

Oral Health Coverage and Care for Low-Income Older Adults

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Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since 1972 we have focused our efforts on older adults who have been marginalized and excluded from justice such as people of color, women, LGBTQ+ individuals, disabled individuals, immigrants, and those who have limited English proficiency.

Key Lessons

1. Oral health is essential to older adults' overall health. Oral health coverage is foundational to accessing care and maintaining good oral health. The lack of oral health coverage drives disparities in access to care and overall health for older adults.
2. Health care programs serving older adults do not offer guaranteed oral health coverage. **Medicare**—the most common insurance coverage for older adults—specifically excludes routine preventive and restorative oral health care except in limited circumstances. Medicare enrollees, however, may be able to obtain dental coverage through private Medicare Advantage plans with varying coverage. **Medicaid** may provide free dental coverage for low-income older adults, but the extent of coverage varies greatly from state to state. The **Veterans Administration** (VA) offers dental coverage to limited categories of veterans.
3. Other forms of dental coverage options are available to older adults, including private stand-alone dental plans and dental credit cards. Older adults should exercise extreme caution when evaluating these coverage and payment options.
4. Federally Qualified Health Centers, pop-up clinics, and dental schools may be available to provide dental care for older adults who cannot afford dental insurance or whose coverage is too limited to meet their needs.

Why Oral Health Matters for Older Adults

Older adults experience high rates of poor oral health, with certain populations suffering more acutely. Nationwide, 17% of older adults have no remaining natural teeth—a rate that has been steadily decreasing each year. Yet, among Black older adults, the percent of individuals with complete tooth loss is 28%—almost double the national average—with minimal change over the past decade.¹ Meanwhile, 1 in 5 older adults have untreated tooth decay, and rates of periodontal disease—or gum disease—are similarly high. 1 in 10 individuals 65 and over experiences severe gum disease, with Black and Hispanic older adults two to three times more likely to have severe gum disease than white older adults.²

Poor oral health has a substantial impact on the overall health of older adults and exacerbates health disparities while driving increased health care spending for chronic conditions. For example, periodontitis is associated with chronic diseases like diabetes and heart disease.³ Most recently, oral health has been linked to

Alzheimer's and dementia.⁴ Research shows that poor oral health increases the risk of developing dementia, and conversely, individuals with dementia are more likely to have poor oral health.⁵

Further, untreated gum disease can lead to infections like aspiration pneumonia resulting in costly hospitalizations and deaths,⁶ particularly among nursing facility residents, while ongoing pain associated with untreated oral health disease increases the likelihood that opioids will be prescribed and abused.⁷ Poor oral health also has a significant impact on overall quality of life. Studies show that people of all ages reduce participation in social activities due to oral health issues, increasing the likelihood for social isolation and depression. Having access to oral health coverage is therefore critical to ensuring the health and well-being of older adults.

Section 2: Oral Health Coverage Options for Older Adults

Access to oral health starts with insurance coverage of oral health care. Unfortunately, the health insurance programs serving older adults do not provide guaranteed coverage for oral health.

Original Medicare

Medicare is the primary source of health insurance coverage for adults age 65 and older, as well as for individuals under age 65 who have been disabled for over two years. Original (fee-for-service) Medicare, however, has never covered routine or preventive dental care, such as cleanings, dental exams, restorative dental treatment like root canals or crowns, or prosthetics like dentures. In fact, the Medicare statute specifically excludes dental coverage, with limited exceptions (see below).⁸ As a result, 47% of Medicare enrollees—approximately 24 million individuals—have no dental coverage.⁹ Without coverage, many Medicare enrollees cannot afford to seek care. For example, nearly half (47%) of Medicare enrollees did not have a dental visit in the last year. This rate was even higher for Black (68%) and Hispanic (61%) Medicare enrollees.¹⁰

