employer-based dental coverage, resulting in higher deductibles and consumer co-payment levels for children’s oral health care. The AAPD does not take a position on whether a certain type of pediatric dental insurance plan (SADP or embedded) or any specific insurer is superior to another. That said, a plan or insurer must encourage preventive care to be effective, or the coverage will not result in improved oral health status.

The largest ACA challenges related to pediatric dental coverage are:

- **No mandate to buy.** Due to the technical wording in the ACA related to SADPs, the Department of Health and Human Services concluded that, *within* an exchange, a family can obtain a medical qualified insurance plan with no pediatric dental coverage and not purchase a SADP. Conversely, in an individual or small group market *outside* of an exchange, a family must purchase a medical plan with embedded pediatric dental coverage, or the plan must be reasonably assured that the family has purchased a SADP. To complicate the issue further, each state creates its own definition of “reasonably assured,” and for some states, it is sufficient that SADPs are merely offered. As a result, many parents have not purchased dental insurance for their children.^{121,122}
- **High combined deductibles in embedded plan.** A 2015 AAPD member survey ascertained the current ACA impact on pediatric dental practices. Many pediatric dentists reported problems with families not realizing their medical plans with embedded dental coverage had a high combined deductible (such as \$5000). **As a consequence, families cancel or delay preventive dental appointments for their children.**¹²³

- **No Medicaid dental improvements.** Unlike the higher Medicaid reimbursements for primary care providers, the ACA makes no improvements to Medicaid for dentists. As noted earlier, while 70 percent of pediatric dentists see Medicaid patients, only 38 percent of general dentists participate in Medicaid due to low reimbursements and high administrative burdens.⁹⁶ The ACA also extended the Medicare Recovery Audit Contractor program to Medicaid with little guidance, resulting in inefficiencies in the audit process and further dissuading dentists from participating in the program.

Proposed Solutions

The AAPD makes the following recommendations to assure that children receive the oral health care they need:

- **At the federal level.** Any required health insurance coverage for children should include pediatric oral health coverage, either through an appropriately structured SADP or embedded medical plan. Preventive dental services should have “first dollar” coverage. In other words, they should be exempt from deductibles and co-pays in embedded medical plans and SADPs. Embedded plans should have separate deductibles for dental services.
- **At the state level.** Medicaid dental programs should be improved by providing fair and market-based reimbursement rates and reducing administrative burdens for dentists, which includes using fair and reasonable audit practices based on the AAPD’s clinical recommendations.

Under ACA insurance exchanges, states have wide leeway in what dental services are covered, what deductibles and copays are required, and whether dental insurance is offered as a stand-alone or embedded policy. The result is a hodgepodge of dental plans and costs vary widely from state to state. However, states can improve access to pediatric dental care on their own. For example, several states (California, Kentucky, Nevada and Washington) require consumers to buy pediatric dental insurance, filling the gap left open by the ACA.

The AAPD and the ADA recommend to policy-makers that the following services, in line with the AAPD’s dental periodicity schedule, be included in the definition of preventive oral health services provided in a dental plan without cost-sharing implications:

- Clinical oral examination and adjunctive diagnostic tools

- Oral hygiene and dietary counseling for parents
- Removal of supragingival and subgingival stains or deposits as indicated
- Systemic fluoride supplements, if indicated
- Caries risk assessment
- Topical fluoride treatments every six months or as indicated by the individual patient’s needs (ages 12 months and above)
- Scaling and cleaning the teeth every six months or as indicated by the individual patient’s needs (ages two years and above)
- Pit and fissure sealants for caries-susceptible primary and permanent molars, premolars, and anterior teeth (ages two years and above)
- Substance abuse counseling, including smoking and smokeless tobacco (ages 12 years and above)

ACA Developments

Congressional efforts to repeal and replace the ACA have not been successful to date. Based on recent election outcomes, it appears as if the ACA is here to stay in one form or another. The AAPD supports retention of pediatric oral health as an essential health benefit (EHB) under the ACA. The 2019 Notice of Benefit and Payment Parameters proposed expanding states’ abilities to alter EHBs, as well as providing new benchmark plan options and additional flexibility¹²⁴. Both the AAPD and the ADA expressed concern that these provisions would allow states to drop pediatric dental coverage as an EHB.¹²⁵ Fortunately, final regulations provide that all states’ benchmark plans will be required to include coverage for all 10 EHB categories of benefits.¹²⁴

Some good news for families: Starting in 2019, premium tax assistance for purchase of stand-alone dental plans will be available for those who purchase a qualified health plan not including pediatric dental benefits. This assistance comes thanks to a regulatory decision by the Department of Treasury, advocated by the AAPD, ADA, and a number of other dental and health-related organizations.¹²⁶

Conclusion

Although the ACA holds great promise to improve pediatric dental care, much effort and collaboration remains necessary to realize that promise. In lieu of amendments to the ACA, however, each state has significant latitude to address the issues discussed in this report.

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