Policy Options for Improving Dental Coverage for People on Medicare

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Since its inception, Medicare, the national health insurance program for more than 60 million older adults and younger people with long-term disabilities, has explicitly excluded coverage of dental services, with limited exceptions. Some Medicare beneficiaries have access to dental coverage through other sources, such as Medicare Advantage plans, Medicaid, or private plans (either employer-sponsored retiree plans or plans purchased by individuals), but the scope of coverage under these plans varies widely and is typically quite limited.

Nearly two-thirds of the Medicare population – 37 million beneficiaries – have no dental coverage at all. Cost concerns and lack of dental coverage contribute to beneficiaries foregoing routine and other dental procedures. Lack of dental care can exacerbate chronic medical conditions, such as diabetes and cardiovascular disease, contribute to delayed diagnosis of serious medical conditions, and lead to preventable complications that sometimes result in costly emergency room visits. As a result, there is ongoing interest in policy options to make dental care more affordable by broadening dental coverage for people on Medicare.

This issue brief begins with a review of dental coverage permitted under current Medicare law to set the context for understanding proposals that could improve oral health coverage for the Medicare population. It reviews a range of policy options that could make dental care more affordable, examines basic policy features associated with each proposal, and discusses potential implications for key stakeholders, including Medicare beneficiaries, taxpayers, insurers, and dental professionals.

This brief describes five potential ways to strengthen oral health care for older adults (Table 1). The first two options would create a new dental benefit under Medicare: one would add dental benefits to Medicare Part B, and the other would establish

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a separate dental benefit under a new part of Medicare, similar in some ways to the Part D benefit for prescription drugs. The other three options would be expected to provide less help in improving dental coverage and reducing out-of-pocket costs for dental care, and would have a more limited impact on Medicare spending.

**Overview of Current Rules for Medicare Coverage of Dental Care**

Current law states that Medicare will not pay for dental services, except under very limited circumstances. Under Section 1862(a)(12) of the Social Security Act, Medicare will not make payments:

"...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."  

Medicare does cover dental services if they are incident and integral to a covered procedure such as when the reconstruction of a ridge is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes). Medicare also specifies an exception to the "incident and integral to" rule when a dentist extracts teeth to prepare the jaw for radiation treatment for cancer.  

While the dental exclusion includes exceptions that allow coverage of limited medically-related services, current policy is not completely clear or consistent. For example, Medicare Part A will cover an oral examination for patients who are hospitalized for a comprehensive workup prior to a kidney transplant, but it will not cover an oral examination for patients prior to transplantation of organs other than kidneys. Even in this circumstance, there is no payment under Medicare Part B for the dentist’s service, just to the hospital for the service of an employed dentist. As a result of the lack of clarity and consistency in the dental exclusion, there has been ongoing discussion about whether the law can be interpreted to cover a wider range of medically necessary dental services.

**Options for Strengthening Dental Coverage**

Several approaches could make dental coverage more widely available and more affordable for Medicare beneficiaries. The first two options discussed in this brief would create a new Medicare dental benefit – one option would cover dental services under Part B and another option would offer dental services under a new voluntary part of the program, similar to the approach taken with the Part D prescription drug benefit. For either of these approaches to be implemented, the statutory dental exclusion would need to be modified. Each of these two approaches would require decisions about:
• the scope of covered benefits;
• cost sharing for specific services;
• how premiums would be calculated;
• provider rules for participation and payments;
• assistance for low-income beneficiaries;
• coordination with existing dental coverage; and
• spillover effects on other payers and programs.

Other issues likely to emerge with each of these approaches include how to determine when dental services are reasonable and necessary (as required for all Medicare-covered benefits), how to measure and monitor the quality of dental care provided, and how to ensure patient access to dental services across the country, including in rural and other underserved areas.

Add a Dental Benefit to Medicare Part B

The Medicare statute could be amended to allow dental services to be covered under Medicare Part B. Under this approach, all Part B enrollees would be entitled to Medicare-covered dental services, just as they are covered for physician care and other defined outpatient services. 9 While enrollment in Medicare Part B is voluntary, the vast majority of beneficiaries who are entitled to Part A are also enrolled in Part B. 10

A new dental benefit under Part B would build upon the current structure of premiums, cost sharing, and low-income assistance of Part B. In general, Part B enrollees pay a standard monthly premium that covers 25 percent of Part B expenditures, with the other 75 percent covered by general revenues. Higher-income beneficiaries pay an additional income-related premium, and lower-income beneficiaries have their premiums, and in some instances, cost sharing, paid for by Medicaid through the Medicare Savings Programs. Most Part B services are subject to an annual deductible ($185 in 2019) and 20 percent coinsurance, with no cost sharing required for certain preventive services, such as cancer screenings.

Establishing a new dental benefit under Medicare Part B would require several policy decisions that would affect how much dental coverage beneficiaries get, the impact on premiums and out-of-pocket spending, beneficiaries’ access to dentists across the country, and health outcomes. These decisions will also directly affect federal spending, and could impact spending by other payers.

