



ORAL HEALTH CARE AND THE AFFORDABLE CARE ACT Issue Brief

Improving Oral Health Care: ACA Initiatives and IOM Recommendations

Introduction

Good oral health is essential to good overall health. The largely preventable problem of poor oral health has widespread repercussions ranging from lost time at school and work to reduced quality of life and increased incidence of non-oral health problems. It is exacerbated by lack of access to quality care and disproportionately concentrated among underserved people.

In 2000, the Surgeon General released a groundbreaking examination of the state of oral health in America. While noting that progress had been made over the previous half-century, the Surgeon General concluded that a “silent epidemic” of untreated dental and oral diseases exists throughout the country. He called for a national partnership to improve the oral health care delivery system and to address disparities in access to care.¹

In 2011, the Institute of Medicine (IOM) released two reports that examine the progress that has been made since the Surgeon General’s report.² The IOM concludes that many oral health problems stem from poor oral health care and sets forth strategies and recommendations to improve access to care, particularly among underserved and vulnerable populations. The Patient Protection and Affordable Care Act (ACA) contains a number of provisions that target poor oral health directly, as well as a large number designed to increase access to care and quality of public health and health care in general.³

This Issue Brief describes the problem of poor oral health care in America. It then discusses the solutions suggested by the 2011 IOM reports and the provisions of the ACA intended to positively impact oral health care in America.

Discussion

Nearly all adults have had cavities and most adults over age twenty-five have some form of periodontal disease.⁴ Many Americans also suffer from other oral health conditions, including oral and throat cancer, oral herpes and cleft palate.⁵ Cavities, which strike five times more five-to-seventeen year olds than asthma, are the most common chronic illness of childhood.⁶

Approximately one in five children aged two to eleven have untreated tooth decay in their primary teeth.⁷ Forty-two percent of six- to-nineteen-year-olds have had cavities in their permanent teeth, and approximately fourteen percent have untreated tooth decay.⁸ By age seventeen, over seven percent of American children have lost at least one tooth due to



decay; the average fifty-year-old has lost twelve teeth and by age sixty-five over one quarter of Americans have lost all their teeth.⁹

Poor oral health has severe negative repercussions on overall health, productivity and quality of life. Untreated oral health problems in children can result in attention deficits, trouble in school and problems sleeping and eating.¹⁰ Employed adults lose more than 164 million hours of work each year due to dental disease and dental visits, and in 2009 over 830,000 emergency room visits were the result of preventable dental conditions.¹¹ Poor oral health is also associated with a number of other diseases, including diabetes, stroke and respiratory disease.¹² In older adults, poor oral health is significantly associated with disability and reduction in mobility.¹³

Wide Disparities in Access and Outcomes

Poor and underserved Americans are both more likely to need dental services and less likely to receive them.¹⁴ According to the National Center for Health Statistics (NCHS), 4.6 million children did not obtain needed dental care in 2008 because they could not afford to see a dentist.¹⁵ People who live below the federal poverty line (FPL) are less than half as likely to have visited a dentist in the past year as those whose incomes are over 400 percent of the FPL.¹⁶ In a recent nationwide survey, forty-one percent of Americans reported that they or someone in their household has put off dental care because of cost.¹⁷

Lack of access to care translates into poor oral health. Compared to people with incomes above the poverty line, low-income adults are more likely to have missing and decayed teeth than non-low-income people.¹⁸ Severe periodontal disease is much more common among those of low socioeconomic status (SES) than those in middle or high SES groups.¹⁹ Poor children experience almost twelve times more restricted-activity days as a result of dental problems than higher-income children.²⁰

Wide disparities exist both in access to oral health care and oral health outcomes across populations.²¹ Poor Hispanic and black children have more than twice the proportion of untreated tooth decay as poor non-Hispanic whites.²² Similar racial and ethnic disparities exist among nearly all age groups and income levels.²³ People with disabilities and special health care needs tend to have poor oral health and problems accessing health care as well.²⁴ There are also marked disparities between rural and urban areas, and between states. For example, a 1999 study revealed that nearly half of all West Virginians over age sixty-five had lost all of their natural teeth, while the corresponding number for Hawaii was less than fourteen percent.²⁵ Disparities also exist between people of different education levels. Fewer than twenty-two percent of people who did not graduate high school had a dental visit in 2004, compared to over fifty-four percent of college graduates or children with a college graduate caregiver.²⁶

