Policy Achievements and Challenges

Putting Teeth in CHIP: 1997–2009 Retrospective of Congressional Action on Children's Oral Health

Burton L. Edelstein, DDS, MPH

When Congress reenacted the Child Health Insurance Program (CHIP) in 2009, it incorporated a range of dental provisions that had not been considered when the program was initiated in 1997. This paper posits that this change evidences the establishment of pediatric oral health as a distinct policy issue within Congressional deliberations.

During this period, the US Congress received impetus for action on behalf of children's oral health from multiple streams of activity: the Surgeon General's Report, *Oral Health in America,* policies enacted by states, advocacy by the professions, promotion by policy groups, attention by the press, and actions of federal agencies. The death of 12-year-old Deamonte Driver appears to have created a tipping point for action that dovetailed with Congressional need to reauthorize CHIP. Federal legislative policymaking is a complex process that frequently builds on an issue that has emerged as timely and relevant. Although much remains to be done, children's oral health, cast as a public policy issue of import, is one such idea that appears to have gained traction among members of Congress.

KEY WORDS: public policy; oral health; dental care; health policy; children

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Twelve years after the US Congress enacted the State Child Health Insurance Program (SCHIP)[1] in 1997 to provide health insurance to children of "working poor" families, President Obama signed into law the program's continuation as the Child Health Insurance Program (CHIP)[2]. Much was accomplished on behalf of children's oral health between SCHIP in 1997 and CHIP in 2009. SCHIP provided states only the "option" of covering dental services, whereas CHIP contains 6 explicit oral health provisions (Table 1).

Focus, energy, and action to promote children's oral health—generated in part by the *Oral Health in America: A Report of the Surgeon General*[3] (SGROH)—explains this dramatic change. This paper describes congressional attention on children's oral health between SCHIP and CHIP enactments and explores many of the factors that drove that change. These factors typify the policy drivers common to legislative successes: the important roles played by champions, advocates, and experts; the impact of media coverage, particularly following a dramatic event; the availability and use of evidence and data; and the development of policy solutions by states and health policy groups. During the period between SCHIP and CHIP, pediatric oral health seemingly emerged as a recognizable policy subdiscipline of pediatric health. Its practitioners engaged each of these policy drivers to effectively bring children's dental concerns to the attention of the highest levels of US government.

This contribution is neither a scientific analysis of oral health policy's political evolution nor an exhaustive review of factors contributing to that evolution. Rather, it seeks to describe exemplars of actions, publications, and events that contributed to congressional recognition of pediatric oral health as a bona fide policy concern at the federal level. Considered are the impacts of state level precedents, dental professional actions, policy group attention, press engagement, federal program development, and the SGROH itself on congressional action on behalf of children's oral health. The experience of improving and expanding oral health provisions in CHIP may serve as an example of how other pediatric and general health policy issues can be made to "move" through the federal legislative process.

CONGRESSIONAL ACTION ON CHILDREN'S ORAL HEALTH IN CONTEXT

SCHIP was the first new federal health insurance program for children since the Early and Periodic Screening Diagnostic and Treatment Program (EPSDT) defined pediatric Medicaid coverage 30 years earlier and the Department of Defense's TRICARE health insurance was extended to military dependents through privatization in the late 1980s. The enactment of SCHIP renewed a long-standing philosophical debate in Congress over whether government-sponsored health insurance should be modeled on commercial health benefits (in which dental benefits are typically add-on or optional coverage) or whether government-sponsored insurance should be more comprehensive than commercial plans in its coverage, and therefore include dental benefits. Since the 1960s,

From the Section of Social and Behavioral Sciences, Columbia University College of Dental Medicine, New York, NY.

Address correspondence to Burton L. Edelstein, DDS, MPH, Section of Social and Behavioral Sciences, Columbia University College of Dental Medicine, 601 West 168th St, Suite 32, New York, New York 10032 (e-mail: ble22@columbia.edu).

