The Case for the Expansion of the Scope of Medicare to Include Dental Coverage

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Abstract

Current Medicare policy strictly limits the amount of dental care coverage for Medicare recipients, i.e. the majority of the elderly population within the United States. Poor oral health, caused in large part by the high cost of dental care, has been linked to the development of heart disease, malnutrition, and serious infections. Nursing professionals have an ethical obligation to advocate for the expansion of Medicare to include dental coverage for the elderly population of Baker, Louisiana and the entire United States. The purpose of this white paper is to educate the public, patient advocates, and lawmakers about the need for comprehensive dental care coverage to be added to Medicare.

Keywords: Medicare, Baker, Louisiana, cardiovascular disease, nutrition, dental care, oral health
Executive Summary

According to Nancy Milio’s Framework for Prevention, “Organizational decisions directly affect the options available to people and the ease with which they may make daily, habitual selections” (Milio, 1976). This statement reflects the major issue underlying limited Medicare coverage for dental care for the elderly population. Current Medicare policy in Parts A, B & D dictates that certain dental services are only covered when they are necessary to enhance the outcome of a particular medical procedure (CMS, 2013). As such, routine dental procedures, including examinations, cleanings, root canals, cavity fillings, and dentures, are not currently covered under Medicare. This limitation on coverage can lead to serious oral health problems in elderly patients who cannot afford dental care, and these patients may develop cardiovascular disease and malnutrition as a result.

The limitation on dental care coverage is both a financial and an ethical dilemma. In a financial sense, many Medicare recipients end up accessing the health care system, including hospital emergency departments and primary health care providers’ offices, due to complications from poor oral health. This leads to a strain on the health care system’s finances and resources. In addition, many Medicare recipients who elect to access dental care that is not covered have high out-of-pocket costs. In relation to ethical principles, public policy’s major goal is to achieve public good. The restraint on dental care coverage for Medicare recipients fails to uphold the true meaning behind public policy.
Position Statement

Members of the nursing profession have an obligation to advocate for changes to Medicare to include comprehensive dental care coverage. Nurses’ responsibilities include not only educating patients about the importance of oral health, but also making efforts to influence policy for the good of the public.

Discussion

Target Audience

The target audience for this white paper includes several groups, beginning at the individual level with elderly citizens who are directly affected by the high cost of dental care. Congress and state legislators are also important targets because they are ultimately the country’s policy makers. Organizations which advocate for the public, such as the American Nurses Association, could promote this issue on behalf of patients throughout the country in hopes of bringing about a policy change. This paper also targets other groups such as gerontologists, dentists, and other care providers whose practices may take on the financial burden of treating complicated health problems which could have been prevented with good oral care. Public and private hospital systems also have an interest in this matter since they will end up treating those Medicare patients who develop heart disease, malnutrition, or systemic infections originating from poor dental health.

Cultural and Ethnic Implications

The health need of dental care for the elderly population has important cultural implications. A major issue impacting this health need is limited Medicare coverage for dental care. The majority of Medicare recipients are over the age of 65. According to the Centers for Disease Control and Prevention, one-fourth of persons age 65 and older have no remaining teeth.
and nearly one-third of older adults with teeth have untreated tooth decay. Also, there is a strong correlation between severe gum disease and heart disease, diabetes, stroke, and respiratory distress (Association on Aging, 2013). These conditions affect a disproportionately large percentage of minorities in the United States, and therefore this same population is also disproportionately affected by the lack of Medicare dental coverage.

The residents of Baker, Louisiana are especially impacted by this health need. In Baker, the over age 65 population is “approximately 11.5 % and has increased by 2% since the 2000 census” (Drivon, Murray, Norwalt, Victorian, & Zito, 2013). According to data collected from the Louisiana Department of Health and Hospitals, “the leading causes of death among residents in Louisiana aged 65 and older include diseases of the heart” (Drivon et. al., 2013). In the city of Baker there are seven dental care facilities. However, many of them are not utilized by residents 65 and older due to limited insurance coverage (Drivon et. al., 2013). The elderly population in the South is already at risk for heart disease due to poverty, diets high in fat and sodium, and comorbidities such as diabetes, and these issues are compounded by poor dental care.