• **Scope of covered services.** A key issue would be defining which dental services to cover. These decisions could be informed by a variety of sources, including surveys of beneficiary preferences, patterns of utilization among older adults, and current sources of dental insurance. Presently, the **scope of covered dental benefits varies greatly across Medicare Advantage plans, Medicaid, and private dental insurance.** A new Part B dental benefit could be structured in different ways, and could be defined to cover a relatively narrow scope of dental benefits (e.g., preventive services only), the full array of dental services, or something in between. For each of these approaches, coverage policies would need to be developed to determine when treatments are “reasonable and necessary.”
One approach could provide a comprehensive dental benefit that covers preventive services such as cleanings and x-rays, basic procedures such as fillings and extractions, and more extensive (and expensive) treatments, such as crowns, dentures, and implants. This approach would be parallel to the comprehensive nature of Part B medical benefits. A second and more limited approach could cover only preventive services and routine treatment. A third approach could cover all procedures once beneficiaries exceed a certain dollar threshold, essentially providing a catastrophic-only dental benefit, where beneficiaries pay the up-front costs of their dental care out-of-pocket (or obtain dental coverage to cover these front-end expenses) with Medicare picking up the cost for services above a certain dollar limit (similar to a high deductible health plan).

A fourth approach could be a doughnut-type benefit, with Medicare coverage of preventive services and catastrophic expenses, and beneficiaries responsible for expenses in the gap – similar to the structure of the Medicare Part D benefit when it was first implemented in 2006. Part D was initially designed in this fashion to meet budget targets, but over time, the law has been modified to close the so-called “doughnut hole” to provide better protection for beneficiaries.

The scope of covered benefits would directly affect Medicare Part B premiums and Medicare spending. The structure and comprehensiveness of the benefit would also have spillover effects for other sources of coverage, including Medicare Advantage plans (discussed below).

**Comprehensive dental benefit.** A benefit that provides all reasonable and necessary dental services, including preventive and minor and major restorative services, would offer the most extensive coverage for beneficiaries. This approach would also be expected to significantly increase Part B premiums and program spending, much more than a more narrowly defined benefit package, and would likely replace other sources of dental coverage, such as private dental insurance plans and Medicaid, for those who have it (discussed below).

**Preventive dental benefit.** A more limited dental benefit that covers only preventive services could provide some help for the majority of Medicare beneficiaries, and may lead to earlier diagnosis of conditions that require follow-up medical attention. It would also have a lower price tag for the Medicare program and lead to smaller increases in Part B premiums than a more comprehensive benefit since preventive services tend to be less expensive. However, it would not cover the most expensive services that often cause beneficiaries to postpone or go without needed care. While Medicare Part B preventive dental benefit could duplicate dental coverage that some have today, it would create an opportunity for private dental insurers to offer supplemental dental benefits to cover more extensive and expensive services.

**Catastrophic-only dental benefit.** A catastrophic-only dental benefit package could be especially helpful for beneficiaries who need high-cost services but cannot afford the services on their own. However, it would offer no help to beneficiaries who are unable to cover the cost of routine dental hygiene or preventive care. Beneficiaries who are unable to afford these preventive services could go without needed care, which could result in potentially avoidable expensive dental or
medical treatments, as occurs today. Further, a catastrophic-only dental coverage approach could create incentives for providers to increase volume for certain procedures or perform higher-cost procedures so that beneficiaries more quickly reach the catastrophic threshold where Medicare coverage begins, which could result in higher costs for both beneficiaries and the Medicare program.

*Doughnut-type dental benefit.* Like the more limited dental benefit and catastrophic benefit, a doughnut-type benefit would help to provide coverage for the preventive services most beneficiaries need while also helping those who require higher cost services. It would also increase Part B premiums and program spending less than a comprehensive benefit. However, this option would expose beneficiaries to high dental expenses in the coverage gap, potentially creating financial barriers to care for those who are unable to cover these costs before qualifying for catastrophic protection. Like the catastrophic-benefit, this option could also create incentives for providers to increase volume for certain procedures or perform higher-cost procedures so that beneficiaries move through the doughnut-hole more quickly to reach the catastrophic benefit.

- **Cost sharing.** A dental benefit in Part B would be subject to the standard annual Part B deductible, 20 percent coinsurance on each service, and balance billing protections, if designed to track other Part B benefits. Preventive dental benefits could be provided with no cost sharing, similar to other Part B preventive benefits, and as envisioned in some legislative proposals. Currently, private dental plans often cover preventive services with limited (or no) cost sharing required. Other dental benefits could be covered with a 20 percent coinsurance. Private dental insurers typically impose coinsurance that varies by service, with higher coinsurance required for more expensive procedures if covered, which can range from 20%-50%. Imposing coinsurance rates for Part B dental services that exceed 20 percent would make dental services less affordable for beneficiaries, but less costly for the Medicare program.

- **Annual caps.** Private plans that cover dental services, including employer-sponsored retiree and individually purchased plans, often cap the annual amount the plan will pay for covered dental services. The median limit for private plans (not exclusive to the Medicare population) that impose such limits is $1,500. Among Medicare Advantage plans that offer dental benefits, caps are also fairly common, and are typically around $1,000. No Medicare Part B benefits are currently subject to an annual dollar limit.

Imposing an annual dollar cap on Medicare payments for dental services would limit the financial exposure of the Medicare program, and limit the potential increase in beneficiaries’ Part B premiums. However, beneficiaries would be exposed to unlimited expenses once they exceed the annual cap on covered benefits. They would continue to be responsible for the cost of relatively expensive dental treatments, which could make certain procedures, such as crowns and implants, beyond the reach of beneficiaries with modest incomes. For example, for an individual living on an income of $26,200 (the median per capita income for people on Medicare in 2016) and subject to a $1,000 cap on covered dental services, they would be exposed to unlimited expenses for dental treatments once the annual cap is exceeded.
dental benefits, out-of-pocket expenses could easily exceed 10 to 20 percent of his or her income for extensive dental services, such as crowns, implants and dentures.\textsuperscript{15}

- **Frequency limits.** Private dental plans and Medicare Advantage plans with dental coverage often impose limits on the frequency of obtaining certain procedures a plan will pay for during a defined timeframe. For example, Medicare Advantage plans typically limit oral examinations and cleanings to once every six months. Dental plans could also limit the number of a specific procedure (e.g., x-rays, fillings) that may be covered each year. Some procedures and treatments may require longer periods of time between covered services, such as a periodontal exam once every three years or dentures once every five years.\textsuperscript{16}

Frequency limits on certain dental services would help constrain the costs associated with the new dental benefit, help limit the impact on beneficiary premiums, and could conform to dental standards of care. However, Medicare Part B does not generally impose frequency limits for diagnostic or therapeutic services that must be covered.

