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Oral health provisions in U.S. health care reform

Burton L. Edelstein, DDS, MPH; Fariha Samad, BA; Libby Mullin, BA; Meg Booth, MPH

President Barack Obama identified health insurance reform as a top domestic policy priority for his first year in office and charged Congress to work out the details. Concerns driving this priority were the large and growing numbers of uninsured Americans, rapidly escalating health care costs, and insurance industry practices of excluding coverage for preexisting conditions and imposing rescissions when beneficiaries become ill. By the close of 2009, both the House of Representatives and the Senate had finalized competing reform bills that each contained a variety of provisions directly affecting dentistry. At each step of the parallel processes, key committees drafted and vetted a host of legislative provisions and worked toward synthesizing final legislation.

Although both chambers of Congress were controlled by the Democrats, bipartisanship initially was strong, particularly in the Senate Finance Committee, in which three senior senators from each party (Democrats Max Baucus, Jeff Bingaman and Kent Conrad and Republicans Chuck Grassley, Mike Enzi and Olympia Snowe) worked diligently to secure a unified approach. However, during development of these bills, the legislative process became increasingly politicized and partisan, thereby limiting procedural opportunities to merge

ABSTRACT

Background. During 2009, both chambers of the U.S. Congress passed health care reform bills that contained a variety of provisions specific to oral health and dental care. In March 2010, the Senate version—the Patient Protection and Affordable Care Act (referred to as the Affordable Care Act [ACA])—was signed into law.

Methods. The authors establish the context for ACA dental provisions by reviewing prior federal legislation pertaining to dental coverage. They analyze the final U.S. House and Senate health care reform bills for their oral health content and draw observations regarding congressional interest in oral health.

Results. The authors identify and describe more than 30 provisions of direct relevance to dentistry within the domains of insurance coverage, dental workforce, safety net, prevention and surveillance. Although the two bills differed in many details, both address oral health infrastructure and delivery of care, with particular attention to underserved child and adolescent populations.

Conclusions. The oral health provisions in the health care reform bills evidenced strong congressional interest in oral health and dental care, with an emphasis on equitable care for children.

Practice Implications. The effect of each congressional action on the future of dental practice will depend on how the provisions are regulated and implemented. The dental profession needs to recognize the strong and ongoing interest of lawmakers in oral health care and must maintain active engagement in the policymaking process.

Key Words. Dentistry; public policy; government affairs; national health programs; insurance, dental benefits; access to care; dental care for children; dental health services; Medicaid.

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the two bills through conference. On the Democrats' loss of the supermajority after Democratic Sen. Edward Kennedy's death and succession by Republican Sen. Scott Brown, the House elected to enact the Senate version, thereby negating the need for resolution of differences between the two bills. On March 23, 2010, the president signed into law the Senate bill, entitled the Patient Protection and Affordable Care Act¹ (referred to as the Affordable Care Act [ACA]), and the House bill, entitled the Affordable Health Care for America Act,² was scrapped.

It is of value to examine both the House and Senate bills, as each evinces federal lawmakers' concerns about, and approaches to, oral health and dental care. In this review, we detail the legislative precedents leading up to the final bill, describe the oral health provisions in both bills and discuss how these provisions demonstrate the interest of Congress in dental care, 2009.

BUILDING ON PRECEDENT

Understanding the more than 30 provisions specific to dentistry in the bills^{3,4} requires knowledge of congressional precedent regarding dental coverage in federal insurance programs. The federal government first became a major health insurer in 1965, when President Lyndon Johnson's Great Society programs established Medicare⁵ for older adults and Medicaid⁶ for the poor and disabled. Medicare excludes routine dental coverage while Medicaid allows the states to determine benefits, thereby providing them with the option of offering dental care. To this day, states vary greatly in their Medicaid dental coverage for adults—ranging from no care or emergency care only in one-half of the states to reasonably comprehensive coverage in nine states (American Dental Association [ADA], Department of State Government Affairs, unpublished data, 2009).

Early Periodic Screening, Diagnosis, and Treatment. A federal mandate for dental coverage was first established, albeit indirectly, in 1967 with enactment of a pediatric Medicaid benefit called Early Periodic Screening, Diagnosis, and Treatment (EPSDT).⁷ EPSDT was designed to remove financial barriers to comprehensive health care for poor children and those younger than 21 years and to promote preventive care. Under EPSDT, states are required to provide periodic examinations conducted according to a set schedule that is determined by each state's health professional organizations, including

dental organizations, so that health is promoted and problems are diagnosed and treated before they become complex. Included are periodic dental screenings and comprehensive pediatric dental care, along with screenings of growth and development, vision and hearing.

