

# An Oral Health Benefit in Medicare Part B: It's Time to Include Oral Health in Health Care.

## Background

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Medicare is the federal health insurance program created in 1965 for people ages 65 and over, regardless of income, medical history or health status. The program was later expanded to cover certain persons with disabilities who are under age 65, as well as individuals who have End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).<sup>1</sup> Today, Medicare plays a key role in providing health and financial security to 59 million older people and people with disabilities.<sup>2</sup> Yet, the oral health status of the Medicare population and its ability to afford and access oral health care are issues of serious concern that must be addressed.

Many people lose their dental insurance when they retire, and traditional Medicare does not include coverage for routine oral health care like checkups, cleanings, and x-rays, or restorative procedures (fillings, crowns, bridges and root canals), tooth extractions and dentures. While some Medicare beneficiaries may be able to obtain dental coverage through other sources such as private Medicare Advantage plans, employer-sponsored retiree health plans or individually-purchased dental plans, the scope of dental benefits varies widely across plans. Persons with low income may qualify for Medicaid in addition to Medicare, but whether Medicaid will provide oral health coverage at all and the scope of that coverage varies widely across the country, depending on individual state Medicaid policies.

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Accordingly, an estimated 70 percent of seniors lack or have limited dental insurance and fewer than half access dental care each year.<sup>3</sup> The gap in coverage leads to high out-of-pocket expenses for those who do access dental care. For those on a fixed or reduced income who may not be able to afford dental care, it can lead to higher expenditures for medical and emergency care associated with

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untreated dental problems. About 1 in 5 older Americans has untreated tooth decay,<sup>4</sup> and more than 70 percent have periodontal disease.<sup>5</sup> Younger Medicare beneficiaries with disabilities also lack oral health coverage, and over a third of these adults have untreated dental caries.<sup>6</sup> A significant percentage of this group, as well as the low-income Medicare population, have reported delaying or foregoing dental care due to cost.<sup>7</sup>

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Oral health problems can adversely affect one's ability to maintain optimal nutrition, self-image, social interactions, and mental and physical health. Caries and gum disease may lead to chronic pain, tooth loss and serious infections. It is also not uncommon for Medicare beneficiaries to have medical conditions and medications that worsen their oral health, or oral health issues that exacerbate or complicate treatment of their other medical conditions.

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Increasingly, studies are showing that oral health is closely correlated to overall health. Adding comprehensive oral health coverage to Medicare would keep older adults and persons with disabilities healthier and reduce other health care costs. This white paper discusses the need and support for this policy change and proposes how a comprehensive oral health benefit could be integrated into Medicare Part B.

## Statement of Need

People who rely on Medicare face numerous barriers to maintaining their oral health, including lack of coverage and affordable care, as well as costly medical conditions that can also impact their oral health. While the importance of good oral health is generally accepted, dental care use among older adults diminishes with age for those with limited income or no dental insurance.<sup>8</sup> Since income and dental insurance coverage are typically tied to employment,

the ability to pay for dental services decreases with both age and retirement.<sup>9</sup> Similarly, people who leave work due to permanent disability lose dental coverage at a time that they also have lost income.

Medicare beneficiaries spend a significant portion of their income on health care. More than one-third of beneficiaries in traditional Medicare spend at least 20 percent of their per capita total income on out-of-pocket health care costs. Between 2013 and 2030, out-of-pocket health care costs are projected to increase from 41 percent to 50 percent of average per capita Social Security income.<sup>10</sup> The spending burden is even greater for individuals in poor health, aged 85 and over, and those with modest income or who derive most of their income from Social Security. In fact, cost is the number one reason that older adults cite for not having gone to a dentist in the past year.<sup>11</sup>

The majority of persons on Medicare are of modest means and median per capita income declines with age, which limits their ability to afford dental coverage and care. The median incomes for white beneficiaries over age 65 (\$30,050) is significantly greater than for black (\$17,350) and Hispanic (\$13,650) beneficiaries. The median income for beneficiaries under the age of 65 with disabilities is even lower, \$17,950. Between 2013 and 2030, median income and savings are projected to increase after adjusting for inflation, but much of that growth will be concentrated among a small subset of beneficiaries with relatively high incomes and assets.