Poor oral health has a number of causes, including inadequate health literacy and poor oral care, lack of standardized quality measures, and poor knowledge of and attention to oral health among primary care providers.²⁷ Physicians and nurses are generally poor at recognizing and treating oral health problems, and many dentists do not have specialized training in treating older adults and other populations with special needs.²⁸ However, the proximate cause of poor oral health is often a simple lack of dental insurance coverage.²⁹ Children who lack health insurance are three times more likely to have an unmet dental need than insured children.³⁰ Since most private dental coverage is provided through the workplace and Medicare does not include dental insurance, the average person aged sixty-five or over is more than twice as likely as a person aged 45-64 not to have dental insurance.³¹ Likewise, more than forty-one percent of people living below the poverty line have no dental insurance, compared to fewer than twenty-five percent of those earning more than 400 percent of FPL.³² Fewer than half of Americans who did not graduate high school have dental insurance, compared to almost seventy-five percent of college graduates.³³

Dental insurance coverage is not always sufficient to ensure access. Over forty-seven million people live in dental Health Professional Shortage Areas, which are found throughout the United States.³⁴ Even where providers exist, they may not take insurance or may take only private insurance. Although most poor children should have access to dental care through Medicaid, in practice many dentists refuse to take Medicaid patients.³⁵ In 2004, Americans with private dental insurance were nearly twice as likely as those with public dental coverage or no dental coverage to visit a dentist.³⁶



The Affordable Care Act and Oral Health

The ACA aims to improve access to health care and outcomes through a number of mechanisms, including requiring most individuals to carry health insurance, prohibiting insurers from denying health insurance coverage based on pre-existing conditions, creating exchanges through which individuals and families not eligible for employer- or government-sponsored health insurance may purchase coverage, and expanding eligibility for the Medicaid program.³⁷ The ACA also contains a number of provisions targeted at improving oral health.³⁸

Perhaps the most important of these is a requirement that most health plans cover a set of essential health benefits (EHBs) that includes pediatric oral care.³⁹ Beginning January 1, 2014, qualified health plans sold in health insurance exchanges must cover EHBs.⁴⁰ They must also be covered by Basic Health Plans and plans offered to most people eligible under the new Medicaid expansion.⁴¹ In addition, the ACA prohibits insurers from imposing cost-sharing on some preventive oral health services, including oral health risk assessments and fluoride supplements for children whose water source does not contain fluoride.⁴²

The ACA also requires, funds and encourages a number of oral health prevention activities. First, it directs the Centers for Disease Control and Prevention (CDC) to establish a five-year national oral health education campaign.⁴³ This campaign is required to use science-based strategies and to target children, pregnant women, parents, the elderly, individuals with disabilities and ethnic and racial minority populations, including Native Americans.⁴⁴ The ACA also creates demonstration grants to study the effectiveness of research-based oral health programs, which will be used to inform the public education campaign.⁴⁵

The ACA expands an existing school-based dental sealant program to each of the fifty states and territories and to Indians, Indian tribes, tribal organizations and urban Indian organizations.⁴⁶ It directs the CDC to enter into cooperative agreements with state, territorial and Indian organizations to establish guidance, conduct data collection and implement science-based programs to improve oral health.⁴⁷ It also requires the Department of Health and Human Services (HHS) to improve the oral health measures in a number of existing federal surveillance reports.⁴⁸

The ACA authorizes HHS to make grants to, or enter into contracts with, dental schools, hospitals and nonprofits to participate in dental training programs.⁴⁹ This funding can be used to provide financial assistance to program participants, including dental and dental hygiene students as well as practicing dentists, and for loan repayment for faculty in dental programs.⁵⁰ The ACA also creates a demonstration project that will provide grants for up to fifteen demonstration programs to train or employ alternative dental health providers in underserved communities.⁵¹ In addition, it provides general funding for graduate medical education and residency programs, both of which can be used by dental students.⁵²

