Creating an Oral Health Benefit in Medicare: A Statutory Analysis

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Georgia Burke
Directing Attorney, Justice in Aging

Amber Christ
Directing Attorney, Justice in Aging

Jennifer Goldberg
Deputy Director, Justice in Aging

Fewer than half of older adults have access to dental care each year,[1] and there is growing recognition of the oral health needs of seniors. There are also significant oral health disparities among older adults based on race/ethnicity, income level, education, and region that are largely attributable to the lack of access to affordable care. An interdisciplinary white paper issued by Oral Health America, *An Oral Health Benefit in Medicare Part B: It's Time to Include Oral Health in Health Care*,[2] makes a case for the need for a Medicare oral health benefit and for creating that benefit as part of the existing Medicare Part B benefit program. Justice in Aging contributed to the white paper, which was written by experts from the dental and health policy fields.

This issue brief builds on the white paper by providing an analysis of the current statutory framework for Medicare Part B. The brief begins by identifying the barriers older adults face in obtaining oral health services, the current gaps in Medicare coverage, and the advantages of creating the benefit through existing Part B structures. It examines the statutory provisions that prohibit oral health coverage as well as those that may be inadequate to accommodate oral health practice. It further details specific statutory provisions that could be changed to add an oral health benefit. The issue brief concludes by identifying some of the current legislative initiatives for a Medicare oral health benefit.

Barriers to Oral Health for Older Adults

Medicare is the primary source of health coverage for older adults, but without a Medicare dental benefit, 70 percent of older adults have no to very limited oral health coverage.[3] As a consequence, one in five older adults has untreated tooth decay[4] and 70 percent have periodontal (gum) disease.[5] Cost is the primary barrier older adults cite in obtaining dental treatment.[6] Half of all Medicare beneficiaries have incomes below $26,200 and have less than $74,450 in savings, including retirement accounts.[7]

Poor oral health and problems with access to care are particularly acute for low-income seniors, people of color, and seniors living in rural areas. For example, 27 percent of Black older adults have complete tooth loss compared to 16 percent of white older adults.[8] Similarly, lower income older adults are twice as likely as those with more income

to have a cavity that needs treatment, have untreated root caries, or need periodontal treatment.[9] There is wide variation in income and savings across populations. Black and Hispanic Medicare beneficiaries have significantly less income and savings than white beneficiaries,[10] and are less able to pay out-of-pocket for oral health care. Education is another factor that contributes to economic and health disparities, as those with college degrees have three times as much income and twenty-two times as much savings as those with less than a college education.[11]

Access to oral health care also depends on where older adults live. More older adults live in rural areas, where there are fewer available providers than in suburban and urban regions.[12] The majority of dental provider shortages in the United States are in rural regions.[13] This, combined with the cost of oral health treatment, means rural seniors have less access and poorer oral health. For example, one in five rural seniors has had all their teeth extracted compared to one in seven urban seniors.[14]

Adults under age 65 with disabilities who rely on Medicare also face barriers to accessing oral health care due to lack of affordable coverage. Less than half of younger adults with disabilities have dental coverage compared to nearly 70 percent of individuals without a disability, and as a result, they receive less oral health care. For example, while 59 percent of younger adults without disabilities report receiving a dental checkup within the last year, only 45 to 52 percent of individuals with disabilities report the same.[15]

The impact of poor dental health on older adults is significant. Tooth decay and associated mouth pain lead to weight loss and poor nutrition, and exacerbate chronic conditions like high blood pressure and diabetes—conditions that individuals are more likely to acquire later in life.[16] Poor oral health also leads to increased infections, which research associates with higher risk for heart and lung disease, suffering a stroke, and experiencing diabetic complications.[17] For older adults with weakened immune systems, oral infections can become chronic.[18] Adding a dental benefit to Medicare would help address these significant health needs and increase access to oral health coverage for older Americans and other Medicare beneficiaries who cannot get their dental needs met now.