Further, Medicare beneficiaries also have limited savings. One-out-of-four Medicare beneficiaries have savings below \$14,550, no savings or are in debt. Half of Medicare beneficiaries have under \$75,000 in savings, including retirement accounts. As with income, median per capita savings vary greatly across demographic characteristics, with lower rates of savings among black (\$16,000), Hispanic (\$12,250), disabled under age 65 (\$33,300), and single (\$25,750) beneficiaries. For people who have less than a high-school education, per capita savings is only \$11,450.<sup>12</sup>

While some seniors continue to have sufficient income to enjoy private dental benefits after turning 65, half of all Medicare beneficiaries live on annual incomes below \$26,200, one-quarter have incomes below \$15,250.<sup>13</sup> Over half of beneficiaries ages 85 and older have incomes of less than \$20,400. And, 70 percent of all seniors have no dental coverage. Further complicating access to dental care is the belief by many retirees that oral health coverage is included within Medicare, and many of those that do report having dental insurance do not realize that their Medicare coverage does not include a dental benefit.<sup>14</sup> Numerous studies have documented that more than 50 percent of people, ages 50-64, do not know that Medicare does not include dental coverage.

A substantial segment of the Medicare population with fixed incomes and limited resources will need to spend more of their incomes on dental care if they choose to access care, while others may forgo this vital care except in emergency cases, while prioritizing other life necessities like food and shelter.<sup>15</sup> Providing dental coverage to older Americans and people with disabilities would close previous gaps in dental use and expense between the uninsured and the insured,<sup>16</sup> and ensure that America's seniors and people with disabilities have access to good oral health throughout their lifetime.

## Medical Necessity

Disparities in oral care for older adults are significant for those with few financial resources and limited oral health education, particularly if they are entering their senior years with a significant history of oral disease. The prevalence increases for those who are homebound or institutionalized and is more pronounced among groups who have been traditionally underserved, such as black, Asian and Hispanic adults, persons with low incomes, and those without dental benefits.<sup>17</sup> Untreated, decay and other oral

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diseases result in pain, chronic and acute infection, tooth fractures and loss, as well as compromised oral function and quality of life.<sup>18</sup>

To adequately address their oral health needs, older adults and persons with disabilities who receive health care through Medicare require a comprehensive oral health benefit. Given the importance of oral health as part of overall health, integrating a dental benefit into the Medicare structure is essential. Medicare beneficiaries face increased risks to their oral health as a consequence of direct and indirect consequences of systemic diseases, conditions and medications common to older populations. Oral pain and tooth loss can make it difficult to eat, leading to poor nutrition, weight loss or gain, and exacerbation of chronic conditions like hypertension, diabetes, and hyperlipidemia – conditions that individuals are more likely to acquire later in life.<sup>19</sup> Further, for older adults with weakened immune systems, oral infections can act as a source for ongoing infection.<sup>20</sup> Without the means to address oral health problems, many Medicare beneficiaries face adverse consequences to their overall health, oral health, quality of life and financial stability.

There has been a paradigm shift in dentistry with increased focus on risk assessment, interprofessional collaboration and minimally invasive treatment to maintain oral health, an approach that is especially critical for adults with multiple morbidities and frail older adults at the end of life.<sup>21</sup> While the inclusion of oral health care as an integral part of health care is important, these models are not widespread. Lack of resources and an absence of coordinated care results not only in more extensive and expensive care, but also prevents the collection of data that will further our knowledge about the relationship between general and oral health. Without the addition of a dental benefit to Medicare, many older adults will not have the resources to benefit from these changing models in health care that include oral health as part of comprehensive care. Access through Medicare Part B would provide a significant opportunity for more coordinated oral and primary health care.

## Adding Dental to Medicare Part B

Since Medicare Part B is the part of the Medicare program that covers outpatient services, a comprehensive oral health benefit would be most effectively administered and delivered through Part B. Such a benefit would include medically necessary procedures, as well as preventive services – a set of services similar to those covered by Part B for other forms of medical care.

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The Medicare Part B benefit would be amended to

include dental services using the medically necessary and reasonable standard that applies to all Part B services: Part B would cover care that is medically necessary and reasonable to address the oral health condition. Preventive services such as cleanings, x-rays, screenings, and examinations would be defined and covered in a similar fashion to services already provided through Medicare “wellness visits” and preventive services.