With the exception of extending dental benefits to military dependents, there were no additional dental coverage mandates until 20 years later, when the EPSDT dental benefit was strengthened by the Omnibus Budget Reconciliation Act of 1989.⁷ This act required that dental screenings were to be performed by dentists rather than physicians, thereby ensuring children's entry into the dental care system.

State Children's Health Insurance Program. By the time the State Children's Health Insurance Program (SCHIP) was enacted in 1997,⁸ Congress had established a precedent that children's dental coverage was mandated while coverage of adults was not. SCHIP broke with that precedent by making dental coverage for children optional and empowering states to determine its election. Across the next five years, nearly every state elected to establish a dental benefit in SCHIP. An ADA analysis of SCHIP's first 10 years found that the dental benefit has been valuable to beneficiaries by increasing their use of dental services, decreasing the occurrence of unmet need and providing more children with a usual source of care and that SCHIP has clearly improved the oral health and dental care of children from working poor families.⁹ The ADA joined 11 national dental organizations in endorsing a series of SCHIP principles (Children's Dental Health Project on behalf of the Dental Access Coalition, unpublished data, March 2007) that called for a dental coverage mandate; supplemental

ABBREVIATION KEY. ACA: Affordable Care Act. ADA: American Dental Association. CDC: Centers for Disease Control and Prevention. CHIP: Children's Health Insurance Program. CHIPRA: Children's Health Insurance Program Reauthorization Act. DHAT: Dental health aide therapist. DRA: Deficit Reduction Act. EPSDT: Early and Periodic Screening and Diagnostic Treatment. FPG: Federal poverty guidelines. MACPAC: Medicaid and CHIP Payment and Access Commission. MEPS: Medical Expenditure Panel Survey. NHANES: National Health and Nutrition Examination Survey. NOHSS: National Oral Health Surveillance System. PRAMS: Pregnancy Risk Assessment Monitoring System. SCHIP: State Children's Health Insurance Program.

dental coverage through SCHIP to income-eligible children who have medical but not dental coverage through their parents' employment ("the wrap"); and a requirement that states report on their dental program's performance.

As in Medicaid, far more children insured by SCHIP obtained medical care than dental care¹⁰ primarily because of the paucity of participating dentists.¹¹ A congressionally mandated SCHIP evaluation in 2005¹⁰ found that one in eight parents of enrolled children (12 percent) reported that their child had an unmet need for dental care, which was six times greater than the number of parents who reported an unmet need for medical care.

Deficit Reduction Act. Congress revisited benefits in Medicaid and SCHIP when it passed the Deficit Reduction Act (DRA) of 2005, which offered states budget-cutting flexibility options in these programs. Expressing the political philosophy of "new federalism" promoted by the Republican majority at the time, DRA allowed states for the first time to make EPSDT changes without first obtaining federal waivers of program requirements. A number of states experimented by adding "personal responsibility" requirements, modeling Medicaid on private employer-sponsored insurance (which often lacks dental coverage) and changing cost-sharing provisions. For example, West Virginia's two-county experiment focused on personal responsibility by providing beneficiaries with a comprehensive benefits package, including dental care, only after parents signed and abided by a membership responsibility agreement.¹²

Children's Health Insurance Reauthorization Act. SCHIP expired in 2007. Its reauthorization as the Children's Health Insurance Program Reauthorization Act (CHIPRA) was signed into law by President Obama in 2009 after two previous congressional reauthorizations were vetoed by President George W. Bush. Unlike SCHIP 12 years earlier, CHIPRA returned to congressional precedent by mandating dental benefits for children and adolescents. This action was fueled by growing awareness of children's oral health that resulted from the surgeon general's 2000 report *Oral Health in America*,¹³ actions by dental and pediatric advocacy groups and the highly publicized death of a 12-year-old boy from Maryland of sequelae of a dental abscess.¹⁴ CHIPRA broke new legislative ground with regard to children's oral health.¹⁵ As in EPSDT, CHIPRA mandated a pediatric dental benefit. It created a new legal

definition of dental care: "dental services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions."¹⁶ CHIPRA addressed prevention, workforce, quality, reporting and the dental safety net. It also addressed low utilization of dental care in Medicaid and CHIP by mandating a congressional study of dentists' willingness to care for low-income children and of new workforce models that hold promise to improve access to dental care for beneficiaries.

