# Adding a Dental Benefit to Medicare:

## Addressing Racial Disparities

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# INTRODUCTION

Medicare is the primary source of health coverage for older adults and younger individuals with disabilities. Yet, Medicare explicitly excludes coverage for most dental services.[1] Consequently, nearly half of all Medicare beneficiaries did not see a dentist in the past year.[2] Without access to treatment, Medicare beneficiaries experience significant adverse health outcomes, with certain populations suffering more acutely.

Populations of color are disproportionately impacted by the exclusion of dental coverage in Medicare. Nationwide 17 percent of older adults have no remaining natural teeth—a rate that has been steadily decreasing each year. Yet, among Black older adults, the percent of individuals with complete tooth loss is 31 percent—almost double the national average—with minimal change over the past decade.[3]

In this paper, we examine how adding a dental benefit to Medicare would be a step towards reducing disparities in access to care and oral health outcomes on the basis of race. The paper begins with an overview of the disparities in access to oral health coverage, services, and outcomes based on race. Next, we examine how adding a dental benefit to Medicare would help to reduce those disparities. We conclude with a list of additional policy options aimed at reducing disparities beyond expanding oral health coverage.

In an issue brief, *Creating an Oral Health Benefit in Medicare: A Statutory Analysis*,[4] Justice in Aging provided an analysis of what statutory changes would be needed to add an oral health benefit in Medicare Part B. This paper builds on that issue brief and is the first in a series that will examine how to address disparities in access to care and oral health outcomes among certain groups of Medicare beneficiaries, including people of color, younger individuals with disabilities, older adults with dementia and cognitive impairments, and nursing facility residents.

# DISPARITIES IN ACCESS, DISPARITIES IN OUTCOMES

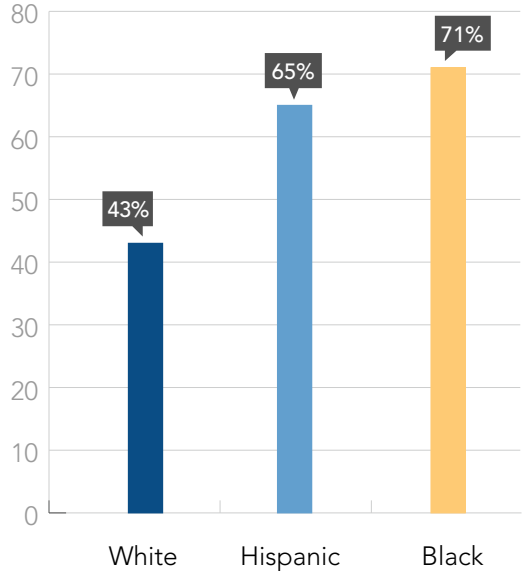
## Dental Coverage & Access Disparities for Medicare Beneficiaries

Today, 65 percent of Medicare beneficiaries—approximately 37 million individuals—have no dental coverage.[5] Oral health care is expensive, so it is not surprising that those without coverage or even those with limited coverage cite cost as the biggest barrier to accessing care. Unable to afford care, nearly half of all Medicare beneficiaries did not have a dental visit in the last year. [6]

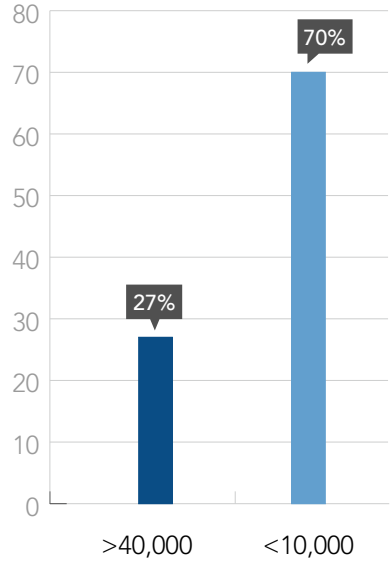
The lack of dental coverage and access to services disproportionately impacts populations of color. For example, seven out of ten Black Medicare beneficiaries and six out of ten Hispanic beneficiaries did not see a dentist in the last year compared to four out of ten white beneficiaries.[7] Income levels also intersect with race, decreasing access to services. Seventy percent of beneficiaries with incomes less than $10,000 did not have a dental visit in the last year compared to twenty-seven percent with incomes greater than $40,000.[8]

> **Seven out of ten Black Medicare beneficiaries** and **six out of ten Hispanic beneficiaries** did not see a dentist in the last year **compared to four out of ten white beneficiaries.**

