THE STATE OF LITTLE TEETH
Tooth decay has become epidemic among our youngest children. A rapid form of tooth decay, known as early childhood caries (ECC), is the most common disease faced by young children—and it’s on the rise. Research shows that ECC can cause lasting harm to a child’s oral and general health, and social and intellectual development.

Children from low income and minority families are particularly vulnerable to ECC. One reason is that they are less likely to see a dentist than other children. Even though the Affordable Care Act (ACA) includes pediatric dental benefits, experts fear this trend may get worse rather than better.

What is most frustrating for our organization, the American Academy of Pediatric Dentistry (AAPD), is most tooth decay is preventable.

To address this nation-wide threat to children’s health, the AAPD is launching an educational campaign to arm parents and caregivers with important tools and information to help fight tooth decay. As part of this initiative we are also introducing our first-ever “State of Little Teeth Report” that explores the key issues related to the oral health of our children.

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 young children in the U.S., including a look at the impact of the ACA on children’s oral health. The report also includes the results of a new survey of parents and caregivers conducted as part of our educational campaign. In addition to examining the problems and their causes, this report also explores what can be done to solve them.

In examining the tooth decay epidemic, its impact and causes, the report found:

- A troubling gap between parental knowledge and action.
- Early dental visits are strongly recommended but rarely made.
- Dental pain management is difficult and potentially dangerous in unskilled hands.
- Little-known “Dental Homes” are critically important.
- Too few dentists see children on Medicaid.
- A shortage of dentists skilled in treating children and the need to expand pediatric dentistry.

We hope this report supports our educational campaign by providing the basis for a meaningful discussion about the challenges facing the oral health of our children – and what we can do about them.
Caries is on the rise among very young children in the United States and around the world, especially children from poor families. It is a public health crisis that poses an immediate and long-term threat not just to the teeth of young children but to their overall health and development.

The social and economic consequences of this epidemic extend far beyond the families of the affected children to engulf the medical, social and economic health of the greater community.

Due to the aggressive nature of ECC, cavities can develop quickly and, if untreated, can infect the tooth’s pulp tissue. Such infections may result in a medical emergency that could require hospitalization and the extraction of the offending tooth. As already noted, children who are given pacifying bottles of juice, milk or formula to drink during the day or overnight are prone to developing ECC, as the sugar contents pool around the upper front teeth mix with caries-producing bacteria it gives rise to rapidly progressing tooth destruction. Other factors that put children at risk for caries include enamel defects, frequent consumption of sugary drinks and snacks, lack of dental hygiene, lack of fluoridation, chronic illness, certain medications, and mouth breathing.

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 key cause of the disease is putting children to bed with a bottle of juice or milk. ECC is now the most common chronic early childhood disease in the United States; for instance, ECC is five times more common than asthma. In addition to being highly prevalent and on the rise among young children, caries is often untreated in children under the age of three, according to national surveys.

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"Caries," which derives from the Latin word for “rotten” and is commonly referred to as “cavities” or “tooth decay,” is a disease that is chronic, infectious and transmissible. It results from exposure to bacteria through contact with saliva, often from the primary caregiver but sometimes from other caregivers or playmates. The bacteria metabolize sugars to produce acid which, over time, demineralizes tooth structure. The earlier children are exposed to these bacteria, the more likely they are to develop caries and the greater the risk to their oral health. Children infected while infants are far more likely to develop immediate and long-term oral health issues than those who are not infected so young.

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ECC AFFLICTS POOR AND MINORITY KIDS THE MOST

Few population groups are more vulnerable to oral health disease and its consequences than young children, who depend on others and have trouble communicating their needs. Although children represent 24 percent of the overall population, they represent 36 percent of the poor; children who are Hispanic, African-American or Native American are about three times more likely to be poor than Asian-American or white non-Hispanic children.27,28

These young children from poor or minority families are vulnerable to health and development issues, particularly oral health issues, according to the National Institutes of Health.29 This includes children who are born to single mothers and whose parents have low education levels.2

Poverty has an especially strong correlation with ECC, as the percentage of young children with untreated tooth decay rises as family income declines.24 Children ages 2 to 9 living in poverty are twice as likely to suffer tooth decay than their more affluent peers; in addition, their disease is more than twice as likely to go untreated (36.8 percent of poor versus 17.3 percent of non-poor), according to Oral Health in America: A Report of the Surgeon General.24 For instance, the rate of tooth decay is five times more common among children below the poverty line (30 percent) than children in families 300 percent or more above the poverty line (6 percent).24,14

Young Mexican-American and non-Hispanic black children are more likely to have tooth decay than young white children – a disparity that is increasing.1 One study shows that among 2 to 5-year-olds, 40 percent of Mexican-American and 29 percent of black children have had ECC compared with 18 percent of white children.31 Another study showed that among children aged 2 to 4 years and aged 6 to 8 years, Mexican-American and non-Hispanic black children were more likely to suffer from tooth decay than were their white peers.32

As these children get older, the problems only get worse.

