

RESEARCH REPORT

# The Role of Medicaid Adult Dental Benefits During Pregnancy and Postpartum

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# Executive Summary



## A pregnant person's overall health is inextricably linked to the health of their baby.

- Hormonal changes during pregnancy increase the risk of oral disease.
- Oral health issues can raise the likelihood of poor birth outcomes and exacerbate underlying conditions, with a [greater percentage of Black women experiencing complications than white women](#).
- Diabetes and hypertension can be worsened by poor oral health, putting pregnant persons at higher risk of negative health outcomes such as depression.
- Poor oral health during pregnancy is linked to adverse birth outcomes including preeclampsia (high blood pressure during pregnancy), preterm birth, and low-birth-weight infants.
- Continued oral care after pregnancy (during the postpartum period) should be included as a standard component of postpartum health care.
- Children's oral health outcomes are associated with the birthing parent's oral health and dietary habits.

## Barriers to oral health care during pregnancy and postpartum persist despite safety of dental treatment.

- One of the main reasons pregnant persons do not seek dental care is the high cost of care.

- A [large percentage of dentists surveyed](#) say oral health care is an important part of prenatal care. However some dentists are unwilling to provide restorative procedures and periodontal scaling and root planing procedures throughout all stages of pregnancy.
- Obstetrician and certified nurse midwives play a valuable role in providing oral health education during prenatal and postpartum care.

### **Advocating for access to dental care includes care for pregnant and postpartum persons.**

- Adults with Medicaid dental benefits have greater access to and utilization of regular dental care that can prevent dental disease and costly dental emergencies.
- As of March 2020, pregnant persons in 10 states had access to [enhanced Medicaid dental coverage](#) compared with the general adult population.
- Factors affecting Medicaid coverage eligibility vary by state and include, but are not limited to: income, duration of coverage, benefits, and population groups.
- As of October 2022, [all 50 states and the District of Columbia offer some form of dental coverage](#) for Medicaid enrollees who are pregnant and postpartum through at least 60 days after the pregnancy ends.

### **Strategic recommendations for federal and state policymakers must include expansion of Medicaid adult dental benefits.**

- 1 All states should extend postpartum Medicaid dental coverage for birthing parents from 60 days to at least 12 months.
- 2 All states should provide extensive Medicaid dental benefits to all adults — including postpartum adults.
- 3 All states should extend Medicaid coverage to adults with incomes at or below 138% of the Federal Poverty Level.
- 4 Adult dental benefits should be made an essential health benefit in the Affordable Care Act (ACA) Marketplace, and oral health care should be included in the definition of maternity care benefits.





# The Role of Medicaid Adult Dental Benefits During Pregnancy and Postpartum

The United States is in the midst of an infant and maternal health crisis. The [maternal mortality rate](#) rose from 17.4 deaths per 100,000 live births in 2018 to 20.1 in 2019 to 23.8 in 2020. In 2020, [Black women died from maternal-related causes](#) at a rate nearly three times that of white women. As oral health is inextricably linked to overall health, there is a critical need for pregnant and postpartum individuals to have good oral health in order to ensure that birthing parents and their children are healthy.

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# Importance of Oral Health During Pregnancy and Postpartum

Oral health is directly linked to overall health and well-being. When oral health deteriorates, it can have far-reaching consequences and health effects [beyond the mouth](#). Good oral health is essential throughout the lifespan and takes on added importance during pregnancy. A pregnant person's overall health is inextricably linked to the health of their baby. During pregnancy, hormonal changes increase a person's risk of oral disease.

[Approximately 60–75% of pregnant people](#) experience oral health issues that raise the likelihood of poor birth outcomes and exacerbate underlying conditions that can lead to major complications and even death. These percentages are even higher for expecting Black women, who are [27% more likely to experience severe pregnancy complications](#) than white women.

Conditions like [diabetes and hypertension are worsened by poor oral health](#) and can put pregnant persons at higher risk for depression. Furthermore, [poor oral health during pregnancy has been linked to adverse birth outcomes](#) including preeclampsia (high blood pressure during pregnancy), preterm birth, and low-birth-weight infants.

## Definitions

[Perinatal](#) is the time before and after the birth of a child.

[Prenatal](#) is the time a person is pregnant, before birth occurs.

[Postpartum](#) is the time following the birth of a newborn.

[Premature birth](#) (also known as preterm birth) is when a baby is born too early, before 37 weeks of pregnancy have been completed.

[Low birth weight](#) is defined as less than 2,500 grams (approximately 5.5 pounds).

