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Access, Use, and Costs of Dental Services in the Healthy Kids Program

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Healthy Kids dental coverage has led to use of dental services among a sizable portion of enrolled children.

Tooth decay is a significant problem. By 3rd grade, it affects two-thirds of children in California. Some 750,000 elementary school children—28 percent—have untreated tooth decay (Dental Health Foundation 2006). Poor children and children of color—particularly Latino children—are much more likely to have tooth decay and suffer the consequences of untreated disease (Dental Health Foundation 2006). For every child without medical insurance, 2.6 children lack dental insurance. Children from families without medical insurance are 2.5 times less likely than insured children to receive dental care. Children from families without dental insurance are 3 times more likely than insured children to have unmet dental needs.[1]

This brief provides data from San Mateo County, California, a county that provides subsidized health and dental insurance to uninsured children living in families with incomes below 400 percent of the federal poverty level who are ineligible for Medi-Cal (the federal-state insurance program for low-income children) and Healthy Families (California's SCHIP program) due to family income or documentation status. This coverage is provided through the Healthy Kids program, which falls under the Children's Health Initiative (CHI), an effort to extend health insurance to virtually all children in the county either through Healthy Kids, Medi-Cal, or Healthy Families.

San Mateo County has undertaken a five-year evaluation of Healthy Kids, providing a rare window into various aspects of access to and use of services among previously uninsured children, including access to and use of dental care. Further, the evaluation provides examples of how a locally based program has instituted policies and practices designed to increase use of dental services among Healthy Kids members. These local examples may serve as "smart practices" for other county, state, or even national programs. More information on the San Mateo CHI and the Healthy Kids program is available in three annual reports.[2]

Are Children Using Dental Services?

Healthy Kids dental coverage has led to use of dental services among a sizable portion of enrolled children. About two-thirds of San Mateo County's Healthy Kids enrollees who were enrolled for the full 12 months between July 1, 2004, and June 30, 2005, had at least one dental service. This is comparable to kindergarten children in California, though slightly lower than 3rd graders (Dental Health Foundation 2006). Use of dental services varies considerably by age (figure 1). Adolescents (age 13–18) were the least likely to have a dental service (56.9 percent), while children age 0–5 and 6–12 had higher rates (61.7 and 69.5 percent,

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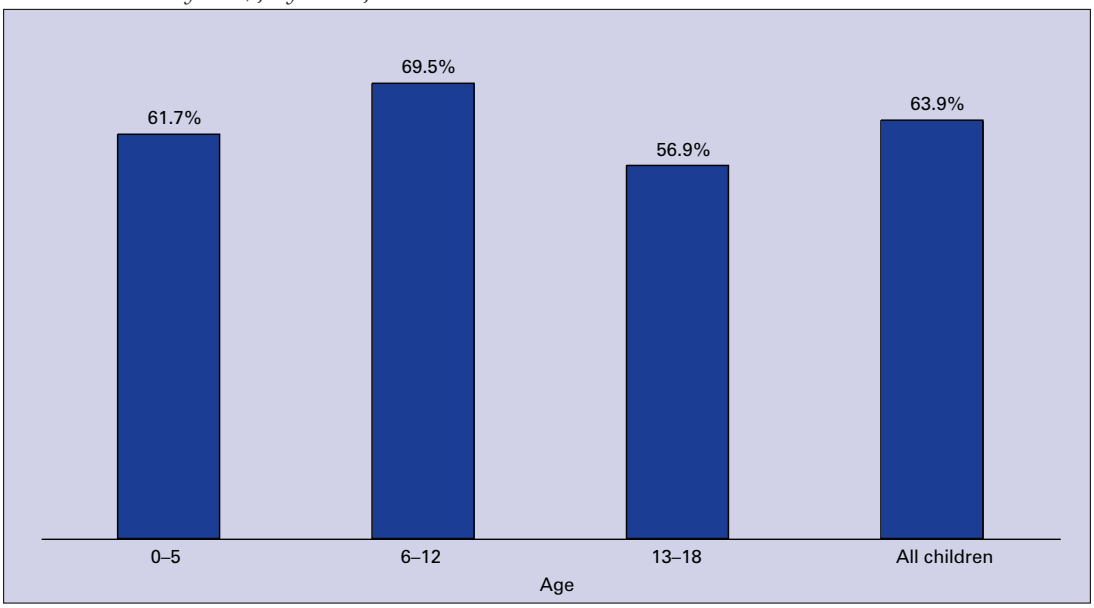
FIGURE 1. Share of Children with Any Dental Service by Age, among Children Continuously Enrolled in Healthy Kids, July 2004–June 2005