An oral health benefit fully integrated into the Medicare Part B benefit would be subject to the same cost-sharing rules as other Part B components (i.e. the same deductible, coinsurance requirements and protections). Additional costs would be funded as Part B is now, through general revenues and beneficiary premiums (\$134 per month for beneficiaries paying the standard premium in 2018), using the current Medicare processes to determine premium amounts. Low-income individuals would receive the same level of financial assistance and protections regarding oral health services as they do for other Part B services. Additionally, Medicare Advantage plans would be required to provide oral health coverage just as they cover all other Part B benefits.<sup>22</sup>

## Part B Coverage, Costs

Medicare Part B covers physician services including surgery, consultations and visits, outpatient services, x-rays, lab work, and other diagnostic tests, certain preventive benefits,

durable medical equipment and prosthetic devices. Part B benefits are subject to a deductible (\$183 in 2018), and most Part B benefits are subject to coinsurance of 20 percent. No coinsurance or deductible is charged for an annual wellness visit or for preventive services that are rated ‘A’ or ‘B’ by the U.S. Preventive Services Task Force.

Medicare is a defined benefit program. Coverage is grounded in the “medically reasonable and necessary” standard. Part B is funded by general revenues and beneficiary premiums. State Medicaid programs pay the Part B premiums, as well as cost-sharing for some low-income beneficiaries. Beneficiaries with incomes greater than \$85,000 for individuals or \$170,000 for married couples pay a higher, income-related monthly Part B premium, ranging from \$187.50 to \$428.60 per month in 2018.

In 2017, the majority of the 57 million people on Medicare were covered by traditional Medicare, with one-third (33 percent) receiving their Medicare benefits through a private Medicare Advantage (MA) plan that may impose different premium and cost-sharing requirements. These plans must provide all items and services that are covered under Medicare Parts A and B, except for hospice.

## Proposed Structure & Cost Analysis

As part of an ongoing investigation of alternatives to serve the dental care needs of a growing elder population, the American Dental Association (ADA) recently commissioned a study that analyzed the cost structure for various dental benefit designs within Medicare. Pricing was based on 2016 self-insured market rates. This study estimated that a comprehensive benefit without dollar value caps would cost the federal government 31.4 billion in 2016 dollars, or \$32.3 billion in 2018. This estimate assumes a general fund contribution of 75 percent of all costs, similar to the current Medicare Part B funding structure.

The estimated base premium increase for a Part B benefit is \$14.50 per beneficiary per month. This cost estimate accounts for low-income beneficiary subsidies applied to premiums and cost-sharing and surcharges paid by high-income beneficiaries. A standard 20 percent

co-insurance was applied across all services. Additionally, this model assumes dental services are not subject to any additional deductible.

This study assumes a reimbursement rate at the median (50th percentile) fee (i.e. fees charged by at least 50 percent of dentists in the United States.) Funding a benefit at appropriate levels to support participation is essential to assure adequate access for Medicare beneficiaries. Apart from cost of services, overhead charges experienced by dental offices are significant. Unlike a typical physician's office, a dental practice that offers comprehensive services houses significant equipment, creating a relatively larger overhead. Unlike Part B, within Medicare Part A, hospitals are paid a facility fee to account for equipment costs for each service rendered in the hospital.

Further, within dental fee-for-service reimbursement models, other unique costs such as dental laboratory material and supplies are included within the fee for each procedure. Practice viability is dependent upon a mix of patients who are eligible for various discounted rates versus full-fee paying patients in a practice. Thus, practice overhead, along with total cost of the services relative to discounted fees, will be an important factor for dental practices considering whether to participate in Medicare.

Note that these estimates are based on the current coverage trends for working-age adults. For example, the cost of coverage for dental implants is not included within these estimates. Should dental coverage include services like implants (necessary for some Medicare recipients), the utilization and cost of such services would need to be added to these estimates. Similarly, any current "pent-up" demand for dental services has not been modeled within these estimates.

The ADA<sup>23</sup> continues to consider many options to address care for elders.

## A CASE FOR INCLUSION PUBLIC OPINION

Surveys show that consumers widely support adding oral health coverage to Medicare. A recent survey of likely voters among the general public indicated that 86 percent support including dental coverage as part of Medicare.<sup>24</sup>

Regardless of income or education, a majority of older adults (52 percent) expect dental coverage in Medicare and do not realize Medicare does not cover routine or preventive dental care.<sup>25</sup> To better understand older adults' views and attitudes on adding a dental benefit to Medicare, Oral Health America (OHA) and the ADA's Health Policy Institute (HPI), commissioned Wakefield Research to conduct a series of focus groups with adults aged 50 years or older. Findings showed that an increasing number of older adults<sup>26</sup> understand the link between oral health and overall health and virtually all (93 percent) - despite cost concerns - want dental coverage in Medicare.