**Feasibility and Expected Outcome**

The expected outcome of this policy statement describing the health need of dental care for the elderly population is to draw awareness to the issue and to ultimately change Medicare policy. Awareness starts with providing accurate and substantial information to educate the public, lawmakers, and potential advocates. A potential advocate from the nursing profession is the American Nurses Association. This outcome may take years to achieve, but once this issue is brought to the forefront of political and social discussion by advocates and lobbyists, implementation of policy change can occur.
Resources and Financial Implications

Medicare is funded by two trust fund accounts held by the U.S. Treasury. The first trust fund is the Hospital Insurance Trust Fund, and it is primarily funded by the payroll taxes of most employees, employers, and people who are self-employed. It is also funded by income taxes paid on Social Security benefits, interest earned on the trust fund investments, and Medicare Part A premiums from people who aren't eligible for premium-free Part A (CMS, 2013). The second trust fund that funds Medicare is the Supplementary Medical Insurance (SMI) Trust Fund, and it is funded by funds authorized by Congress, premiums from people enrolled in Medicare Part B (Medical Insurance) and Medicare prescription drug coverage (Part D), and interest earned on trust fund investments (CMS, 2013). If dental coverage for Medicare recipients were added to the Medicare bill, these resources could be utilized to fund dental services as well. Additionally, dentists could agree to accept assignments just as some physicians do which would mean that they would accept a Medicare-approved amount as full payment for covered services, thus becoming a resource for Medicare patients who were seeking dental coverage.

If Medicare were expanded to include dental coverage, there would likely be both positive and negative financial implications. First, the trust funds that fund Medicare would either have to be expanded to pay for dental coverage for Medicare recipients and/or the amount paid to physicians would have to be decreased in order to allocate money from the trust funds to dentists. If the trust funds were expanded, that would cost employees, employers, and people who are self-employed more money since they are the primary contributors to the trust funds. Additionally, dentists who treat Medicare recipients would be receiving less money for their services if they treat Medicare patients like many physicians who service Medicare patients. On
the other hand, dentists’ profits may increase overall due to an expanded client base which may include Medicare recipients who could not afford dental coverage previously.

Since studies have shown that poor oral hygiene is linked to some health disorders including heart disease, stroke, and diabetes, perhaps adequate oral care provided to Medicare patients can lead to better outcomes and less need for treatment and hospitalizations related to these medical conditions. This could mean saving more money over the “long haul” which would enable expansion of Medicare services without soliciting more funds from taxpayers.

**Application of Nancy Milio’s Framework for Prevention**

In order to address the complex health issue of dental care for the elderly population, it is important to understand why barriers to care exist. These barriers are created mostly by community and population-level problems, such as Medicare policy and the high cost of dental care. Nancy Milio, an important and respected nursing theorist, challenged the idea that the main determinant for unhealthful choices is lack of knowledge. She explained that we must do more than educate individuals on what they can do to improve their health; we must also investigate the environmental constraints and policies that make it difficult for individuals to make healthy choices (Milio, 1976). Milio’s Framework for Prevention describes the role of community health nursing in examining the determinants of a community’s health and attempting to influence those determinants through public policy (Current Nursing, 2013). Milio further explains that behavioral patterns of individuals and populations are a “result of habitual selection from limited choices” (Milio, 1976).

Milio’s Framework for Prevention can be applied to the issue of dental care for senior citizens. Most people in the United States have a basic understanding of how they can maintain their oral health by brushing and flossing regularly and visiting the dentist for preventive and
restorative care once or twice per year. The connection between oral health and cardiovascular health has also been widely researched and publicized in recent years. Yet, despite the general public’s knowledge about oral care, one fourth of persons age 65 and over have no remaining teeth and one-third of older adults with teeth have untreated decay and severe gum disease (Administration on Aging, 2013). This situation is consistent with Milio’s assertion that health education is not the most important determinant of health, but that the health status of populations is a function of the lack or excess of health-sustaining resources (Stanhope, 2012).

One of the main health-sustaining resources that is lacking in the United States is access to affordable dental care. The majority of seniors in the U.S. rely on Medicare to pay for their health care needs, but Medicare pays for almost no dental services. This policy is further evidence of Milio’s theory that “organizational decisions determine the range of personal resources available” and “behavior patterns of populations are related to habits of choice from actual or perceived limited resources and related attitudes” (Stanhope, 2012). The high cost of dental care puts oral health out of reach for many Americans, and changes in health policy at the national level will be needed in order to improve the oral health of the elderly population.

