AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 119
(A-22)

Introduced by: Medical Student Section

Subject: Medicare Coverage of Dental, Vision, and Hearing Services

Referred to: Reference Committee A

Whereas, The Social Security Act expressly prohibits coverage for most dental services, specifically "services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth," by Original Medicare for its beneficiaries[1]; and

Whereas, Though Medicare covers "medically necessary" dental care, the Centers for Medicare & Medicaid Services presently interprets this to cover a very limited scope of services and coverage determinations are often inconsistent--for example, Medicare Part A will cover an oral examination as part of a comprehensive workup in preparation for a kidney transplant, but not for transplantation of non-kidney organs[2,3]; and

Whereas, Almost 24 million Medicare beneficiaries have no dental coverage, comprising nearly half of Medicare beneficiaries[4]; and

Whereas, In 2021, 16.6 million Medicare Advantage enrollees have some dental benefits through their plans, but 78% of those with coverage are enrolled in plans with annual dollar limits on dental coverage (average annual limit of $1,300), 10% are required to pay an additional premium for dental coverage, and plans with coverage for extensive dental services often necessitate significant coinsurance cost-sharing (most common cost-sharing of 50%)[4]; and

Whereas, Lack of dental coverage and dental underinsurance leads to Medicare beneficiaries forgoing recommended care, with 47% of those enrolled in Medicare not visiting the dentist in 2018[4]; and

Whereas, Racial inequities are perpetuated in access to dental services, with Black and Hispanic Medicare enrollees most likely to have not seen a dentist in the past year (68% and 61%, respectively)[4]; and

Whereas, Only 7.27% of Medigap (Medicare Supplement) plans offer additional benefits such as dental, hearing, and vision coverage[5]; and

Whereas, A 2016 analysis of over 1,200 older adult respondents in the Health and Retirement Study found that only 68% used dental services, and two-thirds of those who wanted to use dental services but did not do so reported cost as a reason they did not receive dental care[6]; and

Whereas, The 2016 analysis of the Health and Retirement Study found that 42% of those using dental services received a filling, bonding, or inlay; 34% received a crown, implant, or prosthetic; 26% received a gum treatment, tooth extraction, or surgery; and 10% received dentures[6]; and

Whereas, Poor dental health has myriad negative repercussions for patients' health, including nutritional deficiencies secondary to tooth loss, exacerbation of diabetes and cardiovascular disease by untreated caries and periodontal disease, infections, and delayed diagnoses resulting in preventable complications and adverse outcomes, including for cancer[7,8]; and

Whereas, Original Medicare does not cover routine eye examinations or refractions for eyeglasses or contact lenses, nor does it cover eyeglasses or contact lenses themselves other than eyeglasses following cataract surgery[2,9]; and

Whereas, Untreated vision loss is correlated with increased risk of falls, depression, cognitive impairment, hospitalization, and mobility limitations among older adults[10]; and

Whereas, Thirty-nine percent of Medicare beneficiaries reported having trouble seeing even with their glasses, and low-income beneficiaries were most likely to have vision trouble[10]; and

Whereas, Among Medicare beneficiaries, forty-three percent who have difficulty seeing have not had an eye exam within the last year[11]; and

Whereas, Only thirty-seven percent of Medicare beneficiaries over the age of 65 had an eye exam at least once every 15 months in one recent study[12]; and

Whereas, Medicare beneficiaries with supplemental vision plans spent an average of $415 for vision care, while those with Medicare Advantage spent an average of $331, with 61% and 65% of spending being comprised of out-of-pocket costs to the patient, indicating that even those who have some vision care have significant out-of-pocket expenses for vision care[10]; and

Whereas, Medicare beneficiaries hospitalized for common illnesses were shown to have longer mean lengths of stay, higher readmission rates, and higher costs both during hospitalization and ninety days post-discharge if they had partial or severe vision loss compared to matched hospitalized Medicare beneficiaries with no vision loss, resulting in an estimated $500 million in excess healthcare costs annually[13]; and

Whereas, Among Medicare beneficiaries, low vision is associated with an increased risk of hip fractures, depression, anxiety, and dementia, and more prevalent among Black and Hispanic patients[14]; and

Whereas, Medicare beneficiaries with vision impairment reported lower well-being, which was found to be mediated by limitations on mobility and household activities/ instrumental activities of daily living relative to Medicare patients without visual impairment[15]; and