A major dental concern during pregnancy is periodontal disease. Gingivitis, an early stage of the disease that occurs when the gums become red and swollen from inflammation, affects 60–75% of pregnant people. If left untreated, gingivitis



can lead to bone and tooth loss, and the gums can become infected. Teeth with little bone support can become loose and may eventually need to be extracted. [Periodontal disease has been associated with preterm birth and low-birth-weight infant deliveries.](#) Additionally, left untreated, periodontal disease raises the risk of heart attack and stroke. Periodontal disease and diabetes share a two-way relationship, meaning that diabetes may raise the risk of and severity of periodontal disease and vice versa.

The Centers for Disease Control and Prevention (CDC) defines the [postpartum period](#) as extending through 12 months after the end of pregnancy. During this time, postpartum care focuses on a [range of needs](#) including recovery from childbirth, follow-up on pregnancy complications, management of chronic health conditions, access to family planning, and addressing mental health conditions. Continued oral care and management of dental caries, periodontal disease, oral infections, and oral cancers is equally important during the postpartum period and should be viewed as a critical component of postpartum care.

The impacts of poor oral health, and the need for ongoing oral health care, continue after birth for both parent and child. A child's oral health is closely linked to that of their birthing parent. A study assessing children's oral health status found that children are [three times more likely to develop dental disease](#) if their mother<sup>1</sup> had untreated dental disease during pregnancy. Furthermore, five-year-old children whose [mothers consumed sugar-sweetened beverages](#) in the postpartum period had more dental decay than those whose mothers did not consume sugar-sweetened beverages.

Untreated decay can cause pain and suffering and affect well-being and academic achievement. Furthermore, children with dental decay are less likely to eat a [nutritionally balanced diet](#). Children with poor oral health status are [nearly three times more likely to miss school](#) because of dental pain. Children suffering from tooth decay are [four times more likely to earn lower grades](#) in school.

The impact of poor oral health extends far beyond the individual and family. It can have far-reaching consequences for communities and can affect health care spending and costs.

- The March of Dimes estimates that the [average societal cost of each preterm birth](#), which includes medical care, early intervention services, and lost productivity, is \$65,000.

## **Continued oral care and management of dental caries, periodontal disease, oral infections, and oral cancers is equally important during the postpartum period and should be viewed as a critical component of postpartum care.**

- According to the March of Dimes, the average medical costs of the first year postpartum, including both inpatient and outpatient care, were about [four times greater for preterm \(\\$49,140\) than for term infants \(\\$13,024\)](#) in 2016.
- In 2016, the annual societal economic cost (medical, educational, and lost productivity) associated with preterm births in the United States was [at least \\$25.2 billion](#).

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<sup>1</sup> Throughout most of this paper, terms such as "birthing parent(s)," "pregnant people," and "pregnant individuals" are used to be inclusive of all individuals who give birth. The terms "mother(s)" or "women" are used when describing results of certain research studies that refer specifically and exclusively to mothers or women (i.e., men, fathers, or other caregivers were not included in the study).

# Use of Dental Services During Pregnancy

The use of dental services during pregnancy is [safe, and a full range of services](#) — including dental examinations, radiographs, cleanings, local anesthetics, restorative care, and dental surgery — can be utilized. These services are necessary to prevent or slow the progression of dental diseases such as tooth decay and periodontal disease.

Although dental care is important and recommended during pregnancy, access to care is [inconsistent due to barriers](#) including: lack of patient and provider knowledge about the safety and importance of care; inability to find dental providers willing to treat pregnant persons; inadequate publicly funded insurance coverage that ends too soon after birth; and [inability to complete treatment before giving birth](#).

Several studies have examined use of dental care during pregnancy. While most (84%) pregnant patients believe dental care during pregnancy is safe, [less than half \(44%\) received dental care during their pregnancy](#), primarily due to financial barriers. The majority of pregnant individuals (77%) report having dental insurance during their pregnancy, but those without insurance are [less likely to receive dental cleanings](#) while pregnant than those with insurance. Nearly all dentists surveyed (91%) say oral health care is an important part of prenatal care, yet [only 37% indicate that they provide restorative procedures](#) and periodontal scaling and root planing procedures throughout all stages of pregnancy.

