Oral Health in Medicare
Considerations for 21st-Century Coverage

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Since its introduction in 1965, Medicare has included a near-total exclusion for oral health care. Over the subsequent 55 years, both medicine and dentistry have evolved to become more complex, complementary, and overlapping. It is now known that diseases of the oral cavity can adversely affect the success of treatments often covered by Medicare, including heart valve replacements, hematopoietic stem cell transplants, bisphosphonate therapy, and radiation therapy. Orodental disease may also modify chronic disease processes, such as type 2 diabetes and rheumatoid arthritis. Yet, Medicare coverage remains very separate—almost nonexistent—for oral diseases.

A Survey of Current Oral Health Policy
When it was written, the Social Security Act of 1965 included a statutory coverage exclusion for all “services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth,” with very few exceptions (42 USC §1395y). The last major change occurred in 1980, when the law was amended to allow for coverage of certain procedures that require hospitalization, such as multiple dental extractions in patients with severe coagulopathies. The law also allows for coverage of certain medically necessary oral health services and those that are “incident and integral” to other covered procedures and performed under very specific circumstances. Even then, coverage is incomplete and inconsistent. For example, an oral evaluation and the removal of infected teeth is covered for patients with jaw tumors, but not necessarily for those with malignancies affecting different locations of the oral cavity, despite a similar (if not greater) risk of long-term complications. Longitudinal oral health care following solid organ and stem cell transplants, valve replacement, and radiation therapy is also not covered, despite recommendations from professional societies.

The question of medical necessity has long been a barrier to the coverage of oral diseases. The explicit coverage exclusion not only creates a situation in which patients are not able to access treatment but also implicitly suggests that oral disease is not worth treating. A 2000 Institute of Medicine report that evaluated this dichotomy concluded that although it is reasonable to assume that a biological pathway exists such that management of orodental disease improves health outcomes, available supporting evidence at the time was insufficient to warrant a change in policy. In the same year, the US surgeon general cited orodental disease as a “silent epidemic,” particularly among vulnerable populations, including older adults, causing “complications that devastate overall health and well-being, and financial and social costs that diminish the quality of life and burden US society.” Twenty years later, this epidemic is still largely silent, despite an increased understanding of the interconnectivity of disease. Untreated dental decay, the most common health condition globally, affects almost 20% of older adults in the US. Although some individuals are covered through public or private supplemental plans, an estimated 37 million individuals with Medicare currently do not have any type of dental insurance. A review of data from the 2016 Medicare Current Beneficiary Survey showed that 73% of low-income beneficiaries did not see a dentist in the past year, with 10% of the total Medicare population foregoing a visit entirely as a consequence of cost.

Management of Orodental Disease as Part of Other Covered Procedures
An expansion of medically necessary services through a broader interpretation of the existing law could increase access in certain patient populations without a legislative change. A patient with a prosthetic aortic valve would have any oral infection managed prior to valve replacement and would receive routine follow-up to address hygiene and any subsequent issues, potentially reducing the risk of prosthetic valve endocarditis, particularly those caused by viridans streptococci. People taking bone-modifying agents or angiogenesis inhibitors for certain malignancies would be able to obtain consistent preexposure and postexposure management of oral disease, potentially preventing debilitating osteonecrosis of the jaw. Patients with head and neck cancer treated with radiation would be able to routinely receive management of dental cavities, increasing the ability to maintain nutrition and decreasing the likelihood of unnecessary pain and reduced quality of life.

Although providing an oral health benefit for medical necessity would not address the needs of all Medicare beneficiaries, a phased approach into more expansible benefits could allow for infrastructure, documentation, and workforce to expand to meet projected demand required by more generous plans. This is a reactive rather than proactive approach to...
addressing the oral health needs of Medicare beneficiaries and fails to consider coverage for larger patient populations, such as those with diabetes or cardiovascular diseases other than valvular heart disease. It is also likely less expensive. As part of a similar proposal to expand the interpretation of medically necessary oral health treatment introduced in 1997, the Congressional Budget Office estimated an approximate annual cost of expansion at $5 per beneficiary, inclusive of cost savings.6 A 2016 analysis estimated the cost of adding preventive and basic treatment coverage to Medicare at $29 per beneficiary per year, exclusive of cost savings.7 The true current cost of oral health coverage based on medical necessity is unknown, and will vary depending on the extent of coverage. In addition, it is quite possible there will be some cost savings by improving oral health and reducing related health consequences that are covered by Medicare.

**Current Proposals for Improved Access to Oral Health Care**

Multiple alternative solutions to strengthen access to care in the Medicare population have been proposed, including consideration for various degrees of coverage in the Medicare expansion plans currently before Congress and discussed during the 2020 Democratic presidential debates. For example, the Medicare for All Act of 2019 proposes removal of the statutory exclusion for oral health care in favor of coverage for all necessary dental treatment within a certain scope (S.1129, 116th Cong [2019-2020]). In 2019, the House of Representatives passed the Elijah E. Cummings Lower Drug Costs Now Act, which proposes expansion of coverage to include benefits such as twice-yearly examinations and cleanings, dentures every 5 years, and certain basic and major procedures at different cost-sharing levels (HR 3, 116th Cong [2019-2020]). The inclusion and exclusion of services would be at the discretion of the US Department of Health and Human Services secretary and subject to limitations in both frequency and scope. The appeal of the Elijah E. Cummings Lower Drug Costs Now Act is that the cost of expanding oral health benefits is assumed to be covered by the saving accrued from prescription drug negotiation in Medicare.

**Conclusions**

In the current political climate, there needs to be a more robust discussion of health, including what it means, how much it costs, and whether it can (and should) be more comprehensive. The US population is growing older and living longer with chronic illnesses, and the successful management of some diseases is influenced by oral health. Further, given the rise in alternative payment models, such as capitation and bundled payments, clinicians treating patients with illnesses such as those described above should be able to refer patients for oral health services without significant financial barriers. Consistent follow-up for surveillance, reduction of oral pathogens, and patient education are all valuable parts of the long-term management of many high-cost, high-morbidity conditions. Strengthening the role of oral health in Medicare could allow for coverage (and access) that is more congruent with the changing needs not only of specific individuals, but of the health care system as a whole, acknowledging that without good oral health, complete health is simply not possible.

**ARTICLE INFORMATION**

Published Online: September 10, 2020. doi:10.1001/jama.2020.3003

Conflict of Interest Disclosures: Dr Willink reported receiving grants from the Commonwealth Fund during the conduct of the study and receiving a speaker honorarium from the American Speech-Language-Hearing Association and consulting honorarium from BioMedical Insights. No other disclosures were reported.

**REFERENCES**


