

Policy Brief

What California Should Know About Other States' and Federal Efforts to Fund Children's Oral Health

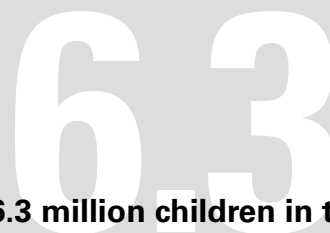
Good oral health is essential to the overall health and well-being of California's children. Unfortunately, the state's current system of delivering oral health care to the children who need it most is vastly under-resourced, resulting in a large and growing number of children who suffer from preventable oral health diseases. In order to effectively combat this critical problem, additional investment in California's oral health care system is required.

Many other states, as well as the federal government, have already investigated ways to generate new revenue to improve children's oral health care. For the well-being of its children and its future prosperity, California should do the same.

California Has Not Made Sufficient Investments in Children's Oral Health

Historically, the significance of oral health in the lives of California's children has been underrepresented in public health policy. As a result, approximately two-thirds of children in the state—or 6.3 million—suffer needlessly from poor oral health by the time they reach the third grade.¹ Untreated oral health problems impact a child's ability to thrive in school and unnecessarily increase dental and medical costs for everyone.

In 2000, the *Surgeon General's Report on Oral Health* cited tooth decay as the most common chronic childhood disease in the nation. It reported that over 51 million school hours are lost each year across the country due to dental-related illness.² Those missed school days translate into lost educational opportunities for children. In addition, untreated dental disease in children leads to substantial costs to the state; such costs are avoidable as they are associated with preventable complications.



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California ranks at the bottom nationally on children’s oral health status. In the most recent *National Survey of Children’s Health*, California children’s oral health ranked

worst among all the states: only 59% of parents rate their children’s teeth in “excellent” or “very good” condition, compared to 69% for the nation as a whole.³ The state’s failure to invest in oral health impacts children’s lives significantly, and over time this leads to substantial costs associated with major dental work and medical problems, such as cardiovascular disease.⁴

Real Story #1:

Poor Oral Health Undermines a Student’s Efforts

Elli is a science teacher at a small public school in Oakland, California. One of her students, Mariah, an eighth-grader whose favorite subjects are math and science, had a broken front tooth and a history of root canals. Elli was worried, and she reported that those oral health problems kept Mariah out of school for many days and distracted her in class. Mariah became self-conscious because other students constantly asked her what happened to her teeth, and, as a result, she stopped talking in class. “Saddest of all,” Elli said, “Mariah smiled less.”

The broken tooth hurt, but Mariah wasn’t able to get a dental appointment for over a month and a half. When Mariah did see a dentist, she was forced to miss two of the six days of standardized tests at her school; she needed another root canal to fix her broken front tooth, and had fifteen cavities filled.



Elli outside her school

Children in Pain Can’t Succeed in School

In California alone, over 551,000 children missed one or more school days as a result of oral health problems.⁵ Children simply cannot pay attention or learn if they are in pain. Oral pain impacts their ability to get a good night’s rest and poses a challenge for them to eat healthy and nutritious meals.

More than two-thirds of California’s third-graders have active tooth decay or filled cavities, and nearly one-third go to school with untreated tooth decay. When separated by ethnicity/race, Latino children fare even worse.⁶ Nationally, 56% of first-graders have evidence of cavities, while 85% of 12th-graders have decayed or restored teeth.⁷ Such findings make clear that the problem persists throughout the formative school years. As a result, children’s academic opportunities are undermined by the absences and distractions caused by oral health problems. Furthermore, school districts lose at least \$35 in state funding each day a child is absent due to poor oral health.⁸

Limited Access to Providers

Poor oral health disproportionately affects low-income children, especially children of color. Many of those children are uninsured or participate in public health programs, such as Denti-Cal (the dental coverage portion of Medi-Cal, California’s Medicaid program) or Healthy Families (California’s State Children’s Health Insurance Program, low-cost coverage for slightly higher-income children).

