FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Medicare Oral Health Benefit Passed by the House of Representatives Sets Bold Precedent but Should Be Strengthened to Best Serve Low- and Moderate-Income Enrollees

Last month, the House of Representatives passed legislation that would add dental coverage to Medicare as part of H.R. 3, the *Elijah E. Cummings Lower Drug Costs Now Act*. This is an enormous step in the effort to raise the visibility and importance of covering oral health for Medicare enrollees. Adding a Medicare dental benefit would help more than 56 million[1] seniors and people with disabilities afford much needed dental care.

However, even if this landmark legislation is enacted as drafted, many seniors and other Medicare beneficiaries would still face barriers to affordable oral care because of high cost-sharing, and potential for insufficient reimbursement rates. To ensure that oral care for low- and moderate-income seniors is affordable, the House should improve the framework set by H.R. 3 should in several ways.

This issue brief makes four recommendations to Congress to ensure that any dental benefit that is added to the Medicare program is designed to make high-quality, affordable oral health care accessible to all beneficiaries, including those with limited incomes.

Align Dental Benefit Cost-Sharing with Current Part B Cost-Sharing

Under current Medicare law, Part B generally pays 80% for most outpatient services. For designated preventive services, such as annual wellness visits, Medicare currently pays 100% of the cost, making these services free to beneficiaries.

H.R. 3's oral health benefit is less generous than current Part B benefits. It would pay only 50% for complex services, even with a multi-year phase-in to this rate, and just 80% for screening, preventive, and wellness services. Thus, under H.R. 3, most enrollees would face higher cost-sharing for oral care than for other Part B services.

Coverage of just 50% of costs for major dental services means many expensive services would remain unaffordable. For example, a root canal plus a crown can cost at least $2,800 in a major city.[2] If Medicare paid half of that, the enrollee would still face a $1,400 bill – which is entirely unaffordable for a moderate-income enrollee who is struggling to pay for housing, utility, and food.

Coverage of just 50% of costs for major dental services means many expensive services would remain unaffordable.

Congress should improve the oral health benefit framework in H.R. 3 in two ways:

- **Cover 100% of preventive oral health services**
- **Cover 80% of other oral health services**

Reimburse Providers Adequately to Ensure Access to Care for Low- and Moderate-Income Beneficiaries

The Qualified Medicare Beneficiary (QMB) program limits cost-sharing for low-income Medicare beneficiaries: State Medicaid programs cover the cost-sharing that would otherwise be charged to beneficiaries.

H.R. 3 wisely improves access to the QMB program by increasing the income eligibility threshold for QMBs from 100% to 150% of the federal poverty line (from $1,063 to $1,595/month for an individual, from $1,437 to $2,155 for a couple in 2020). It also waives certain in-kind income limits.

However, this measure alone will not make care accessible to enrollees. That is because reimbursement rates for providers who serve QMBs can be lower than the rates charged for other Medicare beneficiaries. Specifically, federal statute allows states to reimburse providers *at any rate* up to the Medicare payment rate as long as it is at least the rate that the state pays for that service to other beneficiaries under its Medicaid state plan.[3] For example, a state could decide to use its Medicaid rates for children's dental services for the newly covered QMB population.

As of 2016, states' Medicaid reimbursement rates for covered dental care varied widely. In the states that covered any kind of adult dental care, Medicaid fee-for-service payment rates ranged from 31% to 66% of private dental insurance reimbursement. Medicaid payment rates for children's dental care, which all states cover, ranged from 36% to 98% of private insurance rates.[4] In Medicaid programs, these low payment rates consistently reduce dental providers' participation and contribute to access problems.

H.R. 3 wisely improves access to the QMB program by increasing the income eligibility threshold for QMBs from 100% to 150% of the federal poverty line.

With states on the hook to pay a significant portion of the remaining costs, many states may be unwilling to reimburse providers at an adequate rate.

To minimize their own costs under H.R. 3, states would have a strong incentive to set lower reimbursement rates for dental care providers for QMBs compared to what Medicare pays for other enrollees. As noted above, when reimbursement rates are too low, many providers will refuse to see low-income Medicare enrollees.

The cost to states associated with adding a dental benefit to Medicare would be greatest in the early years of the program. When first implemented in 2025, H.R. 3 would require Medicare to pay only 10% of major dental costs, leaving state and federal governments, through Medicaid, to share the remainder of the cost for low-income beneficiaries that would be reimbursed at the state's Federal Medical Assistance Percentage (FMAP). Even when the Medicare oral health benefit is fully phased in after 2029, Medicare will pay for only 50% of the cost of major dental care. With states on the hook to pay a significant portion of the remaining 50% of costs, many states may be unwilling to reimburse providers for major dental services at an adequate rate.

Congress should ensure adequate reimbursement for dental providers who serve low-income enrollees in two ways:

- **Require provider reimbursement for QMBs at the Medicare-approved rates instead of leaving rate-setting to state discretion.**
- **Provide 100% of the federal medical assistance percentage (FMAP) for the new dental benefits for QMBs.**

Endnotes

[1] As of October 2019, 56,087,000 people were enrolled in Medicare for both hospital insurance and supplementary medical insurance – that is, they had either Medicare A and B or Medicare Advantage. "Medicare Enrollment Dashboard," Center for Medicare and Medicaid Services, page last modified February 13, 2020, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard.

[2] This is the average allowed amount for endodontic therapy for a molar tooth (excluding final restoration), including oral evaluation, x-ray, test, plus the average allowed amount for a crown in Washington, DC. fairhealthconsumer.org, accessed December 16, 2019.

[3] Social Security Act §1902(n); 42 USC §1396a(n).

[4] N. Gupta et al., *Medicaid Fee-for-Service Reimbursement Rates for Child and Adult Dental Care Services for all States, 2016* (American Dental Association Health Policy Institute, April 2017), https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0417_1.pdf. States are not required to consider the resources involved in performing a procedure to set their Medicaid fee scales in the manner that these factors must be considered in setting Medicare fee scales. See "Provider Payment Under Fee for Service," Medicaid and CHP Payment and Access Commission, accessed December 18, 2019, https://www.macpac.gov/subtopic/provider-payment/.

This publication was written by:
Shawn Greminger, Senior Director of Federal Relations
Cheryl Fish-Parcham, Director of Access Initiatives, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):
Kimberly Alleyne, Senior Director, Communications
Melissa Burroughs, Senior Oral Health Campaign Manager
Justin Charles, Digital Media Associate
Nichole Edralin, Senior Manager, Design and Publications
Adina Marx, Communications Associate

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

1225 New York Avenue NW, Suite 800
Washington, DC 20005
202-628-3030
info@familiesusa.org
FamiliesUSA.org
facebook / FamiliesUSA
twitter / @FamiliesUSA

OH2019-366-022120