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Who's Smiling Now?: Disparities in American Dental Health

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WHO'S SMILING NOW?: DISPARITIES IN AMERICAN DENTAL HEALTH

*Janet L. Dolgin**

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"I am very angry that my son had to lose his life just because we didn't have insurance. . . . My son had to die—12 years old—because of a tooth."¹

"Dental practitioners credit wealthy baby boomers, reality television makeover shows and new dental technology for the surge in demand."²

INTRODUCTION

Teeth tell stories. Disparities in dental condition—as well as social perceptions of those disparities—reveal a great deal about class structure in the United States. Missing teeth suggest poverty.³ Straight, even, white teeth mark middle and upper class status.⁴ Such differences offer visible signs of socioeconomic status in a nation long confused about how to identify class status and how to understand the nation's opaque class hierarchy.

1. Richard Besser, *Poor Kids Without Dental Insurance Can Suffer Deadly Consequences*, ABC NEWS (May 2, 2007), <http://abcnews.go.com/GMA/OnCall/story?id=3120743>.

2. Marguerite Higgins, *Taking Better Care of Adult Pearly Whites*, WASH. TIMES, May 5, 2005, at A01.

3. See U.S. DEP'T OF HEALTH & HUMAN SERVS., ORAL HEALTH IN AMERICA: A REPORT OF THE SURGEON GENERAL 66–67 (2000) (reporting that the rate of edentulism for those living at equal to or twice the federal poverty level is about half that of those living below that level (6.9% versus 14.9%)). A similar pattern may exist in some other countries. For instance, one study asked 115 law students at a university in Israel to assess people from photos. The students responded quite differently to photos that differed only in that one "face" had good teeth and the other "face" (identical in other regards) had decayed front teeth. The students offered more positive assessments of the social and professional lives of those pictured with healthy teeth than of those pictured with decaying teeth. See Ilana Eli, Yoram Bar-Tal & Ina Kostovetzki, *At First Glance: Social Meanings of Dental Appearance*, 61 J. PUB. HEALTH DENTISTRY 150 (2001).

4. See *infra* Part II.

Moreover, the legal system in the United States has never focused vigorously on ensuring access to dental care for low-income people.⁵ Even after implementation of most provisions of the Patient Protection and Affordable Care (ACA)⁶ in 2014, many adults will not have coverage for basic dental care.

In short, a person's dental condition is a powerful sign of socioeconomic status at both ends of the nation's class hierarchy. People without dental coverage and financial resources are often reduced to pulling out diseased teeth, even without the aid of a dental professional.⁷ And at the same time, for those who do have financial resources, teeth have become consumer goods—more effective markers of class status, even, than clothing, jewelry, and hairstyle.⁸ Yet, people do not speak (except perhaps with humor or chagrin) about “wearing their teeth.” Rather, teeth are a very visible part of a person's embodied self. It is much harder to change teeth than to change jewelry or hair. All of this is significant in a society within which, to quote Sarah Nettleton, “The body has come to form one of the main sites through which people develop their social identities.”⁹

This Article approaches American dental health as a reflection and re-enforcer of class status in the United States. Within that frame, it explores two poles of oral health. Those without adequate dental coverage or other resources to pay for dental care are at risk of losing teeth and suffering from gum disease and other serious health problems correlated with poor dental health.¹⁰ At the same time, many wealthy people purchase cosmetic dentistry in a manner similar to the purchase of face-lifts and bariatric surgery procedures.¹¹ An adult's teeth are presumptively a permanent part of his or her body (at least for most people and in most parts of the United States) and may, therefore, suggest aspects of a person's underlying identity far more powerfully than other symbols of class status.

Part I explores the medical, legal, and social implications of dental status in the United States. It describes the potentially life-

5. See *infra* Part I.C.

6. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119-1025 (2010) (codified as amended in scattered sections of 42 U.S.C.).

7. See SUSAN STARR SERED & RUSHIKA FERNANDAPULLE, UNINSURED IN AMERICA: LIFE AND DEATH IN THE LAND OF OPPORTUNITY 166 (2005).

8. See *infra* Parts II, IV.B.

9. Sarah Nettleton, *The Sociology of the Body*, in THE BLACKWELL COMPANION TO MEDICAL SOCIOLOGY 52 (2001).

10. See *infra* notes 29–37 and accompanying text.

11. See *infra* Part II.

threatening consequences of dental disease, considers access to dental care in the United States, and notes how limitations in the ACA suggest that the ACA's implementation for many people will not make it significantly easier to gain access to health care. Part II considers "good teeth" as a sign of prosperity and examines the consequent focus of many groups within the United States and elsewhere on cosmetic dentistry. Part III reports on disparate dental status and differences in the symbolic importance of dental condition in urban and rural settings and across ethnic groups in the United States. Finally, Part IV presents an overarching frame within which to understand the potential significance of teeth as both a sign of poverty and of socioeconomic success.

I. DENTAL STATUS AND POVERTY

In 2007, a *New York Times* story about anti-immigrant responses toward an amnesty bill under consideration in the United States Senate featured comments from a Wisconsin man, a retired police officer.¹² The man, whose photograph accompanied the story, had lost a tooth on the left side of his mouth—the side shown in the photograph. After the story appeared, the *Times* received an avalanche of emails criticizing the paper for picturing a man with a missing tooth.¹³ According to Clark Hoyt, the *Times's* public editor, many of the emailers complained about what they saw as the paper's presumption that all those who opposed the Senate bill on immigration, as did the man pictured in the photo, had missing teeth.¹⁴ E-mailers referred to the photographed man as a "'toothless freak' and worse," reported Hoyt,¹⁵ who concluded by criticizing those individuals who "assumed" that because the man pictured "was missing a tooth, he was missing a brain."¹⁶ Equally, he criticized those who assumed that the *New York Times's* editors "shared their

12. See Julia Preston, *Grass Roots Roared and Immigration Plan Collapsed*, N.Y. TIMES, June 10, 2007, at 1, 35.

13. See Clark Hoyt, *The Ugly Part Wasn't His Face*, N.Y. TIMES, June 17, 2007, at C12.

14. See *id.*

15. *Id.*

16. *Id.* (noting as well that many of those who emailed to criticize the newspaper's using the photo "assumed that editors at The Times shared their prejudices and were attempting to ridicule opponents of the immigration bill").

prejudices.”¹⁷ The prejudice exists, however, and for those without either dental coverage or resources adequate to pay for dentistry, losing teeth and the prejudice that follows can be painful.

Most importantly, lack of dental care and its consequences can result in serious illness and even death. Many low-income people in the United States have no dental coverage and very little access to dental care.¹⁸ Although Medicaid covers pediatric dentistry,¹⁹ many children in low-income families may not be able to find a dentist who will treat them.²⁰

A. Lacking Dental Coverage and Dental Care

In the United States, scores of millions of people lack coverage for dental care and do not have the resources to pay privately for that care.²¹ In 2012, 130 million people in the United States had no dental coverage.²² Medicare provides very little coverage for dentistry, and depending on the state, Medicaid includes no benefits or only minimal benefits for non-pediatric patients.²³ For many people with some dental coverage, the cost-sharing requirements of most dental plans make it hard, if not impossible, to obtain comprehensive dental care even though they have some coverage.²⁴ The ACA, passed in

17. *Id.* Hoyt noted that the photographer decided to picture the fellow's left side (the side with a missing front tooth) because on the right side, he was missing an eye. *See id.*

18. *See infra* notes 95–104; 156–64 and accompanying text.

19. *See Early and Periodic Screening, Diagnostic, and Treatment, MEDICAID.GOV*, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html> (last visited July 14, 2013); *see also infra* Part I.C.3.

²⁰ *See supra* notes 66–72 and accompanying text.

21. *See infra* Part I.C.

22. *See* BERNARD SANDERS, S. COMM. ON HEALTH, EDUC., LABOR & PENSIONS, DENTAL CRISIS IN AMERICA: THE NEED TO EXPAND ACCESS 3 (2012), *available at* <http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf>.

23. Medicaid programs are required to cover pediatric dental care, but many low-income children do not get adequate routine or even emergent care. *See* KAISER FAMILY FOUND., KAISER COMM'N ON MEDICAID & THE UNINSURED, CHILDREN & ORAL HEALTH: ASSESSING NEEDS, COVERAGE, AND ACCESS 5 (2012), *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7681-04.pdf>. It is difficult to find dentists who accept Medicaid patients because Medicaid payment rates tend to be very low. *See id.* (noting dentists describe low rates of pay as the primary reason they hesitate to accept Medicaid patients). Dental specialists are even less likely than other dentists to participate in Medicaid. *See id.*

24. *See* SANDERS, *supra* note 22, at 3.

2010,²⁵ will leave about thirty million people in the United States without health coverage and many more without dental coverage.²⁶ It is not surprising that poor dental health is far more common in communities at the bottom of the nation's socioeconomic hierarchy than in wealthier communities.²⁷ Even for people with coverage, a large part of the cost of dental care still may fall to the patient.²⁸

As a matter of public policy, the importance of dental coverage often has been forgotten, even amidst heightened concerns about health care coverage generally.²⁹ Yet, going without dental care can

25. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119-1025 (2010) (codified as amended in scattered sections of 42 U.S.C.).

26. See Part I.C.5; see also Robert Pear, *Court's Ruling May Blunt Reach of the Health Law*, N.Y. TIMES, July 25, 2012, at A16. In 2008, Debra Dickerson questioned why neither of the frontrunner presidential candidates—Hilary Clinton and Barack Obama—spoke about dental coverage as part of their plans for overhauling the United States' health care system. Dickerson suggested that the explanation was perhaps that neither candidate had a plan for expanding dental coverage. See Debra J. Dickerson, *My, What Rotten Teeth Poor People Have: The Hidden Health Care Crisis and the Dems*, MOTHER JONES (Jan. 23, 2008, 10:03 AM PST), <http://www.motherjones.com/mojo/2008/01/my-what-rotten-teeth-poor-people-have-hidden-health-care-crisis-and-dems>. The Affordable Care Act defines dental coverage for pediatric patients as an essential health benefit. Section 1302 of the Affordable Care Act lists ten categories of care (referred to as "essential health benefits"). See Patient Protection and Affordable Care Act § 1302, 42 U.S.C. § 18022 (2012); see also ULMER ET AL., INST. OF MED., ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST 3, 79 (2010). The state exchanges can, but do not have to, offer stand-alone dental plans. See Patient Protection and Affordable Care Act § 1311(d)(2)(B), 42 U.S.C. § 18031(d)(2)(B).

27. See James A. Gillcrist et al., *Community Socioeconomic Status and Children's Dental Health*, 132 J. AM. DENT. ASSOC. 216, 216 (2001) ("An increasingly disproportionate burden of [dental] disease is found in indigent children and those of racial or ethnic minority groups who are least able to access preventive and restorative dental services."). The authors reported that the need for dental treatment of children in communities with low socioeconomic status (SES) were significantly higher (49% of children) than the need for dental treatment of children in high-SES communities (26% of children) or middle-level SES communities (24% of children). See *id.* The American Dental Association (ADA) was established in the middle of the nineteenth century and reports having 157,000 members. See *About ADA*, AM. DENTAL ASS'N, <http://www.ada.org/aboutada.aspx> (last visited June 28, 2013).

28. See *infra* notes 94, 109 and accompanying text.

29. See Diane Rowland, Exec. Vice President, Kaiser Family Found., Remarks at Public Forum: Dental Care Coverage and Access 2-4 (June 19, 2012) (transcript available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/transcript_dentalforum_061912.pdf) (remarking that "oral health is an often overlooked part of individual health and wellness").

have terribly detrimental consequences.³⁰ Lack of preventive dental care can lead to periodontal disease and cavities.³¹ Periodontal disease³² has been linked with coronary disease, stroke, and diabetes,³³ and in pregnant women, it has been associated with low birth weight babies and premature births.³⁴ Poor dental health in children has been associated with a number of serious health problems, including sinus and ear infections and weakened immune systems.³⁵ Dental disease can also interfere with breathing and eating and with the development of speaking, smiling, and social adaption.³⁶ Oral disease results in many school absences.³⁷ Untreated dental disease can result in serious illness and even death for children and for adults.³⁸

The consequences of dental disease are often more visible than the consequences of other disease processes. In the United States, adults with missing teeth look poor and are at risk of becoming poorer: it is

30. Lack of access to dental care can lead to death. The tragic story of Deamonte Driver is illustrative. See generally Paul S. Casamassimo et al., *Beyond the DMFT: The Human and Economic Cost of Early Childhood Caries*, 140 J. AM. DENTAL ASS'N 650 (2009); Mary Otto, *For Want of a Dentist: Pr. George's Boy Dies After Bacteria from Tooth Spread to Brain*, WASH. POST, Feb. 28, 2007, at B01. Deamonte, from Prince George's County in Maryland, died in February 2007 at age 12. Casamassimo et al., *supra*, at 650. Deamonte's death was the result of a brain infection that began with an infected tooth. Otto, *supra*, at B01. Deamonte's story, described in more detail *infra* Part II.B., is tragic but not unique. See Casamassimo et al., *supra*, at 652; see also Lauren Bishop, *Death After Tooth Infection Raises Questions About Care Options*, CINCINNATI ENQUIRER, Sept. 3, 2011 (quoting Larry Hill, former director of Cincinnati Health Department and dentist, to have reported that such cases are not "as rare as you might think").

31. See CTRS. FOR DISEASE CONTROL & PREVENTION, ORAL HEALTH: PREVENTING CAVITIES, GUM DISEASE, TOOTH LOSS, AND ORAL CANCERS: AT A GLANCE 2011, at 2 (2011), available at <http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2011/Oral-Health-AAG-PDF-508.pdf>.

32. Periodontal (gum) disease is caused by bacteria under the gum tissue. See *id.* at 2-3. This can result in the destruction of the gums and even of bone. See *id.*

33. See *Oral Health: Overview & Impact*, HEALTHYPEOPLE.GOV, <http://www.healthypeople.gov/2020/LHI/oralHealth.aspx> (last updated June 6, 2013).

34. See *Oral Health in New York City*, NYC VITAL SIGNS (NYC Dep't of Health & Mental Hygiene), June 2012, at 1, available at <http://www.nyc.gov/html/doh/downloads/pdf/survey/survey-2012oralhealth.pdf>.

35. See KAISER FAMILY FOUND., *supra* note 23, at 1.

36. See generally Carol Cristina Guarnizo-Herreno & George L. Wehby, *Children's Dental Health, School Performance, and Psychological Well-Being*, 161 J. PEDIATRICS 1153 (2012) (reporting link between poor dental health among children and poorer performance in school).

37. See Ian Urbina, *In Kentucky's Teeth, Toll of Poverty and Neglect*, N.Y. TIMES, Dec. 24, 2007, at A12 (noting that in Kentucky dental pain is a "leading cause of missed school days").

38. See sources cited *supra* note 30 and accompanying text.

difficult to find a job if one visibly is missing teeth.³⁹ Even partial edentulism (missing teeth), especially in the front of the mouth where the absence of teeth is most apparent, limits economic and social opportunities.⁴⁰ Missing teeth makes it harder to enter or to remain in the labor market.⁴¹ As one middle-aged diabetic woman featured in a 2006 story in the *New York Times* about unemployment and poverty explained: "Since I didn't have a smile . . . I couldn't even work at a checkout counter."⁴² The speaker had lost all of her teeth a few years earlier and did not have the necessary financial resources to have them replaced.⁴³

In their study of the experience of going without health coverage and health care in the United States, Susan Starr Sered and Rushika Fernandopulle found that the majority of the people whom they interviewed specifically expressed anxieties about their poor dental health.⁴⁴ Even more, Sered and Fernandopulle reported that most of the people that they interviewed explained that their "first priority," if health coverage were to become available to them, would be dental care.⁴⁵

It is a vicious circle: "rotted teeth," a mark of poverty, render people less employable than they otherwise might be and thus further decrease the opportunity to obtain employment that might in turn offer health coverage.⁴⁶ Moreover, visibly poor oral health sometimes carries a peculiar moral stigma.⁴⁷ Sered and Fernandapouille describe the responses of a group of middle-class mothers, teachers, and health care professionals in Idaho to the dental condition of people in their community who were living in poverty⁴⁸:

39. See Abby Goodnough, *Hard to Grin While Bearing Cuts in Medicaid Dental Coverage*, N.Y. TIMES, Aug. 29, 2012, at A16 (noting that Massachusetts Medicaid has resumed coverage for fillings in the front of the mouth because of the difficulty of conducting a successful job search with missing front teeth).