Finally, the ACA authorizes and requires a number of public health initiatives that should improve access to oral health care, including an \$11 billion five-year initiative that funds construction, capital improvements and service expansions at community health centers.⁵³ The ACA also establishes a National Health Care Workforce Commission to serve as a resource to evaluate education and training to determine whether demand for health care workers is being met, identify barriers to improved coordination and encourage innovations to address identified needs.⁵⁴

Key Affordable Care Act Oral Health Provisions

- Requires health plans to cover pediatric oral health services as Essential Health Benefits
- Creates 5-year national public health education campaign focused on oral health care prevention
- Provides grants for the study of evidence-based cavity prevention activities
- Expands school-based dental sealant programs
- Improves oral health measures in existing reports
- Provides grants for dental training programs
- Provides funds for demonstration programs for non-dentist health professionals
- Provides funds for community health centers
- Creates National Health Care Workforce Commission and identifies oral health care as a priority area



Institute of Medicine Reports

In 2011, the Institute of Medicine (IOM) released two reports regarding oral health in America. One addresses the overall issue, while the other focuses on improving access for vulnerable and underserved populations.⁵⁵ These reports go beyond previous efforts by not only cataloguing the scope of the problem but also putting forward specific recommendations for improvement.

Advancing Oral Health in America

In 2009, HHS asked the IOM to convene a panel to recommend actions HHS could take to improve the state of oral health in America.⁵⁶ In May 2011 the IOM produced *Advancing Oral Health Care in America*, a report that contains both an examination of the state of oral health care in the country as well as specific recommendations to improve it. The Report notes that, while access has improved somewhat since the Surgeon General's 2000 call to action, numerous problems persist. Access to oral health care and dental insurance remains poor. There are few standards, quality measures or best practices in oral health, making it difficult for clinicians to improve quality of care and for individuals to make decisions about their own care. These problems are compounded by a generally low level of oral health literacy and knowledge among both the general population and non-dental clinical providers.⁵⁷

The report notes that although HHS oversees or funds a number of initiatives aimed at improving oral health care, support and funding for these initiatives has been inconsistent, and clear leadership has been lacking.⁵⁸ The IOM finds that HHS has suffered from a lack of high-level accountability regarding oral health, and has failed to coordinate oral health initiatives among its various agencies. The Report notes that in 2010 HHS launched a cross-agency effort, termed the Oral Health Initiative, to improve oral health care nationwide, but that this effort is insufficient.⁵⁹

The IOM recommends a number of approaches for HHS to consider as part of or in addition to that effort. These approaches are referred to as the New Oral Health Initiative (NOHI). The NOHI is based on ten high-level organizing principles.⁶⁰ Seven specific recommendations are made.⁶¹ The IOM concludes that, moving forward, it will be extremely important for HHS to maintain varied stakeholder involvement and strong HHS leadership.⁶²

Organizing Principles for HHS and the New Oral Health Initiative

1. Establish high-level accountability
2. Emphasize disease prevention and oral health promotion
3. Improve oral health literacy and cultural competence
4. Reduce oral health disparities
5. Explore new models for payment and delivery of care
6. Enhance the role of non-dental health care professionals
7. Expand oral health research, and improve data collection
8. Promote collaboration among private and public stakeholders
9. Measure progress toward short-term and long-term goals and objectives
10. Advance the goals and objectives of Healthy People 2020



IOM Recommendations for the New Oral Health Initiative

1. Provide leader(s) of NOHI with authority and resources to successfully integrate oral health into the planning, programming, policies and research that occur across all HHS programs and agencies
2. All relevant HHS agencies should promote and monitor use of clinical-based preventive services in oral health and counseling across the life span
3. All relevant HHS agencies should undertake oral health literacy and education efforts aimed at individuals, communities and health care professionals
4. HHS should invest in workforce innovations to improve oral health
5. The Centers for Medicare and Medicaid Services (CMS) should explore new delivery and payment models for Medicare, Medicaid and CHIP to improve access, quality and coverage of oral health care across the lifespan
6. HHS should place a high priority on efforts to improve open, actionable and timely information to advance science and improve oral health through research
7. To evaluate the NOHI, leaders should convene an annual public meeting of the agency heads to report on NOHI progress