Under the Medicare statute, dental coverage is allowable under a narrow exception when dental services are needed to treat an underlying medical condition.¹¹ Historically, the Centers for Medicare & Medicaid Services (CMS) has narrowly interpreted the extent of allowable coverage under this exception. However, in November 2022, CMS released new guidance clarifying and expanding their interpretation.¹² For example, the new guidance makes clear that Medicare will pay for dental examinations prior to a Medicare-covered organ transplant, cardiac valve replacement, or valvuloplasty procedure, and allows these services to be rendered in an outpatient setting.¹³ While the exception remains narrow, the new guidance does ensure those with very complex health care needs have Medicare coverage for dental services “inextricably linked and substantially related and integral to the clinical success of other covered medical services.”¹⁴

Practice Tip

The appeal rights for medically necessary dental procedures are the same as for any other Medicare services. It is important to work with both the physician treating the medical condition and the dental provider, since dental services must be related to a Medicare-covered medical service.

Medicare Advantage

As an alternative to Original Medicare, enrollees have the option of joining a private plan with a health insurance company that has a contract with Medicare to administer Medicare enrollee benefits. These are known as Medicare Advantage (MA) plans. In addition to providing all the coverage to which an enrollee is entitled under Original Medicare, most MA plans offer some form of dental coverage as well.¹⁵ Approximately 48% of all Medicare enrollees are enrolled in a Medicare Advantage plan,¹⁶ and in 2021, 94% of individuals enrolled in an MA plan had some form of dental coverage.¹⁷ However, the scope of dental care covered by these plans varies widely plan to plan. Most plans (86%) offer extensive coverage, while some (14%) just cover routine examinations and cleanings.¹⁸

MA plan dental coverage can also vary widely with regard to cost sharing, including premiums, co-pays, co-insurance, and maximum benefit amounts. While few plans overall (10%) charge a premium for dental coverage, most have significant cost-sharing, particularly for more costly dental services. For example, for restorative services, most plans pay just 50%, leaving the enrollee responsible for the remaining 50%.¹⁹

It is also common (though not universal) for plans to limit the total amount they will pay toward dental care in a given year—called the “maximum benefit amount.” The average annual maximum benefit amount in 2021 was \$1300.²⁰ This means that an enrollee who needs expensive restorative work, such as dentures, would have to pay out of pocket for all costs in excess of the maximum benefit. Further, MA plans often also impose limits on the *frequency* of covered dental care, e.g., they may cover one cleaning a year or a new set of dentures only once every five years.

Practice Tip

Deciding whether to enroll in any Medicare Advantage plan—and if so, deciding which one—depends on many factors specific to the enrollee and their health, including access to their health care providers, prescription drug coverage, and the availability of supplemental benefits like dental. There is no “one size fits all.” Moreover, if the enrollee is dually eligible for both Medicaid and Medicare, and has adequate dental coverage under their state’s Medicaid coverage, it may not benefit them to enroll in any MA plan if, for example, the plan network restricts them from seeing a provider they prefer who participates in Original Medicare and Medicaid.

The enrollee should contact their State Health Insurance Assistance Program (SHIP) for guidance. The state SHIP provides free, unbiased assistance to enrollees in determining which available plan option is best for their specific health coverage needs. The SHIP can help an enrollee to make an informed decision about Medicare, Medicaid, Medicare Advantage, and Medigap plans. The enrollee should be directed to www.shiptacenter.org to find the SHIP in their state, or call 877-839-2675 to be automatically connected to their state SHIP.

Medicaid

Medicaid is a joint federal/state health insurance program for low-income individuals, including older adults and people with disabilities that is administered by the states. Older adults must apply for Medicaid through their local state department of social services. The financial qualifications for Medicaid vary significantly from state to state, but are typically quite low for older adults, with countable income near or below the federal poverty level and countable assets below \$2,000.²¹

Under federal law, states are allowed, *but not required*, to cover adult dental services under their Medicaid programs. Because it is up to each state whether to offer any dental coverage, Medicaid adult dental coverage varies greatly across states with some offering no to very limited coverage, such as emergency services, to others offering more extensive coverage, or some states making coverage only available to specific populations.²²

