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EXAMINING THE DENTAL CARE CRISIS IN AMERICA: HOW CAN WE MAKE DENTAL CARE MORE AFFORDABLE AND MORE AVAILABLE?

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

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ON

EXAMINING THE DENTAL CARE CRISIS IN AMERICA, FOCUSING ON MAKING DENTAL CARE MORE AFFORDABLE AND MORE AVAILABLE

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C O N T E N T S

STATEMENTS

THURSDAY, MAY 16, 2024

EXAMINING THE DENTAL CARE CRISIS IN AMERICA: HOW CAN WE MAKE DENTAL CARE MORE AFFORDABLE AND MORE AVAILABLE?

Thursday, May 16, 2024

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10:02 a.m., in room 430, Dirksen Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders [presiding], Baldwin, Kaine, Hassan, Lujàn, Hickenlooper, Cassidy, Murkowski, Braun, and Tuberville.

OPENING STATEMENT OF SENATOR SANDERS

The CHAIR. Good morning. Thank you all for being here. The Senate Committee on Health Education, Labor, and Pensions will come to order. When we talk about the healthcare crisis in America, I'm afraid that far too often we ignore a very important aspect of that crisis, and that is, the tens of millions of Americans who are either unable to afford or unable to access the kind of dental care that they need.

As a result, there is widespread suffering throughout the country that largely goes unseen. This is an issue really that is not talked about anywhere near enough, and I have distributed for the Members of the Committee just a number of statements that we assembled from all over the country.

We did a send out an email in Vermont, which as you know, is a very small state. We got 500 people, 500 people who talked about the cost of dental care or their inability to access dentists. And we got a thousand, I think, nationwide. So, this is an issue that's on people's mind and I think it's an issue worthy of serious discussion here.

Today in America, nearly 70 million adults and nearly 8 million children have no dental insurance, and many of those who do have dental insurance, find that coverage to be totally inadequate. In fact, nearly half of Americans who have dental insurance have skipped their appointments because they could not afford to pay for the dental procedures they need. And I hope one of the issues that the panel will talk about today is why dental care is so very expensive. People walk into a dental office and they find that they get a huge bill or pay it off for years. Maybe we can discuss that.

Nearly one out of five seniors in America have lost all of their natural teeth, and many of them cannot afford dentures, which can cost many thousands of dollars.

70 percent of older Americans have some sort of periodontal disease, which can lead to rheumatoid arthritis and cardiovascular disease.

But it's not obviously just seniors who are hurting here. More than 40 percent of children in America have tooth decay by the time they reach kindergarten, primarily because their parents could either not afford or cannot find a dentist on time.

The lack of affordable dental care in America is a problem all over our Country, but it is especially acute for lower income Americans, pregnant women, people with disabilities, veterans, those who live in rural communities and Black, Latino, and Native Americans.

The situation has become so absurd, and this is really quite remarkable, and I think we will hear a little bit of this today, that every year, hundreds of thousands of Americans leave the United States go to countries like Mexico, Costa Rica, India, Thailand, and Hungary, where it is much less expensive to get the dental care they need, and it's even cheaper after paying all of your transportation costs.

We should be thinking about why that's happening in America. And the reason is not difficult to understand. The price of a dental implant in our Country can cost about $5,500 compared to around $850 in Mexico, $800 in Costa Rica, and $450 in India. The same treatment, the average price of a root canal in America can cost $1,275 compared to less than $250 in Mexico, et cetera.

Over the past week, as I mentioned, my office sent out a request. Tell me how you are dealing with dental care? And the response we got was just overwhelming. And the responses that we got; you would not think would be taking place in the richest country in the world. We can understand if we were living in some very poor country, but that's not the case.

I think everybody knows in the medical profession, if people don't receive high quality dental care, they are in danger of living their lives with severe pain.

We need to understand that a major cause of absenteeism, interestingly enough, from school, is a result of toothache and dental pain. We need to understand that nearly half of adults in America have some sort of periodontal disease. It makes them two or three times more likely to have a heart attack, stroke, or some other serious cardiovascular emergency. We need to understand that when your teeth are in bad shape and you cannot chew your food properly, you're in great risk of diabetes, digestive problems, and poor birth outcomes.