Experts in medicine and dentistry agree on the [importance of oral health care in pregnancy](#). A federally facilitated panel produced a National Consensus Statement on the issue in 2012. In 2013, the American College of Obstetricians and Gynecologists affirmed that

**“Ample evidence shows that oral health care during pregnancy is safe and should be recommended to improve the oral and general health of the woman.”**

Obstetricians play an important role in advancing oral health and dental treatment for their pregnant patients. However, while most (80%) obstetrician-gynecologists (OB/GYNs) and certified nurse midwives (CNMs) acknowledge that oral health is an important consideration for optimal prenatal care, [only 53% report having oral health-related questions](#) on their intake documents. Of the OB/GYNs and CNMs surveyed, only one third (35%) discussed oral health with their pregnant patients, 29% conducted an oral cavity exam, and 42% recommended that their patients see a dentist. Meanwhile, most OB/GYNs surveyed ([77%](#)) [reported that patients of theirs had been “declined” treatment by dentists](#).

A pregnant person’s inability and/or reluctance to access care can lead to unmet dental treatment needs. A recent study of dental service utilization and unmet oral health needs during and prior to pregnancy, using data from the [Pregnancy Risk Assessment Monitoring System \(PRAMS\)](#), found that:

- Only about half of the women (51.7%) reported that they had at least one dental visit for a cleaning during their most recent pregnancy.
- One in five women (19.7%) experienced dental problems during pregnancy, and 34.4% of these women did not visit a dentist to address the problem.
- Non-Hispanic Black women had 14% lower odds of visiting a dentist for a cleaning during pregnancy compared with non-Hispanic white women. There was no difference in dental visits prior to pregnancy between non-Hispanic Black and white women.
- Women enrolled in Medicaid had significantly lower odds of visiting a dentist for a cleaning during pregnancy compared with women covered by private health insurance.

In a similar study of PRAMS data, when compared with white pregnant women without dental coverage, [Black pregnant women without dental coverage were more than 30% less likely to visit a dentist](#).





# Dental Coverage for Pregnant and Postpartum Persons

Coverage is a critical piece in the access-to-dental-care puzzle. Compared to those without dental coverage, adults with Medicaid dental benefits have greater access to and utilization of regular dental care that can prevent dental disease and costly dental emergencies. Providing dental coverage to adults also [increases the likelihood that their children will receive timely and appropriate care](#). Furthermore, adults with dental coverage are also [more likely to enter and remain in the workforce](#) than those without dental coverage.

Medicaid is a significant source of insurance for millions of Americans. By covering [more than 42% of all births](#), the joint federal-state program plays an important role in pregnancy and postpartum health care.

While pregnancy-related services and benefits exist, there are no federal requirements for the provision of dental care for nonpregnant adults ages 21 and older who are enrolled in Medicaid. However, as of October 2022, [all 50 states and the District of Columbia offer some form of dental coverage](#) for Medicaid enrollees who are pregnant and postpartum through at least 60 days after the pregnancy ends.

**Thirty-six states and the District of Columbia have implemented or are planning to implement an extension to the Medicaid postpartum coverage period. In the remaining 14 states, pregnancy coverage ends at 60 days postpartum.**

As of April 2022, federal incentives are available to states to [extend Medicaid coverage for postpartum people to a full year](#), including benefits that are not only “pregnancy-related.”

Some states provide an extensive oral health benefits package, some provide coverage for only emergency dental services, and a small handful of states continue to provide no dental coverage of any kind to non-pregnant adults.<sup>2</sup> In many states, coverage of dental services also [varies by population group](#), such as pregnant persons, individuals with physical or development disabilities, or individuals with certain chronic conditions.

As of March 2020, pregnant persons in 10 states had access to [enhanced Medicaid dental coverage](#) compared with the general adult population. Below is a sampling of states along with the varying coverage offered to their general adult population beneficiaries and their pregnant beneficiaries.

In [2020](#):<sup>3</sup>

- Colorado and Minnesota offered more frequent coverage of cleanings (four per year) to pregnant adults than they offered to non-pregnant adults (two per year and one per year respectively).
- Georgia and Minnesota offered coverage for the application of fluoride twice per year for pregnant adults compared to no coverage (Georgia) and coverage once per year (Minnesota) for non-pregnant adults.
- Georgia, Maryland, Missouri, and Virginia offered fillings and crowns to their pregnant population but not to the state's general adult population.
- Missouri and Virginia offered root canal treatment to their pregnant population but not the state's general adult population.
- Colorado, Kentucky, Maryland, Nevada, Oregon, and Virginia offered coverage of periodontal services to their pregnant population, compared with either no coverage or less frequent coverage for their general adult population.
- Missouri, Vermont, and Virginia offered dentures to their pregnant population but not their general adult population.
- Minnesota offered dentures to both their pregnant and general adult population but offered more frequent coverage to their pregnant population (coverage once every three years versus once every six years for the general adult population).

