



Adding a Dental Benefit to Medicare: Addressing Oral Health Inequity Based on Disability

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INTRODUCTION

Medicare is the primary source of health coverage for older adults and people under 65 with disabilities. Yet, Medicare explicitly excludes coverage for most dental services.¹ Consequently, nearly half of all Medicare enrollees did not see a dentist in the past year.² Without access to treatment, Medicare enrollees experience significant adverse health outcomes, with certain populations being disproportionately harmed.

There are approximately 8.6 million individuals under 65 with disabilities enrolled in Medicare.³ The Medicare dental exclusion harms this group in multiple ways. On average, Medicare enrollees under 65 have lower incomes compared to Medicare enrollees overall, and, therefore, are less likely to have the ability to pay for oral health coverage and access treatment. Further, the very underlying medical conditions and functional limitations that establish the basis for Medicare eligibility for individuals under 65 can affect oral health, increasing the importance of regular access to dental care. Ableist policies that fail to provide sufficient assistance and accommodations for individuals with disabilities to perform routine oral care also contribute to untreated oral disease. In turn, untreated oral disease worsens underlying medical conditions and diminishes overall health. During a pandemic in which individuals with disabilities are already at higher risk for serious illness or death due to COVID-19, untreated oral disease can exacerbate this risk.

In this paper, we examine how adding a dental benefit to Medicare would reduce disparities in access to care and oral health outcomes for adults with disabilities under 65. The paper begins with a description of Medicare enrollees under 65 with disabilities, followed by an overview of the disparities in access to oral health coverage, services, and outcomes based on disability. Next, we examine how adding a dental benefit to Medicare would help to reduce those disparities and resulting oral health inequity. We conclude with additional policy proposals to address systemic barriers people with disabilities face in trying to access oral health care.

In an issue brief, [Creating an Oral Health Benefit in Medicare: A Statutory Analysis](#),⁴ Justice in Aging provided an analysis of the statutory changes that would be needed to add an oral health benefit in Medicare Part B. This paper builds on that issue brief and is the second in a series that examines how to address inequities in access to care and oral health outcomes among certain groups of Medicare beneficiaries, including [people of color](#),⁵ individuals with disabilities, older adults with dementia and cognitive impairments, and nursing facility residents.

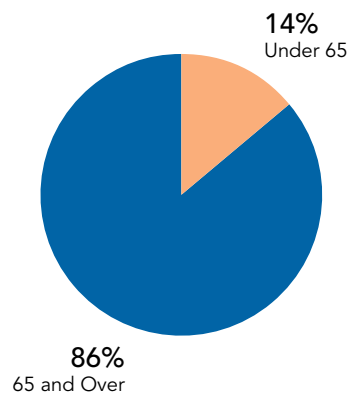
Thank you to [Disabled and Here](#), a photo and interview series celebrating disabled Black, Indigenous, and people of color, for the beautiful photograph on the cover.

Characteristics of Medicare Enrollees Under 65 with Disabilities

Medicare is available to certain individuals with disabilities who are under age 65. To be eligible, individuals must have been found disabled by the Social Security Administration, have sufficient work history, and have received disability benefits for 24 months (plus a five-month waiting period before benefits begin). Individuals diagnosed with End Stage Renal Disease (ESRD) and Lou Gehrig's Disease are automatically eligible for Medicare as soon as they apply, with no 24-month requirement.⁶