Improving Access to Oral Health Care for Vulnerable and Underserved Populations

In July 2011 the IOM, in conjunction with the National Research Council (NRC), released *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*.⁶³ In this report, an expert committee commissioned by the Health Resources and Services Administration (HRSA) found that vulnerable and underserved groups continue to face persistent, systemic barriers to accessing oral health care, which contribute to “profound and enduring” oral health disparities.⁶⁴

The IOM makes recommendations in six categories: integrating oral health care into overall health care, creating optimal laws and regulations, improving dental education and training, reducing financial and administrative barriers to oral health care, promoting research and expanding capacity.⁶⁵ Briefly summarized, the IOM recommends:

- **Integrating Oral Health Care into Overall Health Care:** The expert committee found that one important barrier to access is that oral health care is often viewed as a separate entity from overall health care, instead of an important component of it. With proper training, many non-dental health professionals can screen for oral health problems and deliver preventive care services. The IOM recommends that HRSA convene key stakeholders to develop a core set of competencies for non-dental health professions to be incorporated into certification, testing and accreditation requirements.⁶⁶
- **Creating Optimal Laws and Regulations:** The IOM concluded that many state-level laws and regulations—most commonly scope-of-practice regulations—act as a barrier to oral health care. The IOM recommends that state legislatures amend existing laws and regulations to permit dental health professionals to practice to the full extent of their education and training and to permit those professionals to provide care outside of the physical presence of a dentist.⁶⁷
- **Improving Dental Education and Training:** The IOM noted that many dental students do not come from or receive experience working with vulnerable and minority populations. The IOM recommends that students receive clinical experience in community-based settings and with patients with complex oral health needs. It also recommends that dental education programs increase recruitment and support for students from underrepresented populations, require student experiences in community-based rotations and recruit and retain faculty with expertise in caring for vulnerable and underserved populations.⁶⁸
- **Reducing Financial and Administrative Barriers:** As noted earlier in this issue brief, access to dental insurance is a major determinant of access to and utilization of oral health care. The committee recommended that CMS fund and evaluate state-based demonstration projects of oral health coverage for adults. The committee also recommended that states raise Medicaid and Children’s Health Insurance Program (CHIP) reimbursement rates for oral health care, streamline providers’ administrative processes and increase case management services for beneficiaries.⁶⁹
- **Promoting Research:** The committee identified deficiencies in the collection, analysis and use of data related to oral health. It recommends that Congress, federal agencies and private foundations support oral health research and evaluation of new methods and technologies for the delivery of oral health care to vulnerable and underserved populations.⁷⁰
- **Expanding Capacity:** The committee recommends that the federal government work with states to ensure that each state has the infrastructure necessary to perform core dental public health functions. The committee also recommends that HRSA help

improve the capacity of Federally Qualified Health Centers (FQHCs) by supporting the use of a variety of oral health care professionals and enhancing financial incentives for their recruitment and retention, providing guidance to FQHCs for best practices, and assisting FQHCs in the provision of oral health care outside their physical facilities.⁷¹

Conclusion

The United States can do much more to ensure that all individuals, particularly those most at risk, have access to quality oral health care. In 2000, the Surgeon General highlighted the scope of the problem and issued a call to action. There is evidence that oral health is improving, but at an unacceptably slow pace.⁷² The Institute of Medicine's recent recommendations, together with the Affordable Care Act's many dental health initiatives, can help to sustain and accelerate this positive trend—but only if they are given the attention and funding necessary to put them into action.

SUPPORTERS



Robert Wood Johnson Foundation

The Network for Public Health Law is a national initiative of the Robert Wood Johnson Foundation with direction and technical assistance by the Public Health Law Center at William Mitchell College of Law. This document was developed by Corey Davis, J.D., M.S.P.H., staff attorney, Network for Public Health Law-Southeastern Region and the National Health Law Program with assistance from Colleen Healy, 2L at Duke University School of Law. The Network for Public Health Law provides information and technical assistance on issues related to public health. The legal information and assistance provided in this document does not constitute legal advice or legal representation. For legal advice, please consult specific legal counsel.