- **Provider participation.** A new Medicare Part B dental benefit would only succeed if a sufficient and geographically dispersed number of dentists elected to participate in Medicare, and accept Medicare payment rates. Medicare law already includes dentists in the definition of physician,\textsuperscript{17} but most dentists are currently not enrolled in the Medicare program and would have to choose to enroll in order to receive Medicare payments for Medicare-covered dental services.\textsuperscript{18}

A government outreach strategy would help to inform dentists about the new benefit, encourage them to enroll in the program, treat Medicare patients, and submit bills to get paid by Medicare. Without robust participation among dentists in Medicare, some beneficiaries would continue to have problems accessing affordable dental care or would pay high out-of-pocket costs for the dental services they receive. Beneficiary education would also be needed so that beneficiaries understand the implications of receiving covered services from a dentist who has not enrolled in Medicare.

- **Payment and fee schedules.** Currently, for the very limited circumstances under which Medicare pays for some dental services, Medicare makes payments to dentists based on the physician fee schedule. For services not included on the fee schedule, regional Medicare Administrative Contractors (MACs), which are responsible for administering Medicare claims, determine the payment amount. If a dental benefit were to be added to Part B, Medicare would need to modify the physician fee schedule to include payment amounts for routine and other dental services that are not currently covered or establish a separate fee schedule for dental services.\textsuperscript{19} The specifics of the fee schedule would affect the cost of the new benefit and the willingness of dentists to participate in the Medicare program. The physician fee schedule amounts paid by Medicare for each service reflect the amount of physician time, technical skill and judgment required (“work values”), the associated practice expenses (e.g., non-physician clinical staff, supplies, a share of other staff and overhead costs), and professional liability expenses.
To develop a fee schedule for dental services, research would be needed to determine appropriate work values, practice expense, and liability to assign values for the covered dental services. In considering the appropriate level of payment, the American Dental Association (ADA) Survey of Dental Fees or similar information may be a useful reference point. To ensure that payments are for diagnostic and therapeutic services that are “reasonable and necessary” as broadly required under Medicare law, coverage and coding policies would be needed to monitor that payments are made appropriately.

In addition, it would be important to consider whether to include dentists in the Merit-based Incentive Payment System and, if so, what measures to use to assess performance of dentists on quality of care, cost, promoting interoperability of electronic health records, and practice improvement activities. If dentists are included, a particular focus would need to be identification or development of consensus-based quality measures that focus on the oral health needs of Medicare beneficiaries.

- **Low-income beneficiaries.** If Part B is expanded to include a dental benefit, about 10 million low-income beneficiaries who are dually eligible for Medicare and Medicaid would have their premiums for the new Part B dental benefit automatically paid on their behalf by Medicaid (jointly funded by states and the federal government) through the Medicare Savings Programs, just as is done for other Part B benefits. Beneficiaries eligible for full Medicaid benefits and Qualified Medicare Beneficiaries (QMBs) could also have their cost sharing paid at least in part by Medicaid (depending on the fees otherwise paid by Medicaid relative to Medicare dental fees). Unlike a separate, voluntary benefit, the process for low-income beneficiaries would be automatic, without a separate process to determine eligibility for assistance.

  The financial assistance would help with the increase in Medicare Part B premiums associated with the dental benefit for low-income Medicare beneficiaries who qualify for Medicaid and the Medicare Savings Programs. However, this would mean additional costs for states and the federal government. Many low- and moderate-income people on Medicare would not qualify for premium and cost-sharing assistance because their income and assets exceed eligibility levels for those programs.

- **Interactions with other insurance.** Adding coverage of dental services to Medicare Part B would affect other sources of dental insurance, including coverage provided under some Medicare Advantage plans, individually purchased dental policies, employer-sponsored retiree dental coverage, and Medicaid. It would also affect Medigap policies that cover the 20 percent coinsurance under Part B. These spillover effects are discussed below.

  **Medicare Advantage.** Most Medicare Advantage plans offer dental services (or access to dental insurance) as an optional "extra" benefit. If a dental benefit were added to Part B, all Medicare Advantage plans would be required to cover the dental benefits provided by traditional Medicare. Depending on the scope of covered benefits under Part B (e.g., comprehensive or preventive only), Medicare Advantage plans could provide supplemental dental benefits that wrap around the new Part B benefit.
With a new Part B dental benefit, Medicare payments to Medicare Advantage plans would rise because payments are based on per capita spending in traditional Medicare, and traditional Medicare per enrollee spending would likely increase with the new benefit. As a result, plans that currently provide some dental coverage would receive higher payments by Medicare to provide dental benefits under Part B, even if the dental coverage is similar to what they currently provide as a supplemental benefit. Additionally, these Medicare Advantage plans would have extra money to spend on new supplemental benefits since plans would likely be providing fewer dental supplemental benefits.