Percent of Medicare Beneficiaries
No Dental Visit in Past Year by Race




Percent of Medicare Beneficiaries
No Dental Visit in Past Year by Income

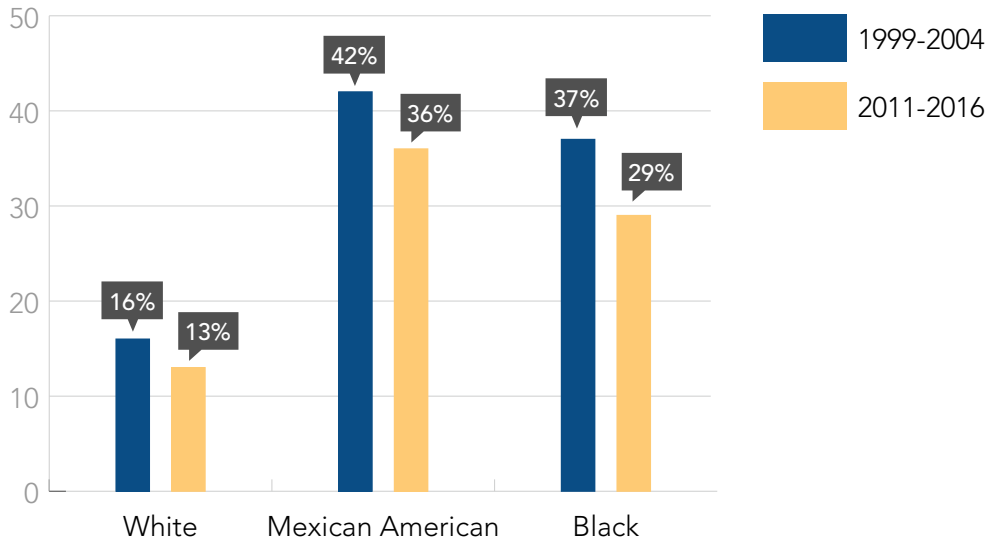



*Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey (MCBS), 2016*

## Disparities in Outcomes

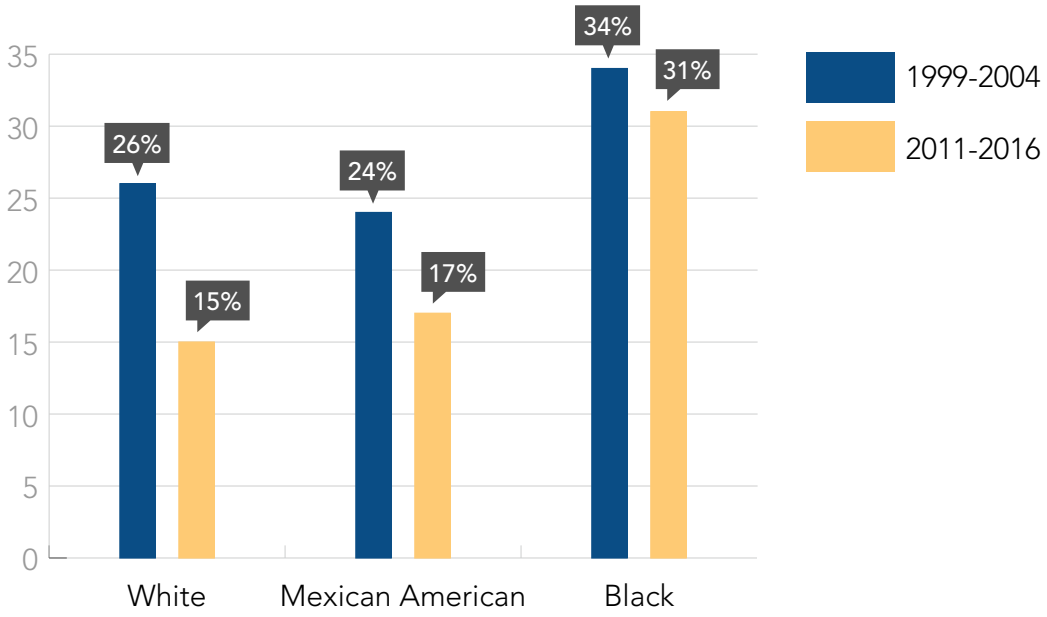
With disparities in access come disparities in outcomes. When we look at two oral health measures, untreated tooth decay and complete tooth loss, the disparities in access for older adults of color by and large mirror disparities in health outcomes. For example, over one third of Mexican American[9] older adults have untreated tooth decay compared to just 13 percent of white older adults. When reviewing complete tooth loss, Black older adults experience complete tooth loss at over two times the rate of white older adults (31 percent versus 15 percent).[10] While progress has been made towards improving health outcomes over the last decade, the data demonstrates that significant disparities persist.