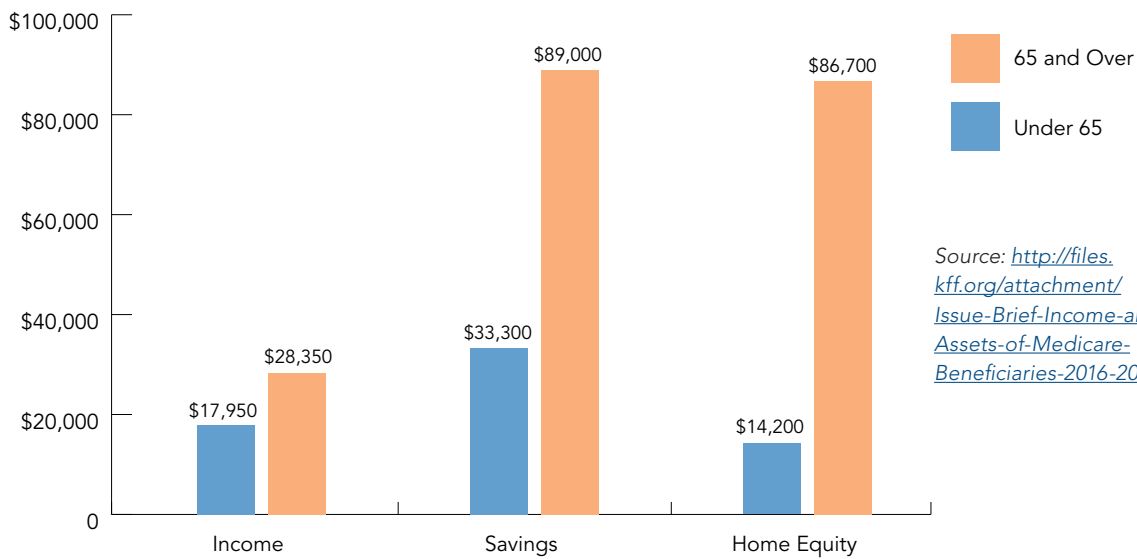
Individuals under 65 with disabilities represent 14% of all Medicare enrollees—a total of 8.6 million individuals (Figure 1).⁷ Medicare enrollees under 65 are more likely to have low-incomes, less in savings, and less home equity compared to older Medicare enrollees. Enrollees over age 65 have a median income 1.5 times higher than enrollees under 65; median savings 2.5 times more; and home equity 6 times more (Figure 2).⁸ Medicare enrollees under 65 are therefore more likely to be dually enrolled in both Medicare and Medicaid. Only 11% of those enrolled in Medicare only are individuals under 65 (Figure 3).⁹

Figure 1. Percent of Medicare Enrollees by Age and Disability



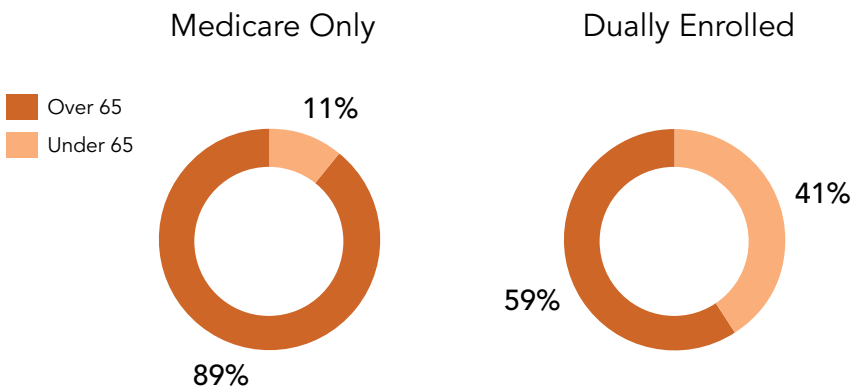
Source: Centers for Medicare & Medicaid Services, "Total Medicare Enrollment: Part A and/or Part B Total, Aged, and Disabled Enrollees, Calendar Years 2013-2018," available at <https://www.cms.gov/files/document/2018-mdcr-enroll-ab-3.pdf>.

Figure 2. Income and Assets of Medicare Enrollees, 2016



Source: <http://files.kff.org/attachment/Issue-Brief-Income-and-Assets-of-Medicare-Beneficiaries-2016-2035>

Figure 3. Percent of Enrollees by Age Enrolled in Medicare Only and Dually Enrolled in Medicare and Medicaid



Source: "PUF_2012" tab in [Medicare-Medicaid Linked Enrollee Analytic Data Source \(MMLEADS\) Public Use File \(PUF\) Version 2.0 \(2006–2012\) \(02/2019\) \(XLSX\)](#), Centers for Medicare & Medicaid Services (CMS), "MMCO Statistical & Analytic Reports."