## Medicaid Requirements

Federal law sets several [baseline requirements](#) that each state must follow for administration of its Medicaid program:

- **Income eligibility** — All states must provide Medicaid coverage for pregnant persons with incomes up to 138% of the federal poverty level (FPL). States may set income eligibility thresholds higher than the federal minimum requirement.
  - **Duration of coverage** — States must provide coverage through 60 days postpartum. States may opt to extend coverage past this point.
  - **Cost-sharing** — States are prohibited from imposing cost-sharing requirements, such as copays and deductibles, on beneficiaries for pregnancy-related services.
  - **Benefits** — Beyond inpatient and outpatient care, federal law does not generally define the services that states must cover for pregnant beneficiaries. States that have enhanced Medicaid eligibility under the Affordable Care Act (ACA) are required to cover services that fall under the federal requirements for coverage of [preventive services](#) established by the ACA, including many prenatal screening tests, folic acid supplements, and breastfeeding services. **No requirements exist for states that have not extended Medicaid eligibility.**
- Vermont offered coverage for orthodontic services for their pregnant population but not their general adult population.

<sup>2</sup> On January 1, 2023, [Maryland](#) and [Tennessee](#) implemented dental benefits for all adults enrolled in their Medicaid programs. Effective October 1, 2022, [Alabama](#) provides dental services to pregnant and postpartum adults but does not cover any type of dental care for non-pregnant or postpartum adults.

<sup>3</sup> Please note that [Virginia](#) expanded its dental benefits to all adults in July 2021.

## Dental coverage for specific adult populations can lead to coverage for all adults

In many states, expansion of dental benefits happens incrementally, with states adding coverage for specific procedures or services over time. In other states, incremental expansions are put in place for specific population groups, such as pregnant adults. In some instances, such as Virginia, the incremental expansion of benefits for a specific population leads to later expansion in benefits for all adult beneficiaries.

**In many states, expansion of dental benefits happens incrementally, with states adding coverage for specific procedures or services over time.**



## Look at Virginia

In 2015, Virginia added an extensive dental benefit for Medicaid-enrolled adults during pregnancy and 60 days postpartum. As part of a 10-part plan to increase access to health care for 200,000 uninsured Virginians, the [dental benefit was implemented](#) after state oral health surveillance and needs assessment data indicated a substantial unmet need for oral health care for pregnant women and infants. Prior to 2015, emergency extractions were the only covered services provided to Medicaid adults. The [addition of dental services](#) for pregnant adults in Medicaid has yielded positive results for Virginia, with a [17% increase in use of dental services](#) after the implementation of this extensive benefit. Pregnancy Risk Assessment Monitoring System (PRAMS) data show that the number of pregnant adults receiving dental services doubled between 2014 and 2019. Building on the successes of the dental benefit for pregnant individuals, the state began providing this same level of extensive benefit to all adult beneficiaries in 2021.



## States to Watch in 2023

Two states, Maryland and Tennessee, may well serve as case studies of states making significant investments in oral health designed to improve the health of all residents — and succeeding. In 2022, recognizing the connection between maternal oral health and birth outcomes and infant health, both states extended the Medicaid postpartum coverage period to 12 months and began providing comprehensive dental benefits to their pregnant and postpartum beneficiaries. On January 1, 2023, both states also began providing dental benefits to all their adult members — a benefit that neither state has historically offered. These new benefits will be offered to a total of more than 1.4 million residents in the two states (800,000 in MD and 610,000 in TN). This change could have positive ripple effects across the system. For example, although Medicaid members comprise only 17% of Maryland adults, they account for 54% of all the state's emergency visits for non-traumatic dental conditions and 46% of the total cost of these ED visits.





# Recommendations

The periods prior to, during, and following pregnancy are of critical importance to the health and well-being of birthing people and their children. While Medicaid provides a key source of coverage and care for millions during pregnancy, it is often unavailable to adults before pregnancy and more than 60 days after birth. Furthermore, Medicaid coverage in

many states is inadequate to meet the oral health needs of adults. Even when coverage exists, gaps in patient and provider knowledge as well as limited access to care pose hurdles to establishing and maintaining good oral health. Below are key recommendations and additional considerations for federal and state policymakers to address these barriers.