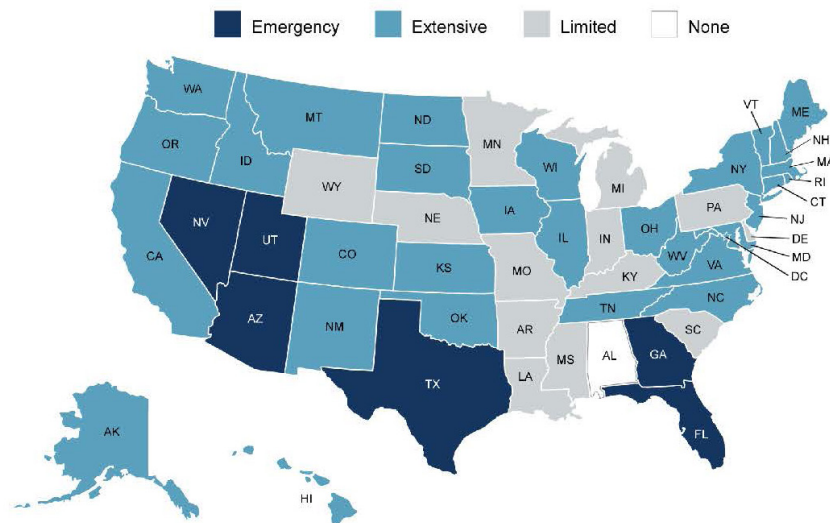
The coverage that states offer tends to fall into one of four tiers ranging from lowest to highest (see coverage map below):²³

- No coverage: Only one state does not cover any dental care (Alabama).
- Emergency coverage: Covers only relief of pain or infection under limited emergency circumstances. Six states offer emergency coverage only (Arizona, Florida, Georgia, Nevada, Utah, and Texas).
- Limited coverage: Covers fewer than 100 diagnostic, preventive, and minor restorative procedures (e.g., cleanings and filling of cavities), potentially with a maximum benefit limit of \$1000. Thirteen states offer limited coverage only (Arkansas, Delaware, Indiana, Kentucky, Louisiana, Michigan, Minnesota, Missouri, Mississippi, Nebraska, Pennsylvania, South Carolina, Wyoming).

- Extensive coverage: Covers a comprehensive mix of over 100 diagnostic and preventive services, as well as minor and major restorative procedures, but often with a per-person annual expenditure cap starting at \$1,000. The thirty remaining states and the District of Columbia provide extensive coverage.

Like MA plans, state Medicaid policies also vary with regard to the amount, duration, and scope of covered services and as of 2021, 13 states imposed an annual maximum.²⁴

State Medicaid Coverage for Adult Dental Services



As of January 2023

Source: MACPAC, Access to Covered Dental Benefits for Adult Medicaid Beneficiaries, April 2023.²⁵

Many states now enroll some or all of their Medicaid beneficiaries in managed care organizations (Medicaid MCOs) that have a contract with the state to administer Medicaid benefits. These MCOs can offer more extensive dental services than the state fee-for-service Medicaid plan.²⁶ Accordingly, depending on the state, a Medicaid enrollee may have access to enhanced dental services through their Medicaid MCO plan.

Veterans Benefits

The Veterans Administration (VA) offers dental care benefits based on different classes of eligibility. Veterans who are 100% service connected or who receive the 100% rate due to unemployability, or who were prisoners of war are entitled to necessary dental care. Veterans who have a compensable service-connected dental disability or condition are entitled to any dental treatment necessary for that service-connected condition. Veterans with a non-compensable service-connected dental condition are also entitled to dental care, with some restrictions, including treatment for a dental condition that occurred within 180 days of discharge from service (with some exceptions to the 180-day rule). Treatment for dental problems that aggravate a service-connected condition or whether the dental condition is complicating or aggravating a separate treated condition is also covered.²⁷

Practice Tip

Veterans should consult their local Veterans Affairs Medical Center, or contact the VA at 1-877-222-VETS (8387), or visit <https://www.va.gov/health-care/> and <http://www.va.gov/disability/> to find out if they qualify for any dental care. If an individual does not qualify for VA dental benefits, but is otherwise enrolled in VA health care, then the individual can enroll in one of two VA-sponsored private dental plans at a reduced price through the [VA Dental Insurance Program \(VADIP\)](#).²⁸ Veterans can also seek assistance from a patient advocate <https://www.va.gov/health/patientadvocate/>.