Individuals under 65 with disabilities are also more racially and ethnically diverse: 38% of Medicare enrollees under age 65 are people of color, compared to 22% of older enrollees (Figure 4).¹⁰ Medicare enrollees under 65 also have increased functional needs. They are more likely to report limitations with three or more activities of daily living like bathing, dressing, and toileting.¹¹ They are also over three times more likely to have a cognitive impairment compared to enrollees 65 and over.¹²

Dental Coverage & Access Inequities for Medicare Enrollees Under 65 with Disabilities

Today, nearly two out of three Medicare enrollees have no dental coverage from any source.¹³ The lack of dental coverage disproportionately impacts individuals with disabilities' access to oral health services. For example, 62% of individuals with disabilities under 65 report that they have not seen a dentist in the last year compared to 49% of Medicare enrollees overall.¹⁴ Further, they are more than twice as likely to forgo needed dental care due to cost compared to Medicare enrollees overall, a result consistent with their lower average income and resources.¹⁵

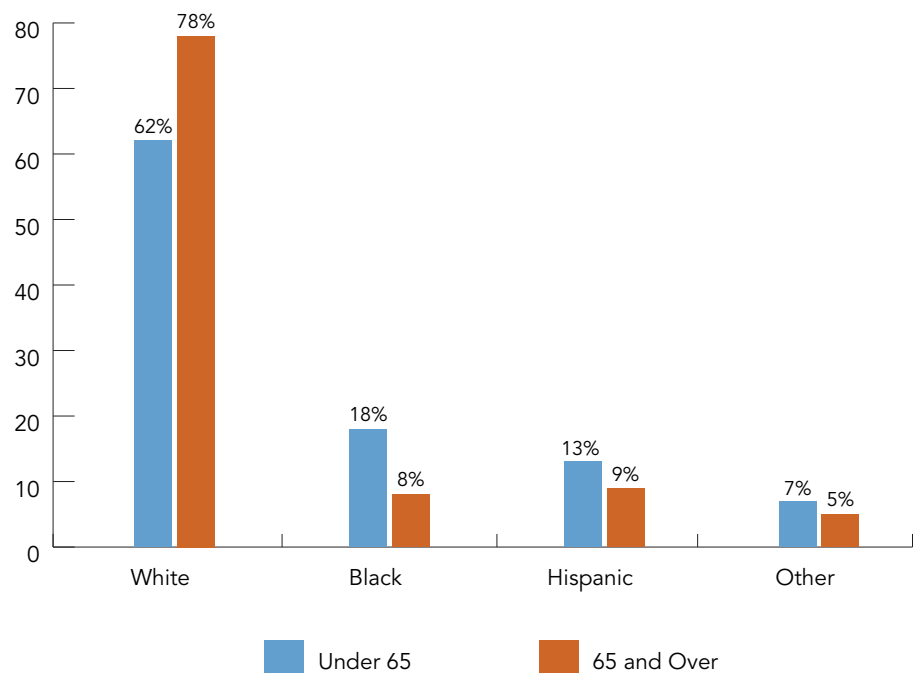
Sixty-two percent of Medicare enrollees with disabilities under 65 report not visiting a dentist in the past year. These enrollees are more than twice as likely as Medicare enrollees overall to identify cost as the reason for forgoing care.

Oral Health of Medicare Enrollees Under 65 with Disabilities: A Dearth of Data

In 2000, the Surgeon General released its seminal report, *Oral Health in America*, noting that no national studies had been conducted to determine the prevalence of oral health disease for individuals with disabilities.¹⁶ Unfortunately, that remains the case twenty years later.