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Table 1. Comparison of SCHIP 1997 and CHIP 2009 Legislative Dental Provisions*

Legislation	Dental Provisions
SCHIP 1997	Allowed states to elect dental coverage for income-eligible children who had no medical or dental insurance
CHIP 2009	Requirements 1. "Basic dental coverage" that meets a specific legal definition of dental care 2. Parental education on caries prevention at the time of birth 3. Inclusion of oral health quality measures in program oversight 4. Reporting requirements on dental utilization and sealant placements to track program performance 5. Enhanced information to families on dentist participation in Medicaid and CHIP 6. A Government Accountability Office study of dentists' willingness to care for low-income children and new workforce models that hold promise to improve access

*SCHIP = State Child Health Insurance Program; CHIP = 2009 continuation of State Child Health Insurance Program.

Congress has resolved this debate differently for children than for adults. For children, it has typically assumed the comprehensive approach (eg, by mandating pediatric dental benefits in EPSDT and including dental coverage in TRICARE). For adults, it has instead mimicked commercial coverage, making dental benefits optional (eg, adult Medicaid) or unavailable (eg, Medicare). In this context, SCHIP represented a major setback in federal policy on children's oral health coverage because it pulled primary dental care out of primary pediatric care and designated it as "optional," like prior adult programs. CHIP, however, renewed Congress' prior commitment to children by assuring that dental coverage is reintegrated as an integral component of health insurance coverage.

In 1997, Congress had focused on the health coverage needs of 10 million "working poor" children whose parents' employers did not offer them medical coverage, but not the estimated 26 million whose parents' employers did not offer them dental coverage. Missing from the debate at that time—3 years prior to the SGROH—was significant attention to children's oral health. The field of oral health policy before SCHIP enactment was not sufficiently developed to provide substantive advocacy support for a dental benefit. A smattering of federal reports,[3,4] analyses of federal data,[5–7] and Medicaid lawsuits on children's oral health[8] had earlier suggested that minority, low-income, and Medicaid-enrolled children did not have access to comprehensive dental care. But detailed analyses of caries experience[9] and dental utilization[10] by income were not yet available. Key members of Congress and their staff were unaware that dental caries is the single most prevalent chronic disease of children, or that common dental problems in children are consequential. In 1997, there were no advocacy or professional groups actively advocating for mandatory dental coverage in SCHIP, no widely disseminated press coverage of children's deaths from sequelae of dental infections, few state-level oral health coalitions, little activity by federal agencies or state conversion foundations beyond Medicaid, and lesser involvement by national organizations of state policymaker groups.

Ideologically, many members of Congress in 1997 were anxious to create a new health insurance program that paralleled employer coverage, including its historical distinction between medical and dental coverage. Such members opposed expanding Medicaid EPSDT with its far-reaching guarantees that they viewed as too taxing on states. Other members championed EPSDT specifically because of those extensive guarantees, believing that states should provide comprehensive coverage for all eligible children. Ultimately the decision was delegated to the states as Congress offered states the alternatives of developing novel child health insurance plans based on commercially available insurance "benchmarks" or expanding Medicaid. States that expanded Medicaid were required to include dental coverage as mandated by EPSDT, whereas states that developed commercial-style plans were not. Enactment of SCHIP in 1997 featured this state prerogative and reflected the "federalist" concept of US government—in which governmental power is divided between central authority in DC and states—by prefacing Child Health Insurance Program with the word *State*. Enactment of CHIP in 2009 explicitly removed the word *State* from the program's name to emphasize a "nationalist" concept of US government (in which governmental power is more centralized to create greater uniformity of federal programs across states). This shift from SCHIP to CHIP also reflects the role of political parties, as the federalist-leaning Republican party had control of Congress in 1997, whereas the nationalist-leaning Democratic party controlled Congress in 2009.