The statistics are alarming. The rate of tooth decay in primary (baby) teeth of children aged 2 to 5 years increased nearly 17 percent from 1988-1994 to 1999-2004. Based on the most recent data, 28 percent of children aged 2 to 5 years in the entire U.S. population are affected by tooth decay.31 By the age of 3, 5 percent to 10 percent of U.S. children have oral health issues.31 By age 5, about 60 percent of U.S. children will have had caries at some point, including the 40 percent of children who have it when they enter kindergarten.31

The issue is not just that kids have caries – it’s that, for many kids, caries is not being treated and turning into more serious problems. The Dental Health Foundation’s report, Mommy It Hurts to Chew, indicated that 28 percent of California third-graders had untreated tooth decay.22

In many cases, the level of decay was so severe that the child needed general anesthesia before undergoing an extensive procedure to treat the decay.22 In a Washington State study, about 52 percent of all children aged 3 1/2 years and younger have their first health care encounter for a dental-related illness in the emergency room (ER).31 About half of these visits result in the extraction, rather than the repair, of the decayed tooth or teeth.22

When treatment for ECC is delayed, a dangerous downward spiral of unmet needs develops; the longer that ECC remains untreated, the more time there is for the condition to worsen and become more difficult to treat; as a result, the costs of treatment go up, and the number of clinicians who can perform the increasingly complicated procedures required go down.24 In other words, as treatment is delayed, the problem becomes more serious and more difficult to treat, and access and cost issues multiply.

The worst case scenario can be tragic. Deamonte Driver, a 12-year-old boy in Maryland, died in 2007 after bacteria from an abscessed tooth spread to his brain.31,34

BY THE AGE OF 3

5-10% of U.S. children have oral health issues

BY AGE 5

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Percentage of Children With Untreated Caries by Family Income

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As a result, it is not surprising that children seen in the emergency room for caries-related dental pain are predominantly poor, minority children from single-parent families. Oral health researchers expect growing income disparities and demographic trends to exacerbate these disparities.32

THE SHORT- AND LONG-TERM IMPACT OF CARIES

Caries compromises the health, development, and quality of life of young children both in the short run and over the long term.33 Acute caries pain affects the health and well-being of young children as much or more than acute asthma.34 Caries also makes the child 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.35,36

“When kids have dental pain, it affects their growth and development,” said Dr. Warren Brill, 2013-14 president of the American Academy of Pediatric Dentistry. Studies have shown that ECC, especially if left untreated, can result in:

- Life-threatening infection;
- Significant pain;
- Chewing difficulty due to pain leading to malnutrition and gastrointestinal disorders that can result in a failure to thrive or delayed or insufficient growth; and
- Poor speech articulation, poor sleep habits, low self-esteem, social ostracism and poor school performance that leads to a diminished overall quality of life.

HEALTH IMPACT

A child with unhealthy teeth is at risk for future oral health problems as an adult. For instance, if the tissue in the central portion of the tooth is infected, the abscess can potentially damage permanent teeth. Also, if baby teeth are lost early or broken down, the child’s permanent teeth are more likely to erupt out of proper position or be impacted, leaving them more susceptible to caries and gum disease and subjecting the child to years of twisted teeth or orthodontia.37 ECC puts children at elevated risk for oral health problems throughout their lifetimes, studies suggest.38,39

Additionally, undetected and untreated tooth decay can lead to infection, loss of teeth, and expensive and mostly preventable emergency and restorative interventions; in extreme cases, ECC and its treatment can lead to serious disability and even death.40,41,42

Finally, a child’s oral health can affect their overall health because the mouth is the gateway to a person’s overall health.43 Kids with tooth decay are prone to repeated infections in their ears, in their sinuses and in the cuts and abrasions that are common in childhood.44 As the child grows older, an unhealthy mouth can be associated with obesity, diabetes and even heart disease.45,46