The few studies that exist on adults with disabilities focus on the oral health status of adults with developmental disabilities including, for example, cerebral palsy, Down Syndrome, intellectual disability, and autism. In a large study reviewing the oral health of nearly 5,000 adults with developmental disabilities, researchers found that 32% had untreated dental caries and 80% were diagnosed with periodontitis (gum disease).¹⁷ These disease rates are even higher than those for adults 65 and over, who also have high rates of dental disease. For comparison, 14% of older adults have untreated caries and 68% have periodontitis.¹⁸ Further, Medicare enrollees under 65 are more likely to be people of color and have low incomes, and those characteristics also correspond with higher rates of oral disease.¹⁹

Figure 4. Medicare Enrollees by Race and Age, 2012



Source: Kaiser <https://www.kff.org/medicare/issue-brief/medicares-role-for-people-under-age-65-with-disabilities/>

“62% of Medicare enrollees with disabilities under 65 report not visiting a dentist in the past year.”

COVID-19 and Medicare Enrollees Under Age 65

Data widely demonstrate that populations who are at higher risk for oral disease are also at highest risk for COVID-19, including older adults, people of color, and younger individuals with disabilities. Data show that Medicare enrollees under age 65 are hospitalized at rates of 360 individuals per 100,000²⁰—a rate that is two times higher than the nationwide cumulative hospitalization rate for all individuals.²¹ Rates are even higher for those under age 65 who are dually eligible for Medicare and Medicaid, who are hospitalized at rates of 521 individuals per 100,000.²² Increased access to oral health coverage and treatment is urgently needed to both minimize risk for COVID-19 and to prevent widening disparities in oral health outcomes for Medicare enrollees under age 65.

A Medicare Dental Benefit Is Needed to Reduce Inequity

As discussed above, cost is one of the biggest barriers to accessing dental care, and Medicare enrollees under 65 with disabilities are disproportionately affected. Adding a dental benefit to Medicare would reduce inequity in coverage by providing oral health care coverage to *all* Medicare enrollees.

Studies support that when adults with disabilities have access to oral health coverage, dental treatment increases. For example, 51% of adults with a disability who have private insurance and 23% with Medicaid reported a dental visit in the last year compared to 19% who have no insurance coverage.²³ In terms of dental treatment broadly, only 7% of adults with disabilities with private insurance reported that they were unable to access dental care compared to 20% with Medicaid and 25% with no coverage.²⁴

While 3.1 million Medicare enrollees are dually enrolled in Medicaid, they do not necessarily have increased access to oral health care. This is because adult dental services are an optional benefit under Medicaid. As of 2019, only 19 states offered extensive dental benefits. Three states offered no dental coverage at all to adults; twelve states offered emergency services only; and 16 states offered limited benefits.²⁵ In times of fiscal crisis, as we face today due to the COVID-19 pandemic, states often cut funding to or eliminate the Medicaid adult dental benefit entirely. This occurred during the Great Recession of 2009 and, as of the time of this report, at least three states—California, Colorado, and Nevada—have proposed or passed reductions in funding to Medicaid adult dental services in response to budget shortfalls in 2020, placing those harmed most by the pandemic at more risk.²⁶ This additional strain on the already limited patchwork of Medicaid dental coverage brings the need for comprehensive Medicare coverage into even sharper focus.

Adding a dental benefit to Medicare would ensure access to oral health coverage to all Medicare enrollees with disabilities regardless of where they live or their income.

Coverage is Essential, But More is Needed to Address Inequity Based on Disability

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 inequity based on disability, but it is not the only step. The data suggest that factors other than coverage or lack of coverage result in inequity based on disability. It is therefore critical to address these other factors that contribute to inequity in access and outcomes. Steps needed to address these factors include, but are not limited to:

“In times of fiscal crisis—as we face today due to the COVID-19 pandemic—states often cut funding to or eliminate the Medicaid adult dental benefit entirely.

- **Integrating oral health with overall health.**

Historically, oral health has not been integrated with other medical care. This is particularly problematic for individuals with disabilities, who have multiple health conditions that are affected by their oral health.²⁷ Integrating oral health into primary care as well as into health care delivery systems is critically important and would increase access to preventive services and improve coordination between medical and dental providers. Adding a dental benefit to Part B in Medicare with other medical coverage would be a substantial step in advancing integration.