Source: Howell et al. (2006).

respectively). The mean annual number of visits for those who used any care was essentially the same across age groups: 3.0 visits for children age 1–5, 2.8 for children age 6–12, and 3.0 for children age 13–18 (data not shown).

The majority of Healthy Kids who used dental services had either one (25.6 percent) or two (27.0 percent) dental visits in the year (table 1). Conversely, almost half had more visits, suggesting that they needed more than preventive dental care. Among these children, 37.9 percent had between three and five visits, and a smaller proportion (9.5 percent) had more than five. There was no difference in the frequency of visits by age (data not shown).

The most common dental services provided to Healthy Kids enrollees were for diagnostic and preventive care services, such as exams, x-rays, prophylaxis, sealants, and fluoride treatment (table 2). Fully 90.8 percent of dental users had a diagnostic exam and 84.8 percent had x-rays, with lower rates for routine and preventive services including prophylaxis (80.3 percent), sealants (63.7 percent), and fluoride treatment (56.9 percent). Many children had more serious dental problems; for example, 17.7 percent of dental users had restorative treatment, suggesting significant pent-up dental needs.

While these data on dental service use show frequent use for most children, especially the youngest children, 36.0 percent of continuously enrolled Healthy Kids enrollees had no dental service use during the year. Because there is no separate insurance card for dental coverage under the Healthy Kids program (but it is referenced on the medical card), some parents may be unaware of the coverage. Whether parents of these children were, in fact, unaware of the dental benefit, how to access services, the importance of routine dental care, or a combination of these factors is not known. It is known, however, that the Healthy Kids

TABLE 1. Average Number of Visits for Dental Service among Children Continuously Enrolled in Healthy Kids, July 2004–June 2005 (N = *1,788)*

Number of visits	Percent
1	25.6
2	27.0
3 to 5	37.9
More than 5	9.5

Source: Howell et al. (2006).

TABLE 2. Share of Enrollees Receiving Dental Care by Type of Service, among Children Continuously Enrolled in Healthy Kids (N = *1,788)*

	Percent
Diagnostic Services	
Exams	90.8
X-rays	84.8
Preventive Care	
Prophylaxis	80.3
Sealants	63.7
Fluoride treatment	56.9
Other	29.9
Restorative Treatment	17.7
Endodontics	12.7
Oral Surgery	14.9
Peridontics	7.6
Other	0.1

Source: Howell et al. (2006).

Note: Percentages do not sum to 100 because most children had more than one service.

population generally has limited experience with insurance and with using dental care. Over time, it is anticipated that the proportion of Healthy Kids' enrollees without dental service will decline.

What Do Healthy Kids Dental Services Cost?

Children seeking dental services were more costly for the Healthy Kids program than those without dental services, and the cost of dental services represented a substantial proportion of the overall cost of their care. As shown in table 3, the average total cost per child who had at least one dental service was $648, compared with just $338 for those without any dental care. The average annual costs for other services for children with dental care ($354) and those without dental care ($338) indicate that there does not appear to be an (immediate) offsetting reduction in medical care cost among these children. However, medical costs savings or subsequent dental costs savings may not be realized for a number of years; therefore, these numbers may not reflect longer-term costs and benefits of extending medical and dental insurance coverage to children. Of the three age groups, the average dental care cost was highest for adolescent dental users, suggesting more dental treatment or higher cost services for those children (data not shown). Increasing the number of dental care users—a program goal—would increase the overall cost of care for Healthy Kids children.