Tragically, low-income children, who are most at risk for oral health disease, are also least likely to access the care they need. Only half of 0- to 11-year-olds covered by Denti-Cal recently visited a dentist, and 27% have never visited a dentist. Children enrolled in Healthy Families fare somewhat better: 54% recently visited a dentist, and 16% have never visited a dentist.⁹

Numerous barriers hinder a child's ability to access dental care in California. One principal obstacle is that few dental providers accept Denti-Cal patients. Only 40% of California's dentists accept publicly-insured patients, and less than half of pediatric dentists in the state participate in Denti-Cal. Among dentists who do accept Denti-Cal reimbursement, two-thirds place restrictions on their participation, such as limiting the number of publicly-insured patients they see each year.¹⁰

Provider reluctance to accept Denti-Cal is driven by low reimbursement rates. Current rates are one-third to one-half of dentists' usual fees and often do not even cover the cost of providing the service. Recent studies confirm that Denti-Cal reimbursement rate increases are a necessary component of improving low-income children's access to oral health care, but other changes are also needed.¹¹ Additionally, California dentists report that Denti-Cal's administrative processes—lengthy paperwork and required pre-authorization for certain routine services—are obstacles to their participation in the program.

Many providers do what they can to serve this vulnerable population of children—in some cases, even providing dental care for free. One such provider is Dientes Dental Clinic in Santa Cruz, which serves approximately 400 children per month and over 4,000 children annually.¹²

**Real Story #2:
A Successful Program Relies on
Supplemental Funding**

Zenaida, a mother in Santa Cruz, California, knew that something had to be done for her 2-year-old, Ricardo. Ricardo kept crying at night because his teeth hurt. Ricardo was finally referred to Dientes Dental Clinic. Under anesthesia for about two hours, Ricardo received four extractions, seven crowns, three fillings and seven root canals. After an hour of feeling groggy, Ricardo was on the road back to normalcy and a pain-free life.

Dientes is now the family's regular source for dental care, and Zenaida plans to make sure her children have routine check-ups. Dientes, however, could not have afforded to provide Ricardo's care without donations from individuals and businesses within the community and other sources of funding. Denti-Cal and Healthy Families reimbursements simply don't cover the full cost of services and overhead. The clinic also has a waiting list to accept new patients because the need for their services is so great.



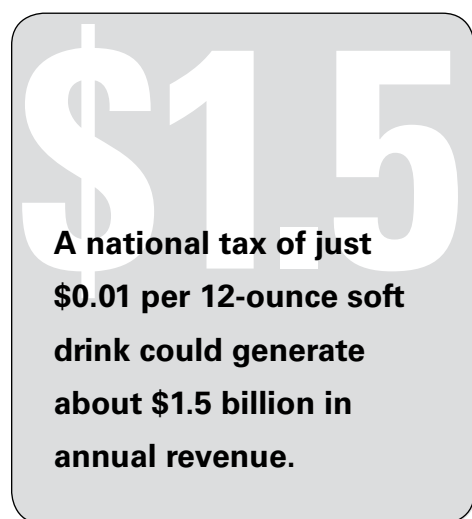
Dientes Dental Clinic

Investing in Children’s Oral Health: What Other States Are Doing

California is not the only state facing a children’s oral health crisis. The problem is nationwide, especially among children receiving dental coverage through the Medicaid program. Using state general funds to improve children’s oral health and access to care makes good sense: the return on investment is substantial.¹³ Some states, however, are also investigating ways to raise additional revenue outside the state general fund to address the issue, such as levying taxes on soda sales and fees on specialty (“vanity”) license plates. In order to sufficiently invest in children’s oral health, a combination of tactics will likely be necessary.

Soda Taxes

Soda taxes are not a new idea. Since 1933, California has imposed a sales tax on soda (most other beverages are exempt from sales tax). Throughout the past century, over two-thirds of states have considered or passed a soda tax, usually during economic downturns and most often directing revenue to the state general fund. It is estimated that a national tax of just \$0.01 per 12-ounce soft drink could generate about \$1.5 billion in annual revenue.¹⁴



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Over the past decade, many states’ efforts to pass soda taxes have been linked to messages about obesity prevention, since childhood obesity has been shown to be connected with soft drink intake. A strong link also exists between soda consumption and dental caries in children, due to the high concentration of sugar in regular soda and acid in diet soda.¹⁵

Since 1992, Arkansas has taxed soda syrup at \$2.00 per gallon, which translates to a \$0.02 tax per 12-ounce soft drink. The tax produces about \$40 million annually, which provides 14% of the total budget for the state’s Medicaid program.¹⁶ It was implemented during a state budget crisis that threatened to cut services from Medicaid and close rural hospitals. Lobbyists for the soft drink industry have been unsuccessful in repealing the tax, partly because the Medicaid program relies so heavily on proceeds from the tax.

Most recently, Maine enacted a \$4.00 per gallon tax on soda producers that will go into effect July 2008. Bottled sodas will carry a new tax of approximately \$0.05 per 16-ounce bottle. Other beverages, such as beer and wine, will also be taxed.¹⁷ The soda tax is estimated to raise \$11.6 million annually.¹⁸ The total new revenue of approximately \$58 million a year will help fund Maine’s Dirigo Health program, which provides affordable health insurance to many of the state’s residents.