IMPACT OF STATES' ACTIONS ON CONGRESSIONAL ACTION

As state policymakers enacted commercial-style SCHIP plans in 30 states, they were universally attentive to children's oral health. All elected to include dental coverage,[11,12] thereby establishing precedent for inclusion of a dental mandate in CHIP. In the years following SCHIP enactment, national associations of state policymakers contributed significantly to the knowledge base and awareness required for both federal and state action.

Examples are manifold: the National Governors Association convened Policy Academies[13] through which 21 states developed action plans and effective coalitions that resulted in significant dental Medicaid improvements in 6 states (Delaware, Massachusetts, South Carolina, Tennessee, Virginia, and Utah). The National Conference of State

Legislatures provided information to its nearly 7400 state legislator members[14] through policy briefs on dental disparities,[15] access,[16] Medicaid,[17] and workforce.[18] The National Academy for State Health Policy engaged the issue[19] with a focus on state health care reform.[20] The National Association of State Medicaid Directors detailed access barriers and explored options for program reform.[21] Additional groups representing state and local health officials (Association of State and Territorial Health Officials and the National Association of County and City Health Officials), state dental public health officials (Association of State and Territorial Dental Directors), state and local maternal and child health officials (Association of Maternal and Child Programs, CityMCH) and rural health (National Rural Health Association) all engaged in this issue. Building on these activities, state Medicaid and SCHIP officials responsible for dental programs founded their own national organization in 2004, the Medicaid SCHIP Dental Association, for "developing, promoting, and promulgating evidence- and best practices–based state and national Medicaid/SCHIP oral health policies and practices."[22]

IMPACT OF PROFESSIONAL AND POLICY GROUPS ON CONGRESSIONAL ACTION

Congress also turns to the authority of professional organizations when addressing a niche policy issue like children's oral health for which technical information is needed. A coalition of dental professional membership groups, organized by the independent nonmembership Children's Dental Health Project (CDHP), argued collectively that explicit inclusion of dental benefits in CHIP simply codified existing state practice and did not effectively create a new benefit. The Dental Access Coalition members were the American Dental Association, Academy of General Dentistry, American Academy of Pediatric Dentistry, American Dental Hygienists' Association, American Dental Education Association, National Dental Association, and Hispanic Dental Association. This coalition promoted a variety of provisions in CHIP and also ensured the integrity of EPSDT dental benefits when enactment of the Deficit Reduction Act of 2005 made it possible for states to implement program changes without first obtaining federal waivers of program requirements.[23]

The American Dental Association provides extensive information on state Medicaid programs[24,25]and successful Medicaid dental demonstrations.[26] In 2007, it also commissioned a SCHIP dental program analysis that identified program shortcomings subsequently addressed in CHIP.[11] Its Give Kids a Smile annual event, which like Mission of Mercy and Remote Area Medical volunteer programs highlight unmet needs for dental care, has been successful in gaining press coverage that reaches members of Congress as they monitor constituent needs.

Oral Health America, an independent nonprofit advocate for population oral health, issued 2 state-by-state oral health report cards in 2001[27] and 2003,[28] and a follow-up report recognizing significant state advances in 2005.[29] These allowed legislators to compare directly their state's performance on oral health status and dental programs with other states and thereby determine how much of an oral health problem their constituents confronted.

The American Academy of Pediatrics (AAP) and American Academy of Pediatric Dentistry promoted inclusion of children's oral health in well-child care and expansion of the pediatric dental workforce, respectively, in their lobbying efforts during the period between SCHIP and CHIP. In 1997, the AAP organized and has since maintained an influential Child Health Group composed of over 40 organizations that support progressive pediatric health policies. Through this group's regular interaction with key Congressional staff, the issue of children's general health as well as their oral health has been regularly featured.