What Types of Dental Care Providers Serve Healthy Kids Children?

Table 4 presents the types of dental providers serving Healthy Kids enrollees. As shown, two-thirds of the dental visits were provided by private dentists and private dental groups, and just over a third were seen in the public system (either at the San Mateo Medical Center clinic or one of the three affiliated clinics). (A very small percentage was seen at Sonrisas Dental Clinic—a private nonprofit clinic in the Half Moon Bay area—or by the Tooth Mobile, a mobile clinic that travels throughout the county.) Among the private dentists

TABLE 3. Average Annual Cost per Enrollee for Dental and Other Services among Children Continuously Enrolled in Healthy Kids, July 2004–June 2005

	Dental users	Other enrollees	All enrollees
Dental care costs	$294	$0	$187
Other care costs	$354	$338	$348
Total costs	$648	$338	$535
N	1,788	1,012	2,800

Source: Howell et al. (2006).

TABLE 4. Dental Users by Type of Dental Provider, among Children Continuously Enrolled in Healthy Kids, July 2004–June 2005 (N = 1,788)

Provider	Percent of all users
San Mateo Medical Center and County Clinics	39.1
Private dentists	43.3
Private dental groups	20.9
Sonrisas Dental Clinic	5.8
Tooth Mobile	0.5

Source: Howell et al. (2006).

Note: Percentages do not sum to 100 because some children saw more than one type of provider.

and dental groups, 25 private offices and 15 dental groups billed for Healthy Kids, yet care provided by the private sector was concentrated heavily in a few private providers. Two individual dentists saw more patients than the remaining private-sector dentists combined.

Are There Ample Numbers of Dentists to Serve All Healthy Kids Enrollees?

One goal of the Healthy Kids program is to assist families in navigating the health care system to ensure that all Healthy Kids members use the preventive care covered by the program's benefits package and receive appropriate treatment. Interviews with dental providers and agency stakeholders, as well as focus groups with parents, pointed to a widely held perception of insufficient dental provider capacity in the county to serve all Healthy Kids enrollees and other low-income children.

For example, researchers conducted intensive interviews with five participating and five nonparticipating private dentists in 2005. The dentists interviewed were unclear about the extent of availability of private providers to serve Healthy Kids, though most were aware of county-based services. Those interviewed indicated that they understood that private dentists represented only a small proportion of dental providers for low-income children. Some private dentists were described as serving low-income children pro bono through free clinics, free community dental screening events, and in their own offices on a limited basis. But many are unwilling to face the cumbersome paperwork and relatively low reimbursement rates associated with insurance programs for low-income children, according to those interviewed. (It is also likely that the longstanding stigma toward the Medi-Cal program by providers may affect participation in all programs for low-income children.) These specific views were generally shared by parents, agency stakeholders, and dental providers.

Further investigation revealed evidence that a wider network of private dentists is available to serve Healthy Kids children as contracted through Delta Dental (the Healthy Kids dental carrier). Delta Dental conducted an analysis of its current provider network and determined that 98.0 percent of Healthy Kids members live within 10 miles of a Healthy Kids dental provider. In addition, staff of the CHI and the Health Plan of San Mateo (HPSM) called 21 private dentists and dental groups on the list of Delta Dental participating dentists and found that all of them currently accept Healthy Kids patients with relatively short waiting times for appointments (1–3 weeks). This is in contrast to waiting times of 1–4 months for routine dental care at county clinics.

These data suggest that adequate capacity likely exists to serve all Healthy Kids enrollees. But additional efforts may be required to link families with these providers and provide navigational assistance to ensure appropriate use.

Program Efforts to Increase Use

Several steps have been undertaken, or are planned, to provide families with support to increase appropriate use of CHI, HPSM, and Delta Dental.

Because Delta Dental has not conducted activities to increase use (such as providing families with periodic reminders about the need for checkups or offering member newsletters) these activities will be incorporated in subsequent contracts between Delta Dental and the HPSM as an aid in boosting utilization. Specifically,

- twice each year Delta Dental will send postcards, in Spanish (the Healthy Kids threshold language), to members reminding them to schedule dental exams and to use their children's dental benefits;
- Delta Dental will provide dental education materials to the CHI and HPSM as needed; and
- Delta Dental will send postcards to new members who have not used their dental benefits for at least six months following enrollment.

