How Well Is CHIP Addressing Oral Health Care Needs and Access for Children?

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ABSTRACT

OBJECTIVE: We examine how access to and use of oral and dental care under the Children's Health Insurance Program (CHIP) compared to private coverage and being uninsured in 10 states.

METHODS: We report on findings drawn from a 2012 survey of CHIP enrollees in 10 states. We examined a range of parent-reported dental care access and use measures among CHIP enrollees. Comparisons of the experiences of established CHIP enrollees to the experiences of newly enrolling children who had been uninsured or privately insured were used to estimate the impacts of CHIP on children's oral health and dental care.

RESULTS: Most children enrolled in CHIP had a usual source of dental care and had received a dental checkup or cleaning in the past year, and most over age 6 had had sealants placed on their molars. In addition, parents of most CHIP enrollees were aware that CHIP covered dental benefits, and most reported not having trouble finding a dentist to see their child. Even so, 12% of CHIP enrollees had unmet dental care needs. Compared to being uninsured, CHIP enrollees did better across nearly all oral health measures. Compared to being privately insured, CHIP enrollees were more likely to have dental benefits, to have a usual source of dental care, and to have had a dental checkup/cleaning, but they were more likely to have trouble finding a dentist and less likely to say that their child's teeth were in excellent/very good condition.

CONCLUSIONS: Enrolling eligible uninsured children in CHIP led to improvements in their access to preventive dental care, as well as reductions in their unmet dental care needs, yet the CHIP program has more work to do to address the oral health problems of children.

KEYWORDS: access and use of health care; CHIP; dental services; impacts of health insurance coverage; oral health; public health insurance; unmet dental needs

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WHAT'S NEW

Dental disease is common and preventable among children. The Children's Health Insurance Program (CHIP) includes pediatric dental coverage. Relative to privately insured children, children enrolled in CHIP have better access to dental benefits and are more likely to have a usual source of dental care and a preventive dental visit, but the condition of their teeth is worse and they have more trouble finding a dentist.

ORAL HEALTH IS an important component of children's overall health and well-being. Despite recent progress in pediatric oral health care, poor oral health is common among children, and dental caries (tooth decay) is the most common childhood disease.[1] Expansions of public health insurance programs after enactment of the Children's Health Insurance Program (CHIP) in 1997 led to increases in access to dental benefits for low-income children (those in families with incomes at or below 200% of the federal poverty level). After the enactment of Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which included a provision requiring states with separate CHIP plans to provide dental coverage, all children covered by CHIP had coverage for dental services.[2] For children who would be eligible for CHIP based on income but who are enrolled in private coverage with limited or no dental benefits, CHIPRA included a provision allowing states with separate CHIP plans to provide supplemental dental coverage. Thus, low-income children who lack access to dental coverage are generally either uninsured children or privately insured children without either private dental benefits or supplemental dental coverage through CHIP.

Several studies have examined receipt of dental services among low-income children by age, race/ethnicity, and other characteristics of children and their parents. Previous research has shown that being uninsured is associated with a decreased likelihood of visiting a dentist for children overall and for low-income children.[3] Low-income children with no dental insurance are also more likely to have unmet dental needs compared to low-income children with private or public dental insurance.[4] Previous research has also demonstrated that children with lower family incomes, those whose parents are black, and those who have a parent

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with less than a college education are less likely to have the recommended number of dental visits and more likely to have postponed dental care.[5] Low-income children ages 6 to 12 years are more likely to have had a preventive dental care visit than those who are preschool age (4 to 5 years) or adolescents (13 to 17 years).[4] An analysis of 4 national health surveys with data spanning 2003 to 2007 showed that children who were uninsured or publicly insured had a decreased likelihood of any dental care, a decreased likelihood of preventive dental care, and a higher likelihood of delayed dental care compared to privately insured children.[6]

Other research has shown that ensuring access to oral health and dental services remains a concern for children enrolled in public coverage, as manifested by differences in the rates of preventive and dental treatment services across geographical areas, despite the availability of dental benefits and recent efforts to improve the quality of oral health care for these children.[7,8]