CHIPRA also created a new federal commission—the Medicaid and CHIP Payment and Access Commission (MACPAC)—to advise Congress on Medicaid and CHIP policies affecting children's access to covered items and services, including dental care services. CHIPRA requires that MACPAC include at least one dentist with "national recognition for [his or her] expertise."¹⁷

Health care reform. Because of the two-year delay in reauthorizing CHIP, Congress' attention to children's oral health occurred just as initial health care reform bills were being developed. CHIP oral health care decisions directly influenced health care reform considerations. The Senate focused more on oral health than did the House, largely because of Sen. Jeff Bingaman's earlier work drafting a dental health improvement act, which received the input of major consumer and dental groups, including the ADA. Additional oral health champions who engaged actively in crafting oral health provisions were Sen. Olympia Snowe, who was instrumental in securing the CHIPRA wrap, and Sen. Debbie Stabenow, who led efforts to include the dental stand-alone plans (that is, plans that offer dental coverage only). House members who were particularly active in securing oral health provisions included Reps. Henry Waxman, John Dingell, Elijah Cummings, G.K. Butterfield and Diana DeGette, whose various modifications and formal amendments addressed issues reflected in the table.

DENTAL PROVISIONS IN HEALTH CARE REFORM BILLS

In formulating health care reform, legislators' primary concern was coverage, but they added provisions on workforce, safety net, prevention, infrastructure, surveillance, financing and accountability to make the coverage effective and to improve conditions that promote health. The table lists dental provisions in each of the final health care reform bills gleaned from detailed leg-

TABLE

Summary of final House and Senate health care reform bills' dental care provisions.*

PROVISION	HOUSE BILL AFFORDABLE HEALTH CARE FOR AMERICA ACT†	SENATE BILL PATIENT PROTECTION AND AFFORDABLE CARE ACT‡
Coverage		
Pediatric dental coverage mandate	Yes	Yes
Adult dental coverage mandate	No, but Secretary of Health and Human Services required to submit report to Congress	No
Dental coverage in Medicare Advantage	None	Requires Medicare Advantage plans to use rebates for dental care and other services
Stand-alone dental plans (not owned or operated by medical insurers)	Requires stand-alone plans to function only as subcontractors; extends consumer protections to small group market five years after enactment	Allows stand-alone plans to participate in the exchange and exempts them from consumer protections (Stabenow amendment)
Oversight		
Medicaid and CHIP§ Payment and Access Commission (MACPAC)	None	MACPAC tasked with reviewing state and federal Medicaid and CHIP access and payment policies and reporting to Congress twice each year
Health Benefits Advisory Committee	Requires participation of oral health experts	None
Dental Workforce		
Federal support for dental training	Grants, loans, scholarships (\$1.6 billion across five years)	Establishes unique dental training funding line of \$30 million per year; expands program to include curricular, faculty, predoctoral, dental hygiene and new program development; requires technical assistance to pediatric dental training programs to integrate public health; expands primary care residency programs and graduate medical education funding, including dental training
Workforce innovations	Interdisciplinary workforce demonstrations	Authorizes up to \$12 million per year for alternative provider demonstrations in up to 15 sites, where allowable by states
Workforce advisory committee	Specifies oral health in workforce advisory committee charge	Specifies oral health in National Health Care Workforce Commission with greater authority and range than the House version
Dental health aide therapists	Prohibits dental therapists in Alaska from extracting permanent teeth; prohibits dental therapists in Alaska from being deployed to other states	Allows dental therapists on Indian Health Service sites in states that sanction dental therapists (Franken amendment)
Faculty loan repayment program	None	Establishes a dental faculty loan repayment program with incentives for primary care, interdisciplinary care and care of underserved populations
Dental public health workforce	None	Establishes multidisciplinary primary care training program
Safety Net Enhancements		
School-based dental clinics	Establishes grant program with allowable dental care services	Same as House bill
<p>* Adapted from materials developed by the Children's Dental Health Project.^{3,4}</p> <p>† Affordable Health Care for America Act.²</p> <p>‡ Patient Protection and Affordable Care Act.¹</p> <p>§ CHIP: Children's Health Insurance Program.</p> <p>¶ CDC: Centers for Disease Control and Prevention.</p> <p># PRAMS: Pregnancy Risk Assessment Monitoring System.</p> <p>** NHANES: National Health and Nutrition Examination Survey.</p> <p>†† MEPS: Medical Expenditure Panel Survey.</p> <p>‡‡ NOHSS: National Oral Health Surveillance System.</p>		