_Individually purchased dental plans._ A new Part B dental benefit would potentially replace private dental coverage currently purchased by an estimated 4.5 million Medicare beneficiaries in 2016; this would shift costs to Medicare that are currently covered by private plans and enrollees and potentially affect Medicare Part B premiums. While private insurers are not permitted to duplicate benefits covered under Medicare under current law, they would be able to offer coverage that supplements the new Part B dental benefit. Total out-of-pocket dental spending, including premiums, could decrease for individuals who drop their current dental coverage, since the federal government pays 75% of Part B premiums.

_Employer-sponsored retiree dental plans._ With a new Medicare Part B dental benefit, employers that currently offer dental benefits as a supplemental benefit for their retirees would either offer dental coverage that wraps around the Part B benefit, or drop dental coverage altogether, unless the law was written in a way to encourage employers to maintain these benefits (e.g., favorable tax treatment or direct subsidies). If employers scale back or drop retiree dental coverage, the costs otherwise incurred would be shifted from employer plans to Medicare. This would affect retirees unevenly, depending on the comprehensiveness and cost of their former employer’s dental coverage, and the network of dentists in their employer plan relative to those who participate in the Medicare program.

_Medicaid._ Medicaid and the Medicare Savings Programs would automatically cover the incremental cost of dental benefits under Part B for low-income beneficiaries. For states that currently cover some dental benefits for dually eligible beneficiaries, the new Part B benefit would shift costs from the states to the Medicare program for dental benefits, resulting in lower spending for these states. In 2016, the majority (88 percent) of full dually eligible beneficiaries lived in states that offered some dental benefits to full dual eligibles, covering about 6.2 million beneficiaries. At the same time, Medicaid spending on behalf of dually eligible individuals could increase to cover the higher Part B premiums associated with the new Medicare dental benefit, and coinsurance, to the extent Medicaid pays the coinsurance for covered Medicare services.

To reduce federal costs, it would be feasible to establish a maintenance-of-effort requirement for states, which would have uneven effects across states; those that provide adult dental coverage under Medicaid would be required to make a maintenance of effort payment on behalf of dually
eligible beneficiaries, but states without adult dental coverage would not be subject to this requirement.

For dually eligible Medicare beneficiaries, a new Medicare Part B dental benefit could help to improve access to dental professionals across the country.

Medigap. Medigap does not currently cover dental services, but Medigap policies that currently cover Part B coinsurance, which includes most Medigap policyholders, would also cover the coinsurance for a Part B dental benefit. Thus, a new Medicare Part B dental benefit could increase Medigap premiums for beneficiaries with Medigap policies that cover Part B coinsurance.

- Monitoring the effects of the new dental benefit. In establishing a new Medicare Part B dental benefit, policymakers may want to consider ways to monitor the extent to which improved dental care contributes to better health outcomes for Medicare beneficiaries, assess how well the new benefit is meeting the needs of a growing Medicare population, and develop recommendations as needed.21,22

IMPLICATIONS
Adding a dental benefit to Part B would provide subsidized dental coverage to virtually all Medicare beneficiaries, addressing a widely recognized gap in Medicare coverage, and doing so in a way that integrates dental care with other Medicare-covered medical services. Today, two-thirds of all Medicare beneficiaries do not have dental coverage, and either pay for the services they receive out-of-pocket, or forego needed care.23 A dental benefit under Part B has the advantage of using a structure in place, rather than setting up a new and separate part of Medicare that would require its own set of rules and would contribute to the complexity of Medicare for beneficiaries. Unlike a new voluntary, stand-alone dental benefit (described below), a Part B benefit would be relatively straightforward for beneficiaries because dental services would be integrated seamlessly with other covered medical benefits.

Integrating dental into Part B does present some tradeoffs, however. All beneficiaries would be required to pay for the new dental benefit through increased Part B premiums, regardless of whether they need or use dental services. However, some beneficiaries may prefer to go without dental coverage to avoid a higher Part B premium, even one that is heavily subsidized by the federal government. Or, they may prefer to choose their own private dental plan based on their individual needs and circumstances. The overall impact of a new Medicare Part B dental benefit on beneficiaries would depend on a number of factors, including the scope and comprehensiveness of covered dental services, cost-sharing requirements, how much Medicare pays providers under the fee schedule, the extent to which dentists choose to participate nationwide and in underserved areas, and other factors.

A new Part B dental benefit would also increase Medicare spending, the magnitude of which would also depend on a number of factors, including the scope of covered services, premium and cost-sharing requirements, and payments to providers. A comprehensive dental benefit under Part B with the usual
beneficiary cost sharing would likely add substantial costs to the Medicare program since Medicare typically pays 80% of the fee for Part B services, and nearly 55 million people are currently enrolled in Part B. Additionally, this approach would shift some costs from employer and union-sponsored plans, and Medicaid to the Medicare program, and would increase federal payments to Medicare Advantage plans.

Create a Voluntary Dental Benefit under a New Part of Medicare

Another option for strengthening dental coverage under Medicare would be to create a new, separate voluntary dental benefit, similar to the approach taken to provide prescription drugs under Medicare Part D. A new, voluntary dental benefit, offered on its own under a new part of Medicare, could operate similarly to the Medicare Part D prescription drug benefit, where beneficiaries would have the option to sign up for a new freestanding dental benefit for an additional premium. This approach would not require all Part B enrollees to have dental coverage and incur a higher premium, so it would likely cover a somewhat smaller share of the Medicare population than would be provided under Part B.

To operationalize this approach, several key issues would arise, such as determining the scope of covered benefits and cost-sharing requirements, as with the Part B approach. Additionally, the benefit could be administered by the government, through private dental plans only (such as those offered to individuals for purchase), or through a mixture of private plans and a government-administered program. Since the benefit would be separate from Part B, other issues would arise such as how to set premiums and government subsidies, encourage enrollee participation, ensure plan participation (if using private plans), set payments to plans (if using private plans) and/or dentists (if using a government-administered program), and finance the new benefit.