There's something else that we don't talk about, that it's not just health. When we see people without any teeth in their mouth, that is a symbol that they are poor. Walk in, try to get a job without any teeth in your mouth. Good luck to you because you're not going to get it.

We've got to understand that if we're going to seriously address the mental crisis in America, Congress is going to have to act and act boldly. And that's why I've introduced today what I believe is the most comprehensive piece of dental care legislation that we have ever seen in our Country. And what this legislation does, it would've substantially expanded the number of dentists.

When we talk about a workforce crisis in healthcare, not just doctors, not just nurses, it is dentists. And we need to talk about that. Dental hygienists and dental therapists in America, particularly in rural and underserved areas. And I trust we'll be discussing this with the panel.

It is unacceptable to me that 67 percent of rural communities in America are designated as dental professional shortage areas. Furthermore, we need to make sure, and this is a major problem, I hope we discuss as well, you can have a dentist. Many dentists no longer treat lower income people who are on Medicaid. And I know that in the southern part of my state, it is acute. I'm told that kids in the southern part of my state are having a hard time finding a dentist. And for Vermont, generally does better than many other states in these areas.

It is unacceptable to me that only a third of our Nation's dentists provide care to people who are on Medicaid. And that's a problem we got to deal with.

Third, we've got to substantially expand high quality and comprehensive dental insurance in America. Many of our seniors do not have a comprehensive dental insurance because traditional Medicare does not cover most dental procedures. And for years I have talked about, and I hope we will be able to expand Medicare to cover dental, vision and hearing as well.

For Veterans, we have a VA system, which by and large provides good healthcare to its people, but for whatever reason, dental is not part of that. And I hope that we can expand that and our legislation does that. It expands dental care and federally qualified health centers who do a great job but are understaffed in terms of the dentist that they have.

All right, bottom line is this is an issue that we do not discuss enough. It is a crisis issue. And I hope that today we're going to take this issue a major step forward, and I thank the panelists very much for being with us.

Senator CASSIDY.

OPENING STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Thank you, Chairman Sanders. I'm glad we're focusing on quality dental healthcare. The HELP Committee has examined health workforce shortages, and so hopefully we can come out of this with legislation that can pass, that can address issues in the dental field.

By the way, passing legislation takes bipartisan support. And I would ask just one more time, encourage greater participation between the majority and the minority. If everybody representing all the Americans we represent, both Republicans and Democrats

come together and are heard, we're more likely to get something which can actually be signed into law.

That's why I've said repeatedly, asking the majority to engage the minority in preparation and crafting of these hearings. If we want hearings to be a springboard for passing legislation, we must lay that groundwork together.

But I also have to note that there are other urgent issues impacting the lives of our constituents. I've requested for months that we hold hearings on the disturbing antisemitism spreading on college campuses. Jewish students are being threatened and assaulted. No student should be afraid while attending school or be a victim of bigotry, but there's not been a commitment from the majority that we will exercise oversight over this response or the lack of a response from universities and the Department of Education.

We could also hold a hearing on the Biden administration's repeated blunders and rolling out the new Free Application for Federal Student Aid, or FAFSA application. Some students may forego college because without financial aid offers, they don't know if they can afford. But the incompetent Biden administration bureaucrats who bungled the rollout are not facing any consequences, even though students are, these issues should be bipartisan.

We should have Secretary Cardona before this Committee to examine him and their response. We have the time, for example, last week, we didn't even have a hearing.

In fact, we are a year and a half into this Congress and we've not had a single hearing on the state of primary or secondary education in which we are the Health, Education, Labor, and Pension Committee.

I'll stop there because I don't want to take away from discussing dental care. I helped found a public private partnership providing free dental and healthcare to the working uninsured in my area in the capital region of Louisiana. I found out that the pent-up demand for dental care is greater than the pent-up demand for medical care.

The uninsured can go to the emergency room, but they can get it and then get a teeth tooth pulled there, but they can't get anything else there. Dr. Isbell is kind of shaking his head like, he doesn't want that pulled in the emergency room. I get that. But as a rule, the pent-up demand is greater for dental.