## **#1 — All states should extend postpartum coverage from 60 days to at least 12 months.**

*State action: Policymakers should utilize the expedited State Plan Amendment (SPA) process under the American Rescue Plan Act (ARPA) to extend coverage. In addition to expediting the extension process, the SPA ensures that states get the same federal funding match rate across the extension period.*

Knowledge and understanding of the importance of the postpartum period has evolved over time, yet federal policies have not kept pace. The 60-day postpartum coverage period was established by Congress in 1986. Today, more than 275 national and state provider organizations and advocacy groups,

### **Extending the coverage period from 60 days to 12 months postpartum would:**

- Reduce lapses in insurance coverage
- Improve health equity and reduce racial and ethnic disparities in birth outcomes
- Ensure that adults have access to ongoing care to address their health and well-being and that of their children
- Align parental and child Medicaid coverage through age one



in addition to state maternal mortality review committees and departments of health, [agree that states should extend postpartum Medicaid coverage to one year](#).

States are required to extend Medicaid eligibility to pregnant persons and provide pregnancy-related coverage through 60 days postpartum. Additionally, infants are eligible for Medicaid for the first year after birth. As detailed previously, Medicaid eligibility during pregnancy and the 60-day postpartum period [varies by states](#) and ranges from 138% to 380% FPL. These pregnancy-related Medicaid eligibility income limits are equal

to or exceed the income eligibility limits for non-pregnant parents and other low-income adults. This contributes to [coverage loss for individuals who are ineligible for Medicaid](#) through a different pathway when pregnancy-related Medicaid eligibility ends at 60 days postpartum.

Without coverage or affordable access to care, many adults will [abandon medication or other ongoing treatment they may need](#). As detailed previously, the postpartum period is a critical time for new parents, with one third of pregnancy-related deaths occurring during the first year after a pregnancy ends.

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The [American Rescue Plan Act](#) provides states with the option of receiving matching funds to extend full-benefit Medicaid or Children's Health Insurance Program (CHIP) coverage to all individuals enrolled in Medicaid during pregnancy for one year postpartum, regardless of any changes in circumstances. This option is available to states for five years.

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All but 14 states have taken action to extend pregnancy-related Medicaid eligibility beyond the federally mandated 60 days postpartum. As of January 2023, 29 states have funded this eligibility extension using [Medicaid waivers or state funds](#), while the remaining states have introduced or passed legislation or budgetary measures in order to implement this extension.

A recent study by the US Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) found that nearly 720,000 individuals could be guaranteed Medicaid and CHIP coverage for a full year after pregnancy if [all states provided 12 months of postpartum pregnancy-related Medicaid eligibility](#). The study also noted that gains in eligibility would be greatest among enrollees ages 26 and older as they are less likely than younger enrollees to be eligible for Medicaid through other pathways. Additionally, gains would be larger in non-expansion states with lower income limits for parental Medicaid eligibility. Furthermore, providing 12 months of postpartum eligibility would increase eligibility substantially for all racial and ethnic groups, extending coverage for an estimated 222,000 Latino, 133,000 Black, and 6,000 American Indian/Alaska Native individuals.

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**Estimated Changes Under a 12-Month Postpartum Eligibility, by State**

<b>State</b>	<b>Estimated Number of Medicaid-Paid Births Whose Parents Gain Partial or Full-Year Postpartum Eligibility</b>	<b>State</b>	<b>Estimated Number of Medicaid-Paid Births Whose Parents Gain Partial or Full-Year Postpartum Eligibility</b>
Alabama	20,000	Montana	2,000
Alaska	1,000	Nebraska	3,000
Arizona	15,000	Nevada	6,000
Arkansas	6,000	New Hampshire	1,000
California	57,000	New Jersey	11,000
Colorado	9,000	New Mexico	5,000
Connecticut	4,000	New York	26,000
Delaware	2,000	North Carolina	28,000
District of Columbia	1,000	North Dakota	1,000
Florida	52,000	Ohio	21,000
Georgia	39,000	Oklahoma	14,000
Hawaii	2,000	Oregon	7,000
Idaho	3,000	Pennsylvania	18,000
Illinois	21,000	Rhode Island	2,000
Indiana	12,000	South Carolina	16,000
Iowa	6,000	South Dakota	2,000
Kansas	7,000	Tennessee	22,000
Kentucky	10,000	Texas	137,000
Louisiana	14,000	Utah	4,000
Maine	2,000	Vermont	1,000
Maryland	11,000	Virginia	12,000
Massachusetts	8,000	Washington	12,000
Michigan	16,000	West Virginia	3,000
Minnesota	7,000	Wisconsin	13,000
Mississippi	14,000	Wyoming	1,000
Missouri	18,000		

## #2 — All states should provide extensive Medicaid dental benefits to all adults — including postpartum adults.

**Federal action:** Congress should make extensive coverage for adults a permanent part of the Medicaid program and establish a baseline of covered services for all states.