40. See SANDERS, *supra* note 22, at 2.

41. See Shirley Glied & Matthew Neidell, *The Economic Value of Teeth* (Nat'l Bureau of Econ. Research, Working Paper No. 13879, 2008), available at <http://www.nber.org/papers/w13879.pdf>.

42. Eric Eckholm, *America's 'Near Poor' Are Increasingly at Economic Risk, Experts Say*, N.Y. TIMES, May 8, 2006, at A14.

43. See *id.*

44. See SERED & FERNANDOPULLE, *supra* note 7, at 166.

45. See *id.*

46. See *id.* at 168.

47. See *infra* Part IV.

48. States are not obliged to provide Medicaid dental coverage for adults. The Affordable Care Act does not change that situation. See *infra* Part II.C.4. In fact, as

"A lot of people around here have untreated dental [problems]. And they actually need care, starting with the kids. The mothers just stick bottles in their mouths all the time. The mothers are just unable to take care of their kids They're just not educated enough. The kids get bottle rot. And they're not covered by any kind of insurance, so their teeth rot." . . .

These middle-class women identified bad teeth as a sign of poor parenting, low educational achievement, and slow or faulty intellectual development."⁴⁹

Similarly,

Dale Maharidge and Michael Williamson report the words of Debbie, a working-class woman in Alabama in the 1980s, who described [the] face [of poverty] vividly: "There are two classes: those with rotten teeth, with no sign of ever having had any professional dental care, and those whose teeth are perfect" ⁵⁰

These examples underscore the social stigma that people with poor dental health must face.

B. The Worst Consequences of Poor Dental Health

The number of adults with dental coverage is far lower than the number with other forms of health care coverage,⁵¹ and poor adults rarely have coverage for dental care.⁵² Moreover, even though Medicaid has required participating states to cover dental care for Medicaid eligible pediatric patients for many decades, poor children are far less likely than children from higher-income families to receive

states have recently been precluded from restricting Medicaid eligibility, some that had offered optional Medicaid dental benefits to adults have cut those benefits. See Goodnough, *supra* note 39, at A16; see also Margot Sanger-Katz, *Nothing to Smile About: Shortage of Dental Services*, NAT'L J., May 3, 2012, available at <http://www.nationaljournal.com/magazine/nothing-to-smile-about-20120503>. In 2009 about 50 million people in the United States had no health care coverage and 130 million people had no dental coverage. *Id.*

49. SERED & FERNANDOPULLE, *supra* note 7, at 168.

50. *Id.* at 169 (citing DALE MAHARIDGE & MICHAEL WILLIAMSON, AND THEIR CHILDREN AFTER THEM: THE LEGACY OF LET US NOW PRAISE FAMOUS MEN: JAMES AGEE, WALKER EVANS, AND THE RISE AND FALL OF COTTON IN THE SOUTH (1989)).

51. Lena H. Sun, *Survey Cites Disparity in Dental Care*, WASH. POST, Sept. 8, 2011, at B03 (reporting that only 25% of "lower-income" adults with health coverage have policies that include dental coverage; "lower-income" was defined to include adults in households earning less than \$40,000 per year).

52. See SERED & FERNANDOPULLE, *supra* note 7, at 186.

dental care.⁵³ Further, the risk of cavities for poor children is about twice the risk that higher-income children face.⁵⁴

Indeed, dental disease, including tooth decay, is widespread among poor children.⁵⁵ Moreover, dental health disparities follow children into adolescence and beyond.⁵⁶ Children who lack dental care can face devastating health consequences, including death.⁵⁷ The story of Deamonte Driver is illustrative.

Deamonte, a young boy from Prince George's County in Maryland, died in February 2007 at age twelve.⁵⁸ His death resulted from an infection that spread from untreated tooth decay to his brain.⁵⁹ Had Deamonte visited a dentist even after his tooth had become infected, an extraction—which would have cost about eighty dollars—could have saved the boy's life.⁶⁰ By the time Deamonte's condition was diagnosed, his life was in grave danger. Despite weeks of hospitalization and two brain operations, Deamonte died.⁶¹

Deamonte's mother had worked over the years as a baker, a home-health worker, and in the construction industry.⁶² None of these jobs offered health care coverage or dental coverage.⁶³ During his life, Deamonte had been covered by Medicaid from time to time; but that coverage lapsed, apparently because paperwork confirming coverage was sent to a shelter from which the family had moved.⁶⁴ Deamonte still had no coverage when he was finally hospitalized and died.⁶⁵ Without Medicaid—and even sometimes with Medicaid coverage—children like Deamonte are at serious risk for dental disease and its repercussions.

53. See KAISER FAMILY FOUND., *supra* note 23, at 3.

54. See Otto, *supra* note 30.

55. See *id.* (reporting that tooth decay among children is more common than asthma and much more likely to be present among poor children than among wealthier children).

56. See Burton L. Edelstein & Courtney H. Chinn, *Update on Disparities in Oral Health and Access to Dental Care for America's Children*, 9 ACAD. PEDIATRICS 415, 419 (2009).

57. In such cases, the cause of the illness leading to death is often not correctly identified. See Casamassimo et al., *supra* note 230, at 652.

58. Otto, *supra* note 30.

59. *Id.*

60. See *id.*

61. See *id.* Deamonte's medical care cost about \$250,000. See *id.*

62. See *id.*

63. See *id.*

64. See *id.*

65. See *id.*

Even if Medicaid had covered Deamonte's condition, it is not clear that he would have received care. Although Medicaid covers pediatric dentistry, participation in the Medicaid system often does not ensure that a child actually receives dental care.⁶⁶ Ironically, the same year in which Deamonte died—but before the loss of his Medicaid coverage—Deamonte's mother sought dental care for another son, ten-year old DeShawn, who was covered by Medicaid.⁶⁷ It was very difficult, however, to find a dentist willing to accept him.⁶⁸ A local lawyer who worked with homeless people tried to help; she made over twenty telephone calls before finding a dentist willing to accept the Drivers' Medicaid coverage.⁶⁹ At the time, about sixteen percent of dentists in Maryland accepted patients covered by Medicaid, and finding a dental specialist for a Medicaid patient was more difficult even than finding a dentist able to provide basic care.⁷⁰ In 2005, two years before Deamonte's death, less than one third of children in Maryland covered by Medicaid received dental care.⁷¹

Deamonte's story, while tragic, is not unique.⁷² In 2011, a twenty-four-year-old father in Ohio died as a result of dental disease.⁷³ Kyle Willis had an infected tooth, but he could not afford antibiotics because he did not have health care coverage.⁷⁴ When he developed a headache and his face swelled, he went to a local emergency room.⁷⁵ He was offered painkillers for three dollars and antibiotics for twenty-

66. See Burton L. Edelstein, *Disparities in Oral Health and Access to Care: Findings of National Surveys*, 2 AMBULATORY PEDIATRICS 141, 145 (2002).

67. See Otto, *supra* note 30. In 2005, less than one third of children enrolled in Medicaid in Maryland actually received dental care of any sort. See *id.*

68. See *id.*

69. See June Thomas, *The American Way of Dentistry: Why Poor Folks Are Short on Teeth*, SLATE (Oct. 1, 2009, 7:07 AM), http://www.slate.com/articles/life/the_american_way_of_dentistry/2009/10/the_american_way_of_dentistry_3.html.

70. Otto, *supra* note 30.

71. Mary Otto, *Mobile Dental Clinic Brings Care to Poor Children in Prince George's County*, WASH. POST, Feb. 21, 2011, <http://www.washingtonpost.com/wp-dyn/content/article/2011/02/21/AR2011022102040.html>. Among the 5,500 dentists in Maryland at the time, fewer than 1,000 accepted Medicaid patients. See Thomas, *supra* note 69.

72. See Bishop, *supra* note 30 (quoting Larry Hill, former director of Cincinnati Health Department and dentist, to have reported that cases such as Kyle Willis's while not "common" are also not "as rare as some might think").

73. See *id.*

74. See *id.*

75. See Gretchen Gavett, *Tragic Results When Dental Care Is Out of Reach*, FRONTLINE (June 26, 2012, 9:50 PM), <http://www.pbs.org/wgbh/pages/frontline/health-science-technology/dollars-and-dentists/tragic-results-when-dental-care-is-out-of-reach/>.

seven dollars.⁷⁶ He was not able to pay for both.⁷⁷ He took the painkillers and decided to forego the antibiotics.⁷⁸ Willis died when the infection spread to his brain.⁷⁹

Emergency rooms have become the only option for many low-income people without insurance.⁸⁰ Most emergency departments, however, do not provide dental care,⁸¹ and those that do may not be equipped to offer more than painkillers and antibiotics, as happened in Kyle Willis's case.⁸² This level of care is insufficient to avoid the serious health consequences that can result from poor dental health.

C. Dental Coverage in the United States

Across all income groups in the United States, dental coverage is less common than other forms of health coverage.⁸³ Because about 130 million people in the United States had no dental coverage as of 2012,⁸⁴ and there is no "dental safety-net," many people with dental disease turn to emergency rooms,⁸⁵ complaining of pain.⁸⁶ The Pew

76. *Id.*

77. *Id.*

78. *Id.*

79. See *Bootsy Collins' Nephew Dead at 24*, UPI.COM (Sept. 2, 2011, 10:14 PM), http://www.upi.com/Entertainment_News/Music/2011/09/02/Bootsy-Collins-nephew-dead-at-24/UPI-10361315016056/.

80. The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals that accept Medicare and have emergency rooms to screen every patient who comes to the department (not just Medicare patients). For those found to have an emergency condition, the hospital must provide "such further medical examination and such treatment as may be required to stabilize the medical condition" or the hospital must arrange for the transfer of the patient to another facility. Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd (2012). Transfer is only permitted under certain circumstances (e.g., the patient has been stabilized; patient or the patient's surrogate decision maker seeks transfer after receiving adequate information about the patient's situation; or a doctor has certified that the benefits of transfer will outweigh the risks). See *id.*

81. Adding to the tragedy of Kyle Willis's story is that the emergency room where he was offered painkillers and antibiotics did have a dental-care center. See Gavett, *supra* note 75. Gavett suggests that Willis may not even have known that the dental care center existed. See *id.*

82. See Cindy Schroeder, *Wanted: Dentists for Poor in Pain*, CINCINNATI ENQUIRER, Aug. 17, 2012, at A12 (noting that dental patients in emergency rooms in Kentucky, where 70% of adults are without dental insurance, offer pain control, antibiotics, and "instructions to see a dentist" to dental patients).

83. See Sanger-Katz, *supra* note 48.

84. See SANDERS, *supra* note 22, at 3.

85. The EMTALA requires almost all hospitals with emergency rooms to accept all patients who arrive at their doorsteps (at least for screening). See Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd (2012). Thus, sick people

Center on the States reported that dental conditions comprised the primary reason for over 800,000 visits to emergency rooms in 2009.⁸⁷ Most could have been prevented by routine dental care.⁸⁸ The economic costs to society are high,⁸⁹ and the costs in lost health to patients can be even higher insofar as emergency rooms often do not provide dental care beyond antibiotics and painkillers for infections.⁹⁰

For people who lack financial resources and who do not have basic dental coverage, dental care in the United States sometimes consists of pulling out the offending tooth or teeth.⁹¹ Dr. Edwin Smith, whose mobile dental clinic provides care to the poorest people in Appalachia, explained that in the area in which he works, a Medicaid patient with a severely infected tooth has only one option: to have the tooth pulled.⁹² But extraction, especially of front teeth, marks the person as putatively unattractive and poor. It becomes ever harder to find employment.⁹³ Even those people fortunate enough to have

have been able to rely on emergency room for care. This route to care is far narrower for people in need of dental care. Even though someone with a terrible toothache can go to a hospital emergency room, the majority of United States hospitals are not equipped to treat dental problems. See Thomas, *supra* note 69.

86. One commenter on Gretchen Gavett's story about Willis's death noted that his own monthly funds cover only the costs of his food and housing, see Mocknbird2, Comment to Gavett, *supra* note 75, so there is nothing left over for dental care. See *id.* This commenter noted that he receives Medicare, but that that program did not cover the care for a dental infection. See *id.* The commenter notes: "I ended up with a 400 dollar emergency bill which medicare [sic] refused to pay because the doctor said I was there for a dental abcess [sic]. I was there to avoid death." See *id.* The gender of the commenter quoted here is not clear from the Comment. I have arbitrarily used male pronouns to refer to this commentator.

87. See PEW CTR. ON THE STATES, A COSTLY DENTAL DESTINATION: HOSPITAL CARE MEANS STATES PAY DEARLY 1 (2012), available at http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/State_policy/Pew_Report_A_Costly_Dental_Destination.pdf. In Florida alone, emergency room visits involving dental problems cost over \$88 million in 2010. *Id.* at 6.

88. See SANDERS, *supra* note 22, at 4. The number of emergency room visits in 2009 for dental problems represented a sixteen percent increase over the number three years earlier. *Id.*

89. See Goodnough, *supra* note 39, at A16.

90. See Gavett, *supra* note 75.

91. See *supra* note 7 and accompanying text.

92. See Urbina, *supra* note 37, at A12.

93. See *id.* A Kentucky job-trainer for low-income women in Appalachia described the consequences clearly: "Try finding work," she opined, if "you're missing front teeth." *Id.*

dental coverage may not have a policy that guarantees access to care or that covers the largest part of dental bills.⁹⁴

For children from low-income families, dental coverage is available through Medicaid⁹⁵ and through the State Children's Health Insurance Program (SCHIP).⁹⁶ For adults, the situation is more critical. Medicaid does not require states to provide dental care for adults, and some states offer virtually none.⁹⁷ Others offer emergency dental care.⁹⁸ Nine states offer adults somewhat broader dental care through Medicaid.⁹⁹ Some states, however, have cut Medicaid funding for adult dental care since 2008, when the country entered a recession.¹⁰⁰

94. See *Consumer Reports Survey: Consumers Delaying Dental Care Due to Cost*, CONSUMERREPORTS.ORG (Jan. 3, 2012), <http://pressroom.consumerreports.org/pressroom/2012/01/what-you-can-expect-to-pay-for-a-dental-procedure-whether-youre-insured-or-not-yonkers-ny-the-biggest-reason-for-dela.html> [hereinafter *Consumer Reports Survey*].

95. See *Early and Periodic Screening, Diagnostic, and Treatment*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html> (last visited July 14, 2013).