About 1 in 10 kids with ECC suffers pain from caries.47 For these kids, chewing food is painful enough to keep them from eating properly and getting adequate nutrition, and the result can be a failure to thrive, or reduced growth and weight, due to insufficient consumption of nutritious food. For instance, children with ECC are twice as likely to be of below average weight as are their peers without ECC – about 1 in 5 children with ECC weighed in the lowest 10 percent of their age groups.48 Painful teeth keep children from getting enough sleep which, as with lack of nutrition, can hurt their overall health and development.49

DANGERS OF TREATING DENTAL PAIN

Treating dental pain is as important as it is difficult and risky. Pain is difficult to measure due to its subjectivity. Children may not have the language skills to communicate the level of pain they are feeling, and assessing pain levels often depends on the report of parents or pain scale indicators.48 As a result, it’s possible to undertreat or overtreat the pain, each of which carries its own set of health risks. In some populations that experience difficulty accessing care, children may suffer for weeks in pain before families are successful at finding resolution.41

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 In addition to the unnecessary suffering a child endures, failure to adequately treat dental pain has repercussions for the child, such as developing a fear or anxiety about visiting the dentist 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.43,44 Up to 1 in 5 Americans say they avoid going to the dentist due to anxiety or fear.45 Frequent use of asthma drugs and being unable to access emergency rooms due to medications has risks, including the possibility of an overdose that could suppress breathing.46

Even common drugs such as acetaminophen can harm children’s health and endanger their lives. For instance, research using data from the Centers for Disease Control estimates that each year about 150 people in the U.S. die from liver failure due to the accidental overdose of acetaminophen.7 Another study puts the all-causes death rate due to accidental overdose of acetaminophen at 358 deaths per year.7,13 The vast majority of acetaminophen-related liver injury events reported in children were caused by medication errors due to improper measuring devices, dosing the wrong concentration, or lack of dosing information for children under 2 years old.5 As a result, there is a rising concern about the incidence of pediatric dental patients overdosing on pain medication.
Children with oral health problems are three times more likely to miss school due to dental pain than children who did not have oral health problems, according to one study. In addition, children who lacked excellent or very good oral health were more likely to perform poorly in school than those who did have excellent or very good oral health.

ECONOMIC IMPACT
ECC not only exacts a toll on children, affecting their development, school performance and behavior, but it can also affect families and society. Treatment of severe ECC can cost $10,000 per child, especially if children need to be hospitalized and treated under general anesthesia, and can go up to $25,000 in severe cases. The average cost per visit for the treatment of dental caries and pulpal conditions in emergency departments and ambulatory surgical facilities was $5,501 in 2008, and emergency department management of ECC infection and pain often does not result in definitive care for the decayed teeth. Add in mostly preventable emergency and restorative interventions and, in the United States alone, it is estimated that more than $40 billion per year is spent on the treatment of dental caries. The Health Care Financing Administration states that the Medicaid program alone pays between $100 million and $400 million each year to treat ECC in children.

In addition to the cost of treating this preventable disease, missed school and work (among parents) due to the disease have an impact on the economy. Clearly, missing work hurts household income. By affecting a child’s school performance, oral health issues are likely to affect the child’s job and earning prospects later in life. Research has shown that job candidates who do not smile or have missing or crooked teeth are less likely to win the job than those who have attractive smiles.

DUE TO LACK OF UNDERSTANDING, ACTION AND ACCESS

Aside from diagnosing the child’s oral health, the early visit is an important opportunity for dental providers to underscore the importance of establishing good dental habits and dietary practices. Such habits and practices are established early in the child’s life, and they can have a significant impact on the child’s future oral health. For instance, high-risk dietary practices, especially consumption of sugary drinks (including many fruit juices) that are bad for teeth, appear to be established by the time the child is 1-year-old, and they are often maintained throughout early childhood.

Waiting until the child is older – even if it’s just to the age of 2 or 3 – can have an adverse impact on the child’s oral health. In fact, children who wait to have their first dental visit until age 2 or 3 are more likely to require restorative and emergency visits, according to a scientific paper in the journal Pediatric Dentistry.

SUPPORTING THE NEED TO GET CHILDREN TO THE DENTIST BY THE TIME THEY ARE 1-YEAR-OLD
The American Academy of Pediatric Dentistry, the American Academy of Pediatrics, the Academy of General Dentistry and the American Academy of Pediatric Dentistry, are on record supporting the need to get children to the dentist by the time they are 1-year-old.