Other states, such as Wisconsin, are attempting to pass a soda tax for the sole purpose of funding increased reimbursement rates for dentists who treat patients covered

by Medicaid.¹⁹ The recommendation for this tax was included in the Wisconsin Governor’s Task Force to Improve Access to Oral Health in 2005. In 2007, a bipartisan group of legislators introduced Senate Bill 117, called “Two Cents for Tooth Sense,” which proposed to tax wholesalers the equivalent of \$0.02 per 12-ounce soda.²⁰ Due to fierce opposition from the soft drink industry, the legislation failed. Currently, however, efforts to pass similar proposals are taking hold in many other states across the nation.

In states such as California, New York and North Dakota, revenue generated by a soda tax is deposited directly into the state general fund.²¹ California’s soda sales tax, for example, generates approximately \$218 million per year. While the tax boosts the state’s bottom line and may slightly decrease soda consumption over time, it does nothing to improve the state’s investment in children’s oral health or to decrease costly and preventable dental problems.

Specialty License Plates

Several states, including Missouri, Oregon and Florida, currently charge a fee for specialty license plates, which are included in motorists’ annual vehicle fees. This fee is earmarked for specified purposes.

In Florida, nonprofit organizations can propose legislation to establish a new specialty license plate in support of a specific cause.²² If the legislation passes, funds generated by the fee are distributed to the designated organization. Specialty license plate fees range between \$15 and \$25 per year. The organization receiving the funds is required to commission an independent survey of Florida motor vehicle owners to gauge interest in the plate, submit an application fee of \$60,000 and develop marketing plans for the license plate.



Florida specialty license plate

In 2004, The Dream Foundation, Inc., an organization seeking to improve access for the underprivileged to affordable medical and dental treatment, received approval to create its own specialized license plate. In 2007, its “Live the Dream” license plate raised \$143,200. Another organization’s “Invest in Children” license plate raised \$430,760 for juvenile crime prevention and early intervention. Together, Florida’s 107 specialty plates raised \$33.5 million that year.²³

Candy Taxes

Candy taxes are similar to soda taxes in purpose and theory: they impose a small tax to help pay for damage to children’s teeth caused by such products. Since 1992, Minnesota has levied a sales tax on candy, chewing gum and single-serve ice cream, depositing approximately \$45 million annually into its general fund.²⁴

The candy tax is somewhat more complicated to administer because the category of “candy” is difficult to define. For example, while most would agree that chocolate bars are a form of candy, fruit rolls are more difficult to classify. Soda comes in many varieties, but it’s easier to categorize according to sugar content and percentage of natural fruit juice. A carefully designed candy tax—one that includes all items not considered “food” by the Federal Food Stamp Program—could be more straightforward to administer.

Private Investment—Adopt-a-School

California schools and school districts frequently enter partnerships with local businesses for career mentoring, donation of classroom supplies and equipment, often with successful and meaningful outcomes. Businesses may find that they can get an even greater return on investment if they support children’s oral health through school services, especially in low-income districts. Many dentists across California and in other states currently adopt local schools and provide free routine or yearly screenings and treatments to students. For example, Direct Relief International partnered with Oral Health America to launch an Adopt-a-School program to match dentists with elementary schools in Santa Barbara and Ventura counties in California.²⁵

Unfortunately, those efforts are not centrally coordinated and are supported only through the generosity of individual dental providers. A more robust system could be created if business leaders were educated about the great need for children’s oral health services in their communities and solicited to donate funds for the creation of ongoing oral health services at schools.

Federal Action Can Support State Funding for Children’s Oral Health

Movement at the federal level may also help to boost funding specifically targeted for state investment in children’s oral health.

In 2007, a 12-year-old Maryland boy’s death from an untreated tooth abscess elevated children’s oral health as a national issue. The cost of his emergency care was over \$250,000; an \$80 tooth extraction might have saved his life.²⁶ In response, Representative Elijah Cummings (D-MD) introduced H.R. 2371, a bill aimed at improving access to pediatric dental services for medically underserved populations.²⁷ If it passes, the bill will create two five-year, \$5 million pilot programs, one to provide funds for dentists and equipment at community health centers and another to address dentist shortages by enhancing training and recruitment programs for pediatric dentistry. Although the bill has yet to be enacted, it has focused attention on the need for more federal investment in children’s oral health.