That said, recent data shows that 88 percent of Americans have dental coverage. Now, despite this, some call for mandating dental coverage under Medicare and Medicaid Right now under Medicare, approximately 98 percent of Medicare Advantage plans offer dental benefits and more than half of Medicare beneficiaries are enrolled in an MA plan. That's pretty significant.

In addition, states have the option to provide dental coverage to adult Medicaid enrollees as Senator Sanders notes, or at least implies, reimbursement rate under Medicaid is so lousy that frankly it's the illusion of coverage without the power of access. If you're losing money on every patient you see, who's covered by Medicaid, you can't make it up with volume. And that is how I see it. Dr. Swann agreeing with that, that is just a reality.

I'll note that a lot of independent medical practices are struggling to provide quality care with low reimbursement rates and the administrative burden that comes with a Federal mandate and some are selling their practice or the doctor is retiring. I'm afraid that mandating dental coverage might be similarly harmful. And with Medicare on track for insolvency in a little over a decade, we should also think about making that sustainable before adding programs to it.

Now looking at the commercial market, the vast majority of patients in employer sponsored plans have the option of dental coverage. And among employers offering health benefits in 2023, about 90 to 94 percent of them offer dental insurance. And of course, that allows the patient to get the option that serves their need best. So many of these individuals currently get dental coverage through a standalone dental plan.

While major medical plans can offer dental benefits, standalone benefits often also have lower deductibles along with the lower overall medical deductible. However, this year, the Biden administration issued regulations allowing states to require ACA plans.

ACA plans to provide dental coverage doesn't kick in until 2027, but it will raise premiums in these already expensive and often unaffordable plans or will increase the subsidy that taxpayers are paying, which means the cost of the bill is stuck on all of us.

Now, it's important to note the dental care workforce is also an issue, and that's particularly true in rural and underserved areas and also urban areas. Senator Baldwin is the lead sponsor of the Action for Dental Health Act, which reauthorizes a grant program through the Health Resources and Services Administration or HRSA, helping states to increase their oral health workforce and provide dental care, particularly in those underserved communities.

I worked on this before being a Ranking Member, and just to understand the importance. The HELP Committee has dedicated four hearings to examine health workforce shortages and two markups as Congress. We've examined critical programs supporting dental workforce, including the National Health Services Corps. It's important that we get a long-term reauthorization signed into law.

We also need to understand that with dentists, we often don't have a supply problem, but a distribution problem. My dentists tell me that there's certain cities we'll work in, but the rural areas, it's more difficult to support. This year it shows that we have 98 to 99 percent of the dentists and oral surgeons we need, but again, the rural areas, it's only 63 percent of the general dentist and 44 percent of the oral surgeons. So impacting the supply and distribution of dental providers is crucial before directing the solution.

One way to address workforce shortages or work to address workforce shortages should continue to be a top of the mind for the Committee as there will be additional reauthorizations. This includes the Title VII programs of the Public Health Services Act, which contains a number of important programs bolstering dental workforce and access to care. I look forward to the testimony and learning more on how we can responsibly improve dental care for all Americans. Thank you for being here.

The CHAIR. Thank you, Senator Cassidy. Our first witness is Dr. Lisa Simon, a dentist and physician, both who provides primary care to underserved communities in the Boston area. Her research focuses on the role of oral health and overall health and well-being and the impact of Federal and state policy on oral health success and access. Dr. Simon is also a member of the faculty at Harvard Medical School.

Dr. Simon, thanks so much for being with us.

STATEMENT OF LISA SIMON, M.D., DMD, ASSOCIATE PHYSICIAN, BRIGHAM AND WOMEN'S HOSPITAL, MEMBER OF THE FACULTY, HARVARD MEDICAL SCHOOL, BOSTON, MA

Dr. SIMON. Thank you so much, Senator Sanders for having me here today. And thank you, Ranking Member Cassidy. I'm honored to speak with you both today about oral health in our Country. Senator Sanders, is a tireless advocate for the marginalized, and, Senator Cassidy is a fellow physician. I am deeply grateful to both of you for helping shine a light on this invisible form of suffering.