One of the key reasons a preventable disease, like caries, is becoming an increasingly significant threat to the health, welfare and future of the youngest members of our society is that children are not seeing the dentist early enough.

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. Often not until the pain becomes acute or the teeth break do parents realize that their child has caries. Much pain and damage could be avoided if the child visits the dentist earlier.
Unfortunately, visiting the dentist by age 1 is a practice that is far from common. Despite the importance of the first dental visit, just 6 of 10 parents and caregivers agreed it is important for children to see the dentist by their first birthday, according to the AAPD survey. Even more surprising: only 1 in 4 parents and caregivers surveyed (25 percent) actually took their children to see the dentist in the first year.

Other surveys paint an even bleaker picture. Only 16 percent of parents took their child to see the dentist before they turned 2, according to a 2012 nationwide survey by Met Life. Children in Illinois don’t see their family dentist on average until they are 3 1/2 years old, according to 2011 claims data from Delta Dental of Illinois.

There are a number of reasons that so few children are seeing the dentist in their first year of life. One reason is that there appears to be a lack of understanding of the importance of the early dental visit among parents, caregivers and medical professionals. Another reason is that a variety of factors have contributed to restricted access to dental care, especially for poor and minority children.

Research shows that parents are poor judges of their children’s oral health, especially when the children are very young. This problem is particularly true among families headed by parents with low incomes, low education levels or lack dental insurance.

A recent survey conducted on behalf of the AAPD found that more than 8 in 10 parents and caregivers surveyed know that their child’s oral health is important even before they get their adult teeth. This awareness is reflected in the rise in the rate at which children are seeing the dentist. Among children 2 to 20 years old, dental visits have increased from 71.6 percent in 1997 to 77.0 percent in 2010.

But while parents may acknowledge the importance of their children’s oral health, they may not fully understand it. For instance, more than 9 in 10 parents and caregivers in the AAPD survey failed to correctly identify tooth decay as the most common chronic disease among children, ranking it dead last among five choices, including obesity, ear infections, allergies and asthma.

Even when the children are older, such as aged 2 to 5, parents and caregivers often do not take the child to the dentist even though oral health issues are already developing. Although about 19 percent of these children needed to see the dentist, only 9 percent of them had parents or caregivers who recognized this need, according to one study.

The lack of understanding of the importance of infant oral health care is not restricted to parents — it is also all too common among providers in the medical and dental communities.

The survey did not probe the reasons for these gaps, but it seems likely that promoting a better understanding among parents and providers of the risks and benefits of various dental practices would be a good start.

Parents play a critical role in the oral health of their children. Yet despite growing awareness of the importance of children’s oral health, many parents do not follow good dental practices when it comes to their children because they do not understand how to evaluate their child’s oral health or they do not understand the importance of their child’s oral health.

The Affordable Care Act (ACA) marks a potential advance for children’s oral health by making dental insurance available to millions of uninsured children by 2018.

The ACA increases the number of people eligible for Medicaid and makes pediatric dental insurance available through the state insurance exchanges. Ultimately, the more children who have dental insurance, the more access they will have to dental services and the better their oral health will be. The ACA also includes additional initiatives that would support care, education and prevention early in the child’s life, which should provide oral health benefits throughout the child’s life and reduce costs, too.

“We expect this could improve children’s oral health for generations to come,” said Dr. Paul Reggiardo, D.D.S., a past-president of the American Academy of Pediatric Dentistry who is a pediatric dentist in Huntington Beach, CA.

But while the ACA is an important first step in expanding access to dental care among children, it is just a first step. Much more needs to be done if we are to achieve our goal of wide access to dental care for children.

Many families will still have a hard time finding or paying for dental benefits for their children because the ACA, unlike its provisions for health care, does not require insurers to buy stand-alone pediatric dental insurance as part of state health care exchanges; offer subsidies to help consumers pay for dental insurance; or make improvements to Medicaid to increase dentist participation. In addition, the ACA does not fund the provisions it proposes to improve oral health.

There are two ways to remedy these shortcomings: reformulation of the ACA, or each state can exercise its significant control over expanding access to pediatric dental care among their populations.

