Good News, Bad News...

The news that came late this summer for America's economically disadvantaged children was mixed at best. The US Census Bureau announced in August that the median household income remained unchanged from 2002 to 2003, holding steady at a little more than $43,000 per annum. However, the nation's official poverty rate rose from 12.1% to 12.5%. As is the case with many of these types of statistics, the changes were not uniform across all racial and ethnic groups or regions of the country. Hispanic households had a real decline in median income of 2.6%, while the median native American household income rose by 4%. Southerners saw a slight decline in median household income, while those in the northeast, midwest, and west experienced no change.

Of specific interest to pediatric dentists, the poverty rate of children under the age of 18 rose to 17.6% in 2003, up from 16.7% in 2002. The average poverty threshold for a family of 4 in 2003 was a bit less than $19,000. The poverty rate among non-Hispanic whites was lower than that among African-Americans, Hispanics, Asian-Americans, and native Americans. Non-Hispanic whites, however, comprised 44% of the poverty population.

In another bit of good news/bad news, the number of Americans with health insurance rose by 1.4 million to 243.3 million. On the down side, however, the percentage with coverage decreased from 84.8% to 84.4%, largely a result of a decrease in the percentage of the population covered by employment-based insurance. The percentage of citizens covered by government health insurance programs, primarily Medicaid and Medicare, rose almost 1% to 26.6%. States have struggled in recent years to fund their Medicaid programs, which is the second costliest line item (following education) in almost every state budget. The estimated shortfall in state budgets in 2003 was $70 billion. Coupled with historic increases in health care costs, the nation's poor began to see significant holes developing in the safety net. Medicaid spending did increase by 9% in fiscal year 2003, but mostly in response to job loss and the elimination of insurance benefits by many employers.

States have had to implement cost-cutting measures primarily by decreasing or freezing reimbursement rates, but also by instituting cost controls for prescription drugs, restricting Medicaid eligibility, and restricting benefits. These measures have led to reduced access to basic dental care for the 24 million children covered by Medicaid as dentists withdraw from the program. The ADA's *2003 Survey of Dental Fees* reported that over 18% of pediatric dentists' patients receive public assistance. This figure probably underestimates the true number of disadvantaged children treated by pediatric dentists, however, because many AAPD members provide *pro bono* care to Medicaid recipients rather than working through the system's byzantine requirements, poor reimbursement rates, and slow payments. This is great for the kids, but it hides the true data on dental needs of children and reduces the urgency for state legislators to increase reimbursement rates and make other improvements to the system.

There is some good news in that a few states are attempting to streamline their Medicaid programs, eliminate the need for prior approvals, and even increase reimbursement rates in some cases, though this typically comes at the expense of eliminating payments for selected procedures. Still, most states have not implemented the Medicaid requirement that all children receive early preventive care through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. One way the profession is attempting to meet the treatment needs of economically-disadvantaged children is by enlisting private practitioners to provide care to Medicaid recipients at urban and regional dental clinics.[1] This is a wonderful way for Medicaid non-participants to contribute to the dental health of the nation's poor children. It is not, however, a substitute for improving the system. Until reimbursement rates reach reasonable levels and the payment system approaches that of private insurance plans, access to care for children on public assistance will continue to shrink.

1. http://www.rochesterdandc.com/apps/pbcs.dll/article?AID=/20041002/NEWS01/410020328/-1/ARCHIVE2. Accessed October 24, 2004.

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