Older adults prioritize two categories of care: checkups and pain treatment. One woman from Chicago explained, "I want to be pain-free. And that means getting my regular exam and cleaning, and then dealing with my crowns."

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While research by Marketing for Change showed only 2 in 10 seniors feel emboldened enough to take action on this issue, a local consumer pilot in Orlando, Florida, called Demand Medicare Dental provided an early indication of the power of grassroots organizing. When equipped with consumer-friendly advocacy tools, older adults are ready to take action including signing petitions and sending letters, postcards and toothbrushes to their legislators demanding Medicare include dental coverage.<sup>27</sup>

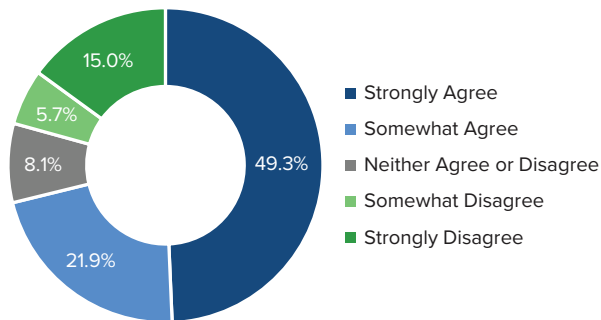
## Provider View

To better understand the views and attitudes of the dental provider community, the Health Policy Institute, with input from the ADA Practice Institute, developed a survey to assess dentists' views and opinions on adding dental services to the Medicare program. Data were collected through an online survey administered to a random sample of licensed, professionally active U.S. dentists between January 8-12, 2018, and responses were weighted to be nationally representative.

Overall, 71.2 percent of dentists agreed<sup>28</sup> that Medicare should include comprehensive dental benefits (see Figure 1). While provider reimbursement under such a benefit requires additional research, the majority of dentists indicated they were willing to comply with typical Medicare practice requirements such as reporting diagnostic codes and using electronic health records.

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Medicare Should Include Comprehensive Dental Benefits



## Advantages

Incorporating the oral health benefit into Part B has several advantages:

- Advances the goal of integrating oral health into total health care by incorporating the benefit administratively into the Medicare program that covers other health care providers. Administrative integration facilitates programmatic integration.
- Provides oral health coverage to everyone enrolled in Medicare, including those in Medicare Advantage plans, and ensures that public funding goes toward allowing the greatest number of beneficiaries access to a basic level of dental care and a healthy mouth. This is logical not only from a health equity standpoint, but because it would also encourage provider participation.
- Including an oral health benefit in Medicare Part B is simpler for beneficiaries and providers than setting up a separate benefit as was done for prescription drugs under Medicare. Beneficiaries would not have to navigate or enroll in a new, potentially confusing program. Oral health providers could interact with each other and the federal government in the same way that medical providers currently interact in the Part B system.
- There are established protections for both Medicare beneficiaries and providers. These include established Part B grievance and appeal procedures, existing precedent on medical necessity standards, and existing provider enrollment procedures, provider rate-setting processes and payment protections for Qualified Medicare Beneficiaries. Including the Part B benefit avoids the need to create new systems and bureaucracies, saving significant time and costs.

## Legislative Changes Needed

Currently, Medicare does not cover dental benefits due to the statutory exclusion in Section 1862(a)(12) of the Social Security Act. Removing this statutory exclusion is the most important legislative change to establish a comprehensive Medicare Part B oral health benefit. However, additional statutory changes would be needed to ensure that a

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scope of services is established and that the oral health benefit is integrated into Medicare Part B as seamlessly as possible.

Specifically, Congress would need to pass legislation to remove the exclusion of oral health benefits from the Medicare Program.<sup>29</sup> Further, the legislation would need to establish dental coverage in Part B<sup>30</sup> and permit payment for services prescribed in the dental benefit.<sup>31</sup> Dental services would need to be defined in the Medicare statute, and various sections addressing provider payment would need to be amended to address oral health services.<sup>32</sup> Also, CMS would require the authority to promulgate any needed regulations to implement and administer oral health benefits as part of Medicare Part B.

## Conclusion

Oral health is necessary for overall health. Older adults need timely and affordable access to dental care in order to age successfully. Oral health care is also essential for millions of those with permanent disabilities. A dental benefit in Medicare Part B will ensure that oral health care is integrated with, and elevated to, the same importance as the rest of health care. All older adults and people who are permanently disabled, regardless of socio-economic status, need increased oral health literacy, along with access to oral health services and preventive care. Further research on the impact of oral health care coverage for Medicare Part B recipients would illuminate how this benefit would enhance overall health and better quality of life without excessive cost.