In addition, the CHI and HPSM will undertake their own activities to promote appropriate use, including

- making new member calls emphasizing the importance of dental checkups;
- calling members who have not used dental service in the past 120 days of new enrollment and who have not had a regular checkup within the last six months; and
- creating materials to promote dental insurance use (including quarterly reminder postcards and member newsletters).

The CHI is also working to update the Healthy Kids provider directory more frequently (from annually to quarterly) and to disseminate this list widely throughout the county to individuals and organizations who come in contact with families.

Conclusions

These findings indicate that the Healthy Kids dental benefit has contributed to a sizable number of previously uninsured children obtaining preventive and restorative dental services. The findings also point to a continued need for ensuring access to appropriate dental services among all Healthy Kids enrollees, including the third of the enrolled population who received no care, as well as the high proportion of children who received more than two dental visits in a year. This conclusion is further bolstered by the high costs associated with dental care for Healthy Kids enrollees; this may reflect pent-up demand for dental care and previously untreated oral health conditions among this population. Therefore, linking these children with dental care is an important goal for the Healthy Kids program.

Significant steps are currently being, and will be, taken to help families better understand their dental benefit, become knowledgeable about the importance of routine checkups, and identify a dental provider suitable for their needs. While some recruitment of additional private providers may be needed (and the CHI intends to conduct additional outreach to the dental community) and stronger relationships built with the existing provider network, sufficient capacity to serve all Healthy Kids enrollees appears to exist. The next steps will be to monitor the impact of these various CHI/HPSM/Delta Dental activities on use of regular checkups and access to treatment, as needed. This investment in improving access to and use of dental services among Healthy Kids enrollees will likely pay off financially for the program as well as contribute to improved health and well-being of the children who receive dental care.

Notes

1. See Centers for Disease Control and Prevention, "Children's Oral Health" fact sheet, http://www.cdc.gov/oralhealth/factsheets/sgr2000-fs3.htm.
2. See Howell et al. (2004, 2005, 2006).

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About the Author

Dana Hughes is a professor of health policy at the University of California, San Francisco, in the Department of Family and Community Medicine and at the Institute for Health Policy Studies. Dr. Hughes's research interests include children's access to health care, health care financing, and health disparities. She serves as a consultant to the Urban Institute on the evaluation of the San Mateo County Children's Health Initiative and plays a key role in a similar evaluation in Santa Clara County.

About the Children's Health Initiative. In January 2003, partners in San Mateo County, California, launched the Children's Health Initiative (CHI), a program designed to ensure that 100 percent of the county's children have access to comprehensive health insurance coverage. The partners—key public and private organizations in the county—have assembled a diverse funding base for the initiative. The goal is to provide health insurance coverage to uninsured children in the county through two strategies: (1) increasing the number of children enrolled in the existing public health insurance programs, Healthy Families and Medi-Cal; and (2) establishing a new health insurance product, Healthy Kids, for children who are not entitled to other forms of public or employer-based insurance. This brief is one of a series of briefs and reports reporting on the results from a five-year evaluation of the San Mateo CHI. Other findings are available at http://www.urban.org.

Methods. This brief combines several data sources from a full-scale evaluation of the San Mateo County Healthy Kids program. In San Mateo County, California, most publicly insured children are enrolled in the county-sponsored health plan, the Health Plan of San Mateo (HPSM). HPSM data presented in the tables and the text are for children continuously enrolled in Healthy Kids from July 2004 to June 2005. To study use and costs, we obtained tables from the HPSM for children continuously enrolled from July 2003 to June 2005. Interviews with dentists who accept Healthy Kids enrollees and those who do not, and key informant interviews with Healthy Kids administrators, county children's dental services providers, and others knowledgeable about oral health services in the county were another source of data. In addition, two focus groups were held with parents in early 2005 to learn about their experiences with their children in the Healthy Kids program.

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