96. State Children's Health Insurance Program, 42 U.S.C. §§ 1397aa-1397jj (2012). SCHIP covers children in low-income families who earn too much for Medicaid eligibility. See KAISER FAMILY FOUND., KAISER COMM'N ON MEDICAID & THE UNINSURED, CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA) 1 (2009), available at <http://www.kff.org/medicaid/upload/7863.pdf> [hereinafter CHIPRA]. The SCHIP Program Reauthorization Act of 2009, Pub. L. No. 111-3, 123 Stat. 85 (2009) (codified as amended in scattered sections of 42 U.S.C.), required SCHIP programs to provide dental care for children covered in independent SCHIP plans, see *id.* § 501(a)(1)(B)(ii)(5) (codified at 42 U.S.C. § 1397cc(c)(5) (2012)), that were not part of Medicaid expansions. See KAISER FAMILY FOUND., *supra* note 23, at 3. Most states, however, already provided dental benefits through their SCHIP programs—including those programs not run through Medicaid. See Burton Edelstein et al., *Oral Health Provisions in U.S. Health Care Reform*, 141 J. AM. DENTAL ASS'N 1471, 1472 (2010). Of twenty states that set up "stand-alone" SCHIP programs, nineteen of them provided dental benefits a decade after SCHIP's enactment. See BURTON EDELSTEIN, DONALD SCHNEIDER & R. JEFFREY LAUGHLIN, SCHIP DENTAL PERFORMANCE OVER THE FIRST 10 YEARS: FINDINGS FROM THE LITERATURE AND A NEW ADA SURVEY: EXECUTIVE SUMMARY 2 (2007), available at http://www.ada.org/sections/advocacy/pdfs/071120_SCHIP_Executive_Summary.pdf. The American Dental Association concluded a decade after SCHIP's enactment that the program was providing a significant benefit to the oral health of children from poor families with at least one working parent. See *id.*

97. See Burton Edelstein et al., *supra* note 96, at 1472.

98. *Id.*

99. *Id.*

100. See Daniel Lippman, *States Drastically Cut Dental Care for Adults on Medicaid*, HUFFINGTON POST, (Oct. 2, 2012, 4:58 PM) http://www.huffingtonpost.com/2012/10/02/medicaid-dental-cuts_n_1930650.html (reporting that California,

Medicare covers almost no dental care.¹⁰¹ Twenty-five percent of Medicare beneficiaries are without "natural teeth."¹⁰² Moreover, care for most dental problems is not available through coverage provided to veterans.¹⁰³ In short, adults without private insurance receive little in the way of dental care not paid for out-of-pocket. In the United States, the number of adults who lack dental coverage is 300% greater than the number of people without medical coverage for other health-related conditions.¹⁰⁴

Private insurance, obtained through an employer or purchased in the marketplace, rarely covers the bulk of dental expenses.¹⁰⁵ Many dental plans differ from plans providing medical coverage, generally, in that they are essentially "discount arrangements," negotiated between dentists and the plan.¹⁰⁶ Further, plans that do provide

Illinois, Massachusetts, Pennsylvania, and Washington have "slashed funding for adult dental coverage").

101. *Medicare Dental Coverage*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://www.cms.gov/Medicare/Coverage/MedicareDentalCoverage/index.html> (last updated Mar. 12, 2012) (reporting that the "dental exclusion" was "part of the initial Medicare program"). Medicare will pay for tooth extractions preceding radiation treatment of the jaw and for dental care that is "an integral part or a covered procedure (e.g., reconstruction of the jaw following accidental injury)." Amanda McCluskey Schwob, *Open Wide—I Meant Your Pocketbook: Repercussions of the Dental Exclusion to the Medicare Act*, 9 ELDER L.J. 83 (2001).

102. See Rowland, *supra* note 29, at 3.

103. See Greg Nycz, Exec. Dir., Family Health Ctr. of Marshfield, Inc., Remarks at Public Forum: Dental Care Coverage and Access 45 (June 19, 2012) (transcript available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/transcript_dentalforum_061912.pdf). Veterans are entitled to dental coverage for "service trauma." Nielson v. Shinseki, 607 F.3d 802 (Fed. Cir. 2010) (quoting 38 U.S.C. § 1712(a)(1)(C)). The Nielson court concluded that the statute does not cover dental care for non-negligent care given during the time that the veteran served in the military. See *id.* at 804–06. More particularly, the court explained:

[W]e think that the prevailing definition of "trauma" at the time the statute was enacted was "an injury or wound produced by an external physical force." The pulling of teeth is an act of force that could fit within that definition. We do not, however, think that Congress in Sec. 1712(a)(1)(C) intended to use the word "trauma" [broadly]; nor do we think it reasonable to conclude that Congress intended to include proper dental treatment designed to remedy an injury or disease to be within the phrase "service trauma."

Id. at 806.

104. See Rowland, *supra* note 29, at 3.

105. See *Consumer Reports Survey*, *supra* note 94. Limitations of private dental insurance are discussed in more detail in Part I.C.3, *infra*.

106. See Jacqueline Fox, *The Epidemic of Children's Dental Diseases: Putting Teeth into the Law*, 11 YALE J. HEALTH POL'Y L. & ETHICS 223, 242 (2011).

coverage often have very low annual payment caps.¹⁰⁷ Such plans oblige the patient to pay the negotiated fee in full.¹⁰⁸

1. *Health Coverage Compared with Dental Coverage: Why Is Dentistry Not Part of Medicine?*

Dentistry has long been separated from medicine.¹⁰⁹ Similarly, coverage for dental care has not routinely been part of coverage for health care, and the need to expand dental coverage to larger segments of the population has received inadequate attention even from those committed to expanding health care coverage.¹¹⁰

The failure of both Medicare and Medicaid (in the case of adults) to require coverage of dentistry is indicative of the nation's attitude toward dental care.¹¹¹ Both programs provide eligible adults with at least some coverage for general health care but almost none for dentistry. Trying to explain the preclusion of dental care from health care more generally is not easy:

[M]ost of the states don't have dental coverage for adults. And if you asked yourself just as a consumer why do they provide adult dermatology coverage, but they don't provide adult dental coverage? Why is that? I mean, is the skin more important than the oral cavity? You know, it's really bizarre We have separate medical records. We have separate insurances [for dental care and other forms of health care] . . . and we ought not to.¹¹²

Dentistry was distinguished from the medical profession as far back as the early eighteenth century.¹¹³ In 1728, Pierre Fauchard described

107. See *id.* at 242. Fox reports that in 2010, "the most generous benefit provided to federal employees under the Aetna dental plan. . . [had] an in-network cap of \$3,000 a year per patient, with co-payments for any major dental work ranging from 40% to 60% of the cost for in-network providers." *Id.* at 242 (citing AETNA DENTAL, A NATIONWIDE DENTAL PPO PLAN 13, 17, 20 (2010), available at <http://custom.aetna.com/fehbp/pdf/2010FedBrochure-FEDVIP.pdf>).

108. *Id.*

109. The American Dental Association (ADA) was established in the middle of the nineteenth century and reports having 157,000 members. See *About ADA*, *supra* note 27.

110. See *infra* Parts I.C.2-5.

111. See *Medicare Dental Coverage*, *supra* note 101.

112. See Nycz, *supra* note 103, at 25-26. It is time, suggested Nycz, to "put the mouth back in the body." *Id.* at 19.

113. See Mark Blackwell, "Extraneous Bodies": The Contagion of Life-Tooth Transplantation in Late-Eighteenth-Century England, 28 EIGHTEENTH-CENTURY LIFE 21, 24 (2004); see also Peter Meiers, *The Birth and Rise of Dentistry*, FLOURIDE-HISTORY.DE, <http://www.fluoride-history.de/dentistry.htm> (last visited June 28, 2013). As early as the seventeenth century, Charles Allen authored a

the skills and obligations of the dentist in *Le Chirurgien Dentiste, ou Traite des Dent* [The Dental Surgeon or Treatise on the Teeth].¹¹⁴ Although physicians have long engaged in research about dental matters, they traditionally avoided engaging in the treatment of dental disease, apparently under the assumption that dental problems were “superficial.”¹¹⁵ By the early nineteenth century, it seemed briefly as if dentistry might be merged with medicine,¹¹⁶ but that did not happen.¹¹⁷

Alyssa Picard reports that within the dental profession, there was some concern at the start of the twentieth century with improving the dental health of children and even of poor adults.¹¹⁸ She attributes that concern to a sense that poor dental health reflected badly on the profession; but by the end of the century, with the medical profession securely established and separated institutionally from dentistry, medicine grew less interested in public health dentistry.¹¹⁹

2. *Opposition to Expanding Dental Coverage for Poor People*

In the present day, establishment dental groups generally have not shown a significant inclination to support more comprehensive dental coverage. Such groups sometimes have organized to limit the use of dental clinics at schools and, more generally, to limit efforts to provide dental care to the underserved.¹²⁰ A 2009 Louisiana bill attempted to preclude dentists from providing care in schools unless

treatise on the significance of preserving oral health. See Blackwell, *supra*, at 25 (citing CHARLES ALLEN, THE OPERATOR FOR THE TEETH (1685)).

114. Blackwell, *supra* note 113, at 24 (citing ROGER KING, THE MAKING OF THE DENTISTE, C. 1650–1760, at 87, 143 (1998)).

115. Meiers, *supra* note 113.

116. According to Meiers, physicians established the Society of Surgeon Dentists of the City and State of New York in 1834. See Meiers, *supra* note 113. But by 1856, the group disbanded. *Id.* And in 1859, dentistry was originally organized as a profession separate from medicine. *Id.* The American Dental Association was formed in 1859. See *id.*; see also *ADA Timeline*, AM. DENTAL ASS'N, <http://www.ada.org/adatimeline.aspx> (last visited June 28, 2013) (reporting that William Henry Atkinson, 1815–1891, the first president of the American Dental Association, was trained as a physician).

117. See Meiers, *supra* note 113; see also *ADA Timeline*, *supra* note 116.

118. See ALYSSA PICARD, MAKING THE AMERICAN MOUTH: DENTISTS AND PUBLIC HEALTH IN THE TWENTIETH CENTURY 8 (2009).

119. See *id.* at 9.

120. See John Fleming, *Other States Have Seen Efforts to Restrict Dental Care*, ANNISTON STAR, Apr. 21, 2010, http://www.annistonstar.com/view/full_story/7145547/article-Other-states-have-seen-efforts-to-restrict-dental-care.

the care was unremunerated.¹²¹ Since mobile clinics serving elementary school children aimed, in particular, to care for Medicaid patients, the bill would have restricted care for the poorest children. The Federal Trade Commission's Office of Policy Planning opined that the bill, favored by the Louisiana Dental Association, would have limited competition and restricted access to care.¹²² The legislation was defeated in the state House by a narrow margin.¹²³

Similar efforts, supported by organized dental groups, to limit the work of dental clinics serving low-income populations, emerged in Florida in the 1990s and in Alabama in both 2010 and 2011.¹²⁴ The Sarrell Dental Clinic in Alabama, the primary provider of dental care for pediatric Medicaid patients in Alabama, faced a challenge by the Alabama Board of Dentistry to the legality of its clinics.¹²⁵ Sarrell, which included almost a dozen clinics and a mobile dental unit, initiated an antitrust lawsuit against the establishment dental group.¹²⁶ In 2011, the parties reached a compromise that allowed the Sarrell clinics to continue to operate.¹²⁷ Sarrell's decision to drop the antitrust case followed Alabama Governor Robert Bentley's signing of a law allowing nonprofit dental clinics to operate only if they registered with the state dental board, freeing them from more restrictive regulations.¹²⁸ In addition, the law permits non-dentists to practice outside the purview of the dental association.¹²⁹ Sarrell, in return, agreed to end its antitrust case against the state's dental association.¹³⁰

121. See *id.*

122. See *id.*

123. See Jordan Blum, *School Dental Work Ban Fails in House*, ADVOCATE, May 20, 2009, at A12.

124. See Fleming, *supra* note 120.

125. See Patrick McCreless, *Sarrell Dental Featured in PBS Documentary Program*, ANNISTON STAR, June 26, 2012.

126. See Fleming, *supra* note 120; McCreless, *supra* note 125.

127. See Fleming, *supra* note 120; McCreless, *supra* note 125.

128. See *Sarrell Drops Lawsuit Against Ala. Dental Association*, DRBICUSPID.COM (June 10, 2011), <http://www.drbuspid.com/index.aspx?sec=sup&sub=pmt&pag=dis&ItemID=307877>.

129. See Donna Domino, *Alabama to Exempt Nondentists from Dental Board Oversight*, DRBICUSPID.COM (June 7, 2011), <http://www.drbuspid.com/index.aspx?sec=sup&sub=bai&pag=dis&ItemID=307836>.

130. See Editorial, *'Huge Victory' for the Children*, ANNISTON STAR, June 13, 2011, <http://www.sarrelldental.org/anniston-star-%E2%80%98huge-victory%E2%80%99-for-the-children>.

Dental therapists offer another source of less expensive dental care than that which private-practice dentists generally provide. They could fill a crucial gap in the United States where, in contrast to many other nations, there are almost no mid-level providers in dentistry.¹³¹ Dental therapists have more training than hygienists but less than dentists, and they can perform routine dental work such as filling cavities.¹³² Dental associations, however, have widely opposed the acceptance of such therapists.¹³³ Two states, Alaska and Minnesota, do allow dental therapists to provide preventive, and some basic, care for dental disease.¹³⁴ This approach increases access to care for low-income populations, in part because the salaries of dental therapists are about fifty percent lower than those of dentists.¹³⁵

3. Medicaid and SCHIP

As noted above, Medicaid requires states to cover dental care for pediatric patients.¹³⁶ Care for children eligible for Medicaid is required through the "Early Periodic Screening, Diagnosis, and Treatment" benefit.¹³⁷ Medicaid allows—but does not require—states to provide dental care for adults.¹³⁸ Thus, many states' Medicaid

131. FRANCES M. KIM, CMTY. CATALYST, ECONOMIC VIABILITY OF DENTAL THERAPISTS 2 (2013), available at, <http://www.wkkf.org/knowledge-center/resources/2013/05/economic-viability-of-dental-therapists.aspx>.

132. See Michelle Healy, *Dental Therapists Aim to Fill Dental-Care Gap*, USA TODAY, Jan. 2, 2013, <http://www.usatoday.com/story/news/nation/2012/12/21/dental-therapists-minnesota/1731979/>.

133. See Goodnough, *supra* note 39, at A16. The dental associations that have opposed broadening the role of dental hygienists have noted safety as the reason. See *id.*

134. See *Alaska and Minnesota: Increasing Access to Dental Care*, STATES IN ACTION (The Commonwealth Fund, N.Y.C.), March/April 2010, available at <http://www.commonwealthfund.org/Newsletters/States-in-Action/2010/Mar/March-April-2010/Snapshots/Alaska-and-Minnesota.aspx>. In Alaska, dental therapists, who provide care within the "tribal health system," must work with a dentist, but the dentist need not be present when care is provided. In Minnesota, dental therapists can only work if a dentist is present in the same office. See *id.*

135. See *id.*

136. See *supra* note 95 and accompanying text.

137. 42 U.S.C. § 1396d(r) (2012). This subsection defines "early and periodic screening, diagnostic, and treatment services" to include dental services which must be provided "at intervals which meet reasonable standards of dental practice," § 1396d(r)(3)(A)(i), whenever "medically necessary," § 1396d(r)(3)(A)(ii), and "which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health," § 1396d(r)(3)(C).

138. See Erika Beras, *In Pennsylvania, Medicaid Cuts Reduce Options for Dental Care*, KAISER HEALTH NEWS (July 15, 2012), <http://www.kaiserhealthnews.org/>

programs offer no dental coverage for adults beyond tooth extraction.¹³⁹ Even more, some state Medicaid programs that once provided dental coverage for adults have eliminated it.¹⁴⁰ In 2012, Pennsylvania's Medicaid program stopped covering root canals and care for gum disease, and it also limited the number of new dentures covered.¹⁴¹ Illinois cut its Medicaid program by one billion dollars in the summer of 2012 and consequently limited adult Medicaid dental coverage to emergency tooth extraction.¹⁴²

Furthermore, even in states that do provide dental coverage for adults through their Medicaid programs, many dentists do not accept Medicaid patients.¹⁴³ This practice echoes the pattern characterizing the experience of pediatric Medicaid-eligible patients.¹⁴⁴ Dentists seem to be more ready to accept low-income patients with private dental insurance than those with Medicaid.¹⁴⁵ With private coverage, payments tend to be higher and administration burdens tend to be lower.¹⁴⁶

Since 2009, SCHIP, following the Medicaid model, also requires states to provide pediatric dental coverage.¹⁴⁷ Congress created SCHIP in 1997, providing for a decade of funding.¹⁴⁸ At first, the law

Stories/2012/July/14/pennsylvania-medicaid-dental-cuts.aspx; see also KAISER FAMILY FOUND., *supra* note 23, at 1.