The Current Oral Health Exclusion in Medicare

At present, Medicare offers almost no coverage for oral health. The statute explicitly prohibits coverage:

> "where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services."[19]

In addition, the statute has an explicit exclusion of coverage for dental prostheses.[20]

Despite the oral health exclusion,[21] the Medicare statute includes dentists within the statutory definition of "physician."[22] Thus, if the dental exclusion were lifted, the definitions of "physician services"[23] and "services and supplies used by physicians,"[24] would include services and supplies used by dentists without further need to amend those sections of the statute.

Advantages of Incorporating Oral Health in Part B

Integrating oral health benefits into Medicare Part B is the most effective way to deliver comprehensive benefits to all Medicare beneficiaries. Medicare Part B covers most outpatient physician services, including covered preventive services. It also covers laboratory tests and durable medical equipment (DME). Incorporating an oral health benefit into this existing structure as a Part B benefit is preferable to attempting to create and overlay a new separate dental benefit, which would create additional complexity for beneficiaries and providers. Most importantly, including

oral health in Part B would ensure that the coverage of oral health services is treated the same way as other health services in the Medicare program. This approach is consistent with the growing recognition that oral health care should be more fully integrated into health care delivery, both in Medicare and more broadly in the health care system. In other words, it would treat the mouth like other parts of the body.

Adding oral health benefits to Medicare Part B also means that the many program mechanisms already established in Part B could be applied to an oral health benefit. These include:

- **Coverage criteria.**

  Part B already has established procedures for determining medical necessity, including National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and case-by-case reviews. The system accommodates innovations in treatment and changes in standards of care without the need to continually modify the statute and regulations as treatment methods evolve.

- **Payment structure.**

  The Part B co-insurance structure includes an initial deductible and 20 percent co-insurance for most services with zero co-insurance for covered preventive services.[25] Using the same structure for oral health services would be administratively efficient. One efficiency is that oral health benefits under Part B can be treated the same as other benefits for the purposes of Medicare supplement plans (Medigap insurance). MediGap plan payment structures are standardized.[26] Each of the standardized plan options includes full or partial coverage of Part B cost sharing. If oral health services were included in the Part B benefit, beneficiaries would receive the same type of assistance with cost-sharing payments for oral health services as with other Part B services.[27]

- **Provider payment.**

  Part B has established procedures for annually determining provider fee schedules, adjusted by region and subject to annual stakeholder comment. [28]

- **Appeals.**

  A multi-level appeals system provides protections for both beneficiaries and providers disputing coverage and payment determinations.[29]

- **Low-income protections.**

  A system of low-income protections already exists in the form of the Qualified Medicare Beneficiary (QMB) program. The QMB program, administered by state Medicaid agencies, protects eligible low-income beneficiaries from any charges for deductibles and co-insurance for all Medicare-covered services. The over 7.5 million Medicare beneficiaries who are enrolled as QMB beneficiaries would have the same protections for oral health services provided under Part B.[30]

Medicare Advantage and the Medicare Oral Health Benefit

Currently, many Medicare Advantage plans offer some dental benefits, either as part of the plan's overall coverage or as an extra benefit that an individual can choose with additional premium liability. Coverage is limited, and a more generous benefit design usually is associated with higher premium costs. Dental benefits are currently offered as supplemental benefits in Medicare Advantage plans, and they are not required.

Because Medicare Advantage plans are required to provide all Part A and Part B services in their basic benefit package, the addition of an oral health benefit to Medicare Part B would require that all Medicare Advantage plans include the full benefit in their service package and use the same coverage criteria as used in original fee-for-service

Medicare. Thus, both beneficiaries in original fee-for-service Medicare and those in Medicare Advantage plans would have full access to the oral health benefit. Similarly, dentists could participate as fee-for-service providers or by joining Medicare Advantage plan networks.

Medicaid and the Medicare Oral Health Benefit

Medicaid dental benefits for adults, including Medicare beneficiaries, currently are optional. Nineteen state Medicaid programs have chosen to provide extensive Medicaid dental coverage; 18 offer limited benefits, and 15 offer none beyond narrowly-defined emergency services.[31] A Medicare Part B benefit would provide more uniform coverage for low-income older adults who are dually eligible for Medicare and Medicaid and would also provide some financial relief for states currently paying for oral health services.[32]

Oral Health and the Current Statutory Structure

To establish an oral health benefit would require changes to the Social Security Act, which governs the Medicare program. The primary changes required are repeal of the sections specifically prohibiting oral health coverage; adding a definition of oral health and dental services; and adding dental preventive services. There may also be a need to make small modifications to provisions concerning Durable Medical Equipment, Prostheses, Orthotics and Supplies (DMEPOS) to ensure appropriate coverage of dental items.