Benefits of ACA for Pediatric Dental Health
By making pediatric dental services one of the 10 essential health benefits that all plans in the individual and small-group markets must offer, the ACA requires 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. As an essential health benefit, the ACA will help ensure basic coverage for both preventive and restorative care beginning early in a child’s life for children who would otherwise not have dental insurance.

The initial projection was that up to 8.7 million children would gain some form of dental benefits by 2018 as a result of the ACA, an increase of 15 percent.
AFFORDABLE CARE ACT (cont.)

The increase in children with dental benefits would come from the following sources:8

• 3.2 million children could gain dental benefits through the Medicaid expansion, a 49 percent increase over 2010 Medicaid levels. While the Medicaid expansion primarily increases adult eligibles by raising the floor of eligibility to 138 percent of the Federal Poverty Level, it is expected to increase the number of eligible but unenrolled children in the program.

• 3 million children could gain dental benefits through the health insurance exchanges by 2018, more than double the number of children with dental benefits purchased through the individual market.

• 2.5 million children could gain dental benefits through employer-sponsored insurance as a result of the mandate for pediatric dental benefits in small employer plans, an increase of about 10 percent compared to 2010 levels.

ACCESS RESTRICTED BY LACK OF BOTH INSURANCE AND AVAILABLE DENTISTS

The rise in children who see the dentist has been aided by a 29 percent decline in the percentage of children who are uninsured – from 14.4 percent in 2000 to 10.2 percent in 2010.10 Although the percentage of children covered by private insurance fell from 66.2 percent in 1997 to 54.2 percent in 2010, during that same period the percentage of children covered by public insurance (Medicaid/CHIP) doubled from 16.1 percent to 32.2 percent.92

Yet, while visits to the dentist have gone up in recent years, not all population groups – poor and minority families in particular – are benefiting from this trend. And whether or not they have insurance is not the only reason why – sometimes it’s hard, especially for families who have insurance through Medicaid, to find a dentist who will treat their child.

First, despite the rise in children covered by dental insurance, more than 22 percent of children in the U.S. are uninsured.93 Lack of dental insurance has been shown to be a compelling reason that families do not seek dental care for children. In fact, children without dental insurance are three times more likely to have an untreated dental care need than children with dental insurance.9

Children from racial minority groups had significantly more difficulty in finding access to dental care, as did those who live in rural areas or counties with fewer dentists per population.102

But lack of insurance alone cannot explain why the use of dental services remains unacceptably low among the most vulnerable to poor oral health, children from poor and minority families.4 That’s because many of these families are on Medicaid.103

As a result, those who are uninsured or who have Medicaid are less likely to have access to dental services than those who have private insurance. In addition, there appears to be a shortage of dentists who are willing and able to treat young children, due in large part to low Medicaid fees.

AFFORDABLE CARE ACT (cont.)

Lack of subsidies. While the ACA offers need-based subsidies to help consumers buy health insurance, it does not offer subsidies to help consumers buy stand-alone dental insurance plans.

No Medicaid improvements. Unlike the higher Medicaid reimbursements for primary care doctors, the ACA makes no improvements to Medicaid for dentists. While most pediatric dentists see Medicaid patients, only a fraction of general dentists participate in Medicaid due to low reimbursement and high administrative burden. The ACA also extended the Medicare Recovery Audit Contractor program to Medicaid with little guidance, resulting in inefficiencies in the audit process and further discouraging reluctant dentists from participating in the program.

Access will be more difficult. Even the limited Medicaid expansion is expected to increase demand for 20.6 million dental visits per year. As a result, the ACA will bring a large influx of children into Medicaid, an already overburdened and under-funded public insurance program with too few participating dentists.4 The result could make it even more difficult for Medicaid patients to find a dentist, and could decrease care coordination as well.105

Website issues. The complexities of navigating healthcare.gov, the ACA website, as well as many of the state health insurance exchanges, and the many glitches associated with that site, has made it difficult for consumers to sign up; enrollment is far lower than expected as a result.11 Navigating the healthcare.gov website is hugely complicated and difficult for people who are supposed to help but are not well trained in explaining the oral health benefits,” said Dr. Reppiaro. As a result of these factors, the initial projection that 8.7 million children will gain dental benefits appears to be overly optimistic. Now many experts project the number of children with dental benefits will be closer to 5 million, more than 62 percent lower than expected.116

Here is why:

No mandate to buy. While the ACA requires most consumers to buy health insurance or face a penalty, it does not require consumers to buy stand-alone pediatric dental insurance as part of state health care exchanges. As a result, many parents will not buy dental insurance for their children because they don’t have to. Ironically, there is a mandated purchase for those seeking coverage in individual and small group markets outside of exchanges.