I speak in support of Senator Sanders Comprehensive Dental Reform Act. Practicing as a dentist in a community health center broke my heart. The weight for my services routinely exceeded 4 months, and I was often forced to extract teeth that I could have saved because of insufficient Medicaid funding.

I will never forget the young woman my own age, whose front teeth were so badly decayed that they all needed to be removed. This remarkable young mother gave me a gift that she could barely afford to thank me for trying to save them. Even though she was left with a smile that would make it more difficult for her to eat, speak, or find work.

It was patients like her who inspired me to enter medical school and work on the crisis in oral health from both sides of the aisle. Through medical school, I practiced dentistry at the Suffolk County Jail, where I had multiple patients tell me that the only good thing to happen to them since they had become incarcerated was that they finally got to see a dentist. Now, as an internal medicine physician, I see even more unmet dental need than I did practicing dentistry because I see the patients who never make it to a dental office.

I have cared for patients in the intensive care unit with life-threatening sepsis from a dental infection. I have met patients who cannot start chemotherapy because they can't afford to remove their infected teeth. I have met patients with nutrient deficiencies from ill-fitting dentures, and I have met patients who even knowing that I'm a doctor and a dentist are so ashamed of their teeth that they won't let me look in their mouths.

My patient suffering is not quantifiable, but their experiences are a part of the $22 billion a year that CMS spends on dental care. A cost that could be much better spent ensuring access to comprehensive and preventive services, and not on the devastating downstream effects of unmet need.

I wish to highlight the following policies that could dramatically improve oral health in the United States. First make adult dental coverage a mandatory Medicaid benefit. Dental benefits for adults

are currently determined at the state level and benefits range from comprehensive to non-existent. These benefits are persistently threatened in times of budget shortfall due to their optional nature. Even though data confirms that Medicaid dental coverage can increase access to jobs for beneficiaries. To say nothing of decreasing, preventable suffering.

Next, Medicare must cover dental care. The 1965 Social Security Act, statutory exclusion of dental care must be reversed. Fewer than half of Medicare beneficiaries see a dentist each year. When they do, they spend more than $1,000 out of pocket on their care.

My research has shown that enrolling in Medicare is associated with a 5-percentage point jump in toothlessness. The new limited dental benefit for which only a very few beneficiaries will be eligible is momentous, but it is a drop in the bucket.

A truly comprehensive Medicare dental plan has been estimated by the Congressional Budget Office to cost CMS less each year than the single Alzheimer's medication, Alhzeon, and this does not include the cost savings of offering preventive care that keeps people healthy.

Dental plans are often a draw for beneficiaries to choose Medicare advantage, but my research has found that beneficiaries with Medicare Advantage have rates of dental access that are just as low and out-of-pocket costs that are just as high as traditional Medicare beneficiaries. Medicare Advantage is not the solution here.

Last, we must make the evolution of dental care a national priority. Dental therapists, a provider equivalent to a physician assistant or nurse practitioner, can expand the dental team and bring care to communities failed by the current system. CMS must increase its oral health infrastructure and resources in order to lead policy innovation.

We need better NIH funding to uncover the causative links between oral health and overall health and how our policies affect both health and healthcare economics.

I should note that much of organized dentistry has repeatedly lobbied against these policies dating back to 1965. This defends the status quo of small business owners and not the oral health of patients and communities, but it does not speak for all dentists. Yet dentistry has been unable or unwilling to change itself to serve the needs of more Americans.

Both my medical and dental patients ask me the same question. Why is it so hard for me to get dental care? There is no good reason. There is no good reason why we live in a country where low-income Americans are 16 times more likely to lose all of their teeth than their wealthy neighbors. It simply isn't fair. My patients deserve better, our Country deserves better. Thank you for helping us achieve it.

[The prepared statement of Dr. Simon follows.]

PREPARED STATEMENT OF LISA SIMON

Chair Sanders and Ranking Member Cassidy,

Thank you for the honor of speaking with you today about oral health in our country. Senator Sanders, as a tireless advocate for the marginalized, and Senator Cassidy, as a fellow physician, I am deeply grateful to both of you for helping shine a light on this invisible form of health inequity and the myriad ways it shapes the lives and suffering of many Americans. I speak in support of Senator Sanders' Comprehensive Dental Reform Act.