139. See sources cited *supra* note 138 and accompanying text.

140. See Beras, *supra* note 138. Pennsylvania justified the cuts to dental coverage as a measure that would save Medicaid millions of the dollars. See *id.*

141. See *id.*

142. See Goodnough, *supra* note 39, at A16. Under the Affordable Care Act, cuts in optional Medicaid benefits are, at least in part, a consequence of their being precluded from shrinking the ranks of those eligible for Medicaid before 2014. At that time, the program will expand in many states to cover people with incomes up to 133% of the federal poverty level. See *id.*

143. See David Grembowski et al., *Disparities in Regular Source of Dental Care Among Mothers of Medicaid-Enrolled Preschool Children*, 18 J. HEALTH CARE FOR POOR & UNDERSERVED 789, 806 (2007).

144. See *supra* notes 66–72 and accompanying text.

145. See Grembowski, *supra* note 143, at 806.

146. See *id.* Grembowski and colleagues conclude that the comparative attractiveness of private insurance over Medicaid for low-income patients may account for the greater likelihood that low-income mothers with private coverage will have a “regular source of dental care.” *Id.*

147. See Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, 123 Stat. 85 (2009); see also KAISER FAMILY FOUND., *supra* note 23, at 3.

148. See Balanced Budget Act of 1997, Pub. L. No. 105-3, 111 Stat. 552 (1997). Some of the socioeconomic implications of the struggle to reauthorize SCHIP between 2007 and 2009 are considered in Janet L. Dolgin, *Class Competition and*

did not require states with independent SCHIP plans¹⁴⁹ to provide dental coverage.¹⁵⁰ As a result, children covered by Medicaid had more extensive coverage than those insured through SCHIP plans.¹⁵¹ In 2009, reauthorization of the program included dental benefits.¹⁵² That inclusion reflected concern, among other things, about children dying, as Deamonte Driver had, from untreated dental decay.¹⁵³ The reauthorized SCHIP program requires the inclusion of dental benefits for children,¹⁵⁴ including preventive services, treatment of oral disease, and emergency dental care.¹⁵⁵ In 2013, state eligibility levels for participation in independent SCHIP programs ranged from 160%

American Health Care: Debating the State Children's Health Insurance Program, 70 LA. L. REV. 683 (2010).

149. The legislation that created SCHIP provided three options for states: states could develop independent SCHIP programs; they could expand Medicaid programs to cover children in somewhat higher-income families than those covered by Medicaid; or they could develop hybrid programs by adding new features to ongoing Medicaid programs. See 42 U.S.C. §§ 1397aa(a), ee(c)(2) (2012). In 2007, as the original SCHIP programs faced expiration, eleven states had expanded Medicaid plans; eighteen states operated separate SCHIP plans; and twenty-one states ran hybrid programs. See KAISER FAMILY FOUND., KAISER COMM'N ON MEDICAID & THE UNINSURED, CHILDREN & A DECADE OF SCHIP EXPERIENCE AND ISSUES FOR REAUTHORIZATION 1 (2007), available at <http://www.kff.org/medicaid/upload/7574-2.pdf>; see also Dolgin, *supra* note 148, at 704–05.

150. The Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006), reduced the difference generally between services required for pediatric patients under Medicaid and those required for independent SCHIP plans.

151. Since 1967, Medicaid required states to provide “early and periodic screening, diagnosis, and treatment (EPSDT)” services for children. See KAISER FAMILY FOUND., KAISER COMM'N ON MEDICAID & THE UNINSURED, HEALTH COVERAGE FOR LOW-INCOME POPULATIONS: A COMPARISON OF MEDICAID AND SCHIP 3 (2006), available at <http://www.kff.org/medicaid/upload/7488.pdf>. EPSDT services included dental services. *Id.*

152. See Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, 123 Stat. 85. Congress reauthorized SCHIP temporarily in 2007. See Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. No. 110-173, 131 Stat. 2492.

153. See *supra* notes 57–71 and accompanying text. Ironically, Deamonte Driver was eligible for Medicaid coverage.

154. CHIPRA, *supra* note 96.

155. *CHIP Benefits*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-Benefits.html> (last visited June 28, 2013).

to 400% of the federal poverty level,¹⁵⁶ and yet millions of poor children still are not covered for dental health needs.¹⁵⁷

Children from low-income families, not poor enough to be eligible for state Medicaid or SCHIP programs, are less likely than poorer children to get dental care.¹⁵⁸ In 2012, 12% of poor children did not have dental coverage.¹⁵⁹ Among “near-poor” children, 21% had no coverage, and among children in families earning at least twice the federal poverty level, 29% had no dental coverage.¹⁶⁰ These differences were reflected in care received. In 2010, more than 80% of poor children with some sort of dental coverage received dental care within the previous twelve months, while only 50% of poor, uninsured children received care during the same period of time.¹⁶¹

States slashed dental Medicaid benefits for adults when the 2008 recession hit.¹⁶² In 2009, millions of poor and/or disabled adults in California lost coverage for dental care through Medicaid.¹⁶³ Increases in pay rates, aimed at encouraging the participation of more dentists in Medicaid programs, largely evaporated after the start of the recession. Eleven states cut dental-pay rates in 2011, and thirteen did so in 2012.¹⁶⁴

As discussed *supra*, dentists in general practice often refuse to accept Medicaid patients, and those that do accept Medicaid patients may limit the number for whom they will provide care.¹⁶⁵ Dental

156. See *Income Eligibility Limits for Children's Separate CHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, January 2013*, KAISER FAMILY FOUND.: STATE HEALTH FACTS (Jan. 2013), <http://kff.org/other/state-indicator/income-eligibility-separate-chip-prog/>.

157. See Otto, *supra* note 71.

158. See KAISER FAMILY FOUND., *supra* note 23, at 3.

159. See *id.*

160. See *id.*

161. See *id.* at 4.

162. See KAISER FAMILY FOUND., KAISER COMM'N ON MEDICAID & THE UNINSURED, MOVING AHEAD AMID FISCAL CHALLENGES: A LOOK AT MEDICAID SPENDING, COVERAGE AND POLICY TRENDS 31–32 (2011), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8248.pdf>. Four states increased dental-pay rates in 2011 and three did so in 2012. *Id.* at 32 tbl.1.

163. See Sarah Varney, *Dental Coverage Cuts Leave California's Poor in Pain*, NPR (Feb. 21, 2010), <http://www.npr.org/templates/story/story.php?storyId=123855834>. From its start, Medicare did not mandate coverage of dental care. See *id.*

164. See KAISER FAMILY FOUND., *supra* note 162, at 32.

165. It is difficult to find dentists who accept Medicaid patients in part because Medicaid payment rates tend to be very low. See KAISER FAMILY FOUND., *supra* note 23, at 5 (noting dentists refer to low rates of pay as primary reason they hesitate to accept Medicaid patients).

specialists (including pediatric dentists) are even less likely than others dentists to participate in Medicaid.¹⁶⁶ Dr. Frank Catalanotto, a Florida dentist, offered one rather discomfoting explanation. Dentists, he explained, tend to come from middle- or high-income families.¹⁶⁷ Their patients tend to come from the same income groups and “they don’t see the 60 [million] to 100 million individuals that don’t have dental insurance.”¹⁶⁸ Thus, at least in part they know about the problem only in theory. They are not moved by personal experience to increase access to dental care for patients whose coverage pays very little.¹⁶⁹ June Thomas has offered a related, but even more critical, explanation: “It’s clear that low fees and bothersome paperwork aren’t the only reasons dentists avoid Medicaid patients. Letting patients with bad teeth, often from lower socioeconomic backgrounds, into their waiting rooms risks upsetting dentists’ full-fee patients.”¹⁷⁰ This claim offers one explanation of dentists’ refusing to take Medicaid patients. It also suggests the extent to which people—including, or perhaps especially, dentists and those sitting in dentists’ offices—judge each other’s class status by assessing their dental condition.

4. *Private Insurance for Dental Care*

Dental care can be beyond the means of even middle-income people. Almost one third of children with private health insurance have no coverage for dental care,¹⁷¹ and three times as many adults do not have dental coverage as do not have general health coverage.¹⁷²

166. *See id.*

167. *Dr. Frank Catalanotto: Why the ADA Is Wrong About Access to Dental Care*, PBS FRONTLINE (June 26, 2012), <http://www.pbs.org/wgbh/pages/frontline/health-science-technology/dollars-and-dentists/dr-frank-catalanotto-why-the-ada-is-wrong-about-access-to-dental-care>. Dr. Catalanotto, chair of the Department of Community Dentistry and Behavioral Science, University of Florida, describes his interest in furthering access to dental care for low-income people to have developed when he spent a couple weeks in a Texas town on the Mexican border in 1985. *Id.* He reports that there he saw “hardworking people” with serious dental problems and no access to dental care. *Id.*

168. *Id.*

169. *See id.*

170. June Thomas, *The American Way of Dentistry: Healthy Teeth for All*, SLATE (Oct. 4, 2009, 11:09 PM), http://www.slate.com/articles/life/the_american_way_of_dentistry/2009/10/the_american_way_of_dentistry.html.

171. *See* Rowland, *supra* note 29, at 3.

172. *See id.*

Even for those with dental insurance, coverage is often partial.¹⁷³ Paying for coverage does not mean that policies provide dental care without significant additional costs.¹⁷⁴ In a survey published by Consumer Reports in early 2012, almost three quarters of the respondents had dental insurance, but of that group, less than half reported that the insurance covered more than fifty percent of the cost of care.¹⁷⁵ Prices for dental care were steep even for those with coverage and much steeper for those without coverage.¹⁷⁶

5. *The Patient Protection and the Affordable Care Act*

The Patient Protection and Affordable Care Act (ACA),¹⁷⁷ which promises to increase access to health care for everyone, including low-income people, will not significantly increase coverage for adults' dental care. The ACA does not require coverage of dentistry for adults and does little to merge dental care, and methods of paying for it, into the nation's system of health care delivery and payment.¹⁷⁸

In theory, at least, the ACA will increase access to pediatric dental care for low-income children.¹⁷⁹ The Act has provided for significant expansion of the Medicaid program to cover everyone earning up to 133% of the federal poverty level.¹⁸⁰ In addition, the Act classifies dental care for children as an "essential health benefit" (EHB), thereby mandating that it be included as a benefit in policies offered on state exchanges.¹⁸¹ Defining dental care as an EHB should

173. *See id.*

174. *Consumer Reports Survey*, *supra* note 94.

175. *See id.*

176. For people without dental insurance in 2012, a filling cost \$288; it cost \$141 (out-of-pocket) for those with dental insurance. *See id.* An implant cost \$3,938 for those without insurance and \$2,825 for those with insurance. *See id.*

177. *See Patient Protection and Affordable Care Act*, Pub. L. No. 111-148, 124 Stat. 119-1025 (2010) (codified as amended in scattered sections of 42 U.S.C.).

178. *See Sanger-Katz*, *supra* note 48.

179. Patient Protection and Affordable Care Act § 1302(b)(1)(J), 42 U.S.C. § 18022(b)(1)(J) (2012) (describing essential dental benefits for children).

180. The Affordable Care Act provides for a 133% minimum eligibility threshold, but the Act includes a new method for calculating income. As a result, those earning less than 138% of the federal poverty level must be eligible for Medicaid under the Act. *See Medicaid Expansion*, AM. PUB. HEALTH ASS'N, <http://www.apha.org/advocacy/health+reform/acabasics/medicaid.htm> (last visited June 28, 2013).

181. Patient Protection and Affordable Care Act § 1302(b)(1), 42 U.S.C. § 18022(b)(1) (essential health benefits include "Ambulatory patient services; Emergency services; Hospitalization; Maternity and newborn care; Mental health and substance abuse disorder services, including behavioral health treatment; Prescription drugs; Rehabilitative and habilitative services and devices; Laboratory

facilitate increased access to dental care for children covered through one of the state exchanges.

Several significant caveats, however, may limit these expansions of coverage. One caveat relates to the Act's intended expansion of Medicaid.¹⁸² The Supreme Court's review of the constitutionality of various parts of the ACA resulted in possible limitations on the expansion of Medicaid that the Act originally contemplated.¹⁸³ More specifically, the Court found unconstitutional the requirement that states opting out of an expanded Medicaid program would lose the right to participate in the program altogether.¹⁸⁴ Thus, states may now retain federal funds for their Medicaid programs without expanding the group of people eligible for Medicaid. Some states have decided not to expand their Medicaid programs, and others may join them.¹⁸⁵ This result cuts significantly into the promise of expanded health care, including dental care, for low-income children.¹⁸⁶

Even if all of the states were to participate in the expansion of Medicaid as the ACA contemplated, the scarcity of dental practitioners willing to accept Medicaid fees would undermine the Act's intentions with regard to dental care unless states significantly increase the rate of pay for dental care.¹⁸⁷ In short, unless dentists are

services; Preventive and wellness services and chronic disease management; Pediatric services, including oral and vision care"); *see also* ULMER ET AL., *supra* note 26, at 61. In effect, these exchanges provide an "online marketplace" within which health consumers can select from among various plans by comparing the price of the plans and the benefits that they offer. *See* Editorial, *Scorecard on Health Insurance Exchanges*, N.Y. TIMES, Jan. 7, 2013, at A18.

182. *See Mapping the Effects of the ACA's Health Insurance Coverage Expansions*, KAISER FAMILY FOUND., <http://kff.org/interactive/coverage-expansion-map/> (follow "Who Benefits from the Affordable Care Act's Coverage Expansions?" hyperlink) (last visited June 28, 2013) (noting that the ACA provides an expansion of Medicaid to include families with incomes up to 138% of the federal poverty level).

183. *See* Nat'l Fed'n Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012). Chief Justice Roberts, joined by Justices Breyer and Kagan, *id.* at 2608 (opinion of Roberts, C.J.), and dissenting Justices Scalia, Kennedy, Thomas, and Alito, *id.* at 2666 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting), all found that compelling states to join an expanded Medicaid program, as contemplated under the ACA, or lose all Medicaid funds exceeded the scope of Congress's constitutional powers.

184. *See id.* at 2608 (opinion of Roberts, C.J.); *id.* at 2666 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).

185. *See Across the USA*, USA TODAY, July 13, 2012, at 5A.

186. *See* KAISER FAMILY FOUND., *supra* note 23, at 5-6.

187. *See* David Satcher, Dir., The Satcher Health Leadership Inst., Morehouse Sch. of Med., Keynote Address at the Morehouse School of Medicine Symposium: Oral Health in America—Revisiting the Surgeon General's Report of 2000 (July 17, 2012). Satcher, noting the expansion of Medicaid contemplated by the Affordable

ready to accept Medicaid patients, the theoretical availability of dental coverage is of little practical moment.