Whereas, A 2018 study published in *JAMA Ophthalmology* found that Hispanic and Black Medicare beneficiaries were significantly less likely to report using low-vision devices than white patients, but there were no similar disparities for low-vision rehabilitation (which is covered by Medicare), leading the study authors to conclude that "policy makers could consider expanding Medicare coverage to include low-vision devices in an effort to address significant disparities in the use of this evidence-based intervention"[16]; and

Whereas, Among adults over the age of 65, the prevalence of falls in the past year for patients with vision impairment was over double that for patients without vision impairment (27.6% versus 13.2%), and the prevalence of activity restriction due to fear of falling was much higher in patients with vision impairment as well (50.8% versus 33.9% for patients without vision impairment)[17]; and

Whereas, A 2017 *JAMA Ophthalmology* study indicated that visual impairment was associated with a 1.9- to 2.8-fold increase in cognitive dysfunction or dementia among adults 60 years and older[18]; and

Whereas, A study of over 22,000 nationwide respondents to the Medicare Current Beneficiary Study found that beneficiaries with vision impairment were significantly more likely to be hospitalized over a three-year period[19]; and

Whereas, Nearly 25% of people aged 65-74 and 50% persons of people over 75 suffer from disabling hearing loss, which is associated with decreased quality of life, increased risk of cognitive decline and hospitalization, and higher healthcare costs by thousands of dollars, outweighing the relative cost of providing hearing services[20-24]; and

Whereas, Fewer than 30% of those aged 70 and older who could benefit from hearing aids have ever used them, with many reporting cost as prohibitive, with an average cost of $2,500 for a pair of digital hearing aids and some ranging up to $6,000[25-26]; and

Whereas, Original Medicare does not cover hearing exams, hearing aids, or aural rehabilitative services, while Medicare Advantage charges additional premiums for hearing coverage, with out-of-pocket costs and annual limits varying significantly across Advantage plans[27-28]; and

Whereas, The *Lancet* Commission has recognized hearing impairment as one of the most important modifiable risk factors for dementia, and observed that "hearing aid use was the largest factor protecting from decline" and "the long follow-up times in these prospective studies suggest hearing aid use is protective, rather than the possibility that those developing dementia are less likely to use hearing aids"[29]; and

Whereas, Medicare beneficiaries with functional hearing difficulty (which reflects perceived hearing under daily circumstances and takes the use of hearing aids into account for patients that have them) experience more unmet healthcare needs, such that study investigators concluded that "rethinking service delivery models to provide better access to hearing care could lead to increased hearing aid use and improved interactions between providers and patients with hearing loss"[30]; and

Whereas, AMA Policy H-185.929, "Hearing Aid Coverage," supports Medicare covering hearing tests, but does not indicate support for hearing aids or aural rehabilitative services (which includes fittings and adjustments); and

Whereas, Numerous recent proposals from the legislative and executive branches have proposed the creation of new dental benefits for preventive and restorative services and additional vision and hearing benefits for routine exams and aids under Medicare Part B, including President Biden's 2022 budget request, legislation (H.R. 3) passed by the House of Representatives in 2019, and most recently, the Senate Democrats' budget resolution[5,31,32]; therefore be it

RESOLVED, That our American Medical Association support Medicare coverage of preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures (New HOD Policy); and be it further

RESOLVED, That our AMA support Medicare coverage of routine eye examinations and visual aids, including eyeglasses and contact lenses (New HOD Policy); and be it further

RESOLVED, That our American Medical Association amend Policy H-185.929, "Hearing Aid Coverage," by addition to read as follows:

Hearing Aid Coverage H-185.929

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team, aural rehabilitative services, and hearing aids as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA POLICY

Eye Exams for the Elderly H-25.990
Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings.
Res. 813, I-05; Reaffirmed: CSAPH Rep. 1, A-15

Hearing Aid Coverage H-185.929
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5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.
CMS Rep. 6, I-15; Appended: Res. 124, A-19

Medicare Coverage for Dental Services H-330.872
Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.
CMS Rep. 03, A-19

Importance of Oral Health in Patient Care D-160.925
Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians.
Res. 911, I-16; Reaffirmed: CMS Rep. 03, A-19