Because dentists are already included within the statutory definition of "physicians," extensive revisions of other portions of the statute are not needed. Once the exclusion is lifted, services and supplies provided or used by dentists are included in the benefit just as for other physicians. All other provisions regarding provider payments and provider rights would apply to dentists.

There is value in a statutory framework that ensures comprehensive coverage, and, as is the case with other health services in Medicare, permits many details of particular covered services to be determined through regulatory and subregulatory processes in order to accommodate changing standards of care, evolving requirements by state licensing authorities, and new delivery models for oral health.

Specific changes to establish an oral health benefit could include:

Removal of the explicit exclusion of dental services.

- **General exclusion**: Strike subsection 42 U.S.C. § 1395y(a)(12), [§ 1862(a)(12) of the Social Security Act]. Note that, although most oral health services would not fall under Part A, striking the general exclusion would also lift the Part A restrictions that are part of the current general exclusion.
- **Exclusion for dental prostheses**: 42 U.S.C. § 1395x(s)(8), [§ 1861(s)(8) of the Social Security Act]. Strike "(other than dental)" and insert "(including dentures)"; and strike "internal body."

Additions to definitions. 42 U.S.C. § 1395x(s), [§1861(s) of the Social Security Act]

- Add a new **oral health and dental services** definition to the "**medical and other health services**" section to support the comprehensive Part B benefit. This definition could include reference to services necessary to address illness, injury, restoration of oral structures to health and function, and maintenance of oral health. Identifying the services as both oral health and dental makes the definition comprehensive.[33] Because both terms are widely used in other contexts, the inclusive language helps to avoid any inadvertent exclusion of services or confusion about coverage.
- Ensure that subsections (6) "**DME**"; (8) "**prosthetic devices**" (after removing exclusion of dental); and (9)

"**braces and artificial limbs**" are sufficient to cover dental devices and, if not, add appropriate language.

- For the definition of "**additional preventive services**" subsection ddd(1)(B), add an appropriate professional body parallel to the U.S. Preventive Services Task Force that can provide expert opinion on preventive oral health treatments.
- For the definition of "**preventive services,"** subsection (ddd)(3), add language about periodic oral health examinations and cleaning and scaling of teeth and other preventive oral health services.

Flexibility to Address Oral Health Care Practices

There are other areas in the statute where changes may be useful to ensure that the statute accommodates the ways in which non-dentist oral health professionals currently work, particularly in underserved areas, and that allow for the variations in state licensure. These could include adding a definition of "dental hygienist and other licensed dental health professional" in the definitions section[34] and adding references to dental hygienists in other sections as appropriate.[35]

Another area for review would be the provisions related to telehealth.[36] They include limitations on the settings in which telehealth services can be delivered to beneficiaries, and it would be important to ensure that those limitations are consistent with how dental telehealth services are delivered.

Conclusion

There have been a number of legislative initiatives in Congress to propose an oral health benefit. Most recently, the Medicare Dental Benefit At of 2019 (S. 22, Cardin) was introduced on January 3, 2019. On January 15, 2019, Rep. Lucille Roybal-Allard introduced H.R.576 to expand Medicare coverage to include eyeglasses, hearing aids, and dental care. In previous Congresses, the Comprehensive Dental Reform Act of 2015 (S.570, Sanders) and the Medicare Dental, Vision and Hearing Benefit Act of 2017 (H.R.3111, Levin) also proposed a Medicare oral health benefit. [37] These initiatives acknowledge the dire need among older adults for greater access to oral health care.