TABLE (CONTINUED)

PROVISION	HOUSE BILL AFFORDABLE HEALTH CARE FOR AMERICA ACT [†]	SENATE BILL PATIENT PROTECTION AND AFFORDABLE CARE ACT [‡]
Prevention		
Oral health promotion	Grants to promote positive health behaviors, including oral health	Public education campaign specific to early childhood caries prevention and high-risk populations
Early childhood caries management	None	Authorizes grant program to demonstrate effectiveness of research-based disease management strategies
School-based dental sealant program	None	Mandates grants to all states (rather than the current 16 states) for CDC [¶] funding of school-based sealant programs
Infant mortality prevention	Grants including oral health counseling	None
Infrastructure		
State oral health infrastructure improvements	None	Mandates CDC cooperative agreements for all states (rather than 16 states) for leadership development, surveillance, safety-net improvements and policy development
Surveillance		
PRAMS[#] (pregnancy survey)	None	Mandates state-specific dental measures (currently optional)
NHANES^{**} (oral health survey)	None	Retains tooth-level data collection and analyses (CDC had planned to cut back to person-level surveillance)
MEPS^{††} (insurance coverage survey)	None	Mandates validation of dental measures commensurate with medical validation
NOHSS^{‡‡} (state and oral health program survey)	None	Mandates participation of all states
Other		
Durable medical equipment	New durable medical equipment, including dental equipment, must be designed for accessibility by people with disabilities	Same as House bill
Emergency responders	Adds dentists to homeland security and national emergency response systems	Establishes Elite Federal Disaster Teams that include dentists

islative language that the Children's Dental Health Project has tabulated.^{3,4}

Dental coverage. Following Medicaid and CHIPRA precedent, both bills mandated pediatric dental coverage, and neither bill provided dental coverage for adults. In describing pediatric dental coverage, neither bill is as explicit as the language in EPSDT or CHIPRA. In the House bill, a national Health Benefits Advisory Committee (which must include oral health experts) would determine the exact pediatric dental benefit. In the Senate bill, state-level advisory committees would make this determination. The House alone recognized that dental coverage for adults is an important issue by requiring the Secretary of Health and Human Services to submit a report to Congress detailing the cost of and need for adult

dental coverage.

Legislators envisioned that mandated dental coverage would be obtained in proposed national (House version) or state (Senate version) exchanges in which uninsured Americans would purchase insurance plans. Insurers who participate in these exchanges are required to abide by a number of consumer protections, including guaranteed issue regardless of preexisting conditions; assurance that an insured person will not be dropped because of subsequent illness or injury; and limits on out-of-pocket costs, including elimination of annual dollar caps on benefits. The two bills handled stand-alone dental insurers differently. The House bill allowed their participation exclusively as subcontractors to qualified health plans, thereby requiring them to abide by con-

sumer protection provisions. The Senate version allowed stand-alone insurers to participate alongside qualified health plans and exempted them from consumer protection provisions. Five years after enactment, the final House bill would have extended consumer protections to the commercial small group market, likely affecting adult as well as child coverage.

The Senate bill maintains CHIP through 2015, while the House version would have terminated CHIP in 2013 and children would have been insured through the exchange or Medicaid, depending on family income. Unlike the comprehensive CHIP dental benefit, the exchange dental benefit was not detailed by the House but was to be modeled on commercial coverage, which varies considerably with regard to the quality of dental coverage. Therefore, this shift might have resulted in a less comprehensive dental benefit for children. Both bills required the Secretary of Health and Human Services to assess whether children would be worse off under the exchange approach before changing the policy that transitions them out of CHIP.

Under the final law, on Jan. 1, 2014, Medicaid will be made available to an estimated additional 16 million people, according to the Congressional Budget Office.¹⁸ These are adults whose incomes are at or below 133 percent of the federal poverty guidelines (FPG) and who will become eligible regardless of current categorical requirements (for example, parents, children or those with disabilities). For these new adult Medicaid beneficiaries, as with current adult Medicaid beneficiaries, states will have the option of providing dental coverage at various levels. People 65 years and older will continue to be covered by Medicare, which, as present, will not provide dental benefits. However, Medicare beneficiaries may purchase, at their own expense, private dental plans, such as those available through AARP. Under ACA, the small number of Medicare beneficiaries enrolled in Medicare Advantage Plans may be offered dental coverage.