**State action:** Policymakers should enhance the state's current dental benefits package to provide and/or enhance the dental benefits offered to pregnant and postpartum adults.

As discussed previously, Medicaid adult dental benefits vary by state in terms of the amount, duration, and scope of covered services. While state Medicaid programs are required to cover dental services for children under 21, services for adults, including pregnant and postpartum persons, are optional.

An [extensive Medicaid adult dental benefit](#) is defined as one that provides coverage for a range of dental procedures considered adequate for the prevention of disease and promotion of oral health, including the restoration of oral structures to health and function and the treatment of emergency/urgent conditions. As of 2020, [three states and the District of Columbia provide this coverage](#) during pregnancy and their defined postpartum period.

Meanwhile, some states retain income limits that dictate Medicaid eligibility for parents and children. In DC, adults with children may remain on Medicaid and continue accessing these dental benefits as long as their family income remains at or below 221% of the FPL. In Alaska and Nebraska, adults with children may also retain their dental benefits through Medicaid as long as their family income remains at or below 138% of the FPL. And in Wisconsin, adults with children may also do so if their family income remains at or below 100% of the FPL.

Millions of people in the US, especially those with lower incomes and people of color, cannot secure the dental care they need due to a variety of factors, including cost, coverage, and provider availability. As a result, wide oral health disparities exist among racial, ethnic, and income groups. Increasing dental coverage is [one policy lever that can make a difference](#) in access to dental care.

The benefits of providing extensive dental coverage through Medicaid are far-ranging. Adults who gain dental coverage have greater access to and utilization of regular dental care than those without dental coverage. Regular dental care can prevent

dental disease and costly dental emergencies. Access to and utilization of care can [effectively reduce racial and ethnic disparities in dental care](#) visits and in the use of preventive and treatment services.

Adults with dental coverage are more likely to enter and remain in the workforce. Adults who gain dental coverage through Medicaid report improved oral health and employability. Among adults with low income in states that do not provide dental coverage to adults in their Medicaid program, 30% report that the appearance of their mouth and teeth [affects their ability to interview for a job](#).

Furthermore, providing dental coverage to adults also [increases the likelihood that their children will receive timely and appropriate care](#). Children whose parents have comprehensive Medicaid dental benefits are [more likely to have attended a dental visit in the preceding year](#) than are children whose parents have only emergency Medicaid dental benefits or none at all. Children of parents with no Medicaid adult dental coverage are [seven times more likely to have no dental utilization](#), compared with children of parents with some dental coverage.

Additionally, recent studies have found that access to dental care has many [financial and social impacts](#). As discussed previously, increased access to dental care can lead to lower medical care costs for individuals who are pregnant or who have chronic conditions such as diabetes and heart disease.

Dental coverage also significantly reduces the number of costly emergency department (ED) visits for dental conditions. Cost savings are realized by diverting care from hospital EDs to more cost-effective settings such as dental offices or community health centers. The average charge for an ED visit

**Increased access to dental care can lead to lower medical care costs for individuals who are pregnant or who have chronic conditions such as diabetes and heart disease.**

for a non-traumatic dental condition is [\\$1,638](#); a similar visit to a dental office or clinic costs [\\$90–\\$200](#). This redirection of care can also lead to better oral health outcomes because patients will get more clinically appropriate treatment for dental

conditions from dental professionals. Dental-related ED visits nationwide cost an estimated \$2.1 billion per year, but [nearly 79% of those visits could be addressed](#) in a dental office, saving up to \$1.7 billion per year.

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*[Policy changes can be made at the federal and state level](#) to improve oral health access. At the federal level, Congress should make comprehensive coverage for adults a permanent part of the Medicaid program and establish a baseline of covered services for all states. At the state level, program administrators and policymakers should continuously examine their Medicaid adult dental benefit offerings to ensure that they are covering procedures and allowing coverage frequencies that support the oral health of Medicaid beneficiaries.*

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### **#3 — All states should extend Medicaid coverage to adults with incomes at or below 138% FPL.**

**State action:** *Policymakers should utilize the SPA process under ARPA to strengthen Medicaid for all adults. Under ARPA, states receive [90% federal matching funds for the expansion population and a 5-percentage-point increase in their regular federal matching rate for the two years after expansion takes effect.](#)*

One of the best opportunities to achieve healthy pregnancies and birth outcomes is to improve the health of birthing parents before they become pregnant. Without access to affordable insurance coverage, needed care is often out of reach.

