

October 16, 2019

The Honorable Richard Neal
Chairman
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
House Ways and Means Committee
1139 Longworth House Office Building
Washington, DC 20515

The Honorable Lloyd Doggett
Chairman
Health Subcommittee
1104 Longworth House Office Building
Washington, DC 20515

The Honorable Devin Nunes
Ranking Member
Health Subcommittee
1139 Longworth House Office Building
Washington, DC 20515

Dear Chairman Neal, Ranking Member Brady, Subcommittee Chairman Doggett, and Subcommittee Ranking Member Nunes,

The American Dental Association (ADA) appreciates that the Ways and Means Committee is bringing attention to the importance of oral health care as a crucial part of overall health for our senior population. As America's leading advocate for oral health, we are writing to provide our Health Policy Institute's current research on the state of oral health care for our nation's seniors. We also wish to highlight key issues to consider for further policy discussions related to improving the oral health of older Americans, particularly those focused on access to dental care.

The Current Landscape of Access to Dental Care for Seniors

It is useful to review the current landscape of access to dental care for older Americans. The ADA Health Policy Institute maintains the most robust data on the U.S. dental care system, drawing on publicly available as well as proprietary data sources.

According to the [most recent data](#), 37.3% of seniors have some source of dental benefits coverage. Approximately 26.3% have private dental coverage, and 11.0% have public dental coverage (for example, Medicaid, Tricare, or the small number who receive dental benefits through Veterans Affairs). The remaining 62.7% of seniors do not have any form of dental benefits coverage.

What does coverage translate to in terms of oral health care use and oral health? According to the most reliable data, 43.3% of seniors had a general dental visit in 2016, up from 38.3% in 2000. However, there are important differences by dental benefits status. Specifically, 68.7% of seniors with private dental coverage had a dental visit in the past year compared

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to 37.5% of those who are uninsured. The rate is even lower (16.1%) among seniors with public dental coverage.

Dental care use also varies by household income. High-income seniors are much more likely to visit the dentist than low-income seniors. Among these high-income seniors with household income above 400% of the federal poverty level, 61.3% visited the dentist compared with 24.4% of low-income seniors (< 100% of the federal poverty level). The gap in dental care use between high- and low-income seniors has widened over the years, with high-income seniors seeing steadily increasing dental care use rates over time and low-income seniors seeing no gains. Hospital [emergency room visits](#) among older Americans are on the rise as well.

The disparity in dental care use by income is driven in large part by affordability or perceived affordability. Among seniors who have not visited a dentist in the past year, nearly three-fourths of low-income seniors report cost as the [main barrier to oral health care](#), compared with one-fourth of high-income seniors. Put another way, the top reason low- and middle-income seniors do not visit the dentist is affordability, while for high-income older Americans, it is lack of perceived need. Moreover, when it comes to all health care services, seniors consistently report that financial barriers are [highest for dental care](#), above prescription drugs and long-term care.

The disparities in dental care use and dental benefit coverage have clear implications for oral health. When it comes to various measures of seniors' oral health, such as prevalence of untreated cavities or tooth loss, disparities by income, race, and dental insurance status are widening over time. That is, high-income seniors, in general, are seeing improvements in their oral health while for low-income seniors, improvements are [either not as large or, in some cases, are non-existent](#).

Improving Access to Dental Care for Seniors

When considering policy options to improve access to dental care among seniors, specifically through Medicare reform, it is important for policy makers to take into account several issues.

Cost Sharing Arrangements:

For example, almost universally, private dental benefit plans in the market today cover preventive and diagnostic dental care services (e.g. exam and cleaning) at 100% with no cost sharing among beneficiaries. Some large dental insurance carriers are also experimenting with expanding preventive services for which there is no cost sharing (e.g. more than two cleanings per year for diabetics).

The standard Part B financing arrangement, if applied to all dental care services, would entail cost-sharing for prevention, potentially to a degree that inhibits access to basic care for our vulnerable seniors. For example, the national average combined cost for providing an exam, x-rays, and a cleaning is \$217. At 20% co-insurance, this would entail a typical out-of-pocket payment of \$43.

Any policy proposal that would include cost-sharing for comprehensive services that designate “major tooth restorations, major periodontic services, bridges, crowns and root canals” as “major treatments” may not allow meaningful access to these services for the low income seniors. Further, these “major treatments” as described above are some of the more common treatment services sought by seniors.

A detailed analysis of the distribution of dental care services typically provided to older Americans could help determine the extent to which a Medicare financing arrangement – as well as any alternative cost-sharing arrangement – would pose a financial barrier to dental care for low- or middle-income seniors. The ADA Health Policy Institute has a robust database, expertise, and collaborative networks in academia to perform such an analysis.

Provider Network:

In order for any dental program to be effective in increasing the oral health of seniors and providing for their care, a robust network of providers is essential. If dentists are to be incentivized to enroll and provide care under a program, reimbursement must be at a level that accounts for the unique cost of dental care delivery, including facility costs similar to a surgical center. This is unlike physicians, whose surgical center costs are reimbursed under Part A.

Part B vs. Part ‘T’ vs. Medicaid:

There are important implications to the specific channel through which dental benefits would be offered. If a dental benefit is included under Part B, it would be universal (to Part B enrollees) and most likely would follow standard Part B cost-sharing arrangements. Under a potentially new program (Part ‘T’) the benefit could be optional with potentially more flexibility in setting cost-sharing arrangements and premium subsidies targeted to low- or low- and middle-income enrollees. A Part T would also allow for a benefit design and reimbursement calculation based on the very real differences between dental and medical care delivery. To put it simply, dental care delivery bears the cost of both Part A and B, because the surgical center facility cost is included.

Another policy option is to require Medicaid programs to provide a dental benefit to low-income seniors. Such a program could potentially better direct resources to the most vulnerable elderly if administered in a way that ensures a comprehensive, broad dental

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benefit and a robust provider network. There are important lessons to draw on from the current approach to dental coverage through Medicaid. The dental benefit for children provided through Medicaid (and CHIP) is very robust in terms of what services are covered and involves little to no cost sharing for beneficiaries. While state experience varies widely, nationally the share of low-income children visiting the dentist has increased significantly, and [oral health outcomes](#) have improved most among low-income and minority children. The way Medicaid has approached dental coverage for children could provide a roadmap for a potential benefit targeted at vulnerable seniors.

The ADA welcomes the opportunity to work with the Ways and Means Committee to further improve the oral health of older Americans. In particular, the Health Policy Institute, as a leading source of data and research related to the U.S. dental care system, welcomes the opportunity to provide the committee with any ad hoc requests for data, custom research, and expertise.

If you have any questions, please contact Mr. Mike Graham at 202-789-5167 or grahamm@ada.org.

Sincerely,



Chad P. Gehani, D.D.S.
President



Kathleen T. O'Loughlin, D.M.D., M.P.H.
Executive Director

CPG:KTO