The House Oversight and Government Reform Subcommittee on Domestic Policy also launched a formal investigation into the Maryland boy's death and the more systemic inadequacy of access to dental care under Medicaid, especially for children's services. The subcommittee's next hearing is scheduled for late May 2008. The subcommittee hopes to encourage federal Medicaid administrators to make dental access an enforcement priority in their review of state programs in order to increase children's utilization rates nationally. Such enforcement could include recommendations to raise reimbursement rates for children's services.

Throughout much of 2007, Congress debated the reauthorization of the State Children's Health Insurance Program (SCHIP). Proposed reauthorization would have required that all state SCHIP programs include guaranteed dental benefits.²⁸ A decision is now on hold until early 2009. California's Healthy Families Program already covers preventive oral health services and treatment. A robust SCHIP reauthorization package could include additional funding that would increase state investment in oral health.

Recommendations for California

Greater financial investment in California's drastically underfunded oral health system is needed, especially for low-income children. In order to begin moving California's children's oral health in the right direction, significant resources—in the hundreds of millions of dollars, if not more—will be required.

Over time, increased general fund investment in this area will be required, which befits oral health's critical role in the overall health and educational success of the state's children. There are also several other options to boost state funding for children's oral health in the short term.

1. Create a sustainable revenue stream to support children's oral health.

California should consider a small soda tax directed to children's oral health

In 2002, Senator Deborah Ortiz introduced a bill (SB 1520) aimed at creating a tax on soft drinks to fund childhood obesity prevention. As originally proposed, 15% of the funds would have supported state and local public health programs that promote oral health. The bill would have levied a tax of roughly \$0.02 per 12-ounce soda.²⁹ The soda tax would have raised an estimated \$342 million a year, according to an analysis by the State Board of Equalization.³⁰ The bill faced stiff opposition from the soft drink industry. Ultimately, SB 1520 was amended and the tax was removed; instead it focused on removing soft drinks from California schools. In 2003, the amended bill was signed into law.

40%
Only 40% of California's dentists accept publicly-insured patients, and less than half of pediatric dentists in the state participate in Denti-Cal.

Although SB 1520 was unsuccessful in its attempt to enact soda tax legislation in 2002, given the right combination of political and public factors, a soda tax could be a viable option to fund oral health care for California’s children. A survey in 2004 indicated that over 60% of Californians support a tax on soda; this public support could be harnessed for a soda tax to fund children’s oral health.³¹

If a soda tax bill were passed in 2008 with similar taxation stipulations as in the 2002 Ortiz legislation, California could raise over \$500 million in new revenue each fiscal year to help address the growing number of California children suffering from preventable oral health problems. A revenue stream of this size would have a significant impact on addressing the oral health needs of California’s children.

California should establish a children’s oral health specialty license plate

The California Department of Motor Vehicles already offers eleven “special interest license plates,” with a “Kids” plate selling for \$20 with a \$15 annual renewal fee.³² In 1992, the California Legislature passed the bill that allowed the sale of “Kids’ Plates” and created the Child Health and Safety Fund. Revenue supports three causes: unintentional childhood injury prevention, prevention of child abuse, and child care licensing and inspection. Expenditures are expected to be about \$1.4 million in fiscal year 2008-09.³³

California could add a children’s oral health license plate to its offerings. With the state’s population approaching 38 million, if just 0.05% of citizens bought a \$25 plate, nearly \$5 million in new revenue would be raised for children’s oral health. Although this amount would not be enough to solve the children’s oral health crisis completely, it could be put to good use funding additional prevention programs.

California should enlist private companies to support children’s oral health

California should leverage the strength of its vibrant business community to partner with schools and districts to address children’s oral health needs. Central coordination of an Adopt-a-School effort would facilitate the program’s efficiency and growth. Though this effort would not suffice as the sole component of a revenue-generating strategy, it could raise awareness about the epidemic and bring additional prevention and treatment resources to school premises.

California should reform the budget so the state can invest adequate general fund dollars in children’s oral health

A longer-term solution for California children’s oral health includes budget reform to properly match revenues and expenditures. This would enable the state to direct appropriate resources toward the oral health crisis.

The American Academy of Pediatrics recommends that 20% of health care funds for children should be spent on improving and maintaining oral health.³⁴ Currently,

just 2% of the total Medi-Cal budget is being spent to provide oral health care.³⁵ Investment in medical care for children certainly has no fat to cut; Medi-Cal reimbursement rates are among the lowest in the nation. New money must be added to increase California's funding for children's oral health.