- **Private plans versus a government-administered program.** A key consideration for this approach is whether to use only private plans (as in the current Part D program), a government-administered program, or a combination of the two. This decision would have spillover effects for payments to oral health providers, since such payments would either be determined by the government or by private plans. It could also have spillover effects for federal spending and beneficiary out-of-pocket costs, although the directionality of the effect is not clear.

There are important trade-offs associated with these approaches. If the notion is to essentially have a Part B-like benefit but make it optional to beneficiaries, a government-administered dental program might be desirable. If instead the goal is to allow more variation in benefits and rely on private plans, rather than broaden the government’s role directly, then having competing private plans might be desirable. A government-administered program would lessen the number of choices beneficiaries need to make about enrolling in various parts of Medicare (which can be complex), but may also limit the ability to choose among a number of dental plans, which some may prefer. Seniors have said that they find the process of choosing a Medicare Advantage or Part D plan to be a frustrating and confusing process, and they could likewise have a similar experience with private Medicare dental
Relying on private plans might require additional government oversight and consumer protections.

- **Financing.** Regardless of whether a new dental benefit is provided by private plans and/or the government, a key consideration would be how to fund the benefit (e.g., the allocation of spending across beneficiary premiums and federal government spending). Following the Part D model, a separate account could be created within the Supplementary Medical Insurance Trust Fund for tracking the premiums or other targeted funding for this new part of Medicare as well as payments made for dental benefits.

- **Premiums.** Another important decision in establishing a separate benefit under Medicare is the methodology for establishing premiums and government contributions. If the government administered the benefit, government actuaries would need to calculate the expected per beneficiary cost of the benefit and the beneficiary premium amount. If private plans administered the benefit, an approach similar to that of the Part D prescription drug benefit could be taken, whereby the federal subsidy is determined based on the national average bid across all plans; beneficiaries are then required to pay the difference between the bid of the plan they elect and the national average bid.

- **Beneficiary participation incentives.** If the dental benefit is offered separately from Medicare Part B, policymakers would need to establish rules to determine when and how beneficiaries would sign up for coverage, and whether to apply penalties for late enrollment. One potential concern with applying a penalty is that it makes the stand-alone dental benefit less “voluntary.” At the same time, with a purely voluntary approach, some individuals might wait to enroll in the dental plan until they know they need services and disenroll after receiving treatment, leading to adverse selection and driving up program costs and premiums.

  Imposing a late enrollment penalty, such as was done for Medicare Parts B and D, would discourage this behavior. For example, under Medicare Part D, Medicare eligible beneficiaries who do not have “creditable coverage”, meaning they do not have drug coverage where the actuarial value equals or exceeds the actuarial value of standard prescription drug coverage under Medicare, face a penalty for late enrollment. Policymakers would need to determine if existing dental plans count as creditable coverage. Using this kind of approach would encourage beneficiaries to sign up when they are first eligible, and build in safeguards against adverse selection.

- **Low-income beneficiaries.** Unlike a Part B dental benefit option, assistance for low-income beneficiaries would not automatically happen for a new voluntary dental benefit. Low-income subsidies could be offered in a manner similar to the Part D program, or a different model could be adopted. For example, under Part D, Medicare beneficiaries with incomes at or below 150% of the federal poverty level are provided with financial assistance to help cover their Part D monthly premiums, annual deductible, coinsurance and copayments. In contrast to the Medicare Savings Program where premiums and cost sharing for low-income beneficiaries are jointly financed by federal and state dollars, they are paid in full by the federal government under Part D, such that
assistance for these low-income Part D enrollees does not directly affect Medicaid spending. Under Part D, federal expenditures are partially offset by Medicaid payments on behalf of dually eligible beneficiaries under a mechanism known as the “claw back.”

- **Provider payments.** As with the Part B approach, if a government-administered separate voluntary dental program was offered, it would be necessary to determine the level of Medicare payments allowed for the services provided by dentists and other oral health providers. Given that it would be a new part of Medicare law, decisions would need to be made about which of the rules and operations currently used for providers under Part B would be extended to providers under this new part. If instead the new dental benefit was offered exclusively by private plans, then private dental plans would determine a methodology for making payments to dental providers on behalf of their enrollees.

- **Plan participation.** If private plans were used to deliver a new voluntary dental benefit, payments to plans would need to be designed in a way that encourages participation of private insurers while also limiting costs. To discourage plans from selectively enrolling lower-cost beneficiaries and limiting losses due to higher than expected expenditures, policymakers could consider a number of approaches, including risk adjustment, reinsurance, marketing oversight, and other measures, as they did with Medicare Part D.

These mechanisms are used to encourage plan participation and market stability, but can also increase the federal costs of such a benefit, as has recently occurred with Medicare Part D. However, such provisions may be unnecessary, particularly if the new dental benefit has an annual cap on coverage, which would limit plans’ liability and associated risk. Annual caps on coverage are common among private dental plans, as noted earlier.

- **Plan requirements.** If a new Medicare dental benefit is administered through private plans, Medicare would need to develop requirements for dental plans contracting with the federal government, and establish a mechanism for oversight and enforcement. These requirements could mirror the approach used for sponsors Medicare Advantage and Medicare Part D plans that contract with the government to provide covered services. As with the Part B option above, dental plan requirements would need to address issues such as the scope of benefits, cost sharing, and coordination of benefits with other dental coverage, among others. However, some additional requirements would need to be assessed if contracting with private plans, such as standards for provider networks, oversight and audits, and the conditions under which Medicare Advantage plans can offer the dental benefit and integrate it with other medical benefits.