CDHP, founded in 1997 to assist states in implementing the SCHIP dental option, framed policy issues in the contexts of financing, workforce, safety net, and prevention.[30] Its approach to informing policymaking involved a variety of common vehicles, including research-based monographs, reports, and databases that provide objective evidence useful in policy formulation. Its policy briefs then use these findings to reason arguments in favor of particular policies. Letters to the editor, op-ed pieces, and press interviews disseminated information to the general public while presentations, webcasts, and workshops disseminated information to targeted audiences. The participation of CDHP in ongoing affinity groups on Medicaid and child health stimulated synergies and collaborations designed to influence policymakers. Its Congressional testimonies provided the most direct opportunities to address key policymakers in a public forum.

Mainstream DC-based policy groups have also positively influenced oral health policy changes between SCHIP and CHIP. Since 1998, the nonpartisan National Health Policy Forum, which supports Congressional staff with briefings, whitepapers, and site visits to promising programs, incorporated oral health in over 60 of its events and publications[31] on topics ranging from children's oral health per se to related issues of HIV/AIDS, Head Start, health care workforce, health care financing, safety net adequacy, insurance coding systems, managed care, health savings accounts, health information technology, and more. Its 2003 background paper on improving oral health[32] and 2007 forum on dental care for low-income children[33] reached many key Capitol Hill staff at influential times during CHIP policy formulations. The bipartisan Alliance for Healthcare Reform, together with the Kaiser Family Foundation, convened a critically timed 2008 Congressional briefing[34] that attracted federal staff engaged in CHIP reauthorization, as well as press, lobbyists, think tanks, corporations, and advocacy groups. The large attendance and active audience participation evidenced that interest in children's oral health was widespread. The Kaiser Family Foundation has increasingly turned its attention to children's oral health, publishing such reports as a 2008 fact sheet on dental Medicaid and SCHIP coverage[35] and an expert-consensus report on

improving dental access.[36] The Urban Institute, one of many think tanks widely used by Congress, examined SCHIP dental performance[37] and gaps in dental care for low-income children.[38,39] The Institute of Medicine, a congressionally chartered research organization that informs public policymaking, engaged oral health in its 1998 study of US children's insurance coverage, which was completed just after the legislation it sought to support was passed.[40] Its 2009 report on adolescent health care services thoroughly integrated oral health considerations, rather than treating them as a supplemental health care issue,[41] and a 2009 report addressed workforce sufficiency in the context of access disparities.[42] Also taking an integrative approach, the George Washington University's Center for Health Policy Research and the Georgetown Center for Children and Families—2 influential DC-based academic centers that target information to federal and state policymakers—included pediatric oral health considerations into their many publications. Additional key contributions that helped expand and enrich the emerging field of oral health policy were made by the Child Health Insurance Research Initiative's paper on dental access,[43] Grantmakers in Health's convocation and report on the role of philanthropy in improving oral health,[44] University of California, Los Angeles, Center for Healthier Children, Families, and Communities' technical briefs on Head Start and Medicaid,[45] and the Center for Healthcare Strategies' primer on dental Medicaid.[46]

Activities by state-level foundations also brought policymakers' attention to children's oral health. Examples of the many influential publications are California HealthCare Foundation report on dentist reimbursement in Medicaid,[47] dental Medicaid performance analyses in California[48] and Kansas,[49] and the Connecticut Health Foundation's work on contracting dentists to health centers[50] and on state options in contracting dental Medicaid programs to managed care organizations.[51]

IMPACT OF A CHILD'S DEATH ON CONGRESSIONAL ACTION

The critical incident of a DC-area child's death (Deamonte Driver) from an odontogenic brain abscess in February 2007, only a few months before Congress first enacted CHIP reauthorization, transformed policymaking on children's oral health by creating a "face" for the issue. The tragedy created a focus on the essential role of oral health to overall health, highlighted problems inherent in dental coverage for low-income children, stimulated some members of Congress to champion the issue, generated a plethora of bills and statements, led to Congressional hearings and investigations, and crystallized the child health advocacy community around children's oral health. But this incident would not have had such potency were it not for 2 additionally critical factors: the *Washington Post*'s continuous and prominent coverage of the child's death (including 40 references to the child's death in articles and editorial pieces[52] that were also reflected in *New York Times* op ed pieces[53,54]) and the decade of intensive oral health policy development that had persistently engaged key policymakers in this issue.