Finally, as policy makers and advocates consider the details of how to structure a Part B oral health benefit, it is important to maintain focus on the real-life consequences for older adults and other Medicare beneficiaries who cannot get oral health care because of costs. It is shocking and unacceptable that one-third of California nursing home residents have no teeth,[38] and in West Virginia, over one-third of all older adults in the state are toothless.[39] The experience of Medicare beneficiaries—pain, avoidable infections and complications, embarrassment and social isolation because they cannot chew, eat, or smile—needs to stay at the heart of the policy discussion.

Endnotes

1 Oral Health America, "A state of decay, vol. II," (2013) (hereinafter "State of Decay"), *available at* oralhealthamerica.org/astateofdecay/archive/; and Agency for Healthcare Research and Quality, "Dental services: use, expenses, source of payment, coverage and procedure type, 1996-2015: research findings," (Jun. 2017) (hereinafter "Dental Services"), *available at* meps.ahrq.gov/mepsweb/data_files/publications/rf34/rf34.pdf.

2 Oral Health America, "An Oral Health Benefit in Medicare Part B: It's Time to Include Oral Health in Health Care," (Jul. 2018), *available at* justiceinaging.org/wp-content/uploads/2018/07/Medicare-Dental-White-Paper.pdf.

3 State of Decay and Dental Services, *supra* note 1.

4 Bruce A. Dye et al., "Dental caries and tooth loss in adults in the United States, 2011–2012," NCHS Data Brief, (May 2015), *available at* ncbi.nlm.nih.gov/pubmed/25973996; and C.M. Vargas, et al., "The Oral Health of Older Americans, National Center for Health Statistics, Aging Trends," (2001), *available at* cdc.gov/nchs/data/ahcd/agingtrends/03oral.pdf.

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6 Dental Services, *supra* note 1.

7 Kaiser Family Foundation, "Income and assets of Medicare beneficiaries, 2016-2035," (Apr. 2017), *available at* kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/.

8 Ctrs. for Disease Control and Prevention, "Prevalence of Edentulism in Adults Aged ≥65 Years, by Age Group and Race/Hispanic Origin — National Health and Nutrition Examination Survey, 2011–2014," (Jan. 2017), *available at* cdc.gov/mmwr/volumes/66/wr/mm6603a12.htm?s_cid=mm6603a12_w.

9 American Journal of Public Health, "Burden of Oral Disease Among Older Adults and Implications for Public Health Priorities," (Mar. 2012), *available at* ncbi.nlm.nih.gov/pmc/articles/PMC3487659/. See also, GAO, "Dental Disease Is a Chronic Problem Among Low-Income Populations," (Apr. 2000), *available at* gao.gov/new.items/he00072.pdf.

10 Kaiser Family Foundation, "Income and assets of Medicare beneficiaries, 2016-2035," (Apr. 2017), *available at* kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/. White beneficiaries have median per capita income of $30,050 compared to $17,350 for Black beneficiaries and $13,650 for Hispanic beneficiaries. White beneficiaries have median savings of $108,250 compared to $16,000 for Black beneficiaries and $12,250 for Hispanic beneficiaries.

11 *Id.* Beneficiaries with a college education have a median income of $44,700, compared to a median income of $14,300 for those with less than a high school education. Beneficiaries with a college degree have median savings of $258,650, compared to $11,450 for beneficiaries with less than a high school education.

12 Rural Health Information Hub, "Rural Aging," (Oct. 2018), *available at* ruralhealthinfo.org/topics/aging.

13 National Rural Health Association, "Improving Rural Oral Healthcare Access," (May 2018), *available at* ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/05-11-18-NRHA-Policy-Improving-Rural-Oral-Health-Access.pdf.

14 Ctrs. for Disease Control and Prevention Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Ga.: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2016. Unpublished analysis by DentaQuest Institute. Available upon request.

15 National Institute on Disability, Independent Living, and Rehabilitation Research, "Adults with Disabilities Get More Preventive Care, but Less Dental Care, Than Adults without Disabilities," (2018), *available at* naric.com/sites/default/files/Adults%20with%20Disabilities%20Get%20More%20Preventive%20Care%2C%20but%20Less%20Dental%20Care%2C%20Than%20Adults%20without%20Disabilities.pdf.