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Here is why:
I believe the system will be much simpler and more transparent in five years," said Dr. Reggiardo. "But at this point, parents have to be very proactive in seeking out the dental benefit." Meanwhile, some states have tried to address the growing imbalance between demand for dental services and supply of dentists, especially those who take Medicaid. While pediatric dentists, who are significantly more likely to take Medicaid than general dentists, are critical to caring for the influx of children who will gain dental insurance coverage under the ACA, there are not enough pediatric dentists to treat the Medicaid population. As a result, states are trying to attract more dentists to Medicaid by streamlining administrative procedures and paying providers closer to market rates.12 States such as Maryland, Virginia and Connecticut have increased dental care among children by taking this approach and ramping up patient outreach.13

CONCLUSION

Although the ACA holds great promise to improve pediatric dental care, there is much work remaining to be done to realize that promise. In lieu of federal reform, however, each state has significant latitude to address the issues.

REFERENCES

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 depends on regular visits to the dentist.

One of the key developments in promoting regular, preventive dental care is the dental home. A dental home is 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.114 Such care takes into consideration the patient’s age, developmental status and psychosocial well-being, and it is appropriate to the needs of the child and family. A dental home provides a network of practitioners specializing in everything from preventive oral care and education to the advanced dental care required to treat emergencies.

“It’s critically important for parents to establish a dental home for their children in their first year of life,” Dr. Brill said. “This is a way for all children, and especially those who are vulnerable to oral health concerns due to their condition or background, to stay healthy.”112

The concept is just beginning to catch on. In the recent AAPD survey, few parents and caregivers (less than 1 in 10) had heard of the “Dental Home” concept; after hearing about it, most (more than 9 in 10) found the concept appealing and wanted to know more about it.114

Here are some of the key benefits of the dental home:

Better oral health: There is growing evidence to show that early establishment of the dental home can reduce ECC.118 There is also evidence that early preventive visits can reduce the need for restorative and emergency care, therefore reducing dental costs among high-risk children.115

Establishing regular care: Children who have dental coverage are more likely to seek care and receive preventive and therapeutic oral healthcare from dentists.116 Dental homes help parents to feel comfortable with the entire dental office, which is particularly important if the child has a dental emergency, according to experts.117

Reducing disparities: Simple, effective infant preventive oral care programs for all children can help stem recent increases in caries prevalence in young children, especially among minorities and the economically disadvantaged.118

EXPANDING THE SUPPLY OF PEDIATRIC DENTAL PROVIDERS

The benefits of early visits and the dental home are not available to those who cannot find a dentist. We have already seen that there appears to be a shortage of dentists who are willing and able to treat young children.

Overall, the shortage appears to be more of a problem of accessibility than of overall supply.119

After all, the overall dentist workforce is growing: Eight dental schools have opened since 2002;120 three additional schools are seeking accreditation for admission of students in 2013 and 2014; and four to five universities are contemplating opening dental schools in the next few years.121 By 2020, with the addition of new dental schools, there will be 5,400 dentists graduating every year, 800 more than in 2010.122

One solution is for more general dentists to accept Medicaid patients, including children. However, general dentists will first need to see significant reforms to Medicaid that result in better reimbursements and fewer administrative burdens, among other things.123 There are indications, however, that if these reforms do take place, participation will improve. For instance, in Connecticut, higher Medicaid reimbursement rates and improved administrative structure encouraged many more private practice dentists to treat children insured under HUSKY A (Healthcare for Uninsured Kids and Youth), the state’s Medicaid program for low-income families. Utilization rates of children continuously enrolled in HUSKY A increased from 46 percent in 2006 to nearly 70 percent in 2011, which is a percentage often used as a benchmark for adequate access to care.

Another solution is to use Expanded Function Dental Assistants (EFDAs) to increase help for dental offices that serve populations who have trouble accessing dental care.124 An EFD is a dental assistant or dental hygienist who receives additional education to enable them to perform reversible, intraoral procedures, and additional tasks (expanded duties or extended duties), services or capacities, under the supervision of a licensed dentist. Since the EFDA practices under the supervision of a licensed dentist, within the dental home, children are ensured access to comprehensive care, including restorative services to eliminate pain and restore function.