A second caveat relates to dental coverage through state exchanges. Under the ACA, many people not eligible for Medicaid will seek health coverage through the state exchanges.¹⁸⁸ A number of plans, however, are exempt from the requirement that they include EHBs in the coverage they offer.¹⁸⁹ The requirement may be further limited by a proposed Health and Human Services rule providing that plans offered through a state exchange need not include pediatric dental coverage if the exchange offers a stand-alone dental plan.¹⁹⁰ In addition, the ACA does not provide details about specific services that must be offered.¹⁹¹ Even more consequential, dental care *for adults* is not categorized as essential.¹⁹² As a result, plans offered on the state exchanges need not include dental coverage for adults as part of the benefits offered.¹⁹³

Once the ACA is implemented, many people are expected to receive dental coverage through employers. Here again, limitations may eviscerate a significant part of the promise of employer-provided dental plans. Under the ACA, so-called “grandfathered” plans are not required to cover even pediatric dentistry.¹⁹⁴ Moreover, large

Care Act, asked: “But the question is not just how many more people would be covered: Who would be available to provide that care?” *Id.* at 4.

188. Beginning in 2014, qualified health plans will be required to offer dental coverage for children because the Affordable Care Act categorizes pediatric dental care among the ten categories of EHB’s. *See* ULMER ET AL., *supra* note 26, at 6.

189. *See id.* at 19 (noting that programs not covered by the essential health benefit requirement include “Self-insured employer-sponsored plans; Grandfathered employer-sponsored plans; Grandfathered plans in the small group market; Grandfathered individual plans in the non-group market: Existing Medicaid plans”).

190. *See* Craig Palmer, *HHS Seeks Comment on Dental Coverage Proposal*, AM. DENTAL ASS’N (Nov. 28, 2012), <http://www.ada.org/news/7998.aspx>; *see also* S. Comm. on Fin. Holds a Hearing on Treasury and HHS Nominations, 112th Cong. (2012) (statement of Sen. Max Baucus, Chairman, S. Comm. on Fin.) (transcript available at <http://political-transcript-wire.vlex.com/vid/sen-max-baucus-treasury-hhs-nominations-414035638>).

191. *See* ULMER ET AL., *supra* note 26, at 1.

192. *See* Patient Protection and Affordable Care Act § 1302(b)(1)(A)–(J), 42 U.S.C. 18022(b)(1)(A)–(J) (2012); *supra* note 181 and accompanying text (listing ten categories of essential health benefits); *see also* ULMER ET AL., *supra* note 26, at 6.

193. *See* KAISER FAMILY FOUND., *supra* note 23, at 1.

194. *See* Michelle Andrews, *Health Law Offers Dental Coverage Guarantee for Some Children*, KAISER HEALTH NEWS (Jan. 14, 2013), <http://www.kaiserhealthnews.org/Features/Insuring-Your-Health/2013/011513-Michelle-Andrews-on-kids-dental-care-coverage.aspx>.

companies are not required to provide dental coverage at all (although many do).¹⁹⁵

Expanding the availability of pediatric dental coverage may impact adult coverage negatively. A spokesperson for the National Association of Dental Plans noted one possible consequence of separating adult dental coverage and pediatric coverage (an "essential benefit") under the ACA is that, should the cost of pediatric coverage be high, parents may refrain from purchasing optional coverage for themselves.¹⁹⁶

After implementation of the ACA in 2014, Medicare will continue to provide coverage for those over sixty-five years old.¹⁹⁷ People eligible for Medicare, like people ineligible for Medicare, may still obtain dental coverage through employers or private purchase. For those dependent on Medicare, however, dental coverage is very limited. This will not change as the ACA is implemented: the Act does not require Medicare to provide dental coverage for its participants.¹⁹⁸

6. *Comprehensive Dental Reform Act of 2012*

The Comprehensive Dental Reform Act,¹⁹⁹ introduced in the 112th Congress by Senator Sanders (I-Vt.) in the Senate and Representative Elijah Cummings (D-Md.) in the House, proposes doing what the ACA does not do: ensuring comprehensive dental coverage to a wide group of people, including the elderly and those with low incomes.²⁰⁰ Title I of the bill details the need for dental coverage: 47 million people have difficulty accessing dental care; 17 million low-income children do not get coverage for dental care; and

195. *See id.*

196. Lori Chordas, *Open Wide: Mandated Dental Coverage for Children May Help to Expand Sales*, 113 BEST'S REV. 24 (2012) (quoting Evelyn Ireland, Exec. Dir., Nat'l Ass'n of Dental Plans).

197. *See* Edelstein et al., *supra* note 96, at 1476.

198. Coverage for Medicare-eligible people may be available for a few dental procedures such as examination, but not treatment, before certain serious operations such as a kidney transplant or a heart valve replacement. Medicare covers tooth extractions precedent to medical radiation of the jaw, as well as a few other matters. *See Dental Plans*, MEDICARE.COM, <http://www.medicare.com/services-and-procedures/dental/medicare-and-dental-plans.html> (last visited June 28, 2013).

199. Comprehensive Dental Reform Act of 2012, S. 3272, 112th Cong. (2d Sess.). The bill was introduced in the Senate by Bernie Sanders (I-Vt.) and in the House by Elijah E. Cummings (D-Md.). *See* Dan Rodricks, *Wall Street Pays, the Nation Smiles*, BALTIMORE SUN, June 17, 2012, at 25A.

200. S. 3272, 112th Cong. (2012).

the Medicaid program is not required to provide dental coverage for adults.²⁰¹ The bill described those most likely not to get adequate dental care to include “individuals with low incomes, racial and ethnic minorities, pregnant women, older adults, individuals with special needs, and individuals living in rural communities.”²⁰²

The bill, if passed, would provide dental care for Medicare recipients as well as for adults receiving care through Medicaid,²⁰³ and for those covered by the Veterans Administration.²⁰⁴ In addition, the bill would create mobile units providing dental care in places where access to dental providers is thin, and it would help fund the training of dental care professionals, including “dental therapists.”²⁰⁵ It would also provide funding to educate emergency room physicians in emergency dental care.²⁰⁶ The bill provides for funding by imposing a tax of 0.025% on securities transactions.²⁰⁷ The bill would significantly minimize disparities in dental health in the United States. The bill provides a good model for what needs to be done. However, it has virtually no chance of becoming law—at least not at this time—as it died in committee.²⁰⁸

II. TEETH EVEN THE “TOOTH FAIRY” MIGHT ENVY

For people with financial resources, dental care in the United States provides not only for patients’ health needs, but also, often, for their aesthetic yearnings. The latter is significant in promoting a culture where people may assess each other’s teeth to determine socioeconomic status. Such assessments cross class boundaries.²⁰⁹ A person’s dental condition can signal poverty and low socioeconomic status. For those without teeth or with visibly mangled teeth, social and economic opportunities can be significantly limited.²¹⁰ At the

201. *Id.* sec. 3 (findings).

202. *Id.*

203. *Id.* §§ 101, 111.

204. *Id.* § 301.

205. *Id.* §§ 201, 225.

206. *Id.* § 320C(c).

207. For every \$10,000 of transactions, \$2.50 would be charged to pay for dental care. *Id.* § 701.

208. See S. 3272 (112th): *Comprehensive Dental Reform Act of 2012*, GOVTRACK.US, <http://www.govtrack.us/congress/bills/112/s3272> (last visited June 28, 2013).

209. See Glied & Neidell, *supra* note 41, at 6–7.

210. See U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 3, at 146 tbl.6.4 (summarizing “Studies of Multidimensional Quality of Life Measures”).

other end of the nation's socioeconomic hierarchy, however, teeth can signal wealth.²¹¹ For middle- and upper-class Americans, contemporary dentistry has diverged from its counterpart of a half century ago.²¹² The fluoridation of water and routine dental care for middle- and upper-class children have significantly limited the types of problems that once brought many Americans to dentists. But dentistry—once considered a has-been profession—has flourished as Americans with means have become hooked by cosmetic dentistry.²¹³

"Americans," reported June Thomas, have become "obsessed with teeth"²¹⁴—a reference not to dental health, but rather to the presumptive importance of dental aesthetics. "A beaming smile," Thomas adds, "is the ultimate testament to American prosperity and self-confidence."²¹⁵ The dental profession itself has supported the presumption that one's teeth reflect one's values. This is evident, for instance, in the profession's support for the proposition that dental health is a product of individual responsibility and choice.²¹⁶ The condition of a person's teeth allows others to place that person on the nation's socioeconomic hierarchy²¹⁷ and to assess his or her moral grit.²¹⁸ In short, teeth have become a barometer of class status.

Unsurprisingly, as middle- and upper-class Americans have focused more and more on the aesthetics of teeth, they have become less satisfied with the appearance of their teeth. At the start of the 1990s, 57% of people in the United States were "very satisfied" with the way their teeth looked.²¹⁹ By the end of the decade, only 46% of the population was similarly satisfied with the appearance of their teeth.²²⁰ The business of reshaping and whitening teeth—cosmetic dentistry—has flourished.

211. See June Thomas, *Q & A with Alyssa Picard*, BOS. GLOBE, Apr. 12, 2009, at C3.

212. See *id.*

213. See David Plotz, *Defining Decay Down*, SLATE (Aug. 18, 1999, 3:30 AM), http://www.slate.com/articles/briefing/articles/1999/08/defining_decay_down.single.html.

214. Thomas, *supra* note 211, at C3.

215. *Id.*

216. See PICARD, *supra* note 118, at 9.

217. See June Thomas, *The American Way of Dentistry: How Dentists Think*, SLATE (Sept. 30, 2009, 9:38 AM), http://www.slate.com/articles/life/the_american_way_of_dentistry/2009/09/the_american_way_of_dentistry.html.

218. See PICARD, *supra* note 118, at 9.

219. See Thomas, *supra* note 217.

220. See *id.*

David Plotz, a journalist who writes for Slate, asked scores of people at the end of the twentieth century what bothered them about dentistry.²²¹ Almost none complained "about cosmetic dentistry. . . . They like their whiter, straighter teeth."²²² Rather, many "griped about the medically advisable treatments that their dentists prescribed."²²³ Plotz quotes a St. Louis dentist, Dr. William Hartel: "'Dentists are aware of providing what patients want.' . . . 'I had a woman come in with a terrible toothache. She needed a root canal, but she did not want it. But she did want her teeth bleached, and she paid cash for it.'"²²⁴

Similarly, historian Alyssa Picard attributes the stunning growth of cosmetic dentistry to both the value of "good" teeth as a mark of status and to the push of the dental establishment, which feared that the successes of twentieth century dentistry (e.g., fluoride) would result in falling incomes for dentists.²²⁵ Cosmetic procedures include whitening, bonding, bridges, implants, contouring, and reshaping, among others.²²⁶

[T]he most powerful and intentional force militating in the direction of the new norms of dental appearance was the activism of American dentists themselves. In the late twentieth and early twenty-first centuries, dentists fearing real and imagined threats to their incomes and professional autonomy sought to inculcate Americans with an aspirational vision of dental health and appearance that depended on extensive individual investment of time and money into dental treatment, and they were largely successful in doing so.²²⁷

221. Plotz, *supra* note 213.

222. *Id.*

223. *Id.*

224. *Id.* (internal quotation marks omitted)

225. See PICARD, *supra* note 118, at 156–59.

226. Each of these procedures is described on the website "About Cosmetic Dentistry." See *Cosmetic Dentistry Procedures*, ABOUTCOSMETICDENTISTRY.COM, <http://aboutcosmeticdentistry.com/procedures> (last visited June 28, 2013). The site seems to be sponsored by individual dentists, showcasing examples of cosmetic dentistry work. See *Cosmetic Dentistry Before & After Photos*, ABOUTCOSMETICDENTISTRY.COM, <http://aboutcosmeticdentistry.com/photos/index.html> (last visited June 28, 2013). And the American Academy of Cosmetic Dentistry explains that cosmetic dentistry, in the hands of "[a] skilled, experienced cosmetic dentist can help to improve your appearance, your smile, even your self-esteem, and confidence." *Cosmetic Dentistry Benefits*, AM. ACAD. COSMETIC DENTISTRY, <http://www.aacd.com/index.php?module=cms&page=557> (last visited June 28, 2013).

227. PICARD, *supra* note 118, at 176.

This success illustrates a more widespread pattern by which industry creates a need in order to sell a product or service.²²⁸ And as Picard reports, in the second half of the twentieth century, dentists encouraged their current and potential patients to consider forms of care that were cosmetic in character.²²⁹ They could not have successfully motivated people to spend thousands of dollars to alter the color, placement, or shape of their teeth were the project not also of service to a deeper set of goals. For Americans, expensive dental care, resulting in teeth indicative of their owner's wealth, became an envied mark of class status in a nation deeply concerned with class status and yet at the same time, uncertain about how to assess it.²³⁰

The process through which dentistry for middle- and upper-class Americans has increasingly included cosmetic care has participated in a larger process through which, at once, cosmetic care has become medicalized and dental care has become de-medicalized. Anthropologist Alexander Edmunds noted a similar process affecting the provision of various forms of plastic surgery in Brazil:

[B]iomedicine can act as a form of politics by other means. . . . [F]rom its unique position on the borders of proper medicine, plastica [cosmetic surgery] not only medicalizes the body but also in a sense "de-medicalizes" itself. Of course, cosmetic surgery is a medical specialty But as plastica becomes infused with the frustrated desires of patients, the competitive logic of markets . . . and the medical and consumer fetishisms of popular culture, the question arises as to whether it is "medicine" in any recognizable form²³¹

In Brazil, cosmetic surgery is offered in public hospitals.²³² In contrast, in the United States, the cost of good teeth—the sort of teeth that mark high class status—can be stunning. Some dentists suggest that remodeling teeth offers an alternative to face-lifts and Botox.²³³ Remolding teeth can cost between \$5,000 and \$80,000 and is

228. Elliott describes the creation of psychiatric illnesses as a "case in point." CARL ELLIOTT, *BETTER THAN WELL: AMERICAN MEDICINE MEETS THE AMERICAN DREAM* 122–26 (2003).

229. PICARD, *supra* note 118, at 176.

230. *Id.* at 11–12.

231. Alexander Edmonds, *'The Poor Have the Right to be Beautiful': Cosmetic Surgery in Neoliberal Brazil*, 13 J. ROYAL ANTHROPOLOGICAL INST. 363, 376 (2007).

232. *See id.* at 363.

233. *See* Laura Johannes, *Taking Years Off Your Smile*, WALL ST. J., Apr. 13, 2010, at B9. It is more likely, in fact, that remodeling teeth for most people who have it done is a supplement, rather than an alternative, to other techniques of presumptive beautification or methods for reducing the appearance of age. *See id.*

generally not covered by insurance.²³⁴ Even procedures requiring no structural work, such as teeth whitening, can come with hefty price tags.²³⁵ Dentists charge \$500 to \$1,000 or more in metropolitan areas for whitening done in the office.²³⁶ Even “at-home” whitening products can cost several hundred dollars.²³⁷ And for cases of serious discoloration, dentists may recommend porcelain veneers, which cost up to \$2,000 per tooth.²³⁸

A variety of factors keep the price of cosmetic dental care high. Among other things, dentists have been able to resist non-dentists’ providing such care. *North Carolina State Board of Dental Examiners v. FTC*²³⁹ involved responses to North Carolina’s dental board’s antagonism to permitting non-dentists to offer teeth-whitening treatments.²⁴⁰ More specifically, a FTC administrative law judge found the state’s dental board engaged in anticompetitive acts by attempting to prohibit teeth-whitening services in centers operated

Dentists have described remolding to affect a transformation of facial “scaffolding.” *Id.*

234. *See id.* (noting that the price depends on the particular dentist involved and the number of teeth involved). Even more, the procedures involved in remolding teeth carry risks, including pain in the jaw and the collection of bacteria at the line of the gum, depending on the shape of the veneer applied. *See id.*

235. Tooth whitening is almost never covered by insurance. *See* Eric Gershon, *Pearly Whites; Teeth-Whitening Options Range from Cheap Home Aids to Pricey*, HARTFORD COURANT, June 6, 2010, at D1.