- **Coordination with current sources of dental coverage.** A separate, voluntary dental benefit could be designed in a way to have fewer spillover effects than a Part D benefit if beneficiaries are able to maintain their current sources of dental coverage. To limit the increase in federal spending associated with dental coverage, policymakers could consider strategies to encourage other sponsors of dental coverage to maintain benefits.
For example, when the Part D benefit was implemented, the retirement drug subsidy (RDS) program was enacted to encourage employers and unions to continue providing prescription drug benefits to their Medicare-eligible enrollees, which reduced Part D spending. Employer and union-sponsored plans that provided actuarially equivalent coverage to the Part D benefit were reimbursed for a portion of their qualifying employees’ costs for prescription drugs. Similarly, a new dental benefit could conceivably be designed to minimize substitution effects: for example, Medicare could deem qualified dental plans as creditable coverage and waive any late enrollment penalties for individuals enrolled in these plans. With an approach that allows for creditable dental coverage, policymakers would need to assess modifications to current law rules with respect to non-duplication of Medicare benefits. However, without such incentives to maintain other public and/or private sources of dental coverage, a Medicare dental benefit would likely replace other sources of coverage.

**IMPLICATIONS**

The approach of creating a voluntary dental benefit under a new part of Medicare, rather than including a dental benefit in Part B, would present trade-offs, which would impact coverage, spending and premiums. Unlike the Part B option, only beneficiaries who choose to enroll in this dental coverage would pay higher premiums. A voluntary dental benefit would likely cover fewer beneficiaries than a Part B approach, allowing beneficiaries to retain their current sources of dental coverage (if allowed under program rules), which could have a smaller impact on Medicare spending.

Under a voluntary approach separate from Part B, the program could be more likely to suffer from adverse selection, particularly in the absence of a penalty for late enrollment. This has the potential to increase premiums for beneficiaries who enroll in the new dental part of Medicare, and increase per capita Medicare spending. Also, if fewer people enroll because coverage is not integrated into Part B, many could continue to go without dental coverage and potentially forego needed care, or incur high costs.

An approach that creates a separate, optional benefit under Medicare would also add to the complexity of choices for Medicare beneficiaries, who currently face complicated decisions about enrolling in Medicare Parts A and B, choosing among Medicare Advantage plans or Medicare Part D plans, or Medigap policies. The complexity would be even greater if structured like Part D, with multiple competing private plan options available. At the same time, the availability of many private plan options would increase patient choice, and allow beneficiaries to shop for a dental benefit package that best suits their oral health needs.

As with an option to add a dental benefit to Medicare Part B, the impact on beneficiaries and program spending would depend on a variety of policy decisions, such as the scope of benefits, premiums and cost-sharing requirements, payment rates to providers (or plans), provider participation, and spillover effects on other sources of dental coverage.
Medicare spending could also be affected by whether the benefit is government-administered or administered by private plans that contract with the government to provide these services. A government-administered plan could constrain costs if Medicare fees for dental services are lower than the rates paid by private insurers, as is now the case for physician services. A more market-oriented approach, modeled on Part D, could also put downward pressure on costs and premiums through competition among private dental plans. Based on the available evidence, it is unclear whether private plans or a government-administered dental benefit would lead to lower prices and lower Medicare spending.

** Permit Greater Access to Medically Necessary Dental Services under Medicare **

Expanding the circumstances under which dental coverage is deemed medically necessary is another possible approach to broadening access to dental care for Medicare beneficiaries. While this approach would increase the number of people who could get some dental coverage through Medicare, fewer beneficiaries would qualify for dental coverage than by adding a comprehensive Part B benefit or a voluntary freestanding benefit.

- **Scope of current law.** The Centers for Medicare & Medicaid Services (CMS) has interpreted the Medicare statute to cover only dental services that are “incident and integral to” a covered procedure and are performed by a dentist under Medicare Part B; routine dental services are excluded from Medicare coverage under current law except when the patient’s condition necessitates inpatient hospitalization for dental services otherwise excluded from coverage. In this case, only the hospital can be paid under Medicare Part A. CMS recognizes some exceptions to the dental exclusion, such as extractions done to prepare the jaw for cancer radiation treatment, and inpatient oral examinations (but not treatment) preceding kidney transplants or heart valve replacements in certain settings. Medicare also covers some dental-related emergency department visits and hospitalizations, but does not cover the cost of the dental care itself.

The extent to which current law provides flexibility for Medicare to cover additional dental services, particularly services needed for the treatment or management of life-threatening medical conditions, is currently the subject of discussion. The Administrator of CMS has indicated that the agency is reviewing its statutory authority to broaden coverage for additional oral health services, the outcome of which is unclear. If the availability of Medicare coverage for dental treatment is not expanded as a result of the review, the law could be changed to broaden coverage for medically necessary dental services, and, for example, cover dental services for people with specific medical conditions or in certain clinical situations.

- **Medically necessary dental care.** Under this option, and in the absence of a change in interpretation of Medicare statute by CMS, Congress could enact legislation to allow Medicare coverage for a wider range of clinical conditions that require dental treatment. For example, Medicare could cover treatment of any dental conditions that needs to be addressed in the context or management of organ transplant procedures, heart valve repair and replacement, stem cell transplantation, cancer
chemotherapy, joint replacements, immunosuppression, and bisphosphonate therapy. Dental services could also be made available to individuals with specified chronic conditions, such as diabetes and cardiovascular disease, for which dental services have been associated with improved health outcomes.