Here we present evidence on a wide range of outcomes related to the receipt of oral and dental care for children in CHIP compared to those with no insurance and those with private coverage in 10 states. Selected oral and dental health care access and use measures were based on parental report, including perceptions of whether their child has dental benefits; their access to a usual source of dental care; their access to dental providers; the use of dental-related services; the presence of unmet dental health needs; and the condition of their child's teeth. The analysis was conducted as part of an independent, comprehensive evaluation of CHIP mandated in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and conducted by Mathematica Policy Research and its partner, The Urban Institute, on behalf of the secretary of the US Department of Health and Human Services and overseen by the Office of the Assistant Secretary for Planning and Evaluation.[9] This is one in a series of articles in this supplement that report on findings from a large 10-state household survey of CHIP enrollees and disenrollees conducted as part of the evaluation. The observed patterns of care may suggest opportunities for improving the oral health of low-income children enrolled in CHIP.

METHODS

SURVEY DATA

The data for this study were drawn from a telephone-based survey of parents of 12,197 CHIP enrollees and disenrollees in 10 states fielded by Mathematica Policy Research from January 2012 through March 2013 as part of the CHIPRA-mandated evaluation of CHIP. The states included were Alabama, California, Florida, Louisiana, Michigan, New York, Ohio, Texas, Utah, and Virginia. These states were selected because they utilize diverse approaches to providing health insurance coverage for children, represent various geographic areas (including a mix of more rural and more urban states and a variety of races/ethnicities), and each contains a significant portion of uninsured children. In 2012, CHIP enrollees in these states represented approximately 57% of CHIP enrollees nationally.[10]

We used state eligibility and enrollment files to construct the sample frame for each state and randomly selected children (18 years or younger) in 3 strata in each state: 1) established enrollees (children who had been enrolled in CHIP for 12 or more consecutive months at the time of sampling), 2) recent enrollees (children who had been enrolled in CHIP for exactly 3 consecutive months, preceded by a gap in public coverage of at least 2 months, at the time of sampling), and 3) recent disenrollees (children who were disenrolled from the program for exactly 2 months, at the time of sampling, and who were previously enrolled for at least 3 months before the month of disenrollment).

Recent CHIP enrollees who transferred from Medicaid or who returned to CHIP after a short gap in public insurance coverage (3 months or less) were excluded from the sampling frame for 2 reasons. First, parents of such CHIP enrollees are often unaware of these coverage transitions and therefore are not able to reliably describe health care experiences before their (re)enrollment in CHIP. Second, because their coverage history reflects a period of public coverage, these children do not represent a useful comparison group for assessing how CHIP differs from private or no insurance coverage.

The final survey data included responses from parents of 5518 established enrollees, 4142 recent enrollees, and 2537 disenrollees. The overall survey response rate was 51% for established enrollees, 46% for recent enrollees, and 43% for recent disenrollees. The survey included a wide range of questions related to the sampled child's current and prior health insurance, health status and needs, and health care use and experiences, many of which were adapted from other large surveys relevant to children's health. Additional details on the survey, including the questionnaire, are available elsewhere.[11] The study was reviewed and approved by the New England Institutional Review Board (NEIRB 12-200).

STUDY DESIGN

We compared the experiences of established enrollees who had been on the program for at least 1 year to the pre-enrollment experiences of recent CHIP enrollees. Established enrollees were asked about their experiences during the last 12 months of enrollment, while recent enrollees were asked about their experiences during the 12 months before their enrollment in CHIP. We focused our analyses on comparisons between established enrollees and 2 subgroups of recent enrollees: first, recent enrollees who were uninsured for 5 to 12 months before enrollment, and second, recent enrollees who were privately insured for 12 months before enrollment. (The children who had private insurance may or may not have had dental benefits included in their private coverage.) We used the previously uninsured children to compare CHIP to being uninsured and the children previously insured by a private plan to consider how outcomes differ under CHIP versus private coverage.

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