**Partnerships**

There are a number of national, state, and local organizations that would make excellent partners for initiating change and achieving better dental care access for the elderly population of Baker, Louisiana and the entire United States. On the local level, members of the Baker City Council could bring awareness of the problem to the community. The Baker Council on Aging and various churches with a large number of elderly members could also be platforms for change. Dentists and other care providers, including nurses, in and around the Baker area would be ideal advocates for including dental care in Medicare coverage.
At the state level, Louisiana Senators and Representatives would be ideal partners for raising the issue of expanding Medicare coverage to include dental care. District 92 Representative Thomas P. Wilmott, who is both an attorney and a registered nurse, would be an excellent partner due to his position on the Health and Welfare Committee and his history as an advocate for various health care issues (Louisiana House of Representatives, 2013). Improvements to dental care financing and access could be implemented by the Louisiana Department of Health and Hospitals, whose mission is to “protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana”. Specific divisions of DHH which could be involved in this change include the Office of Public Health and the Department of Aging and Adult Services.

At the national level, multiple divisions of the U.S. Department of Health and Human Services could be involved in achieving our goal of putting dental services financially and physically within reach of the elderly population. These divisions include the Administration on Aging (AoA), Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration (HRSA), and the Office of Public Health and Science (OPHS). The American Nurses Association website describes the organization as “in part an advocacy organization, charged with using these insights to set policy and influence health care legislation” (ANA, 2013). The ANA and its influential Political Action Committee, along with the American Dental Association, would be valuable partners and advocates.

**Ethical Implications**

The issue of cardiovascular disease and its association with oral health, especially in the elderly population, is a very relevant issue in the community of Baker. Adding dental coverage
to Medicare is an example of the ethical principles of distributive justice and virtue ethics. We are seeking to change healthcare policy, and, according to Stanhope, several ethical tenets underlie policy development. These tenets include that “an important goal of both policy and ethics is to achieve public good” and that “what is ethical is also good policy” (Stanhope, 2012). It is our opinion that providing dental coverage under Medicare is an issue of ethics.

Throughout this paper, the links between oral health, cardiovascular disease, and nutrition have been discussed. The lack of Medicare coverage for dental procedures and checkups puts more elderly people at risk for cardiovascular complications caused by bacteria and inflammation reaching the heart. The elderly population is already at risk, especially in the South, for heart disease due to poverty, diets high in fat and sodium, and comorbidities such as obesity and diabetes. The lack of healthcare resources in Baker has been a concern for our group for the duration of our public health research, and there is also likely a lack of resources available to inform the residents about the importance of good dental hygiene and its link to cardiac health.

The issue of ethics involves both informing the population of the problem and making changes to public policy in order to protect the elderly population. According to an article found on the website for Centers for Medicare & Medicaid Services, “The dental exclusion was included as part of the initial Medicare program. In establishing the dental exclusion, Congress did not limit the exclusion to routine dental services, as it did for routine physical checkups or routine foot care, but instead it included a blanket exclusion of dental services.” (CMS, 2013).

The ethical issue here is that millions of elderly citizens rely on Medicare to meet their basic health needs, yet Medicare does not cover the most basic dental services, such as yearly cleanings and replacement of lost teeth, which are an integral part of overall health. Their
resulting poor oral health affects their ability to maintain adequate nutrition and be free of infection. If dentures or replacement teeth are not covered and the patient does not have the thousands of dollars required replace those teeth, they are left with holes in their mouth which put them at risk for infection, abscess, bleeding, pain, and altered nutrition due to not being able to effectively chew their food. Many elderly residents may not realize that once their teeth are pulled, they cannot afford dentures or replacement teeth.

Baker residents need to be informed of the current Medicare policy and the importance of acquiring supplemental insurance for dental coverage. We also have an ethical obligation to promote oral health since it has broader consequences for overall health and well-being. The community members need to know how they can get involved with local government and policy making in order to bring about a change in the Medicare system to protect the health of their elderly citizens.

Culturally Informed Approach

While analyzing the community of Baker over the past six months, our group has become more familiar with the area and its residents each time we visit, conduct interviews, attend city council meetings, volunteer, and conduct online research. We have become culturally informed by making an effort to understand the culture and beliefs of the citizens of Baker. “Nurses must be culturally competent to modify nursing interventions that are specific to the needs of cultural and ethnic groups. Such actions have the potential to decrease racial and health disparities and foster effective health outcomes” (Stanhope, 2012). Baker has a large elderly population, and through our research and time spent in the community, we have determined that the issues of oral health and cardiac health are important and culturally relevant.
Being culturally informed means more than just researching the population from the outside looking in; it involves actively participating in the community to really feel the culture for yourself. It also involves preventing your preconceived notions about what the community needs from getting in the way of truly hearing what the citizens say they want and need. Multiple citizens and Baker community leaders told us that heart disease is their number one health concern, so we are striving to improve Medicare policy to address this issue. Our interactions with the over-age-65 community have been very rewarding, and the spirit of Baker has inspired us to reach out in order to make an impact on this large and important segment of the population.