Because of increased Medicaid eligibility levels during pregnancy, most deliveries are covered. However, because eligibility levels are significantly lower for non-pregnant persons, many adults are uninsured during the critical months before pregnancy. In fact, a recent national study found that half of women who were insured by Medicaid for their delivery were [uninsured prior to pregnancy](#).

**One of the best opportunities to achieve healthy pregnancies and birth outcomes is to improve the health of birthing parents before they become pregnant.**

Numerous studies have found that Medicaid expansion has reduced the rate of adults of childbearing age who are uninsured and has improved health outcomes. For instance, a pair of recent studies found that Oregon's Medicaid expansion in 2014 has [led to increased prenatal care](#) among low-income women, as well as [improved health outcomes for newborn babies](#). In the three years after the expansion, one study found that Oregon saw an almost 2-percentage-point [increase in first-trimester prenatal care utilization](#), relative to 18% of the pre-expansion population who lacked any access to prenatal care in the earlier stages of pregnancy. In the same period, the second study found that Medicaid expansion was associated with a 29% reduction in low birth weight among babies born to women on Medicaid, as well as a 23% reduction in preterm births.

While 38 states and DC have extended Medicaid eligibility for adults, 12 states have not.

In these 12 states, adults who are not elderly or disabled and who are without children are not eligible for Medicaid, no matter how low their income. Parents are eligible in all the non-expansion states, but generally with [very low-income thresholds](#). The gap between pregnancy and parental eligibility is narrower in the states that have extended Medicaid to adults with incomes at or below 138% FPL. It should be noted, however, that [eligibility coverage gaps exist even in Medicaid expansion states](#), which can lead to disruptions in coverage.



## Medicaid Income Eligibility Thresholds by FPL for Pregnancy and Parental Status (Non-Expansion States), 2021

	Pregnancy Eligibility	Parental Eligibility
Texas	207%	17%
Alabama	146%	18%
Mississippi	199%	25%
Florida	196%	31%
Georgia	225%	35%
Kansas	171%	38%
North Carolina	201%	41%
South Dakota	138%	48%
Wyoming	159%	52%
South Carolina	199%	67%
Tennessee	255%	93%
Wisconsin	306%	100%
<b>Median in Expansion States</b>	<b>201%</b>	<b>138%</b>

[Extending Medicaid eligibility in the 12 non-expansion states](#) would reduce the number of adults of childbearing age who are uninsured before pregnancy and improve maternal and child health outcomes, including a reduction in maternal deaths and infant mortality. Additionally, when paired with an extended postpartum coverage period, Medicaid expansion reduces the likelihood that coverage will fluctuate or lapse. Lapses in coverage can cause disruptions to care and can cause existing health conditions to become more serious and more difficult and expensive to treat.

In its recent study, ASPE found that [nearly 80% of pregnant persons in Medicaid expansion states would remain eligible](#) through other eligibility pathways even if postpartum coverage was not extended. Conversely, only 52% of pregnant persons would remain eligible through other eligibility pathways in non-expansion states.

If all states were to provide 12 months of postpartum Medicaid eligibility, this would result in a 38-percentage-point increase in eligibility for birthing parents in expansion states (from 62% to 100%, or roughly 370,000 additional Medicaid-paid births) and a 65-percentage-point increase in eligibility for birthing parents in non-expansion states (from 35% to 100%, or roughly 350,000 additional Medicaid-paid births).

The largest gains in postpartum Medicaid eligibility would occur in the seven non-expansion states that have the most restrictive parental Medicaid eligibility requirements (at or below 40% FPL). In these states, just 32% of those enrolled in Medicaid during pregnancy remain eligible for Medicaid the

**Lapses in coverage can cause disruptions to care and can cause existing health conditions to become more serious and more difficult and expensive to treat.**

entire postpartum year through another Medicaid eligibility pathway. If all seven of these states adopted 12 months of postpartum eligibility, it would result in a 68-percentage-point increase in eligibility during the postpartum year for the study population in these states.

With the COVID-19 public health emergency and its continuous coverage provision coming to an end in mid-2023, there is added urgency to extend eligibility so that pregnant and postpartum persons are not disenrolled from Medicaid and CHIP coverage.