Percent of Older Adults with Untreated Dental Decay




*Source: Centers for Disease Control and Prevention, Oral Health Surveillance Report 2019, Table 30*

Percent of Older Adults with Complete Tooth Loss




*Source: Centers for Disease Control and Prevention, Oral Health Surveillance Report 2019, Table 35*

# MEDICARE DENTAL BENEFIT WOULD REDUCE DISPARITIES

As discussed above, cost is one of the biggest barriers to accessing dental care, and populations of color are disproportionately affected. Adding a dental benefit to Medicare would act to reduce disparities in coverage, access, and outcomes by providing oral health care coverage for medically necessary services to *all* Medicare beneficiaries.

We can look to the Affordable Care Act (ACA) for evidence that expanding coverage reduces disparities. The ACA provided coverage for the first time to millions of previously uninsured individuals. Populations of color had considerably higher uninsured rates pre-ACA because of systemic barriers, particularly related to their income and employment. So while all groups saw gains in coverage under the ACA, racial and ethnic groups saw the greatest gains, significantly narrowing the coverage gap.[11] Studies evaluating the ACA also showed that gaining coverage reduced disparities in access to care. For example, the percent of Black and Hispanic individuals who reported going without care prior to the ACA dropped by four to five percentage points after gaining coverage under the ACA.[12]

Dental coverage under the Medicaid program also offers evidence that coverage leads to improved access and even reductions in disparities. While no studies specifically examine whether Medicaid adult dental coverage reduces disparities based on race, the data available for children shows that dental coverage can eliminate disparities based on race. For example, when looking at whether a child with Medicaid coverage had a dental visit in the last twelve months, there are no statistically significant differences based on race. In contrast, uninsured Hispanic and Black children are significantly less likely to have a dental visit compared to uninsured white children.[13]

This research and data offer convincing evidence that adding a dental benefit to Medicare would likewise reduce oral health disparities based on race.

## Coverage is Essential, But More is Needed to Address Disparities

Dental coverage is the largest determinant of whether an individual can access oral health care. Therefore, expanding coverage is an essential step in ensuring access and reducing disparities, but it is not the only step. The data suggests that factors other than coverage or lack of coverage are also to blame for disparities—particularly for Black older adults. For example, while the rate of complete tooth loss decreased by 11 percent for white older adults and 7 percent for Mexican Americans overall between 2004 and 2016, it only decreased 3 percent for Black older adults. And while rates of tooth decay are higher for Mexican American older adults than Black older adults, Black older adults are having all of their teeth pulled at almost two times the rate of Mexican Americans, even when controlling for income.[14]

This data demonstrates that while gaining coverage can help reduce disparities in both access and health outcomes, disparities nonetheless persist. It is critical to address other factors that contribute to disparities in access and outcomes including, but not limited to:

- **Integrating oral health with overall health**. Historically, oral health has not been integrated with other medical care. This is particularly problematic for populations of color, who are more likely to have multiple chronic health conditions that are affected by their oral health.[15] Integrating oral health into primary care as well as into health care delivery systems is critically important. Adding a dental benefit to Part B in Medicare with other medical coverage would be a substantial step in advancing integration.
- **Diversifying the oral health workforce**. Today, the oral health workforce does not reflect the diversity of the population.[16] Oral health providers, like providers in other areas of health, have implicit biases and differing cultural backgrounds that contribute to health disparities. There is a need to increase the diversity of providers across the entire oral health workforce, as well as provide training in implicit bias and cultural competence.
- **Co-locating Services – addressing social determinants of health.** To address disparities, it is also important to address the social determinants of health that are acting as barriers to care, including lack of transportation and the difficulty of attending many different health appointments. Providing oral health services where people are through co-location with other healthcare and in senior centers, virtual dental homes, telehealth, and other measures can help to increase access.[17]
- **Promoting good oral health practices**. Good oral hygiene and preventive care have been responsible for major improvements in oral health over the last 50 years. Greater efforts, however, are needed to promote oral health in communities where health disparities persist. This includes building trust in these communities as well as utilizing culturally inclusive oral health promotion practices.[18]

# CONCLUSION

Lack of oral health coverage is the biggest barrier to accessing oral health treatment for the 60 million Medicare beneficiaries who rely on the program, particularly populations of color. Multiple bills have been introduced in Congress this year that would add a dental benefit to Medicare, and, if passed, would help to address coverage and access disparities in oral health treatment based on race.[19] At the same time, advocates, health providers, dental schools, policymakers, and other stakeholders have the opportunity to address disparities in oral health care through changes in policies, practices, and systems.

# ENDNOTES

1 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 www.cms.gov/Medicare/Coverage/MedicareDentalCoverage/index.html.