16 Journal of Nutrition, "Food Insecurity Is Associated with Chronic Disease among Low-Income NHANES Participants," (Feb. 2010), *available at* ncbi.nlm.nih.gov/pmc/articles/PMC2806885/.

17 Dept. of Health and Human Services, "Oral Health in America: A Report of the Surgeon General," (2000), *available at* nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf.

18 *Id.*

19 42 U.S.C. § 1395y(a)(12). A discussion by CMS of the narrow cases where the Medicare program covers oral health services is available at cms.gov/Medicare/Coverage/MedicareDentalCoverage/index.html.

20 42 U.S.C. § 1395x(s)(8).

21 Note that while the Medicare statute excludes routine dental care, and CMS currently interprets this exclusion broadly, there is an argument that CMS can cover medically necessary oral health care under the existing statute. See, Center for Medicare Advocacy, "Legal Memorandum: Statutory Authority Exists for Medicare to Cover Medically Necessary Oral Health Care," (Jan. 2019), *available at* medicareadvocacy.org/medicare-info/dental-coverage-under-medicare/.

22 42 U.S.C. § 1395x(r).

23 42 U.S.C. § 1395x(q).

24 42 U.S.C. § 1395x(s).

25 42 U.S.C. § 1395l.

26 HR 5835, Public Law No: 101-508, "The Omnibus Budget Reconciliation Act of 1990 (OBRA-90)," (Nov. 1990), *available at* congress.gov/bill/101st-congress/house-bill/5835.

27 The CMS "Medicare & You Handbook" at p. 69 includes a chart of MediGap plan options for 2019, *available at* medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf. See also, 42 U.S.C. § 1395ss.

28 42 U.S.C. § 1395l. Information on the CMS fee schedule development process is available at cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html.

29 42 U.S.C. § 1395ff. Information on the fee-for-service appeals process is available at cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html. Information on the Medicare managed care appeals process is available at cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html.

30 QMB enrollment is available to individuals with income below 100% of the Federal Poverty Level and limited assets. Medicaid programs are secondary payers for providers serving QMBs but state payments are often capped at Medicaid rates. For a thorough description of the QMB program and how it works for beneficiaries and providers, see CMS, "Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)," (hereinafter "Access to Care,")(pp. 2-6) (Jul. 2015), *available at* cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.

31 Ctr. For Health Care Strategies, "Medicaid Adult Dental Benefits, An Overview," (Nov. 2018), *available at* chcs.org/media/Adult-Oral-Health-Fact-Sheet_112118.pdf.

32 See Access to Care, *supra* note 30. The financial relief provided to states would be tempered somewhat by state's limited obligations for QMB co-insurance.

33 The recently introduced Medicare Dental Benefit Act of 2019 (S. 22) uses the following definition: "services (as defined by the Secretary) that are necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions, including—

(1) routine diagnostic and preventive care such as dental cleanings, exams, and x-rays;
(2) basic dental services such as fillings and extractions;
(3) major dental services such as root canals, crowns, and dentures;
(4) emergency dental care; and
(5) other necessary services related to dental and oral health (as defined by the Secretary)."

34 42 U.S.C. § 1395x(s).

35 For example, dental hygienist services could be added to the definition of "medical and other health services," at 42 U.S.C. § 1395x(s)(2) and included in the "rural health services and Federally Qualified Health Center Services" section at 42 U.S.C.§ 1395x(aa).

36 See 42 U.S.C. § 1395m(m)(4)(c)(i) and (c)(ii), which specifically limit the locations that can be an "originating site" for delivery of telehealth.

37 Texts for all legislation are available at congress.gov.

38 Ctr. for Oral Health, "A Healthy Smile Never Gets Old: A California Report on the Oral Health of Older Adults," (2018), *available at* centerfororalhealth.org/wp-content/uploads/2018/11/Oral-Health-of-Older-Adults.pdf.

39 West Virginia Department of Health and Human Resources, "2012 West Virginia State Health Profile," (p. 29) (2013), *available at* dhhr.wv.gov/publichealthquality/statepublichealthassessment/Documents/2012%20State%20Health%20Profile%20Final%20May%202013.pdf.