2. Prioritize uses for new revenue.

California should focus on increasing Denti-Cal reimbursement rates for children's services, investing in school-centered oral health services for children, and expanding prevention, education and outreach programs for at-risk young children and their families.

California should increase Denti-Cal reimbursement rates for children's services

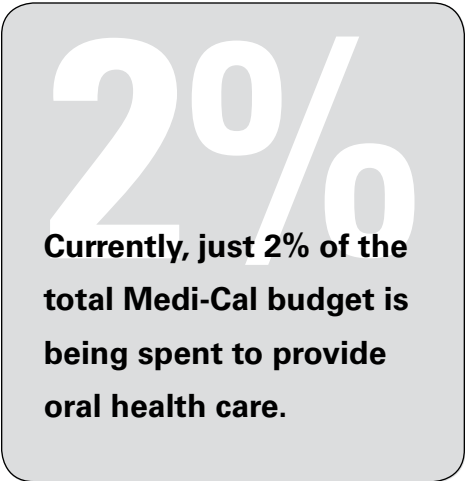
Increased reimbursement rates for common children's dental services would provide much-needed additional incentive for dentists to participate in the Denti-Cal program. In six other states where reimbursement rates were increased, provider participation rates also increased and sometimes doubled following the increase.³⁶ An increase in participating dentists also results in better access for low-income children to the care they need. As children's access to critical services increases, related health and educational outcomes should begin to improve as well.

Most importantly, new revenue should be directed toward stabilizing the Denti-Cal program so dentists and others know it will not be drastically cut during the next state budget crisis. If a program is here today, gone tomorrow, most dentists would find little reason to invest the time and energy to fill out the paperwork and participate.

California should invest in school-centered oral health services

Dental screenings should be provided at every California school, beginning with schools that have a higher percentage of disadvantaged students. Schools are particularly well-positioned to provide oral health screening and preventive services to children because that's where children spend a large part of their day. School services also provide student access to care in a convenient, friendly, and timely manner.

Dental hygienists can also help extend the reach of dentists into schools by providing cleanings and screening for problems that must be addressed by a dentist. Since pediatric dentists are scarce in many areas across the state, adding hygienists and other dental professionals to the pool of available providers is critical.



20%
Currently, just 2% of the total Medi-Cal budget is being spent to provide oral health care.

California should expand oral health disease prevention and outreach programs that target young children and their families

**Real Story #3:
Children With Coverage Struggle to
Access Care**

Melanie, a mother in Davis, California, was glad to have Healthy Families coverage for her daughters, Danielle and Linda. Melanie was very satisfied with the medical coverage offered through Healthy Families, largely because she had a wide variety of doctors to choose from.

The dental coverage was a different story. Melanie made an appointment for one dentist on the Healthy Families list, only to arrive at the office and find that the dentist no longer accepted Healthy Families coverage. The dentist explained that she couldn't meet her overhead costs, since Healthy Families reimbursement rates were so low. Melanie ultimately found the one dentist in her area that still accepted Healthy Families and was able to get oral health care for her kids. She knows, however, that other parents may have a difficult time finding any dentist that will accept public insurance.



Melanie and her family

Many parents do not realize that even very young children need dental screenings and preventive care. Preschool and Head Start programs provide good opportunities for young children to access preventive oral health care on site, as many of those children are at elevated risk for oral health problems.³⁷

Innovative pilot programs that target young children should be identified, tested and expanded across the state. For example, the Dental Health Foundation is partnering with California WIC (Women, Infants & Children) on a demonstration project that uses WIC sites as the entry point for early preventive services and dental care for at-risk one-year-olds.³⁸ Also, the American Academy of Pediatric Dentistry and the Office of Head Start recently launched a partnership to help ensure that all Head Start children regularly access dental care.³⁹

Such programs have the potential to help foster lifelong dental health and reduce the risk of costly future problems caused by untreated tooth decay. Recent evidence shows that children who had early dental visits were more likely to use subsequent preventive services and had less dental-related costs later in life.⁴⁰

California children's poor oral health is an unrecognized crisis. Every day, too many children in the state suffer needlessly from preventable dental diseases due to an inadequately funded system for delivering care to those who need it most. California can and must follow the lead of other states in pursuing significant new revenue to invest in children's oral health.

Endnotes

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Children Now is a nonpartisan, nonprofit organization dedicated to giving all children the opportunity to reach their full potential. Children Now is pleased to be a part of the Oral Health Access Council, a multilateral, nonpartisan effort directed toward improving the oral health status of the state’s traditionally underserved and vulnerable populations. This policy brief was supported by a grant from The California Endowment, in collaboration with the Dental Health Foundation.