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## References

- 1 Kaiser Family Foundation analysis of DYNASIM data (2017) "Centers for Medicare and Medicaid services Medicare current beneficiary 2013 cost and use file," San Francisco, Calif.: <https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/>.
- 2 Kaiser Family Foundation analysis of DYNASIM data (2017) "Centers for Medicare and Medicaid services Medicare current beneficiary 2013 cost and use file," San Francisco, Calif.: <https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/>.
- 3 Oral Health America (2013), "A state of decay, vol. II," <https://oralhealthamerica.org/astateofdecay/archive/> Chicago, Ill.; and Manski R. J. and Rohde F. June (2017) "Dental services: use, expenses, source of payment, coverage and procedure type, 1996-2015: research findings" (No. 34.) Rockville, MD. Agency for Healthcare Research and Quality, [https://meps.ahrq.gov/mepsweb/data\\_files/publications/rf34/rf34.pdf](https://meps.ahrq.gov/mepsweb/data_files/publications/rf34/rf34.pdf)
- 4 Bruce A. Dye et al., "Dental caries and tooth loss in adults in the United States, 2011–2012"; and C.M. Vargas, E.A. Kramarow, and J.A. Yellowitz, (2001) "The Oral Health of Older Americans, National Center for Health Statistics, Aging Trends" (no. 3). <http://www.cdc.gov/nchs/data/ahcd/agingtrends/03oral.pdf>.
- 5 P.I. Eke, B.A. Dye, L. Wei, G.O. Thornton-Evans, R.J. Genco (2012) "Prevalence of periodontitis in adults in the United States: 2009 and 2010." (Vol. 91, Issue 10) Journal of Dental Research, <http://journals.sagepub.com/doi/abs/10.1177/0022034512457373>.
- 6 Kaiser Family Foundation (June 2012), "Oral health and Medicare beneficiaries: coverage, out-of-pocket spending, and unmet Need," San Francisco, Calif.: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8325.pdf>
- 7 Kaiser Family Foundation (June 2012), "Oral health and Medicare beneficiaries: coverage, out-of-pocket spending, and unmet need," San Francisco, Calif.: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8325.pdf>
- 8 Manski R. J. and Rohde F. June (2017) "Dental services: use, expenses, source of payment, coverage and procedure type, 1996-2015: research findings" (No. 34.) Rockville, MD. Agency for Healthcare Research and Quality, [https://meps.ahrq.gov/mepsweb/data\\_files/publications/rf34/rf34.pdf](https://meps.ahrq.gov/mepsweb/data_files/publications/rf34/rf34.pdf); and Manski, R. J. and Brown, E., (2007) "Dental use, expenses, private dental coverage, and changes, 1996 and 2004" (MEPS Chartbook No.17) Rockville, Md.: Agency for Healthcare Research and Quality, [http://www.meps.ahrq.gov/mepsweb/data\\_files/publications/cb17/cb17.pdf](http://www.meps.ahrq.gov/mepsweb/data_files/publications/cb17/cb17.pdf)
- 9 Manski, R.J., Moeller, J.R., Chen, H., St. Clair, P.A., Schimmel, J., Magder, L. and Pepper, J.V., (October 2009) "Dental care coverage transitions," (15 10: 729-735). American Journal of Managed Care
- 10 Kaiser Family Foundation analysis (January 2018 based on 2013 data), "Medicare beneficiaries' out-of-pocket health care spending as a share of income now and projections for the future," San Francisco, Calif.: <https://www.kff.org/report-section/medicare-beneficiaries-out-of-pocket-health-care-spending-as-a-share-of-income-now-and-projections-for-the-future-report/>.
- 11 Manski R. J. and Rohde F. June (2017) "Dental services: use, expenses, source of payment, coverage and procedure type, 1996-2015: research findings" (No. 34.) Rockville, MD. Agency for Healthcare Research and Quality, [https://meps.ahrq.gov/mepsweb/data\\_files/publications/rf34/rf34.pdf](https://meps.ahrq.gov/mepsweb/data_files/publications/rf34/rf34.pdf)
- 12 Kaiser Family Foundation analysis (April 2017 based on 2016 data), "Income and assets of Medicare beneficiaries, 2016-2035", San Francisco, Calif.: <https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/>.
- 13 Kaiser Family Foundation analysis (April 2017 based on 2016 data), "Income and assets of Medicare beneficiaries, 2016-2035", San Francisco, Calif.: <https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/>.
- 14 Moeller, J.R., Manski, R.J., Mathiowetz, N., Campbell, N. and Pepper, J.V., "Response error in reporting dental coverage by older Americans in the health and retirement study," (51:1- 10 January-December 2014) Inquiry.
- 15 Kaiser Family Foundation analysis (January 2018 based on 2013 data), "Medicare beneficiaries' out-of-pocket health care spending as a share of income now and projections for the future," San Francisco, Calif.: <https://www.kff.org/report-section/medicare-beneficiaries-out-of-pocket-health-care-spending-as-a-share-of-income-now-and-projections-for-the-future-report/>.