This option would provide dental coverage to fewer beneficiaries, but would require many of the same decisions as the two prior approaches. The clinical conditions and circumstances that would be covered (as exceptions to the current dental coverage exclusion) could be defined in the law. Alternatively, the Secretary or an independent scientific body, such as the National Academy of Medicine (NAM), formerly the Institute of Medicine (IOM), could be called upon to review clinical evidence and identify the appropriate contexts for medically necessary dental coverage under Medicare. Once these clinical contexts are identified, Medicare could use its normal process for determining which services would be covered.

In 2000, the most recent review undertaken, the IOM/NAM assessed the dental exclusion under Medicare and the circumstances under which Medicare should “broaden the scope of the exceptions to include dental care needed to prevent or effectively manage systemic conditions, including the oral complications of specific illnesses or their medical treatment.” The IOM report noted a general lack of evidence regarding the medical necessity of dental services, and recommended further research to develop recommendations on a condition-by-condition basis for coverage of dental services needed in conjunction with surgery, chemotherapy, radiation or pharmacological treatment of a life-threatening condition. Despite IOM’s assertion that more direct evidence is needed to demonstrate the medical necessity of dental interventions, substantial additional research has not been generated on this topic and no formal recommendations have been produced.

• **Payment for dental services.** Currently, payments by Medicare to dentists for the services covered are generally based on the physician fee schedule, with MACs determining the payment amount for services not on the fee schedule. If dental coverage was broadened, more comprehensive payment policies would likely need to be developed, similar to the option for adding a dental benefit to Part B. In addition, as with the Part B option, coverage policies (e.g., National Coverage Determinations) would need to be established to guide MACs and clarify the scope of Medicare coverage.

**IMPLICATIONS**

Broadening the definition of medically necessary dental care under current law would expand access to dental services for the subset of beneficiaries with the specified medical conditions or circumstances. This option could potentially help those who stand to gain the most in terms of health outcomes; however, it would not address the oral health needs of those whose dental issues do not meet a definition of “medically necessary.” The cost to the federal government would depend on the number of conditions and circumstances covered, the scope of services covered, the potential to reduce or prevent other medical costs, and Medicare payments for the services. The impact on Medicare spending and Part B
premiums would likely be smaller than in the Part B approach, because fewer people would be expected to qualify for medically necessary services.

**Test Models for Dental Coverage**

Another option could be to use the demonstration authority through the Center for Medicare and Medicaid Innovation (CMMI) to test approaches to dental coverage for the Medicare population. A model would help to gather information about the potential costs and savings of adding a dental benefit to Medicare. The CMMI was created to test models and the Secretary can permanently authorize those that either achieve savings without reducing quality of care, or improve the quality of care without increasing spending.

Possible models could include testing the effects of providing dental coverage for Medicare beneficiaries on subsequent emergency department use and medical expenditures. Such a model could include Medicare beneficiaries broadly, target to specific geographic regions or states, or focus on those with specific clinical conditions, such as those with diabetes. Use of services under different cost-sharing designs could be tested as well. This type of model would provide useful data on the potential cost to the federal government of covering dental services. The CMMI could draw on data from Medicare Advantage plans that provide dental coverage in developing this model.

**IMPLICATIONS**

Innovative models are generally small in scale and relatively low-cost. By design, few beneficiaries would gain coverage unless the lessons learned evolved to broader policy change. However, models offer an opportunity to identify strengths and weaknesses of the approaches tested and, in this way, could inform future efforts to provide enhanced coverage more broadly.

**Offer Dental Discount Cards**

Another approach could be to provide Medicare beneficiaries with dental discount cards or another form of cash assistance to help cover the cost of oral health services, similar to what was done in the period before the Medicare Part D benefit was fully implemented. In that case, beneficiaries enrolled in Part A or B (except beneficiaries who received Medicaid drug coverage) were provided the opportunity to enroll in the Medicare Prescription Drug Discount Card program under which they could obtain negotiated discounts on retail prescription drug prices, with card sponsors taking into account rebates, discounts, and other subsidies in order to achieve these negotiated discounts.33

In the case of the temporary discount card program, drug card sponsors were required to cover at least one drug in 209 classes of drugs that were most commonly used by Medicare beneficiaries and were allowed to charge up to a $30 annual fee to purchase the card. A transitional assistance (TA) subsidy was also provided to low-income beneficiaries (those with incomes at or below 135% of the federal poverty level) of up to $600 per year, as long as these beneficiaries did not receive drug coverage from other
sources, including Medicaid, TRICARE, group health insurance, or Federal Employee Health Benefit Plans. These cards primarily assisted people who did not currently have prescription drug coverage.

To operationalize a Medicare discount card approach for dental care, a number of factors would need to be considered, including whether to design and build such a program to be transitional (on the path to a Medicare dental benefit) or permanent. Other policy questions to consider include: which entities could administer the program, which dental services and procedures would be covered, including any service limits; how fees for each procedure would be determined and by whom, who would be eligible to purchase the cards, how the discount would be funded, how dentists would be encouraged to participate in this program, and how dental providers would receive reimbursement for services rendered. In addition, some consideration would need to be given to how such an approach could be structured to help low-income beneficiaries, including those who are currently eligible for dental benefits through Medicaid. Each of these decisions would affect the cost to the Medicare program, and the extent to which it provides meaningful improvements for beneficiaries in terms of out-of-pocket costs and access to dental care.