Other Coverage and Dental Care Options

Stand-alone dental plans

Many private health insurance companies offer individual, stand-alone dental plans. In 2019, 16% of Medicare enrollees were enrolled in Original Medicare plus a stand-alone private dental plan instead of an MA plan.²⁹ A stand-alone dental plan may be a good option for an individual who otherwise wants to remain in Original Medicare but also wants dental coverage. As with MA plans, private, stand-alone dental plans vary widely in coverage and out of pocket costs (premiums; deductibles; copays or co-insurances; maximum benefit amounts; out-of-network limits). They also may have wait times before coverage becomes effective (e.g., 6 months) or bar coverage for pre-existing conditions (e.g., for a tooth that was already missing when the policy was purchased).³⁰ Stand-alone plans should be evaluated carefully regarding these factors and to determine whether the individual's preferred provider is in network and willing to participate.

Federally Qualified Health Centers (FQHCs)

FQHCs are special outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid and are a critical piece of the health care safety net for low income individuals.³¹ They “are required to provide health care to all individuals regardless of their ability to pay and to be located in geographic areas with few health care providers.”³² Most FQHCs provide dental services—at least preventive and sometimes extensive—either at the same site as their medical care (most cases) or by referral to other providers. Out-of-pocket costs can be on a sliding scale with potentially very low to no cost, depending on the income of the individual. Individuals can use the Health Resources and Services Administration (HRSA) website at <https://findahealthcenter.hrsa.gov/> to find an FQHC near them.

Pop-up clinics

There are efforts to bridge gaps in access to dental care by providing care at large pop-up clinics.³³ These clinics are generally staffed by volunteers and provide a range of different services, for free, in a public space. These events are usually crowded with long waits. It is important to do some research before traveling to a pop-up clinic to ensure the services the individual needs will be offered. Such clinics can be located through the [clinic schedule](#) of the America's Dentists Care Foundation.

Dental schools

Some dental schools provide treatment to populations in need, usually on a sliding scale,³⁴ and may also accept some forms of insurance, including Medicaid. It is important to contact the school to determine whom the school serves and whether the treatment sought is offered. An individual can use the website of the [Commission on Dental Accreditation](#) to find the dental schools in their state or city,³⁵ and then contact those schools to ask what services they provide, and to whom.

Dental credit cards

Some credit card companies offer specialized dental credit cards. Individuals should be forewarned, however, that they may end up paying much more over the long term than the up-front dental charge. Some dental credit cards that offer “zero interest” for an initial promotional period of six to twenty-four months do not actually *waive* interest—they just *postpone* charging the cardholder for interest that nevertheless still accumulates during the promotional period.³⁶ As a result, a card holder could experience a sharp increase in minimum payments after that period. A recent 2023 report from the Consumer Financial Protection Bureau concluded that many patients who use medical credit cards pay significantly more than they would otherwise pay and are often eligible for other forms of financial assistance and charity care under federal, state, or local law.³⁷ If necessary, a conventional card with true zero percent initial interest may be better, or simply seeking one of the low-cost alternatives above.

Conclusion

Dental care is critical to the overall health of older adults. Individuals should work with an advocate including their local state SHIP to determine their best coverage options under Medicare, Medicaid, or stand-alone private plans. Veterans may also investigate coverage through the Veterans Administration. Those unable to secure dental insurance of any kind should reach out to their local FQHC, dental school, or dental pop-up clinic.

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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Endnotes

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