236. Matthew Shulman, *Brightening Your Bite: Chew on These Choices for Tooth Whitening, from Home Treatments to Professional Care*, NEWSDAY, Mar. 18, 2008, at B08. A combination whitening treatment, performed partly in a dentist’s office and partly at home, can cost \$550. *See* Jessica Elizarraras, *Steps to Ponder to Upgrade Smile*, SAN ANTONIO EXPRESS-NEWS, Dec. 13, 2010, at 6E.

237. Elizarraras, *supra* note 236, at 6E.

238. Matthew Shulman, *Add Luster to Your Smile*, ORLANDO SENTINEL, Dec. 4, 2008, at G3; *see* Katherine Russell, *Dental Veneers: Dental Hygiene Knowledge and Care of the Ultimate Smile*, ACCESS, Nov. 1, 2008, at 33, 33–34 (noting that porcelain veneers can last more than fifteen years and, for that reason, may be a better option for some people than whitening).

239. N.C. State Bd. Of Dental Exam’rs v. Fed. Trade Comm’n, No. 12-1172, 2013 WL 2367806 (4th Cir. May 31, 2013); *see FTC Decision Jeopardizes Authority of Medical Boards, Doctors Say*, AM. MED. NEWS (Aug. 20, 2012), <http://www.amednews.com/article/20120820/profession/308209943/5/>.

240. The specific issue in the case involved a state medical board’s seeking immunity as a state actor in response to the Federal Trade Commission’s alleging anticompetitive behavior. *See* Peyton M. Sturges, *FTC’s North Carolina Dental Board Lawsuit Tests Reach, Viability of State Action Defense*, 21 HEALTH L. REP. 1081 (2012).

by non-dentists,²⁴¹ which would cost less than the services provided by dentists.²⁴²

In sum, impressive advances in preventive dental health care in the last decades of the twentieth century significantly reduced the number of dental patients with routine problems such as cavities to be filled. As June Thomas put it, "Dental health has improved enormously in the post-fluoride era, but Americans' satisfaction with the way their teeth look has declined."²⁴³ That dissatisfaction provides both business for dentists and an increasingly great disparity between the teeth of the middle—or upper-classes and those without the means to pay for cosmetic dentistry.

III. ETHNICITY²⁴⁴ AND GEOGRAPHY (URBAN V. RURAL): DISPARITIES IN DENTAL CARE AND DENTAL HEALTH

This Part examines differences between urban and rural environments in the United States as well as the role of race and ethnicity in determining dental condition *and* in shaping the significance of dental condition in identifying class status. By way of comparison, this Part also examines British, as compared with American, understandings of the significance of dental aesthetics. Differences in geography (within the United States and globally) and in ethnicity can determine access to care.²⁴⁵ Additionally, such differences suggest variations in sociocultural responses to class status and, accordingly, to embodied signs of class status such as oral health.

Rural and urban communities experience differences in access to dental care. There also seem to be some disparities in dental health; this is less clear. Gaps between access to care and oral health also emerge among ethnic groups in the United States. Furthermore, the salience of visible marks of poor oral health as signals of identity

241. See *FTC Decision Jeopardizes Authority of Medical Boards, Doctors Say*, *supra* note 239.

242. N.C. State Bd. of Dental Examiners v. FTC, 768 F. Supp. 2d 818, 820 (E.D.N.C. 2011).

243. Thomas, *supra* note 217. Thomas reports that one consequence of Americans' developing interest in cosmetic dentistry is that "at least 50% of the average dentist's income now comes from elective cosmetic procedures." *Id.*

244. This Article uses the term "ethnicity" to include what is often referred to as "race and ethnicity." Although race and ethnicity have been understood variously in United States history, the differences are complicated and not of direct relevance to this Article. The Article does use the term "race" or the phrase "race and ethnicity" in reporting on studies or analyzes that employ that term or phrase.

245. See *infra* Parts III.A.2, III.B.

would seem to be greater in heterogeneous social settings and, correlatively, in urban as compared with rural environments. Section A of this Part considers differences in access to oral health care and in dental condition among residents in urban and rural areas, and Section B considers differences in access to care and in dental health among various ethnic groups. Finally, Section C briefly compares the aesthetics of teeth in the United States and in Great Britain.

A. Urban Teeth and Rural Teeth

There are significant differences between urban and rural areas with regard to access to dental care.²⁴⁶ And there are differences in the importance that external markers of class status (including teeth, clothing, and jewelry, among many other things) hold in urban as compared with rural settings, or more accurately, in large cities as compared with smaller communities. In smaller communities and in rural areas, people are more likely to know, or at least to know of, others whom they meet even casually than is the case in larger towns and cities.²⁴⁷ Thus, in small towns and in rural settings, external marks of class status (from teeth to jewels) are less essential to the process of categorizing other people.²⁴⁸ Dental health is important to everyone. But urban dwellers are more likely than those in more rural areas to focus on the aesthetics of teeth. Generally, this focus is not self-conscious. Dental condition is one among a large number of marks of class status that people perceive, generally less than self-consciously, when they meet one another, and assessments are often made quickly and without much conscious attention.²⁴⁹

246. See *infra* Part III.A.1.

247. Paul R. Amato & Jiping Zuo, *Rural Poverty, Urban Poverty, and Psychological Well-Being*, 33 SOCIOLOGICAL Q. 229, 230 (1992).

248. See Part III.A.2.

249. This assertion is developed from a growing literature about how people perceive each other's physicality and how rapidly they make judgments of all sorts about other people on that basis. Susan Fiske has written about prejudicial assessments people make as a result of un-self-conscious assessments of other people's faces and bodies. See SUSAN T. FISKE, *ENVY UP, SCORN DOWN: HOW STATUS DIVIDES US* (2011); Susan T. Fiske, *Look Twice*, 1 GREATER GOOD 14–17 (2008).

Work done at the Face Research Lab has focused on perceptions of faces. See *Face Research Lab*, FACELAB, <http://facelab.org/> (last visited June 28, 2013). Researchers at the University of Aberdeen have reached fascinating conclusions about women's preferences for more or less masculinized or feminized male faces. See *Masculine Men More Attractive to Women in Less Healthy Countries*, UNIV. ABERDEEN (Mar. 17, 2010), <http://www.abdn.ac.uk/news/archive-details-7490.php>.

Two distinct issues emerge in comparing dental care and dental health in rural and urban environments: variations in dental health and the comparative importance of the appearance of teeth in assessing other people's status. The first issue has two components: the availability of affordable dental care and the level of oral health. There are conflicting reports on these matters as between urban and rural communities in the United States. The second issue concerns the significance of visible marks of dental condition, including, at one end, missing and decaying teeth, and at the other, signs of cosmetic dentistry such as straight, even, white teeth. Less attention has been paid to this second matter than to the first in comparisons of urban and rural areas. As a result, the suggestions below about the comparative social consequences of visibly poor dental health and of cosmetic dentistry in different locations in the United States demand further research than has been carried out at this time.

1. *Differences in Access to Dental Health Care and Dental Health Status*

Several studies assessing dental health in the United States have referred to possible discrepancies²⁵⁰ between oral health in urban and rural settings.²⁵¹ Other studies, however, have reached alternative conclusions.²⁵² It does seem to be the case that within particular urban *and* rural settings, socioeconomic status appears to be the predominant factor responsible for differences in dental status.²⁵³

There is an adequate supply of dentists in the United States—by some accounts, in fact, there are too many dentists.²⁵⁴ But the vast

250. By the 1980s studies began to report that rural residents were not less likely than urban residents to receive medical care generally. See Donald L. Patrick et al., *Poverty, Health Services, and Health Status in Rural America*, 66 MILBANK Q. 105, 107 (1988) (noting that "progress has been made in closing the rural/urban gap in access to health services" (citing ROBERT WOOD JOHNSON, SPECIAL REPORT ON ACCESS TO MEDICAL CARE (1987))).

251. See, e.g., Sara A. Quandt et al., *Disparities in Oral Health Status Between Older Adults in a Multiethnic Rural Community: The Rural Nutrition and Oral Health Study*, 57 J. AM. GERIATRICS SOC'Y 1369, 1369 (2009).

252. See Nancy Nairi Maserejian et al., *Rural and Urban Disparities in Caries Prevalence in Children with Unmet Dental Needs: The New England Children's Amalgam Trial*, 68 J. PUB. HEALTH DENTISTRY 7, 7 (2008).

253. See Part III.B.

254. See KENT D. NASH, AM. DENTAL ASS'N, HEALTH POLICY ANALYSIS SERIES: GEOGRAPHIC DISTRIBUTION OF DENTISTS IN THE UNITED STATES 16 (2011), available at http://www.ada.org/sections/professionalResources/pdfs/topics_economic_geo-2011D.pdf.

majority of these dentists practice in urban areas.²⁵⁵ In rural areas, where dentists are few in number and far apart geographically, even people with dental coverage or middle-class incomes may not enjoy easy access to dental care.²⁵⁶ The presence of many practicing dentists in metropolitan areas, however, does not necessarily ensure better dental health for low-income people in urban settings as compared with those in rural areas. Even a plethora of dental practitioners is of little relevance to those unable to pay for dental care.²⁵⁷

Other factors, including water fluoridation, tooth brushing habits, and diet (in particular, the amount of refined sugar eaten), account for some of the disparities in dental health within American communities.²⁵⁸ Urban children, for instance, benefit from fluoridation of their water more often than rural children.²⁵⁹ They may not benefit, however, from the geographic proximity of practicing dentists insofar as access to care is determined by more than mere proximity.²⁶⁰ Yet, studies that have compared access to dental care in rural and urban areas have not always focused on issues beyond “physical proximity to a dentist” that may determine access.²⁶¹ In addition, attitudes toward health and illness and levels of readiness to visit clinicians for routine dental care (as compared with care for dental problems and in particular for dental pain) may differ between rural and urban areas and within particular rural and particular urban areas.²⁶²

255. *Id.* at 28. Nash reported that between 89% and 94% of United States dentists work in one of the 1,090 “metropolitan counties” with the highest per capita incomes in the nation. *See id.* Moreover, in some counties with low incomes and thin populations, there may not be any practicing dentists. *See id.* at 11.

256. *Id.* at 5 (noting almost 90% of United States dentists practice in urban areas).

257. *See* Maserejian et al., *supra* note 252, at 10; *see also infra* notes 265–67 and accompanying text (summarizing Maserejian et al.’s findings).

258. *See generally* Maserejian et al., *supra* note 252.

259. *See id.*

260. *See* JOSHUA ORLANDS ET AL., UCSF CTR. FOR CAL. HEALTH WORKFORCE STUDIES & UCSF CTR. TO ADDRESS DISPARITIES IN CHILDREN’S ORAL HEALTH, DENTAL HEALTH PROFESSIONAL SHORTAGE AREA METHODOLOGY: A CRITICAL REVIEW 19 (2002), *available at* http://www.futurehealth.ucsf.edu/Content/29/2002-10_Dental_Health_Professional_Shortage_Area_Methodology_A_Critical_Review.pdf.

261. *Id.* at 18.

262. Maserejian et al., *supra* note 252, at 10; *see also* L.A. Crocombe et al., *Is Poor Access to Dental Care Why People Outside Capital Cities Have Poor Oral Health?*, 57 AUSTRALIAN DENT. J. 477, 477 (2012) (reporting on dental health in rural and urban areas in Australia).

Because a myriad of factors determines oral health, it is not surprising that studies comparing the health of urban and rural dwellers do not provide consistent conclusions. Several studies have found that rural children are both less likely to have access to dental care and less likely to enjoy dental health than are urban children.²⁶³ A Maryland study, reported at the start of the twenty-first century, found that rural children were at greater risk for caries than urban children.²⁶⁴ However, one study comparing the oral health of low-income children in Boston and in rural Maine found that the urban children were more likely to have caries than were the rural children.²⁶⁵ The study's authors noted that the urban children included in the study had easier access to dental care than the rural children. They suggested that the better dental health of the rural children might have reflected "other disadvantages" that affected the urban children and that accounted for the study's results.²⁶⁶ Two studies carried out in the last decades of the twentieth century found no significant difference in the rate of caries between urban and rural children even though rural children had a greater unmet need for dental care (which was self-reported) than urban children.²⁶⁷ But professor of public health Sara A. Quandt and her colleagues reported that "regardless of poverty," older adults in rural areas are more likely than urban residents in the same age group to have missing teeth.²⁶⁸

Most extant studies have concurred in reporting that within rural areas—whether the oral health of the residents as a whole proved better or worse than that of urban residents—those without financial resources were at greatest risk of having poor oral health.²⁶⁹ Similarly, limited access to dental care in urban areas is almost always a

263. See, e.g., Clemencia M. Vargas et al., *Oral Health Status of Children and Adolescents by Rural Residence*, 19 J. RURAL HEALTH 260, 260 (2003); Gayle R. Byck, Surrey M. Walton & Judith A. Cooksey, *Access to Dental Care Services for Medicaid Children Variations by Urban/Rural Categories in Illinois*, 18 J. RURAL HEALTH 512, 515 (2002).

264. Vargas et al., *supra* note 263, at 267 (citing Clemencia M. Vargas et al., *Oral Health Status of Children Attending Head Start Maryland 2000*, 24 PEDIATRIC DENT. 257, 257–63 (2002)).

265. Maserejian et al., *supra* note 252, at 9–10.

266. See *id.*

267. *Id.* at 8 (noting data from 1988–94 National Health and Nutrition Examination Survey and data from 1997–1998 National Health Interview Survey).

268. See Quandt, *supra* note 251, at 1369–70.

269. See Kate A. Levin et al., *Urban-Rural Differences in Dental Caries of 5-Year Old Children in Scotland*, 71 SOC. SCI. & MED. 2020, 2020 (2010).

consequence of poverty.²⁷⁰ The Surgeon General's Report on Oral Health in America noted more generally that, regardless of residence, those living at or near poverty are less likely than others to have good dental health.²⁷¹

Studies comparing the dental health of urban and rural dwellers outside the United States present similarly inconsistent findings.²⁷² Researchers found a higher rate of caries among those residing in urban, than in rural, areas in China, Burkina Faso, and Sweden, but in Brazil the likelihood of urban schoolchildren having caries was about half that of rural schoolchildren.²⁷³ Similarly, Leonard Crocombe, a dental researcher working in Australia, and his colleagues found that dental health was poorer in rural areas than in urban areas.²⁷⁴ Further, a study sponsored by the Australian government reported that children in rural areas had poorer dental health than those in metropolitan areas, and that finding held true across socioeconomic groups.²⁷⁵

270. See James A. Gillcrist et al., *Community Socioeconomic Status and Children's Dental Health*, 132 J. AM. DENTAL ASS'N 216 (2001) (reporting that a "disproportionate burden" of dental disease is "found in indigent children and those of racial and ethnic minority groups who are least able to access preventive and restorative dental services"). Furthermore, people in urban areas (as well as in rural areas) may not get care because they do not choose to do so. See *id.* This factor is rarely acknowledged in studies of access to care. This Article assumes that a lack of "access" to dental care refers to those unable to gain such gain, for whatever reason, including an inability to pay for care.

271. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 3, at 12-13. The Report notes that the rate of edentulism in the United States for those with incomes of 200% or more of the poverty level is less than half that of people living below 200% of the poverty level. See *id.* at 66.

272. Maserejian et al., *supra* note 252, at 7.

273. See *id.*

274. See Crocombe et al., *supra* note 262, at 477. The authors suggest the poorer oral health of rural dwellers can only in part be attributed to "poorer access to dental care," which is defined to include "patient perceptions of the impact of travel costs and the impact on family life." *Id.* at 477, 483, 484. In Australia, public dental care is provided for those who are "socio-economically disadvantaged." *Id.* at 479. Other significant factors might include water fluoridation—more common in urban than in rural areas—and "differing attitudes to health." *Id.* at 483.