- 16 Manski, R.J., Moeller, J.F., St. Clair, P.A., Chen, H., Schimmel, J., and Pepper, J.V., (February 2015) "Dental use and expenditures for older uninsured Americans: the simulated impact of expanded coverage" (50(1):117-135) Health Services Research; and Manski, R.J., Moeller, J.F., and Chen, H., (2014) "Dental care coverage and use: modeling limitations and opportunities" (104:e80–e87. doi:10.2105/AJPH.2013.301693), Am J Public Health.
- 17 Dept. of Health and Human Services (2000), "Oral health in America: a report of the surgeon general," <http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf>.
- 18 Hyde S, Dupuis V, Mariri BP, Dartevelle S. (2017), "Prevention of tooth loss and dental pain for reducing the global burden of oral diseases," Int Dent J.;67:19-25. doi:10.1111/idj.12328.
- 19 U.S. National Library of Medicine, National Institutes of Health, (February 2010) "Food insecurity is associated with chronic disease among low-income NHANES participants," Journal of Nutrition, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2806885/>
- 20 Dept. of Health and Human Services (2000), "Oral health in America: a report of the surgeon general," <http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf>.
- 21 Manski, R.J., Moeller, J.F., St. Clair, P.A., Chen, H., Schimmel, J., and Pepper, J.V., (February 2015) "Dental use and expenditures for older uninsured Americans: the simulated impact of expanded coverage" (50(1):117-135) Health Services Research; and Manski, R.J., Moeller, J.F., and Chen, H., (2014) "Dental care coverage and use: modeling limitations and opportunities" (104:e80–e87. doi:10.2105/AJPH.2013.301693), Am J Public Health.
- 22 Medicare.gov, "Medicare 2018 costs at a glance," (2018) <https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html>.
- 23 Inclusion of the results of the ADA studies on this issue is not intended as an endorsement of other statements included in this white paper.
- 24 Families USA, results of survey conducted by GS Strategy Group and PerryUndem of likely voters, (December 2017) <http://familiesusa.org/blog/2017/12/public-supports-better-insurance-coverage-dental-care-survey-finds>
- 25 Oral Health America (2015) Results of quick query omnibus survey conducted by Harris Poll, week of July 13, 2015 among Americans 50+. <https://oralhealthamerica.org/participate/take-action/medicaretoolkit/>
- 26 Oral Health America and American Dental Association Health Policy Institute (November 2017), Results of Instant-Feedback qualitative sessions conducted by Wakefield Research on July 20 – 22, 2017, among Americans 50+. <https://oralhealthamerica.org/participate/take-action/medicaretoolkit/>
- 27 Oral Health America (September 2017) Demand Medicare Dental Pilot Campaign Report. Oral Health America. Demand Medicare Dental Pilot Campaign Report. Sept. 2017. [http://oralhealthamerica.org/files/OHA-DemandMedicareDental\\_PilotCampaignReport\\_September2017.pdf](http://oralhealthamerica.org/files/OHA-DemandMedicareDental_PilotCampaignReport_September2017.pdf)
- 28 For more information, contact the American Dental Association Health Policy Institute at [hpi@ada.org](mailto:hpi@ada.org).
- 29 42 U.S.C. § 1395y(a)(12) [Section 1862(a)(12) of the Social Security Act]
- 30 For example, this could be accomplished by amending section 42 U.S.C. § 1395k [Section 1832 of the Social Security Act].
- 31 Preventive services are addressed at 42 U.S.C. § 1395y(a)(1).
- 32 For example, dental could be included in the definition of Medical & Other Health Services at 42 U.S.C. § 1395x(s) or defined separately somewhere in 42 U.S.C. § 1395x. [Section 1861 of the Social Security Act.]

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