- **Increasing the number of providers trained and able to provide care to individuals with disabilities.**

An additional barrier to oral health care for individuals with disabilities is the lack of providers trained to manage their treatment. Starting in July 2020, the Commission on Dental Accreditation (CODA) will start requiring dental schools to include patients with intellectual and developmental disabilities in their curricula and training programs. This is an important step in ensuring dental providers are adequately trained to provide care for individuals with disabilities who have complex care needs.²⁸ Additional policies could include, for example, increased reimbursement for the additional time it takes to render adequate treatment.²⁹

- **Making care accessible.**

To address inequity, it is also important to address physical, emotional, and communication barriers to care. Ensuring transportation is available—particularly accessible transportation—can address an initial barrier to obtaining care. Providing oral health services where people are already receiving services through co-location with other healthcare and through mobile clinics, virtual dental homes, teledentistry, and other measures can help to increase access.³⁰ Co-location of services and the increased availability of teledentistry are particularly imperative during the COVID-19 pandemic when individuals are practicing social distancing to minimize risk of exposure.³¹ Policies that promote and require wheelchair-accessible offices and exam rooms, lifts to assist with transfers, and wheelchair tilts to allow dental services to be rendered in a wheelchair without a transfer are equally important measures to increase access.³²

- **Increasing good oral health practices.**

Good oral hygiene and preventive care have been responsible for major improvements in oral health over the last 50 years. However, people with disabilities are not always able to access the assistance or accommodations they need with everyday oral care. Greater outreach tailored to individuals with disabilities and their caregivers can include, for example, information on how to obtain modifications to tooth brushes or aids, such as floss holders, to accommodate physical limitations in performing oral hygiene.

- **Collecting oral health data on adults with disabilities.**

The current dearth of data collection on both the oral health status and the impact of COVID-19 on individuals with disabilities impedes efforts to identify inequities and measure progress in addressing them.³³ National, state, and local data collection, including intersectional data that include race, age, language, sexual orientation, and gender identity, is needed to inform policies to improve access for this population.

CONCLUSION

Lack of oral health coverage is a significant barrier to accessing oral health treatment for the 60 million Medicare enrollees who rely on the program, particularly for the 8.6 million individuals under 65 with disabilities. The need for oral health coverage is even more urgent in light of the COVID-19 pandemic in which adults with disabilities are at highest risk for serious illness.

Multiple bills were introduced in Congress last year that would add a dental benefit to Medicare.³⁴ If a Medicare oral health benefit package is ultimately passed, it would be a major step to address coverage and access inequities in oral health treatment based on disability.

Actions by advocates, health providers, dental schools, policymakers, and other stakeholders to address other systemic challenges for people with disabilities in accessing oral health services can also have a significant impact.

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 Medicare & Medicaid Services (CMS), “Total Medicare Enrollment: Part A and/or Part B Total, Aged, and Disabled Enrollees, Calendar Years 2013-2018,” available at <https://www.cms.gov/files/document/2018-mdcr-enroll-ab-3.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 Justice in Aging, “Adding a Dental Benefit to Medicare: Addressing Racial Inequity,” (Oct. 2019), available at <https://www.justiceinaging.org/wp-content/uploads/2019/10/Addressing-Oral-Health-Equity-by-Adding-a-Dental-Benefit-to-Medicare.pdf>.
- 6 42 USC §§ 1395c et seq; 42 C.F.R. §§ 409.1 et seq; See also, CMS, “Original Medicare (Part A and B) Eligibility and Enrollment,” available at <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol/index>.
- 7 CMS, “Total Medicare Enrollment: Part A and/or Part B Total, Aged, and Disabled Enrollees, Calendar Years 2013-2018,” available at <https://www.cms.gov/files/document/2018-mdcr-enroll-ab-3.pdf>.
- 8 Kaiser Family Foundation, “Income and Assets of Medicare Beneficiaries, 2016-2035,” (Apr. 2017), available at <http://files.kff.org/attachment/Issue-Brief-Income-and-Assets-of-Medicare-Beneficiaries-2016-2035>.
- 9 CMS, MMCO Statistical & Analytic Reports, “PUF_2012” tab in Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF) Version 2.0 (2006–2012), (Feb. 2019), available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics>.
- 10 Kaiser Family Foundation, “Medicare’s Role for People Under Age 65 with Disabilities,” (Aug. 2016), available at <https://www.kff.org/medicare/issue-brief/medicares-role-for-people-under-age-65-with-disabilities/>
- 11 Id.
- 12 Id.
- 13 Drilling Down on Dental Coverage, *supra* note 2. The remaining 35% of Medicare beneficiaries have some form of coverage through either private or public options including Medicare Advantage plans and state Medicaid programs.
- 14 Id.
- 15 Id.