Because members of Congress are responsive to local audiences, those most engaged by the child's death were those in the Maryland delegation, particularly Representative Elijah Cummings (D, Md) who represents a primarily poor, African American constituency. Traction was facilitated by statements made by the Speaker of the House, who had earlier opened the new session of Congress in 2007 with a call for health care coverage for all of America's children, including coverage for dental care. That these words were reechoed in 2009 when the Speaker listed children's dental coverage as one of the reasons that all Americans should be supportive of health care reform, confirmed that children's oral health has become well established as a recognized health policy issue.

Congress responded to the Driver child's death with 3 hearings during the period leading up to CHIP enactment.[55–57] The Domestic Policy Subcommittee launched investigations on data reporting in Medicaid, on the Administration's decision to not publish its commissioned *Guide to Medicaid Dental Services* manual,[58] and on findings of the federal Technical Advisory Group on dental Medicaid. The Committee did not release its previously completed 2003 study on unmet dental needs of children in Head Start, which highlighted the unavailability of dentists to care for low-income young children (Unreleased draft report of US Congress, Committee on Government Reform, Special Investigations Division. *Children in Head Start Have Significant Unmet Dental Needs: While Head Start Efforts to Find Care for Children, Head Start Program Directors Report Systemic Problems in Access*; 2003. US House of Representatives). The Medicaid "guide" investigation revealed that the Centers for Medicare and Medicaid services had significantly altered the report such that the "document stands in stark contrast to reviews by the Government Accountability Office, the HHS Inspector General, the Surgeon General, and CMS [Centers for Medicare and Medicaid Services] itself. . . . All of [which] identified major failures in access to dental services for children on Medicaid."

The Driver case also stimulated the introduction of 8 bills specific to improving children's access to dental care (Table 2). Additionally, in 2001 Senators Feingold (D, Wis) and Collins (R, Me) successfully reauthorized and expanded funding for their rural dental workforce bill (the *Dental Health Improvement Act,* S3067) which was the first dental-specific bill enacted by Congress. Reintroduced from the prior Congress were also Senator Bingaman's (D, NM) omnibus *Children's Dental Health Improvement Act* and Senator Breaux's (D, La) and Representative Boustany's (R, La) *Special Care Dentistry Act* that calls for expanded dental benefits for people with special needs not otherwise covered by Medicaid.

Congress charged its General Accounting Office with issuing 2 major reports in 2000 describing inadequacies in dental need, coverage, and services among low-income populations[59,60] and included dental

Table 2. Congressional Bills Submitted With Dental Provisions Following the Death of 12-Year-Old*