275. See DENTAL STATISTICS & RESEARCH UNIT, AUSTRALIAN INST. OF HEALTH & WELFARE, URBAN AND RURAL VARIATIONS IN CHILD ORAL HEALTH, RESEARCH REP. NO. 28, at 3-4 (2006) (noting that "[c]hildren from metropolitan areas, across all categories of socioeconomic advantage, had a lower mean deciduous dmft [decayed, missing or filled teeth] than children from rural or remote locations").

2. *Differences in the Significance of Teeth as a Sign of Class Status in Urban and Rural Areas*

Differences between everyday life in urban and rural environments suggest that poor dental health is more likely to mark class status in urban than in rural areas.²⁷⁶ People living in cities are less likely to know their neighbors or to belong to local friendship and kinship networks than are those in rural areas.²⁷⁷ Correlatively, urban residents receive less help from neighbors than rural dwellers.²⁷⁸ That people are less likely to know individuals with whom they interact in urban areas increases the need for a system of categorizing strangers that is not dependent on interpersonal social networks. Thus, signs of group membership (e.g., ethnicity, class) as well as signs of class and personal status may have a greater significance in urban settings than in rural areas. Teeth are one such mark.

Teeth provide a powerful marker of socioeconomic status because dental condition is a sign of poverty and of comparative wealth.²⁷⁹ Such impersonal and putatively objective marks of status become less significant in social contexts in which people are more likely to know each other or to be no more than two or three steps away from knowing each other.²⁸⁰ More specifically, whether or not poor dental health is more common in rural than in urban settings—and, as discussed above, the evidence is mixed²⁸¹—the stigma of missing teeth or presenting visibly decayed teeth is likely to be more significant in urban settings because urbanites must rely far more often on easily observed signs of status to categorize others.²⁸² In rural communities, people who meet in town or in other public contexts are more likely to know each other or, if not, to be able to establish mutual connections easily.

276. See generally L.J. Heaton et al., *Factors Influencing Use of Dental Services in Rural and Urban Communities: Considerations for Practitioners in Underserved Areas*, 10 J. DENTAL ED. 1081 (2004).

277. See Amato & Zuo, *supra* note 247, at 230.

278. *Id.*

279. See *supra* notes 211–13, 228–30 and accompanying text.

280. Many decades ago, in his classic paper about urban life, sociologist Louis Wirth described “urbanites” as being comparatively anonymous and isolated. Those in urban areas, Wirth asserted, forfeited an integrated everyday life because relationships were largely not personal. Louis Wirth, *Urbanism as a Way of Life*, 44 AM. J. SOC. 1 (1938).

281. See *supra* notes 267–68 and accompanying text.

282. See *supra* note 249 and accompanying text.

Relatedly, cosmetic dentistry is more of an urban concern than a rural one. When dentists participating in a dental marketing blog were asked about the wisdom of instituting a specialization with board certification in cosmetic dentistry, the majority disfavored the creation of a specialty in cosmetic dentistry.²⁸³ All of the rural dentists who participated in the survey, however, opposed certification in cosmetic dentistry.²⁸⁴ Almost one-fifth of urban dentists favored development of a cosmetic-dentistry specialization.²⁸⁵ About eight percent of suburban dentists favored specialty status.²⁸⁶ Another dental blogger, “1st Cosmetic Dentist,” suggested that for rural dentists as a group, “cosmetic dentistry just isn’t relevant to their patients’ needs.”²⁸⁷ A second online survey conducted by the American Academy of Cosmetic Dentistry, found that a significant proportion of cosmetic dentists continue to practice in suburban areas, but between 2007 and 2011, there was a discernible shift of cosmetic dentistry practices to urban settings.²⁸⁸

One study of dental condition among farm workers and their children in rural California supports the suggestion that visible oral health—both missing or mangled teeth, signaling poverty, and teeth that appear to satisfy a contemporary aesthetic ideal, signaling

283. See Audre Hill, *Cosmetic Dentistry: Dental Marketing Blog, The Wealthy Dentist.com, Surveys Dentists About Board Certification*, WEALTHY DENTIST (Aug. 4, 2012), <http://www.thewealthydentist.com/blog/3595/cosmetic-dentistry-dental-marketing-blog-thewealthydentist.com-surveys-dentists-about-board-certification/>. The results of the survey, even if representative of a larger group of dentists, may mean that rural patients have little interest in cosmetic dentistry or that there simply are not enough rural dentists to care for basic dental needs or something else.

284. See *id.*

285. *Id.*

286. *Id.*

287. *Should Cosmetic Dentistry Be Its Own Specialty?*, 1STCOSMETICDENTIST.COM, <http://www.1stcosmeticdentist.com/survey12-certification-for-cosmetic-dentistry.html> (last visited June 28, 2013) (featuring material on cosmetic dentistry and allowing users to find a cosmetic dentist serving their locations).

288. See AM. ACAD. OF COSMETIC DENTISTRY, *COSMETIC DENTISTRY: STATE OF THE INDUSTRY SURVEY 2011*, at 16–17 (2011), available at <http://www.aacd.com/proxy.php?filename=files/Footer%20Nav/Media%20Room/Surveys/AACD%20State%20of%20the%20Cosmetic%20Dentistry%20Industry%202011.pdf>. The survey found a significant decline between 2007 and 2011 (a period including the recession that began in 2008) in the number of cosmetic dentists with practices of 1,000 or more patients (from 16% to 4%). *Id.* at 17. Finally, the survey found a marked decline in the “cosmetic dentistry industry,” generally, between 2007 and 2011. See *id.* at 18.

wealth—is of less concern in rural environments.²⁸⁹ The work of anthropologists Sarah Horton and Judith Barker among Mexican American farm workers and their children suggests that the socioeconomic consequences of poor dental health for people living within more or less cohesive communities may not result in significant, self-conscious stigma unless a person from such a community moves out of that community and settles in a more cosmopolitan and diversified area.²⁹⁰ Horton and Barker conducted ethnographic research among farm workers in California.²⁹¹ One child of a single farm-worker mother—a boy named Estevan, born in California in 1977—suffered from poor oral health during childhood, probably as a consequence of bottle-feeding practices and poor dental hygiene.²⁹² A dentist extracted five of Estevan's front teeth.²⁹³ Perhaps as a result of the extractions, the child's permanent front teeth did not grow in straight.²⁹⁴ Only when Estevan left his birth-community to go to college did he become "acutely self-conscious" about his crooked teeth.²⁹⁵ Estevan was not without embarrassment in high school, but, he explained, "It wasn't that big [of a] deal . . . as a lot of people had bad teeth."²⁹⁶ During college, Estevan managed a "welfare-to-work program," and was concerned that he would be perceived as a participant in the program rather than its overseer.²⁹⁷ He paid thousands of dollars to have his teeth straightened.²⁹⁸ Horton and Barker describe this as payment for upward mobility.²⁹⁹ Another boy that Horton and Barker interviewed, Jorge, felt the stigma of his disfigured teeth even while attending a local high school.³⁰⁰ Yet, this boy starred as a high school athlete and was popular among his schoolmates.³⁰¹ In Jorge's mind, the embarrassment he experienced in

289. See generally Sarah Horton & Judith C. Barker, *Stigmatized Biologies: Examining the Cumulative Effects of Oral Health Disparities for Mexican American Farmworker Children*, 24 MED. ANTHROPOLOGY Q. 199 (2010).

290. *Id.* at 200, 212.

291. *Id.* at 203.

292. *Id.* at 212.

293. *Id.* (noting that it was not clear whether Estevan's front teeth could have been saved with pulpotomies).

294. *Id.*

295. *Id.*

296. *Id.* (internal quotation marks omitted).

297. *Id.*

298. *Id.*

299. *Id.* at 212–13.

300. *Id.*

301. *Id.*

high school became more of an impediment to his future success when he enrolled in college.³⁰² Horton and Barker note the significance of social context to the levels of embarrassment felt by these boys: "As Brackette Williams argues, . . . national community is perceived as synonymous with an unmarked ethnoracial group that has the privilege of effortlessly 'blending in' with national culture. Estevan's and Jorge's felt difference highlights their embodied inequality, or their perceived sociocultural and bodily distance from this unmarked norm."³⁰³ This leads directly to consideration of disparities in dental health and access to dental care among ethnic groups.

B. Differences in Dental Care and Dental Health Among Various Ethnic Groups

A number of studies report disparities in oral health among ethnic groups.³⁰⁴ Both objective assessments (through oral examination) and subjective assessments of oral health have shown that those from minority groups are less likely than whites to enjoy healthy teeth and gums.³⁰⁵ Non-white and ethnic children visit dentists significantly less often than white children,³⁰⁶ and many have poor dental health.³⁰⁷ It is often difficult, however, to draw conclusions from extant studies about the extent to which disparities in oral health correlate directly with ethnicity and income levels.³⁰⁸

302. *Id.*

303. *Id.* at 214–15 (citing Brackette Williams, *A Class Act: Anthropology and the Race to Nation Across Ethnic Terrain*, 18 ANN. REV. ANTHROPOLOGY 401 (1989)).

304. See, e.g., Edelstein, *supra* note 66, at 141; Edelstein & Chinn, *supra* note 56, at 415.

305. See Quandt et al., *supra* note 251, at 1374 (citing B.A. Dye et al., *Trends in Oral Health Status: United States 1988–1994 and 1994–2004*, 11 VITAL HEALTH STAT. 1 (2007)).

306. Glenn Flores & Sandra C. Tomany-Korman, *Racial and Ethnic Disparities in Medical and Dental Health, Access to Care, and Use of Services in US Children*, 121 PEDIATRICS e286, e291 (2008).

307. See *id.* at e294–95 (noting that Latino and African American children, in a study including more than 100,000 parents or guardians of pediatric patients, were more than twice as likely as white children to have poor dental health; native American children in the study were twice as likely as white children to have "unmet dental needs").

308. For instance, an excellent paper by Burton L. Edelstein reports that higher rates of dental disease (as measured by caries) are found among children who are disadvantaged by poverty, minority status, and social conditions. See Edelstein, *supra* note 66, at 146. Edelstein includes charts that distinguish among groups by ethnicity

Although the precise causal mechanisms of such correlations may elude specification, studies of both children and adults do report that poor dental health is disproportionately common among low-income and minority groups. Burton Edelstein and Courtney Chinn reported that in the five years between 1999 and 2004, the rate of caries in primary teeth among children between two and eleven years of age was lowest for non-Hispanic white children (38.56%) and highest for Mexican American children (55.40%). The rate among African American children (43.34%) fell between those for non-Hispanic white children and those for Mexican American children.³⁰⁹

Sara Quandt and her colleagues studied the comparative dental health status of African Americans, American Indians, and whites, all over sixty years of age, in rural communities in North Carolina.³¹⁰ They reported disparities based on ethnicity³¹¹ and suggested some differences between the effects of ethnicity and the effects of income on dental health. On self-reported assessments of dental health, whites in the study group reported good oral health (64.4% of those questioned) more frequently than did African Americans (46.9%) and American Indians (45.7%).³¹² Interestingly, having no teeth or few teeth was correlated with socioeconomic factors (low income and comparatively fewer years of education), rather than with ethnicity directly, but having eleven to twenty teeth did correlate directly with ethnicity: both African Americans and American Indians were found more likely than whites to have between eleven and twenty teeth.³¹³ Whites were more likely than members of the other groups to have more than twenty teeth.³¹⁴ The researchers concluded that within the study population, the effect of ethnicity on dental health was not

and by income level, but it is not clear to what extent income level is a function of ethnicity. *See id.*

309. *See* Edelstein & Chinn, *supra* note 56, at 416 (citing B.A. Dye et al., *Trends in Oral Health Status: United States, 1988-1994 and 1999-2004*, 11 VITAL HEALTH STATISTICS 1 (2007)).

310. *See* Quandt et al., *supra* note 251, at 1369.

311. *See id.* In contrast to the National Health and Nutrition Examination Survey (NHANES) study, *see* Dye et al., *supra* note 309. Quandt et al. found that more whites than members of the other groups were edentulous. *See* Quandt et al., *supra* note 251, at 1374. They noted, however, that it was not clear to what this difference could be attributed. One possibility was that whites might have had the means to have diseased teeth extracted and replaced with dentures. *See id.*

312. *See* Quandt et al., *supra* note 251, at 1374.

313. *See id.*

314. *See id.*

eliminated by discounting for socioeconomic factors such as levels of income and education or having dental insurance.³¹⁵

Others have reported that choice of dental health treatment has differed according to patients' ethnicity. Using data from the Department of Veterans Affairs, Nancy Kressin and colleagues studied discrepancies by ethnic affiliation in rates of tooth extraction and of root canal therapy among dental patients who had received one treatment or the other in 1988.³¹⁶ Root canal therapy is preservative of teeth and is generally preferred by practitioners.³¹⁷ The study revealed significant differences in the choice of treatment on the basis of ethnicity.³¹⁸ Among those eligible for "continuing and comprehensive" care, the rate of root canal for Asians was highest (31.0%) and the rate for Blacks was lowest (20.1%).³¹⁹

C. Class and Dental Condition in the United States and in Britain

Despite uncertainties about the implications of some of the data relevant to the causes of disparities in dental health in the United States, it is clear that poor dental health correlates with poverty. And in the last several decades, cosmetic dentistry has become of increasing interest to middle- and upper-class groups. The situation in other countries has differed from that in the United States along a number of important dimensions. In particular, a comparison of dental health and attitudes toward dental health in the United States and Britain deepens an understanding of the data from the United States. This section reviews these differences (some of which have

315. *See id.* In general, the oral health of American Indians found by Quandt and her colleagues resembled that of African Americans except that the level of periodontal disease among American Indians resembled that of whites and was less than that found among African Americans. *See id.*

316. *See generally* Nancy R. Kressin et al., *Racial Variations in Dental Procedures: The Case of Root Canal Therapy Versus Tooth Extraction*, 41 MED. CARE 1256 (2003). Within the United States, the Department of Veterans Affairs is the largest provider of dental care. *See id.* at 1257.

317. *Id.* The authors noted, as well, that despite their assuming two modes of treatment, there were others that might have been preferable. These included "palliative treatment, antimicrobial therapy, extraction with an implant, or watchful waiting." *Id.* at 1260.

318. *Id.* at 1256.

319. *Id.* at 1259. The authors reported that after adjusting for "covariates and clustering within geographic regions," blacks were least likely to receive root canal therapy and Asians were most likely to receive this form of care. *See id.* Whites fell between these two groups. *See id.* at 1259.

faded during the last several decades)³²⁰ and then suggests that, at least traditionally, the comparative transparency of class in Britain rendered embodied marks of socioeconomic status (such as visible dental status) less important than they have been in the United States where class competition is intense, but the implications of class status, and the means for assessing it, remain opaque.³²¹

A 2006 story about dentistry in Britain quoted an American who worked for a do-it-yourself dental emergency supply company in Britain and who compared attitudes toward dental conditions in the two countries: "Prevention and having nice white shiny teeth is [sic] a huge priority for us [Americans] from the moment we're born."³²² In comparison, explained the American, the British are unconcerned with stained teeth and far less obsessed with flossing than are Americans.³²³

Until recently, "British teeth" were a source of amusement in the United States. They were viewed, one British newspaper account noted semi-humorously, as being "so gnarled and yellowed and gappy that they can frighten children across the world into obsessive dental hygiene."³²⁴ At least in some part, the report suggested, the state of British teeth made sense in light of the British class system.³²⁵ More specifically, the author attributed British dental status to a deep sense of privileged identity among the aristocracy, which obviated any need to focus on dental status (and other embodied signs of class).³²⁶ According to June Thomas, when she was a girl in Britain, saving teeth was not important, and dentures were seen as a reasonable option.³²⁷ Thomas reported that after moving to the United States, it was years before she obtained dental insurance, but once she did, she

320. See Cath Blackledge, *No Pain No Kidding*, EUROPEAN, Mar. 2, 1998 (suggesting that Europeans, including the British, were beginning to "cop[y] America's obsession with achieving the perfect smile").