**IMPLICATIONS**

A discount card could reach a broad group of beneficiaries as most could be eligible to take advantage of this benefit. This approach could potentially make dental services somewhat more affordable for people who currently have limited or no dental coverage because the card would provide access to negotiated rates on dental services. However, the extent to which it could help improve access or reduce costs would depend on many factors, including the value of the discount for beneficiaries and the extent to which dental providers participate in the new arrangement.

Launching a temporary or permanent discount program would require many of the same administrative decisions as with the first two options, but would likely have less of an impact on beneficiaries’ oral health care. Medicare would have to establish the discount fee schedule, contract with a network of dentists who agree to provide services at those rates, establish and maintain other requirements for those participating dentists, and ensure provider compliance with the program requirements. If, instead, Medicare contracted with private plans to carry out these functions, it would need to establish rules for the contractors and provide oversight to ensure beneficiary protections are in place.

A dental discount card approach could be less expensive than the Medicare Part B or separate voluntary dental plan options discussed previously, depending on the level of funding allocated to the program. Low-income beneficiaries who are currently unable to afford to purchase dental coverage, or who live in a state with limited or no adult dental care provided under Medicaid, may also benefit if additional assistance was provided to these individuals, as was done under the Part D program. However, even with additional financial assistance, many low- and middle-income beneficiaries may still not be able to afford all the dental services they need with this approach. The scope of the network of participating dentists and the extent of the discounts would determine how useful this approach would be to improving beneficiary access to dental services.
A dental discount card approach could be designed in a way to be less costly to the Medicare program than the other approaches that establish a dental benefit covered by Medicare – a trade-off with direct implications for beneficiary spending. Even so, Medicare would still incur higher costs associated with providing access to discounted services. Depending on how these costs are financed, beneficiaries may also be expected to make a contribution to obtain access to the discounted fees, as was the case with the temporary prescription drug program. Costs aside, policymakers would need to resolve several operational issues, including whether to administer the discount card directly or through a private contractor and how to engage a sufficient number of dentists nationwide to make the program work.

**Conclusion**

Numerous studies confirm the importance of oral health as an integral component of medical care and improved health outcomes. Untreated oral health issues can negatively impact quality of life, lead to serious health complications, and can exacerbate certain chronic conditions and diseases such as diabetes and cardiovascular disease. Lack of oral health care can also delay diagnosis of certain physical health conditions and result in costly emergency room visits. Since the start of the program, Medicare has not covered routine dental care. While a minority of Medicare beneficiaries have coverage through other sources, such as Medicare Advantage, Medicaid, and private plans, most beneficiaries do not have any dental coverage at all. Lack of dental coverage means that dental care is out of reach for many beneficiaries who cannot afford to pay out-of-pocket for their care.

In light of these challenges, a number of options could be considered to broaden oral health coverage to Medicare beneficiaries. Two approaches would add a dental benefit under Medicare either by expanding dental benefits under Part B or by adding a new voluntary dental benefit under a new part of Medicare. Other approaches could include permitting greater access to medically necessary services, testing models to expanding dental care, and offering dental discount cards. Policy options could be designed to reach all beneficiaries or targeted to a subset of beneficiaries (e.g., those needing medically necessary treatments or low-income beneficiaries). These approaches would also have different financial effects on the federal government, beneficiaries, taxpayers, and other payers depending on the scope of services covered, required beneficiary contributions, and other factors. These approaches vary in the extent to which they would improve beneficiaries’ oral health care and improved health outcomes.

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Endnotes


3 See Section 1862(a)(12) of the Social Security Act.


5 The original National Coverage Determination for renal transplant issued in 1979 provided for oral health examination. (Medicare National Coverage Determination Manual, 100-03, Section 260.6) However, subsequent Medicare coverage decisions for other organ transplantation procedures did not specify coverage of an oral examination prior to the procedure.

6 Ibid.


8 Ibid.

9 Medicare law requires that to be covered, items and services must be reasonable and necessary. This means that if a dental benefit were added to Medicare, dental services would need to be medically necessary to be covered. Preventive services are only covered when specified by law.


13 Ibid.


15 From the definition of physician at section 1861(r) of the Social Security Act: “… (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions…”

16 If Medicare created a new dental benefit that followed existing law, in order for dentists to provide Medicare-covered dental services to Medicare beneficiaries, dentists would either have to 1) enroll in Medicare and submit claims on a beneficiary’s behalf for those services 2) opt-out of Medicare and enter into a private contract with the beneficiary for those services or 3) furnish Medicare-covered services for free. For more information, please see Christina Boccuti, “Paying a Visit to the Doctor: Current Financial Protections for Medicare Patients When Receiving Physician Services,” Kaiser Family Foundation, November 2016. https://www.kff.org/medicare/issue-brief/paying-a-visit-to-the-doctor-current-financial-protections-for-medicare-patients-when-receiving-physician-services/


21 A small number of individuals who are eligible for Medicare Part A only if they pay a monthly premium are not eligible to enroll in Part B. More common are beneficiaries who become eligible for Part A at age 65 but delay enrollment in Part B at that time because they are working and have health insurance coverage through an employer plan.


31 The 2000 IOM report also concluded that given limited evidence, “the severe consequences of radiation-induced osteoradionecrosis, and Medicare’s investment in treating patients with head and neck cancer, it is reasonable for Medicare to cover both tooth-preserving care and extractions, which may be medically appropriate for certain patients. The report further concluded that given limited evidence, “the severe consequences of septicemia and other complications of chemotherapy, and Medicare’s investment in treating leukemia patients, it is reasonable for Medicare to cover a dental examination, cleaning of teeth, and treatment of acute infections of the teeth or gums for a leukemia patient prior to chemotherapy.”