Some organizations have advocated for the creation of dental therapists, a midlevel provider somewhat analogous to that of a nurse practitioner in that they perform many of the same functions as a dentist. A recent study of midlevel providers such as dental therapists, however, concluded that their introduction into a community does not reduce rates of dental caries or oral health disparities.125 A number of dental organizations, including the American Dental Association and the AAPD, oppose the introduction of dental therapists because, among other reasons, it would create a two-tiered standard of care in which the nation’s most vulnerable children would receive services by providers with less education and experience.126,127,128 Policy makers must also be aware that by school age, almost half of children have experienced tooth decay, and many within the first few years of life. The behavior of these children often precludes management in the dental office or requires treatment using pharmacologic methods or use of a hospital, both skills and certification not available to proposed mid-level providers. Perhaps the strongest arguments against use of mid-level providers to fix the damage of decay are the avoidance of significant investment in early prevention, the cost of repair, and the lifelong infection of those afflicted and their ongoing restorative dental burden.
Parents who take their children to a pediatric dentist are more knowledgeable about pediatric oral health and dental care than those parents who take their children to a general dentist, according to the AAPD survey.109 Questions regarding brushing children’s teeth, putting a baby to bed with a bottle and the importance of an early trip to the dentist were all answered correctly more often by parents taking their children to pediatric dentists.109

In addition to their low participation level in Medicaid, many general dentists are unwilling or unable to treat young children given their unique needs.110 General dentists, in general, often do not see the importance of the early dental visit.109 General dentists are much less likely to treat infants and toddlers and had more negative attitudes toward infant oral health exams than pediatric dentists, according to a 2010 study in Michigan.111 While most general dentists reported treating children, few provided care for children age 3 or younger, according to a study in Kentucky.114

As a result, pediatric dentists are much more likely and better equipped to see and treat a very young patient than a dentist who does not specialize in pediatric dentistry.

Many parents and caregivers do not understand that pediatric dentists received special training in treating children, and received more training than general dentists, according to the AAPD survey.110 Once they learned about this specialized training, 3 out of 4 parents and caregivers surveyed said that they would be likely to seek out a pediatric dentist for their child.118

One area of specialized training that pediatric dentists receive is in treating special needs children, who are more likely than others to have unmet dental needs.115

In fact, for special needs children, dental care is the most prevalent unmet health care need, exceeding the need for either preventive or specialty medical care.114 Untreated tooth decay can exacerbate the already fragile condition of children with special health care needs.115 Pediatric dentists not only are trained to treat special needs patients, but they often retain these patients until adulthood due to the relationship that they have built with them.116

Training more pediatric dentists should go a long way toward addressing the concentration of early childhood caries (ECC) in very young and in special needs patients by improving access to their specialized skills.116

The AAPD has worked for over 15 years to increase the supply of pediatric dentists, and this has resulted in a doubling of residency positions. However, over 40 percent of all applicants for pediatric dentistry training are still turned away each year.117

As a result, in order to increase the supply of dental providers able to see young children, there need to be more pediatric dentists, more Expanded Function Dental Assistants (EFDAs), and more general dentists willing to accept Medicaid patients and willing and able to treat very young patients.

CONCLUSION

The increase in caries among our youngest and most vulnerable children could have profound repercussions for our society. Not only do ECC and other oral diseases threaten the immediate dental and overall health of these children, but they could have a lifelong impact on their dental and overall health and development. In addition, this public health threat will burden our society with substantial dental and healthcare costs, as well as social and economic costs. ECC, once established, is difficult to eradicate, and often leads to future caries and permanent tooth decay in the child.

The most encouraging – and frustrating – aspect of this health care crisis is that it is preventable. An early visit with a dentist specializing in young children can help minimize the threat of ECC. Establishing a dental home for the child will help prepare the child for a lifetime of robust oral health. Early education and intervention are the keys to preventing caries.118

To be sure, the solution is not as easy as it sounds. We need to better educate the public, as well as the medical community, about the importance of these early dental visits. We need to involve allied health professionals, community organizations and other health professionals in efforts focused on preventing oral disease in young children and on educating parents about the importance of good oral health for their child’s well-being.119

And we need to pave the way for these early visits by improving access to dental care by ensuring that more people have dental insurance. We also need to ensure there are an adequate number of dentists available to meet increased demand – dentists who are trained in treating children who are very young, from poor or minority families or who have special needs.