321. See *infra* Part IV.

322. Sarah Lyall, *In a Dentist Shortage, British (Ouch) Do It Themselves*, N.Y. TIMES, May 7, 2006, <http://www.nytimes.com/2006/05/07/world/europe/07teeth.html>.

323. *Id.*

324. Laura Barton, *Grin and Bare It*, GUARDIAN (U.K.), Mar. 2, 2006, <http://www.guardian.co.uk/lifeandstyle/2006/mar/02/healthandwellbeing.health>.

325. *Id.*

326. See *id.*

327. See June Thomas, *The American Way of Dentistry: The Story of My Teeth*, SLATE (Sept. 28, 2009, 7:36 AM), http://www.slate.com/articles/life/the_american_way_of_dentistry/2009/09/the_american_way_of_dentistry_4.html.

"embraced American dentistry unreservedly: braces, new crowns, gum grafts, implants."³²⁸

Even at the end of the first decade of the twenty-first century Thomas described the British as discomforted by missing teeth, but fairly complacent about teeth that Americans would view as off-color or misplaced.³²⁹ Thomas contrasted the state of "American teeth" with that of the British and some other European groups and suggested that one could identify an American in Europe by looking at teeth.³³⁰

Writer Christopher Hitchens illustrated the differences in a narration of the transformation of his own teeth from what he referred to as British teeth to American teeth. Hitchens explained his hurt when he read Gore Vidal's description of a character in *The Judgment of Paris* as having "British teeth"; Hitchens's discomfort flowed from his sense that his own teeth were similarly "British."³³¹ In the early 1980s, Hitchens immigrated to the United States and became a citizen.³³² Soon after, he had veneers applied to his teeth, largely ridding himself of what he had come to view, with some chagrin, as his British teeth.³³³ Hitchens jovially described the dental procedure as "part of my new passport to Americanization."³³⁴ With the perspective of an "outsider" (and even more, an outsider from a society long certain about the importance of class status), Hitchens offered a trenchant commentary on the importance of dental condition in the United States. His commentary made transparent a set of perceptions about dental condition that—however significant—often remains opaque to Americans.

328. *Id.*

329. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 3, at 138 (noting a study of elderly British people with missing teeth which found that 13% of respondents said they felt embarrassed in social settings).

330. *See* Thomas, *supra* note 327. That suggestion assumes—for the most part correctly—that Americans in Europe are not poor Americans.

331. Christopher Hitchens, *On the Limits of Self-Improvement, Part II*, VANITY FAIR (Dec. 2007), <http://www.vanityfair.com/culture/features/2007/12/hitchens200712> [hereinafter Hitchens, *Part II*]; *see also* Christopher Hitchens, *On the Limits of Self-Improvement Part I*, VANITY FAIR (Oct. 2007), <http://www.vanityfair.com/culture/features/2007/10/hitchens200710> (describing Hitchens's "fanglike teeth" as "British"—"sturdy, if unevenly spaced, and . . . an alarming shade of yellow and brown").

332. *See* Hitchens, *Part II*, *supra* note 331.

333. *See id.*

334. *Id.*

IV. SOCIOECONOMIC STATUS AND DENTAL STATUS

This Part offers a wider frame within which to understand both the significance of teeth as a marker of socioeconomic status and differences in response to dental status among various groups, both within the United States and elsewhere. This Part first considers variations in the meaning of teeth as a symbol of identity. It then contextualizes the discussion of dental status as a mark of class status within the larger American consumerist culture; within that culture, people enjoy the illusion that consumer choices make a "real" difference.

A. Teeth Throughout Time and Space

Teeth have provided a multi-faceted marker of various parameters of personal identity in many societies. Teeth resemble other embodied signs of identity, but several specific characteristics of teeth render them particularly powerful signs of status. First, they sit visibly at the center of the face. Faces, more perhaps than any other part of the body, are "read" to suggest a person's character and personal history.³³⁵ When two people converse face-to-face, they often look at each other's mouths, and thus at each other's teeth. Second, dental condition is perceived as more or less permanent or at any rate, as evidence of years of concern or lack of concern about dental health. In this, it differs from clothing or jewelry—signs of class status that are far more mutable.³³⁶

The anthropological study of the negative social and psychological effects of poor dental health among the children of Mexican American farm workers, carried out by Sarah Horton and Judith Barker in the first decade of the present century,³³⁷ discusses deeply stigmatizing consequences of "bad teeth."³³⁸ The "stigmatized biology" of bad teeth has multi-dimensional causes—most grounded in the disadvantages of poverty.³³⁹ Horton and Barker's study

335. See U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 3, at 140.

336. See *id.* at 137.

337. Horton & Barker, *supra* note 289, at 199–200; see also *supra* notes 290–303 and accompanying text (discussing Horton and Barker's findings).

338. See *supra* Part III.A.2.

339. Primary among the causes that Horton and Barker identified were the children's diets, the feeding practices used by their parents (including, in particular, the practice of leaving children for long periods with bottles containing sugary drinks in their mouths), and the character of the state's dental coverage programs for poor children. Horton & Barker, *supra* note 289, at 200, 203.

provides one instance of the significance of teeth as a forceful marker of identity and status. There are many others, and across cultural settings, metaphors about teeth have conveyed a wide array of meanings.³⁴⁰

Teeth—their absence, their color, their shape—have carried symbolic significance in many periods of time and in diverse cultural settings³⁴¹: “The tooth has always been accorded a special, even magical, role among all peoples and at all times, and has stood for power, and its loss for loss of power.”³⁴² Disparate cultures have viewed lost teeth as a danger because a lost tooth, if retrieved by an enemy, allows that enemy to gain control over the tooth’s original owner.³⁴³

Freudian theory attributed strong symbolic importance to teeth.³⁴⁴ Freud referred to teeth falling out as a “particularly remarkable dream symbol.”³⁴⁵ Teeth, as metaphor, have also found a place in theological presentation. A sixteenth century clergyman even referred to rotten teeth as marks of original sin: “We unfortunate humans: We all have toothache and suffer ever and always from the teeth with which Adam bit the forbidden apple.”³⁴⁶ According to Sir James Frazer, tribal leaders in Africa were disqualified from kingship if they had broken teeth, a state that marked their emasculation.³⁴⁷

A variety of societies have viewed teeth as an aesthetic drawing board, offering culturally specific depictions of identity and personhood. According to the Surgeon General’s report on oral health in the United States, “[c]ultures have sanctioned a variety of alterations to teeth.”³⁴⁸ These alterations have included filing teeth, bleaching them, and placing jewels in them.³⁴⁹ Long before twenty-

340. See U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 3, at 137.

341. *Id.* at 137–38.

342. *Id.* at 137 (quoting D. Kunzle, *THE ART OF PULLING TEETH IN THE SEVENTEENTH AND NINETEENTH CENTURIES: FROM PUBLIC MARTYRDOM TO PRIVATE NIGHTMARE AND POLITICAL STRUGGLE?* 28–89 (M. Feher et al. eds., 1989) (internal quotation marks omitted)).

343. *Id.* (noting that the ritual of the tooth fairy contains vestiges of that fear).

344. See SIGMUND FREUD, *A GENERAL INTRODUCTION TO PSYCHOANALYSIS* 129 (Edward L. Bernays trans., 1920) (noting that the falling or pulling out of teeth symbolizes castration).

345. *Id.*

346. U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 3, at 137.

347. *Id.* (citing T. Ziolkowski, *The Telltale Teeth: Psychodontia to Sociodontia*, 91 PMLA 9 (1976)).

348. *Id.*

349. *Id.*

first century Americans looked to the color of teeth as a mark of class status, Japanese women dyed their teeth black as a sign of marital status.³⁵⁰

B. "American Teeth" and Consumer Culture

In the United States, dental choices for those with means have been incorporated into a vast consumer culture that gives people the illusion of unending choices for shaping presentations of self.³⁵¹ Teeth are among a number of physical traits and accoutrements that signal class and that can serve to reinforce socioeconomic inequality.³⁵² "In a culture where appearance is so often linked to status and self esteem," law professor Deborah Rhode has asserted, "low-income individuals pay a substantial price when they cannot afford to meet conventional standards."³⁵³ In the United States, the cosmetically attractive teeth have become such a standard. Those with decayed or missing teeth may fear smiling or may even limit social interactions with people whom they do not know.³⁵⁴ More generally, personal appearance has socioeconomic consequences, including consequences for success or failure within the labor market.³⁵⁵

In short, cosmetic dentistry is part of a much wider bailiwick of choices for those with means to construct desired presentations of their embodied selves. A great deal of cosmetic care (including dental veneers, Botox, and cosmetic plastic surgery) can be categorized both with procedures and pharmaceuticals aimed at producing or sustaining good health and with procedures and products aimed specifically at beautification. Physicians and other clinicians who provide such care may categorize it with health-producing activities.³⁵⁶ Abigail Brooks, presenting evidence from

350. *Id.*

351. See HENRI LEFEBVRE, *EVERYDAY LIFE IN THE MODERN WORLD* 119 (Sasha Rabinovitch trans., 1971) (noting that "fashion" is good illustration of a system of disconnected signifiers, any one of which can mean virtually anything and in which each can become substitutable for the others).

352. DEBORAH L. RHODE, *THE BEAUTY BIAS: THE INJUSTICE OF APPEARANCE IN LIFE AND LAW* 96 (2010).

353. *Id.*

354. See BONNIE BERRY, *THE POWER OF LOOKS: SOCIAL STRATIFICATION OF PHYSICAL APPEARANCE* 44 (2008).

355. See, e.g., *id.*; Jeff Biddle & Daniel Hamermesh, *Beauty, Productivity, and Discrimination: Lawyers' Looks and Lucre*, 16 J. LABOR ECON. 172, 173 (1998); Glied & Neidell, *supra* note 41, at 4.

356. Abigail Brooks, "Under the Knife and Proud of It": *An Analysis of the Normalization of Cosmetic Surgery*, 30 CRITICAL SOC. 207, 218 (2004). The same or

Vogue magazine, equated visions of cosmetic surgery with visions of "hair coloring or dental work."³⁵⁷ She suggested the central role that each can play in people's efforts to refurbish their embodied selves.³⁵⁸

In detailing the significance of appearance in the United States, Deborah Rhode has noted the far-reaching consequences of America's obsession with physical appearance³⁵⁹: "That appearance matters comes as no surprise. What is less obvious is the extent of its influence on employment, income, self-esteem, and personal relationships."³⁶⁰ In the United States—though not everywhere to the same extent³⁶¹—teeth have become determinants of "employment, income, self-esteem, and personal relationships."³⁶² Assessments of dental condition provide a focal point around which to assess socioeconomic status and identity, more generally.³⁶³

Such evaluations are usually made easily and without conscious thought, but their impact can be far-reaching.³⁶⁴ Those without dental coverage or independent resources are unlikely to enjoy routine dental care impacting health and appearance, which in turn, can make it difficult to find employment and corresponding dental coverage.³⁶⁵

similar procedures and products are also advertised as cosmetics. Botox advertisements—both in print and for television—have proclaimed: "It's not Magic, It's Botox Cosmetic." *Id.* at 216.

357. *Id.* at 216.

358. *Id.* at 228.

359. See RHODE, *supra* note 352, at 5–6.

360. *Id.* at 5.

361. See *supra* Part III.A.2.

362. RHODE, *supra* note 352, at 5 (referring to the importance of appearance generally in the United States).

363. One study of the consequences of dental condition in the labor market noted that:

[A]ccess to water fluoridation during childhood increases earnings by roughly 2% overall, with a larger effect for women. Furthermore, the effects are largest for individuals from low SES families. . . . Our evidence generally supports employer and consumer discrimination as the main channels whereby oral health effects earnings, which supports the "Beauty Myth" argument that women are held to different standards regarding physical appearance than men.

Glied & Neidell, *supra* note 41, at 32–33. The study examined the labor market effect of healthy teeth by assessing the effect of a person's "access to fluoridated water during childhood." *Id.* at 32. The authors used water fluoridation as a correlate of oral health. *Id.* They noted, however, that their concern was "to identify the effects of oral health—not community water fluoridation—on labor market outcomes." *Id.* at 33.

364. See *supra* Part IV.

365. Glied & Neidell, *supra* note 41, at 7–8 (citing Daniel Hamermesh & Jeff Biddle, *Beauty and the Labor Market*, 84 AM. ECO. REV. 1174 (1994)). In their own

In short, the limitations that characterize the nation's system of dental coverage offer a paradigmatic instance of a mode of delivering health care that reflects and exacerbates discrimination grounded on differences in socioeconomic status.

CONCLUSION

Teeth have served as powerful symbols of individual and group identity across time and space, but the specific meanings societies have attributed to teeth vary widely. The significance of teeth in marking socioeconomic status in the United States—with some differences in this regard between urban and rural environments and among various ethnic groups—reveals a great deal about a nation shaped by intense class competition but confused about the implications of socioeconomic status and about how to assess class.³⁶⁶

In the United States, dental condition reflects a person's health status, ease of access to healthcare, and socioeconomic status more generally. Correlatively, dental status plays a significant part in determining health and socioeconomic status. Dental condition is an especially powerful marker of poverty and of wealth. A person with missing, mangled, or decayed teeth is likely to have experienced a lifetime without adequate dental care.³⁶⁷ Since the middle of the twentieth-century, straight teeth have signaled upper middle- or upper-class status.³⁶⁸ Those with significant resources now seek cosmetic dentistry, much as they turn to cosmetic surgery, to reconstruct their own physicality and therein to announce their socioeconomic status.³⁶⁹ At the same time, pressures to purchase new

work, Glied and Neidell found a differential effect by gender; oral health, they reported, increased earnings in the labor market for women more than for men. See *id.* at 32–33.

366. See Janet L. Dolgin & Katherine R. Dieterich, *Weighing Status: Obesity, Class and Health Reform*, 89 OR. L. REV. 1113, 1117–21 (2011).

367. See, e.g., Horton & Barker, *supra* note 289 (analyzing the psychological and social implications of poor dental condition).

368. See June Thomas, *The American Way of Dentistry: The Oral Cost Spiral*, SLATE (Sept. 29, 2009, 7:24 AM), http://www.slate.com/articles/life/the_american_way_of_dentistry/2009/09/the_american_way_of_dentistry_2.html (noting analysis of postwar orthodontics “boom” by Alyssa Picard in her book, *MAKING OF THE AMERICAN MOUTH* (2009)).

369. See *supra* Part IV.

forms of cosmetic dentistry have mounted among those who can hardly afford to pay for them.³⁷⁰

In short, dental status serves as a marker of socioeconomic status *and* as a determinant of opportunities for employment, of one's sense of self, and of one's social relationships.³⁷¹ A lack of governmental commitment to provide high-quality dental care to the nation's population suggests a serious gap in its commitment to social justice. Even as the nation begins to implement the ACA and thus broaden the spectrum of those with access to good health care, dentistry continues to be an outlier. This will magnify gaps that distinguish socioeconomic groups and will increase disparities in their health status. More important still, as long as access to dental care is not defined as an essential benefit for everyone, the nation's commitment to social justice in the provision of healthcare will, at best, remain an aspiration.

370. See Robert H. Frank & Cass R. Sunstein, *Cost-Benefit Analysis and Relative Positive*, 68 U. CHI. L. REV. 323, 369 (2001) (noting a shift in the "frame of reference that defines an acceptable standard of cosmetic dentistry").

371. See RHODE, *supra* note 352, at 5 (writing generally of appearance in the United States).