¹ U.S. Dep't of Health & Human Servs. (HHS), Nat'l Inst. of Dental & Craniofacial Research & Nat'l Insts. of Health, *Oral Health in America: A Report of the Surgeon General* vii (2000).

² See Inst. of Med. (IOM) & Nat'l Research Council (NRC), *Improving Access to Oral Health Care for Vulnerable and Underserved Populations* (2011) [hereinafter IOM & NRC, *Improving Access*]; Inst. of Med. (IOM), *Advancing Oral Health in America* (2011) [hereinafter IOM, *Advancing Oral Health*].

³ For an overview of the ACA's public health provisions, see C. Davis et al., *Public Health Provisions of the Patient Protection and Affordable Care Act*, available at http://www.networkforphl.org/_asset/x4mc6h/ACA-chart-formatted-FINAL.pdf

⁴ HHS, *supra* note 2, at 63, 65. This Issue Brief uses the term "cavity" to refer to clinically significant erosion of the tooth caused by infection or disease.

⁵ HHS, *supra* note 2, at 67-72. Americans also suffer from oral health problems caused by trauma as well as agents such as smokeless tobacco. *Id.* See also IOM & NRC, *Improving Access*, *supra* note 3, at 43.

⁶ HHS, *supra* note 2, at 63.

⁷ Eugenio D. Beltrán-Aguilar et al., *Surveillance for Dental Caries, Dental Sealants, Tooth Retention, Edentulism, and Enamel Fluorosis—United States, 1988-1994 and 1999-2002*, 54 *Morbidity & Mortality Wkly Rep.* at 18 tbl. 3 (2005) (reporting that 21 percent of 2- to 11-year-olds have untreated tooth decay).

⁸ *Id.* at 20 tbl. 7, 21 tbl. 8.

⁹ HHS, *supra* note 2, at 66.

¹⁰ See Burton Edelstein et al., *Experience and Policy Implications of Children Presenting with Dental Emergencies to US Pediatric Dentistry Training Programs*, 28 *Pediatric Dentistry* 431, 433 (2006); Stephanie L. Jackson, et al., *Impact of Poor Oral Health on Children's School Attendance and Performance*, 101 *American Journal of Public Health* 101 1900, 1900 (2011); The Surgeon General estimates that children with oral disease miss over 51 million hours of school each year. HHS, *supra* note 2, at 2.

¹¹ HHS, *supra* note 2, at 3; Pew Center on the States, *A Costly Destination: Hospital Care Means States Pay Dearly* 1 (2012).

¹² HHS, *supra* note 2, at 109-122. See also IOM & NRC, *Improving Access*, *supra* note 3, at 19.

¹³ IOM & NRC, *Improving Access*, *supra* note 3, at 52.

¹⁴ IOM & NRC, *Improving Access*, *supra* note 3, at 51.

¹⁵ B. Bloom et al., Nat'l Ctr. For Health Stats., *Summary Health Statistics for U.S. Children: National Health Interview Survey, 2008*, at 7 (2009).