Practicing as a dentist in a community health center broke my heart. The wait for my services routinely exceeded 4 months, and I was often forced to extract teeth I could have saved because of insufficient Medicaid funding. I will never forget the young woman my own age whose front teeth were so badly decayed that they all needed to be removed – this remarkable young mother gave me a gift (that should could barely afford) to thank me for trying to save them, even though she was left with a smile that would make it more difficult for her to eat, speak, or find work.

It was patients like her who inspired me to enter medical school and work on the crisis in oral health from "both sides of the aisle." Through medical school, I practiced dentistry at the Suffolk County Jail, where I had multiple patients tell me that the only good thing to happen to them since being incarcerated was that they finally got to see a dentist.

Now as an internal medicine physician, I see even more unmet dental need than I did practicing dentistry – I see the patients who never make it to a dental office. I have cared for patients in the intensive care unit with life-threatening sepsis from a tooth infection. I have met patients who cannot start chemotherapy because they can't pay to remove their infected teeth. I have met patients with nutrient deficiencies from ill-fitting dentures. And I have met patients who, even knowing that I am a doctor and a dentist, are so ashamed of their teeth that they won't let me look in their mouths. My patients' suffering is not quantifiable, but their experiences are part of the $20 billion a year that CMS spends on dental care – a cost that could be better spent ensuring access to comprehensive and preventive services, not on the devastating downstream effects of unmet need.[1]

As a researcher, I can confirm with statistics what I have seen. Uninsured and publicly insured adults are far more likely to present to hospital emergency departments for tooth pain,[2] and far less likely to visit a dentist annually.[3] These individuals are also more likely to receive an opioid prescription which can lead to opioid use disorder and overdose death.[4] Black and Indigenous children have higher rates of tooth decay,[5] and Black and Indigenous elders are more likely to have dentures.[6] My research has found that rural adults and children have higher rates of tooth extraction even when they have private dental insurance.[7,8] And entering Medicare at age 65, which does not offer a dental benefit, leads to a five percentage point jump in the loss of all teeth.[9]

Inequities like these exist, tragically, across many health conditions. A key difference is that dental disease is *entirely preventable*; this simply shouldn't happen. I wish to highlight the following policies that could dramatically improve oral health in the US:

1. Make an adult dental coverage a mandatory Medicaid benefit.
The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit confirms that children with Medicaid or CHIP have dental coverage, but this protection disappears the moment they become adults.[10] Dental benefits for adults are currently determined at the state level, with broad variability. Four states cover no dental care, and only eight cover enough care to be considered comprehensive.[11] When states do not have a dental benefit, Medicaid programs still pay the price in preventable emergency department visits for dental problems.[12] Moreover, adult dental care is persistently threatened in times of budget shortfall due to its "optional" nature.

This year, states can now mandate insurance plans on Healthcare Exchanges provide adult dental care as an Essential Health Benefit.[13] The American Dental Association itself passed a resolution in 2020 confirming that dental care was essential healthcare.[14] If dental care is an essential benefit for low-income children and the privately insured, low-income adults must have the same right to health care. In addition, low-income adults find jobs more easily when they have access to dental care,[15] and low-income women exposed to fluoride, a proxy for good dentition, make $0.04 more on the dollar compared to women in nonfluoridated communities.[16] Untreated dental disease results in missed school for low-income children and missed work (and potentially job loss) for their parents, trapping people in a cycle of poverty.[17,18] Medicaid dental coverage is an investment that allows low-income families to thrive, and a cost-effective one at that.[19]

Medicaid dental coverage is often criticized as providing insufficient reimbursement rates for dental providers; fewer than 40% of dentists nationwide accept Medicaid, even for children; only a fraction of these dentists care for more than 10 Medicaid patients every year.[20,21] While ensuring dentists can feasibly accept Medicaid is a critical component of program implementation, states' rate of Medicaid dental reimbursement relative to private plans is *not* associated with rates of Medicaid dentist acceptance.[22] Something other than price is driving dentists to deny care to low-income people.