- 16 U.S. Department of Health and Human Services “Oral Health in America: A Report of the Surgeon General,” 2000, available at <https://www.nidcr.nih.gov/sites/default/files/2017-10/hck1ocv.%40www.surgeon.fullrpt.pdf>
- 17 Morgan, J., et al., “The oral health status of 4,732 adults with intellectual and developmental disabilities,” (Aug. 2012), available at [https://jada.ada.org/article/S0002-8177\(14\)61796-7/pdf](https://jada.ada.org/article/S0002-8177(14)61796-7/pdf).
- 18 Drilling Down on Dental Coverage, *supra* note 2.
- 19 *Id.*
- 20 CMS, “Preliminary Medicare COVID-19 Data Snapshot, August 14, 2020,” (released Sept. 2020), available at <https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf>.
- 21 Centers for Disease Control (CDC), “COVIDView, Cases, Data, & Surveillance,” (accessed Sept. 30, 2020), available at https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2F covid-data%2F covidview.html.
- 22 *Id.*
- 23 MACPAC, “Medicaid Access in Brief: Adults’ Use of Oral Health Services,” (Nov. 2016), available at <https://www.macpac.gov/wp-content/uploads/2016/11/Adults-Use-of-Oral-Health-Services.pdf>.
- 24 *Id.*
- 25 Center for Health Care Strategies, Inc., “Medicaid Adult Benefits: An Overview,” (Sept. 2019), available at https://www.chcs.org/media/Adult-Oral-Health-Fact-Sheet_091519.pdf.
- 26 Center for Health Care Strategies, “COVID-19 Exacerbates Existing Oral Health Care Access Barriers for Adult Medicaid Beneficiaries,” (Sept. 2020), available at <https://www.chcs.org/news/covid-19-exacerbates-existing-oral-health-care-access-barriers-for-adult-medicaid-beneficiaries/>.
- 27 Medicare’s Role for People Under Age 65 with Disabilities, *supra* note 10.
- 28 National Council on Disability, “At NCD’s recommendation, all U.S. dental schools will train students to manage treatment of people with intellectual, developmental disabilities,” (2019), available at <https://ncd.gov/newsroom/2019/dental-schools-IDDD>.
- 29 See, for example, AB 316, “Medi-Cal: benefits: enrollees with special dental care needs,” (2019), available at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB316. If enacted, would require California’s Medicaid Department of Health Care Services (DHCS) to provide permanent additional funding to reimburse dental providers for the extra time and resources necessary to provide critically-needed oral healthcare for special needs patients. Presently, funding is temporary.
- 30 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://students.pulse.pacific.edu/documents/marketing/VDH_FullReport.pdf.
- 31 Brian, Z & Weintraub JA, “Oral Health and COVID-19: Increasing the Need for Prevention and Access,” (Aug. 2020), available at https://www.cdc.gov/Pcd/issues/2020/20_0266.htm.
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- 33 Swenor, B., “Dearth of disability-related Covid-19 data can confound response efforts,” (Jun. 2020), available at <https://www.statnews.com/2020/06/12/dearth-disability-related-covid-19-data-confound-response-efforts/>.
- 34 Seven bills were 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; HR 4650, Medicare Dental Act of 2019; and HR3, “Elijah E. Cummings Lower Drug Costs Now Act.”