- ¹⁶ R. J. Manski & E. Brown, Agency for Healthcare Research & Quality, Dental Use, Expenses, Private Dental Coverage, and Changes, 1996 and 2004, at 7 (2007) (26.5 percent vs. 57.9 percent). In 2011, the Federal Poverty Line for a family of four is \$22,350. 76 Fed. Reg. 3637 (Jan. 20, 2011).
- ¹⁷ *New Survey: Majority of Americans Support Mid-Level Dental Provider to Expand Access to Dental Care*, W. K. Kellogg Foundation (Oct. 4, 2011), <http://www.wkcf.org/news/Articles/2011/10/New-Survey-Majority-of-Americans-Support-Mid-Level-Dental-Provider.aspx>.
- ¹⁸ Nat'l Ctr. for Health Stats., Trends in Oral Health Status: United States, 1988-1994 and 1999-2004, at 10 fig. 8 (2007). In 1996, more than forty-three percent of poor children aged five to seventeen had at least one decayed tooth. The corresponding number for children above the poverty line was just over twenty-three percent. HHS, *supra* note 2, at 63 fig. 4.2 (43.6 percent and 23.4 percent, respectively).
- ¹⁹ HHS, *supra* note 2, at 66 fig. 4.11 (reporting that the percentage of adults aged 45-54 with at least one tooth site with 6 mm or more of periodontal attachment loss was 25.8 percent for those at 185 percent of the U.S. poverty level or below, 16.8 percent for those 185.1 percent to 350 percent of the poverty level, and 8.1 percent for those at 350.1 percent of the poverty level or higher).
- ²⁰ Gov't Accountability Office, GAO/HEHS-00-72, Dental Disease Is a Chronic Problem Among Low-Income Populations 7 fig. 2 (2000). Restricted-activity days are those where children are unable to engage in normal activities, such as attending school. *Id.*
- ²¹ *See generally id.* at 7 (reporting that eighty percent of untreated cavities in permanent teeth are found in roughly 25 percent of children, mostly from low-income and vulnerable groups).
- ²² HHS, *supra* note 2, at 64 fig. 4.4.
- ²³ *Id.* at 64. These disparities are not limited to African-American and Latino Americans. For example, oral health and access to oral health services among many Native American populations are poor. *See, e.g.,* Maxine Brings Him Back-Janis, *A Dental Hygienist Who's a Lakota Sioux Calls for New Mid-Level Dental Providers*, 30 HEALTH AFFAIRS 2013, 2014, 2015 (2011).
- ²⁴ *See, e.g.,* Charlotte W. Lewis, *Dental Care and Children with Special Health Care Needs: A Population-Based Perspective*, 9 Academic Pediatrics 420, 423 tbl. 2 (2009) (reporting that 8.9 percent of children with special health care needs were unable to obtain needed dental care).
- ²⁵ Ctrs. for Disease Control & Prevention, *Total tooth loss among persons aged greater than or equal to 65 years – selected states, 1995-1997*, 48 Morbidity & Mortality Wkly. Rep. 206, 207 tbl. 1 (1999).
- ²⁶ Manski & Brown, *supra* note 16, at 8.
- ²⁷ *See generally* IOM & NRC, *Improving Access*, *supra* note 3.
- ²⁸ *Id.* at 53-54. *See also* Hugh Silk et al., *Oral Health During Pregnancy*, 77 Am. Family Physician 1139, 1139 (2008) (reporting that many prenatal health providers are unaware of the importance of oral health during pregnancy).
- ²⁹ IOM & NRC, *Improving Access*, *supra* note 3, at 49 (reporting that children without dental insurance receive fewer dental services than insured children). Dental coverage for adults is optional in Medicaid, so states can exclude dental care from their state plans. *See* 42 U.S.C. § 1396d(a)(1); 42 C.F.R. § 440.100. According to the Department of Health and Human Services (HHS), almost 35 percent of Americans had no dental insurance in 2004, the latest available data. Manski & Brown, *supra* note 16, at 10.
- ³⁰ Paul W. Newacheck et al., *The Unmet Health Needs of America's Children*, 105 Pediatrics 989, 993 tbl.2 (2000).
- ³¹ Manski, *supra* note 16, at 11.
- ³² Manski, *supra* note 16, at 11.
- ³³ Manski, *supra* note 16, at 12.
- ³⁴ *Designated Health Professional Shortage Areas (HPSA) statistics*, Health Res. & Servs. Admin. tbl. 1 (Feb. 24, 2012), http://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=HTML3.2. *See generally* 42 U.S.C. § 254e (defining Health Professional Shortage Area).
- ³⁵ Gov't Accountability Office, GAO-11-96, *Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns* 12 (2010) (reporting that in twenty-five of thirty-nine states assessed, more than half of all dentists in the state did not treat a single Medicaid patient in 2008); Pew Center on the States, *A Costly Dental Destination*, *supra* note 11, at 2 (reporting that more than 16 million Medicaid-enrolled children – 56 percent – received no dental care in 2009).
- ³⁶ Manski, *supra* note 16, at 13 (reporting that fifty-seven percent of the population with private dental coverage had a dental visit, thirty-two percent of the population with public dental coverage had a dental visit, and twenty seven percent of the population without any dental coverage had a dental visit).
- ³⁷ *See* Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).
- ³⁸ *See generally* Children's Dental Health Project, *Summary of Oral Health Provisions in Health Care Reform (2010)*, available at <http://www.cdhp.org/system/files/Summary%20of%20Provisions-1.pdf>.
- ³⁹ ACA § 1302(b)(1)(J) (codified at 42 U.S.C. § 18022).
- ⁴⁰ ACA § 1301 (codified at 42 U.S.C. § 18021).