In addition to the 16 million people who will become eligible for Medicaid, an estimated 16 million uninsured adults and children will be required to obtain insurance, either through the exchanges or through their employers, or pay a

tax penalty for choosing to remain uninsured. As a result of these changes, children in families with incomes of less than 200 percent of the FPG will have mandated dental benefits from Medicaid or CHIP, while children in higher-income families will have access to dental coverage through their parents' employers or through the state exchanges. After 2014, the majority of U.S. children are expected to have dental insurance through Medicaid, CHIP or private insurance. Children who are themselves undocumented immigrants are not covered by ACA.

Dental workforce. Both final bills contained provisions for expanded federal support for dental education and training, underwrote dental workforce innovations, addressed the Alaska dental health aide therapist (DHAT) and established advisory committees to attend to workforce

issues. Both bills also specified dentists' involvement in emergency response training and deployment. Among provisions relevant to dental education are the following:

- grant, loan and scholarship programs;
- authorization for Congress to segregate primary care training funds between dental and medical education;
- inclusion of dental hygiene

training along with a focus on pediatric, general and public health dentistry;

- allowances to extend federal education dollars for dentists beyond postdoctoral training to include curriculum development, distance learning, faculty support, student stipends, and predoctoral and continuing dental education;
- incorporation of public health information into pediatric dentistry training;
- expansion of primary care residency programs, in part through graduate medical education funding.

National Health Care Workforce Commission. Federal attention to the dental workforce also is evident in the Senate's specification that a new National Health Care Workforce Commission prioritize analyses of dental workforce capacity. This novel commission also will support national, state and local policymaking; coordinate workforce programs across agencies; evaluate the education and training of health care professionals with regard to demand for services; facilitate

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coordination across various levels of government; and encourage workforce innovations.

National Health Service Corps. The intention of Congress to bridge medical and dental care is reflected in its inclusion of provisions designed to enhance multidisciplinary education. The House established a grant program to fund innovations in interdisciplinary care training that included delivery of oral health services. The Senate also established a multidisciplinary health care professional training program for select trainees committed to public health and safety. This program seeks to bring greater attention to underserved populations through the use of stipends, loan repayments and grants to institutions and students, as well as by requiring participants to serve in the National Health Service Corps for a period proportional to the years of training support. The program requires that participants tailor their predoctoral education and postdoctoral training to disciplines pertinent to public health and safety and that educational preparation involve community-based experiences in multidisciplinary teams.

Underserved populations. The Senate bill adds greater capacity for dental care of underserved populations through a targeted dental faculty loan repayment program for general, pediatric and public health dentists. The bill gives higher priority to faculty members who collaborate with medical care providers; demonstrate retention of trainees in primary care and public health dentistry; train rural, disadvantaged and minority dentists; partner with Federally Qualified Health Centers and other safety-net providers; teach in programs that treat underserved populations of all ages and with all medical and social conditions; promote cultural competency and health literacy; succeed in placing graduates in underserved areas or in the service of underserved populations; and address special-needs populations, defined as disabled, cognitively impaired, medically complex, physically limited and vulnerable elderly. To ensure that patients with special health care needs can be treated in health care facilities, manufacturers must design durable medical and dental equipment that accommodates special-needs access.

The House and Senate bills differed markedly in their approach to the dental health aide therapist (DHAT) program currently in place in

Alaskan tribal territories. The House confined the program to Alaska, whereas the Senate allowed DHATs to practice in any state that sanctions dental therapists within the constraints of that state's practice acts. The House approach further limited the range of services that DHATs could provide by prohibiting them from performing uncomplicated extractions of permanent teeth without a prior consultation with a dentist. It also established a panel to review the safety, cost-effectiveness and quality of care delivered by the DHAT.

Midlevel providers. Regarding other proposed midlevel dental care providers, the Senate bill establishes a five-year demonstration program to test new workforce models in up to 15 sites, with funding of up to \$4 million per site across five years. The providers may include the ADA's community dental health coordinator, the American Dental Hygienists' Association's

advanced dental hygiene practitioner, dental therapists and others who may be sanctioned by the Secretary of Health and Human Services, such as the Children's Dental Health Project's pediatric oral health educator. This provision also requires the independent Institute of Medicine of the National Academy of Sciences, Washington,

to conduct an evaluation of these demonstrations after five years and make recommendations about alternative dental care providers.