Bill	Sponsor†	Key Provisions
110th Congress		
S895/HR1535 *Children's Health First Act*	S Clinton (D, NY) R Dingell (D, Mich)	Bill would • expand and incentivize income-tested outreach, eligibility, and enrollment of uninsured children, pregnant women, and legal immigrants in Medicaid and SCHIP‡ • subsidize employers for coverage of low- and modest-income children • require comprehensive health benefits, including dental coverage in SCHIP • establishes a federal Medicaid-SCHIP Payment Advisory Commission • better funds states
HR 976 *Children's Health and Medicare Protection Act*	R Rangel (D, NY)	First House bill to list all of the dental provisions that were finally enacted in CHIP§ Reauthorization
S1893 *Children's Health Insurance Program Reauthorization Act (CHIPRA)*	S Baucus (D, Mont)	Final Senate bill to list all of the dental provisions in CHIP (see Table 1)
S739/HR1781 *Children's Dental Health Improvement Act*	S Bingaman (D, NM) R Dingell (D, Mich)	Bill would • authorize grants to states to improve dental services in Medicaid and SCHIP • provide wrap-around dental coverage for low- and modest-income children who enjoy employer-sponsored medical but no dental coverage • bolster dental care in federally designated underserved areas and incentivize dentists' retention in the Indian and National Health Services • expand sealant programs to Indian schools; organize a Department of Health and Human Services–wide dental program • improve data collection on children's oral health by the Centers for Disease Control and Prevention
S2723/HR5549 *Deamonte Driver Dental Care Access Improvement Act*	S Brown (D, Ohio) R Cummings (D, MD)	Bill would • enhance funding to the dental safety net • pilot a new allied dental professional, promote ECC|| awareness and management, establish a tax incentive to Medicaid-active dentists, and improve Medicaid reporting by states
HR3109 *Dental Health Promotion Act*	R Lewis (R, KY)	Bill would amend the IRS Code to "allow reimbursement from flexible spending accounts for products used to diagnose, cure, mitigate, treat, or prevent the onset of tooth decay (caries), periodontal diseases, and conditions ailing the teeth, gums, and mouth, or affecting their functioning."
HR2472 *Essential Oral Health Care Act*	R Wynn (D, MD)	Bill would • pilot new allied dental professionals in health center sites • increase the proportion of dental Medicaid payments funded by the federal government in states that meet Medicaid access requirements • provide tax credits to dentists for donated care for the underserved • cover operational costs for free-care programs • subsidize purchase of portable dental equipment
S3064 *Oral Health Initiative*	S Cardin (D, MD) S Collins (R, Me)	Bill would "establish a multifaceted approach to improve access and eliminate disparities in oral health care" through coordination of federal agency efforts.
111th Congress		
S275/HR 2 *Children's Health Insurance Program Reauthorization Act (CHIPRA)*	S Baucus (D, Mont) R Pallone (D, NJ)	Final CHIP bill signed by President Obama

*12-year-old Deamonte Driver, from brain abscess of dental origin.
†S = Senator; R = Representative.
‡SCHIP = State Child Health Insurance Program.
§CHIP = 2009 continuation of State Child Health Insurance Program.
||ECC = early childhood caries.

considerations in a study of outreach and enrollment in Medicaid and SCHIP.[61] Additional charges focused on state's enrollment and payment policies[62]and access[63] in 2001 and program reporting in 2003.[64] More recent reports include investigations of data inadequacies[65] and continued high levels of treatment needs among low-income children.[66] CHIP further charged the Government Accountability Office to investigate "the extent to which dental providers are willing to treat children" in Medicaid and CHIP, together with information on dental care distribution and the "feasibility and appropriateness of using qualified midlevel dental health providers, in coordination with dentists, to improve access for children to oral health services and public health overall."

The Congressional Research Service, Congress' internal analytic agency, assesses "legislative options for addressing the public policy problems facing the nation."[67] It has analyzed and abstracted some of the major dental bills listed in Table 2 and continues to develop information related to dental access. The Congressional Budget Office,

which estimates or "scores" costs associated with legislative options,[68] often influences decisions that have financial consequences. During CHIP enactment, initial scoring of the dental benefit suggested a cost that was regarded as too high by key legislators, but a subsequent revision of that estimate put the benefit back in play.

IMPACT OF FEDERAL PROGRAMS ON CONGRESSIONAL ACTION

Since release of the SGROH, Congress has taken an increasingly active role in advancing federal programs that address children's oral health and, in turn, has been positively influenced by those programs. For example, the 2001 *Dental Health Improvement Act* authorized a new dental workforce program that was funded in 2005, leading to 34 new dental programs in 26 states.[69] These programs raise oral health as a policy issue at home for members of Congress and are reported back to Congress by the funding agency, thereby maintaining attention to oral health.

The annual budget and appropriations cycle provides additional opportunities for Congress to respond to dental need. One example is Senator Cardin's (D, Md) successful attachment of an amendment to the 2009 budget bill charging "the Senate Finance Committee to bring a bill to the [Senate] floor that will make sure that we have no more tragedies like [Deamonte Driver] in America, to make sure that our children have access to dental care."[70] Line items in the budget annually begin the process of supporting oral health activities across the Department of Health and Human Services agencies. Report language, which accompanies appropriation bills to guide federal agencies in allocations of funds, has increasingly included reference to oral health programs in recent years. At appropriations hearings, agency officials directly address such Congressional priorities and highlight how their programs are satisfying them.