⁴¹ ACA § 1331(a)(1), (e) (codified at 42 U.S.C. § 18051) (requiring states to offer Basic Health Plans that include the essential health benefits); ACA § 2001(c) (amending 42 U.S.C. § 1396u-7(b)(5)) (requiring state Medicaid programs to provide essential health benefits).

⁴² ACA § 1001 (codified at 42 U.S.C. § 300gg-13). See *U.S.P.S.T.F. A and B Recommendations*, U.S. Preventive Services Task Force (August 2010), <http://www.uspreventiveservicestaskforce.org/uspstf/uspstabrecs.htm>; Health Res. & Servs. Admin. Bright Futures Project & Am. Acad. of Pediatrics, *Recommendations for Preventive Pediatric Health Care* (2008), available at <http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>.

⁴³ ACA § 4102(a) (codified at 42 U.S.C. § 280k). The ACA authorizes, but does not appropriate, funds for this initiative.

⁴⁴ *Id.*

⁴⁵ *Id.* (codified at 42 U.S.C. § 280k-1).

⁴⁶ *Id.* (codified at 42 U.S.C. § 280k-2).

⁴⁷ *Id.*

⁴⁸ *Id.* (codified at 42 U.S.C. § 280k-3).

⁴⁹ ACA § 5303 (codified at 42 U.S.C. § 293k-2) (authorizing HHS to make grants to, or enter into contracts with, a school of dentistry, hospital, or nonprofit entity to plan, develop, operate or participate in “an approved professional training program ... that emphasizes training for general, pediatric, or public health dentistry.”).

⁵⁰ *Id.*

⁵¹ ACA § 5304 (codified at 42 U.S.C. § 256g-1). Approved providers include community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and “any other health professional that the Secretary determines appropriate.” *Id.*

⁵² ACA § 5508 (codified at 42 U.S.C. § 239I-1).

⁵³ See ACA § 10503 (codified at 42 U.S.C. § 254b-2). \$9.5 billion of this funding will allow health centers to expand their operational capacity, and \$1.5 billion is dedicated to capital projects. *Id.*

⁵⁴ ACA § 5101 (codified at 42 U.S.C. § 294q). “Oral health care workforce capacity at all levels” is specifically identified as a “high priority area” for the Commission. *Id.*

⁵⁵ See IOM & NRC, *Improving Access*, *supra* note 3; IOM, *Advancing Oral Health*, *supra* note 3.

⁵⁶ IOM, *Advancing Oral Health*, *supra* note 3, at xi.

⁵⁷ *Id.* at 123-24. According to the report, “Many health professionals know little to nothing about oral health.” *Id.* at xi.

⁵⁸ *Id.* at 3-4. HHS administers or provides financial support to a number of programs including the Indian Health Service and Federally Qualified Health Centers, as well as the Medicaid and Children’s Health Insurance Program. *Id.*

⁵⁹ *Id.* at 2.

⁶⁰ *Id.* at 209.

⁶¹ *Id.* at 210-21.

⁶² *Id.* at 221-24.

⁶³ IOM & NRC, *Improving Access*, *supra* note 3.

⁶⁴ *Id.* at 1.

⁶⁵ *Id.* at 231-49.

⁶⁶ *Id.* at 231-33.

⁶⁷ *Id.* at 233-36.

⁶⁸ *Id.* at 236-40.

⁶⁹ *Id.* at 240-44.

⁷⁰ *Id.* at 244-46.

⁷¹ *Id.* at 246-49.

⁷² From the period 1971-74 through 1988-94, the average number of cavities decreased among all age groups except the elderly. HHS, *supra* note 2, at 64. See also Beltrán-Aguilar et al., *supra* note 7, at 7-8 (reporting reductions in dental caries, increased tooth retention and reduced levels of complete tooth loss among most populations in the United States).