Safety net. Both bills sought to expand care by establishing grant programs for school-based health services including oral health services. The Senate bill expands support for state oral health programs by the Division of Oral Health, Centers for Disease Control and Prevention (CDC), Atlanta, from 16 states to all states. This financial and technical support, provided through cooperative agreements, promotes leadership; public-private collaborations; oral health surveillance and data collection; interpretation of risk; delivery system improvements; and expansion of evidence-based programs, including school-based dental sealant programs and community water fluoridation programs.

Prevention. The House and Senate bills underwrote public oral health education and promotion. Various provisions accomplished this through a public education campaign focused on evidence-based interventions for perinatal populations (Senate bill) or focused on positive health

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behaviors—including oral health—for all populations (House bill); by incorporating oral health into programs addressing infant mortality (House bill); and in school-based programs unique to Native American populations (House bill). In addition, the Senate bill authorized a grant program to demonstrate the effectiveness of research-based disease management strategies for dental caries and established a 50-state school-based sealant mandate. The final Senate bill also requires inclusion of comprehensive preventive services in qualified health plans, as detailed by the U.S. Preventive Services Task Force for adults¹⁹; for children, the bill requires consistency with child health supervision guidelines, such as those articulated by Bright Futures, a national health promotion initiative administered by the American Academy of Pediatrics in cooperation with many health care groups.²⁰

Surveillance. The Senate ensures and improves the quality of existing national surveys that report on oral health so that valid and reliable information will be available to evaluate the impact of programs and to inform Congress in its role as oral health policy-maker. ACA requires states to collect information about the oral health and dental care of pregnant women in CDC's Pregnancy Risk Assessment Monitoring System. Legislators ensured that CDC continues to monitor Americans' oral health through "tooth-level" rather than "person-level" surveillance in the National Health and Nutrition Examination Survey so that longitudinal tracking can continue. In addition, the Senate bill requires all states to participate in CDC's comprehensive National Oral Health Surveillance System. The Senate bill also strengthens the Medical Expenditure Panel Survey at the Agency for Healthcare Research and Quality, Rockville, Md., by requiring retrospective validation of its findings regarding the distribution of dental insurance, expenditures and dental care in the same way that it currently validates medical findings.

OBSERVATIONS ABOUT CONGRESSIONAL INTEREST IN ORAL HEALTH AND DENTAL CARE

Taken together, the House and Senate actions on CHIPRA and health care reform say much about congressional interest and intent with respect to

Americans' oral health and dental care. It is significant that the dental provisions in CHIPRA received bipartisan support, and most of the dental provisions in the health care reform legislation were well vetted before the legislative process became polarized and politicized.

The range and depth of actions taken by Congress suggest that federal legislators now regard oral health as a valid public policy issue in its own right and recognize that discussions about overall health must include consideration of oral health. Many of the legislators' actions reveal government's commitment to those in society who are vulnerable by virtue of age, socioeconomic status or health condition, as reflected in the prioritization of children over adults; targeting of dental education programs to underserved populations; and promotion of new dental care

providers to serve those who have limited access to dental care.

Extensive attention to oral health education and prevention reveals a clear understanding that dental diseases are overwhelmingly preventable and that the best health at the lowest cost is attainable only through aggressive interventions to prevent and manage disease. By including oral health across a variety of programs and

including dentists in multidisciplinary care and emergency preparedness teams, legislators have demonstrated their recognition of oral health as an integral component of systemic health. Congressional actions also demonstrate a determination to approach oral health care inequities in a comprehensive manner by addressing dental coverage, workforce issues, the dental safety net, prevention and public health surveillance.

Although the Senate bill prevailed, it is significant that the bills had considerable overlap with regard to legislators' views and treatment of oral health issues throughout the course of the health care reform debate, as this review has demonstrated.

The ACA dental provisions will need to move through the budgeting, appropriations, regulatory and program development phases of implementation. As they do, a wide range of dental and consumer communities of interest will have many opportunities to work with policymakers to ensure that these provisions are implemented in ways that serve the oral health interests of all

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Americans and support equitable delivery of dental care.

CONCLUSION

The many dental provisions in ACA shape an approach to the future of dental care that reaches more children through expanded coverage, supports dental care professionals through expanded training opportunities, promotes oral health through prevention and disease management activities, improves the nation's dental public health infrastructure through grants to states, and can demonstrate a measurable impact through improved oral health surveillance. Congress was fully supportive of these approaches and now is poised—with encouragement from the profession and the public—to implement the law in ways that hold promise to improve the nation's oral health and dental care. ■

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