**Health Care Policies, Laws, and Regulations**

Currently, Medicare’s coverage of dental procedures is very limited and consists of very specific stipulations. Within the Social Security Act Section 1862, there is a statutory dental exclusion which states “where such expenses for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment 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” (CMS, 2013). To interpret this provision, Medicare does not cover routine dental services or other dental procedures such as cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices (CMS, 2013). It will, however, cover dental services under part A if the dental services are a part of a covered procedure which requires hospitalization such as reconstruction of the jaw after an accident or an
Another example of a dental procedure that may be covered would be an oral exam before a kidney transplant. The oral exam could be covered under Part A or Part B, but Medicare would not pay for treatment (CMS, 2013). This lack of dental coverage can negatively affect recipients of Medicare because in some cases poor dental hygiene can cause and/or further progress a deteriorating condition such as heart disease or diabetes. This shifts the healthcare continuum from a prevention aspect to a treatment and/or reactive aspect which can have dire consequences on the health status of the elderly.

The Health Care System

Medicare currently does not include dental treatment in its Parts A, B, and D plans except when dental services are needed for another procedure that requires dental treatment to enhance the outcome of that procedure, such as a jaw reconstruction due to an injury. Medicare, however, will pay for dental examinations before needed medical procedures, but not for the treatments needed procedures such as filling a cavity or a root canal. Since 1980, the dental exclusion from Medicare plans has not been changed. Only one exception has been made and that was to cover dental procedures not related to an accident when that dental issue was the cause of the patient hospitalization. This treatment would fall under Medicare Part A hospital benefits to which services would be offered by a hospital staff member, or could be included in Part B plan if the treatment was done by a physician (CMS, 2013).

Individuals with diseases caused by lack of oral care can end up in the hospital needing serious and expensive treatments, costing lots of money and putting strain on taxpayers and the entire healthcare system. Lack of dental care in the elderly can lead to tooth decay and dental
caries. Periodontal disease can spread infection through the vascular tissues within the oral cavity. This can then spread to soft tissues possibly leading to sepsis (NCBI, 2011). Research has shown that periodontal disease has both systemic and local inflammatory processes which cause inflammation to occur in the vascular endothelium. This inflammation could possibly increase the occurrence of atherosclerosis, myocardial ischemia, thromboembolic events or a myocardial infarction (Pharmacy Times, 2012). These complications, without being covered through an insurance policy, can increase the cost on the health care system.

In a survey completed in 2009, the dental expenses that were out-of-pocket made up 27% of the overall health care out-of-pocket costs. The average out-of-pocket cost for dental was $873, which exceeded the average prescription out-of-pocket cost, which was $700. Of participants in the survey, 7% had debt due to dental work, with an average amount of $1,018 (Access project 2009). Out of 130 million Americans, 80% of seniors lack the dental insurance that they need. As these health problems go untreated, the cost of eventual treatment begins to rise (National Consumers League, n.d.).

**Impact of Health Care Reform**

The Affordable Care Act, which will take effect in the upcoming calendar year, will not directly change the current status of dental coverage for the elderly through the Medicare program. There are no provisions or stipulations in the ACA that address dental coverage and the Medicare program. The only provision regarding dental services in the ACA addresses “oral pediatric services” as part of the Essential Health Benefit Package (EHBP) under the law (NADP/DDPA, 2011). This provision stipulates that all individuals purchasing small group or individual health insurance inside or outside the Exchange must be offered “pediatric oral services” either through a medical plan or through the purchase of a stand-alone dental plan
beginning in 2014 (NADP/DDPA, 2011). Although this provision does not directly affect dental services offered to seniors within the Medicare program, it acknowledges that oral health plays a significant role in overall health with regards to children. Perhaps this acknowledgement can be a step in the right direction for future acknowledgement of oral health being just as essential to overall adult health, especially that of the elderly. With this recognition may come more efforts to expand dental coverage for the elderly through the Medicare program. The inability of Congress to address this health need with upcoming healthcare legislation further supports the position of this paper in the belief that this health need requires more recognition so that it may be adequately addressed in the future.

**Conclusion**

As our country’s health trends move toward preventive care through the Affordable Care Act and the Medical Home model, Medicare needs to update outdated policies which focus on decreasing “upfront” costs. If we improve policies regarding preventive dental care, health care costs related to complications of dental-associated diseases will ultimately decrease. In conclusion, advocacy for dental health care coverage for Medicare recipients starts with the nursing profession. As healthcare professionals with a focus on holistic care and prevention, it is our duty to strongly advocate on behalf of Medicare recipients.
References