Multiple federal agencies have primary responsibility for pediatric oral health programs that are supported by and, in turn, influence Congress. Key programs that receive this support include dental and craniofacial research at the National Institutes of Health, including support for research on oral health disparities in child populations; dental public health and oral health surveillance programs in the Division of Oral Health at the Centers for Disease Control and Prevention (CDC), including community water fluoridation and school-based sealant programs; maternal and child health programs, dental safety net programs, health professional training programs, HIV/AIDS programs, and rural health programs at the Health Resources and Services Administration (HRSA); Medicaid and SCHIP program management, oversight, and monitoring at the Centers for Medicare and Medicaid Services; analysis of dental service utilization at the Agency for Healthcare Research and Quality; oral health promotion and dental care services through the Office of Head Start in the Administration for Children and Families; direct pediatric dental care programs through the Indian Health Service and the Department of Defense's TRICARE Program; and dental nutrition counseling programs though the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program at the US Department of Agriculture Food and Nutrition Services. Oral health advocates promote these various programs by encouraging Congress to fund them substantially and by encouraging Congress to provide oversight of oral health programs so that senior federal administrators, in turn, prioritize them within their agencies.

Dispersed across a number of different agencies are dental components of larger monitoring programs that collect data of import to Congress. Examples include disease epidemiology, sealant data, and oral health services utilization findings from CDC; parental assessment of children's oral health from HRSA; dental service utilization from the Agency for Healthcare Research and Quality; Medicaid services utilization from Centers for Medicare and Medicaid Services, and oral health status reports from Indian Health Service.

Over the period 1997 to 2009, the Maternal and Child Health Bureau at HRSA and the Division of Oral Health at CDC have actively promoted oral health policies and programs at federal, state, and local levels. They have both promoted state-level coalitions, school-based sealant programs, fluoridation, and state-level planning. HRSA has prioritized oral health internally through coordination across its bureaus and offices and externally by establishing funding priorities for oral health across many of its grant programs. CDC has assisted states in developing their own governmental oral health capacities and encouraging public-private partnerships.

IMPACT OF THE SURGEON GENERAL'S ATTENTION TO CHILDREN'S ORAL HEALTH ON CONGRESSIONAL ACTION

The Surgeon General's Report, *Oral Health in America,* is the single most cited reference to the need for action listed in the findings sections of new federal legislation on children's oral health, addressed in Congressional

Figure. *Action steps to improve children's oral health proposed by the Surgeon General's Workshop on Children and Oral Health in 2000.*

hearings and briefings, and noted in policy statements and speeches. Additionally, specific findings from the Surgeon General's invitational Workshop on Children and Oral Health frequently underpin legislative proposals. These recommendations are summarized in the Figure and are explored in detail in a 2002 supplement to *Ambulatory Pediatrics*.[71] Nearly a decade after the report's release, it continues to resonate with policymakers and influence their decisions in support of children's oral health as evidenced by inclusion of pediatric dental provisions in the initial bills that introduced the health care reform effort of 2009.[72]

SUMMARY

This contribution to the update on the Surgeon General's attention to children's oral health asserts that pediatric oral health policy emerged as a distinct policy issue of importance to Congress during the period between SCHIP enactment in 1997 and its reenactment as CHIP in 2009. Evidencing this development are the dramatic changes in oral health provisions in the 2 laws. This emergence of pediatric oral health policy is attributed to the actions, publications, and events by states, professional associations, policy groups, the press, federal programs, and the Surgeon General's Report itself. Although much remains to be done to attain equity in children's oral health in the United States, Congressional movement on behalf of children's oral health during the last 12 years has been significant and has set the stage for further improvements.

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