## Changes in Postpartum Medicaid Eligibility if Pregnancy-Related Eligibility Extended to 12 Months Postpartum, by State Characteristics

	Eligible for Entire Year Through Another Pathway % (number)	Eligible Part of Year Through Another Pathway % (number)	Not Eligible for Entire Year % (number)	Eligible for Entire Year Through Pregnancy-Related Eligibility % (number)	Percentage Point (PP) Increase in full-Year Eligibility % (number)
<b>ACA Medicaid Expansion Status</b>					
Expansion States	62% (600,000)	18% (174,000)	21% (203,000)	100% (968,000)	38% (370,000)
Non-Exp. States*	35% (189,000)	17% (92,000)	49% (264,000)	100% (539,000)	65% (350,000)
<b>Medicaid Parental Income Eligibility Limit</b>					
At or Below 40% FPL	32% (136,000)	17% (72,000)	51% (216,000)	100% (424,000)	68% (288,000)
40% to <138% FPL	42% (69,000)	17% (28,000)	40% (65,000)	100% (164,000)	57% (93,000)
138%	60% (455,000)	18% (137,000)	22% (167,000)	100% (759,000)	40% (304,000)
>138% FPL	67% (77,000)	15% (17,000)	18% (21,000)	100% (116,000)	33% (38,000)

Source: <https://aspe.hhs.gov/sites/default/files/documents/cf9a715be16234b80054f14e9c9c0d13/medicaid-postpartum-coverage-ib%20.pdf>.

### #4 — Adult dental benefits should be made an essential health benefit in the ACA Marketplace, and oral health services should be included in the definition of maternity care benefits.

In March 2020, as part of COVID-19 relief legislation, states began receiving [increased matching Medicaid funding to states](#) under the condition that they not force Medicaid or CHIP beneficiaries to involuntarily disenroll during the COVID-19 public health emergency. Federal regulations require that once the public health emergency ends, all beneficiaries must have their eligibility redetermined. The Biden Administration has announced that [the public health emergency declaration will end on May 11, 2023](#). It is estimated that [1.7 million](#) people enrolled in a Medicaid or CHIP pregnancy eligibility group will go through the eligibility redetermination process due to the end of this declaration. Children and adults who no longer qualify for Medicaid or CHIP coverage will be disenrolled over the 14 months following the end of the emergency declaration.

As the public health emergency, and this continuous coverage requirement, come to an end in 2023, approximately 15 million Americans are projected to lose Medicaid coverage. This includes [individuals who have reached the end of their postpartum period](#) but were continuously enrolled in Medicaid

#### **Expected coverage losses at the end of the public health emergency:**

Of the 15 million children and adults who are expected to lose Medicaid coverage, more than 8 million will do so because of a change in eligibility.

Nearly 3 million of these individuals are expected to qualify for ACA Marketplace premium tax credits. Among these individuals, more than 60% are expected to be eligible for zero-premium Marketplace plans under the provisions of the American Rescue Plan Act.

Another 5 million would be expected to obtain other coverage, primarily employer-sponsored insurance.

An estimated 383,000 individuals would fall in the “coverage gap” in the remaining 12 non-expansion states — with incomes too high for Medicaid, but too low to receive Marketplace tax credits.

during the public health emergency. As Medicaid coverage for many will end because of a change in their income or family circumstances, these children and adults will need to transition to another source of coverage.

This coverage, as well as financial assistance, may be available to some through the ACA Marketplace.

Insurance plans offered through the Marketplace must meet the requirements of qualified health plans. This designation means they will cover 10 essential health benefits (EHBs), including maternity and newborn care

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### Categories of Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental and vision care

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Dental care is an EHB for children. [Insurers must make pediatric coverage available](#) to children under the age of 18 as part of a health plan or as a separate or stand-alone dental plan.

Dental care is not, however, an EHB for adults. While adults can purchase dental coverage through the ACA Marketplace, insurers are not required to offer it.

**Because it is not a required component of coverage, millions of adults who receive their coverage through the ACA cannot access dental care — even as part of maternity coverage.**

Because it is not a required component of coverage, millions of adults who receive their coverage through the ACA cannot access dental care — even as part of maternity coverage. As detailed previously, costs can be prohibitive, and many will forego coverage and vitally needed care as a result.

[All efforts should be made within Marketplace plans](#) to reduce the barriers associated with obtaining coverage and utilizing care. To that end, the Secretary of Health and Human Services, who is required under the ACA to periodically review and update the EHBs in order to address gaps in coverage, should use his authority to add adult dental coverage to the EHB package for all Marketplace plans. Because EHBs also set the baseline for benefits offered to the Medicaid expansion population in states, this policy change would also help improve access to dental coverage in [states choosing to enhance Medicaid eligibility](#).

Furthermore, the Department of Health and Human Services has proposed a [national minimum coverage standard for maternity care that includes oral health services](#) as part of the upcoming Notice of Benefit and Payment Parameters for 2024 rule.

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## CareQuest Institute for Oral Health

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