2 Kaiser Family Foundation, "Drilling Down on Dental Coverage and Costs for Medicare Beneficiaries," (Mar. 2019) (hereinafter "Drilling Down on Dental Coverage"), available at http://files.kff.org/attachment/Issue-Brief-Drilling-Down-on-Dental-Coverage-and-Costs-for-Medicare-Beneficiaries.

3 Centers for Disease Control and Prevention, "Oral Health Surveillance Report 2019, Trends in Dental Caries and Sealants, Tooth Retention, and Edentulism, United States, 1999-2004 to 2011 to 2016" (2019)(herein after "Oral Health Surveillance Report"), available at https://www.cdc.gov/oralhealth/pdfs_and_other_files/Oral-Health-Surveillance-Report-2019-h.pdf.

4 Justice in Aging, "Creating an Oral Health Benefit in Medicare: A Statutory Analysis," (Jan. 2019), available at https://www.justiceinaging.org/wp-content/uploads/2019/01/Creating-an-Oral-Health-Benefit-in-Medicare-A-Statutory-Analysis.pdf.

5 Drilling Down on Dental Coverage, *supra* note 2. The remaining 35 percent of Medicare beneficiaries have some form of coverage through either private or public options including Medicare Advantage plans and state Medicaid programs.

6 Drilling Down on Dental Coverage, *supra* note 2.

7 Drilling Down on Dental Coverage, *supra* note 2.

8 Drilling Down on Dental Coverage, *supra* note 2.

9 The NHANES data oversampled Mexican Americans in 1999-2004 data. To draw comparisons between 1999-2004 and the 2011-2016 data, the Oral Health Surveillance Report utilizes Mexican American rather than Hispanic data. See, Johnson CL, Dohrmann SM, Burt VL, Mohadjer LK. National Health and Nutrition Examination Survey: sample design, 2011–2014. Vital Health Stat 2. 2014;162:1–33, available at https://www.cdc.gov/nchs/data/series/sr_02/sr02_162.pdf.

10 Oral Health Surveillance Report, *supra* note 3.

11 The Commonwealth Fund, "Did the Affordable Care Act Reduce Racial and Ethnic Disparities in Health Insurance Coverage?," (Aug. 2019), available at https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/did-ACA-reduce-racial-ethnic-disparities-coverage.

12 The Commonwealth Fund, "Reducing Racial and Ethnic Disparities in Access to Care: Has the Affordable Care Act Made a Difference?," (Aug. 2017), available at https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_aug_hayes_racial_ethnic_disparities_after_aca_ib.pdf.

13 MACPAC, "Medicaid Access in Brief: Children's Dental Services," (Jun. 2016), available at www.macpac.gov/wp-content/uploads/2016/06/Childrens-access-to-dental-services.pdf

14 Oral Health Surveillance Report, *supra* note 3. Income data unpublished and available upon request.

15 Health Affairs, "Medicare as a Catalyst for Reducing Health Disparities," (2005), available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.24.2.365.

16 American Dental Education Association, "Diversifying the Dental Workforce and Maximizing Community Care: Summer Health Professions Education Program (SHPEP) 2006–2015," (Nov. 2018), available at https://www.adea.org/uploadedFiles/ADEA/Content_Conversion/policy_advocacy/White_Papers/ADEA-SHPEP-Report-Nov2018-update.pdf.

17 See, for example, Kopycka-Kedzierawski, et al., "Advancement of Teledentistry At The University of Rochester's Eastman Institute For Oral Health," (Dec. 2018), available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05102; US Dept. of Health and Human Services Health Resources and Services Administration, "Integration of Oral Health and Primary Care Practice," (Feb. 2014), available at https://www.hrsa.gov/sites/default/files/hrsa/oralhealth/integrationoforalhealth.pdf; Pacific Center for Special Care, University of the Pacific Arthur A. Dugoni School of Dentistry, "Report of the Virtual Dental Home Demonstration Improving the Oral Health of Vulnerable and Underserved Populations Using Geographically Distributed Telehealth-Connected Teams," (Jun. 2016), available at https://www.pacific.edu/Documents/marketing/VDH_FullReport.pdf.

18 Patrick, D.L. et al., "Reducing Oral Health Disparities: A Focus on Social and Cultural Determinants," (2006), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2147600/.

19 Six bills have been introduced in 2019 to add dental coverage to Medicare: S. 22 Medicare Dental Benefit Act of 2019; HR 2951, Medicare Dental Benefit Act of 2019; HR 1393, Medicare Dental, Vision, & Hearing Benefit Act of 2019; HR 576, Seniors Have Eyes, Ears, and Teeth Act; S. 1423, Medicare and Medicaid Dental, Vision, and Hearing Benefit Act of 2019; and HR 4650, Medicare Dental Act of 2019.