2. Medicare must cover dental care.
Medicare has been barred from providing a dental benefit since 1965, causing substantial harms to seniors and people with disabilities.[23] This must be reversed. Fewer than half of Medicare beneficiaries see a dentist each year;[24] when they do, they spend more than $1000 out-of-pocket on their care.[25] Patients delay dental care due to cost more than any other healthcare service.[26] The Congressional Budget Office estimated that a universal Medicare dental benefit would cost $23.8 billion per year,[27] less than the cost to Medicare of the single discontinued Alzheimer's drug Aduhelm (aducanumab).[28] This estimate does not take into account the potential cost savings that would stem from reductions in pneumonia hospitalizations,[29–32] fewer complications

of cancer treatment,[33,34] lower rates of frailty and malnutrition,[35,36] and the long-term benefits of preventive care.[37]

Starting in 2023, Medicare will now cover some limited dental benefits for Medicare beneficiaries with specific diagnoses, such as those being evaluated for organ transplant, undergoing cardiac surgery, or receiving chemotherapy. While this represents tremendous progress, these benefits do not represent comprehensive dental care and will likely impact fewer than 10% of all beneficiaries.[38]

Dental plans are often a draw for beneficiaries to choose Medicare Advantage, and dental benefits are the most advertised supplemental benefit MA plans offer.[39] Though 98% of Medicare Advantage beneficiaries are enrolled in a plan that reportedly offers a dental benefit,[40] my research has shown they have equivalently low rates of dental access and equally high out-of-pocket costs;[24] Medicare Advantage is *not* the solution.

3. The evolution of dental care delivery must be a national priority.

Oral health research and innovation have lagged behind that in the rest of medicine. CMS only appointed its first Chief Dental Officer in 2021.[41] To further scale up and implement the amazing progress the Office has achieved, such as the new limited Medicare dental benefit, CMS must increase its infrastructure and resources to match the 4% of healthcare costs that are spent on dental care.[1] It is intuitive that dental care is important to overall health and well-being, and numerous observational studies have identified potential benefits to health outcomes and healthcare costs if dental care is provided.[42,43] Yet without sufficient research funding through the NIH, AHRQ, and elsewhere, the clinical trials, bench research, and sophisticated secondary data analysis needed to determine a causal link between oral and systemic health cannot occur. And across federal agencies, oral health information should be included on surveys or collected in administrative data. Several of the most frequently used nationally representative surveys include fatal methodologic flaws in their oral health data[9] or do not collect any oral health data at all. Dental claims data is inconsistently reported to CMS, making policy evaluation, such as determining what dental benefits are provided by Medicare Advantage plans, nearly impossible.

Dental therapists, a dental provider equivalent to a Physician Assistant or Nurse Practitioner, can expand the dental team and bring care to communities failed by the current system. Operating in more than 50 countries for over a century,[44] dental teams including dental therapists have been shown to be safe and highly effective, reducing rates of decay compared to dentists alone.[45] The adoption of dental therapy in the United States has been driven by Indigenous leaders. Alaska Native healthcare systems were the first to implement dental therapy in the United States, and Iḷisaġvik College offered the first dental therapy program in the country.[46] Though dental therapy legislation has now been passed in several states, onerous training requirements instituted through dental association lobbying have defanged the potential of this new profession, with

dental therapists numbering in only the hundreds nationwide.[47] This vociferous opposition flies in the face of the documented benefits to patients and the economic simulations that demonstrate that employing a dental therapist would be profit-generating for dentists while allowing them to care for more low-income patients.[48] Nonetheless, Tribal Nations continue to advocate for the expansion of dental therapy programs through the Indian Health Service Community Health Aide Program; federal support could result in more dental therapy training programs, standardized national training and supervision requirements, and pilot programs in Indian Health Service, Veterans' Affairs, and other federal healthcare sites.

I should note that organized dentistry has repeatedly lobbied against all of the above policies, dating back to the Social Security Act of 1965.[49,50] Its lobbying protects the financial interests of dentists as small business owners, not the oral health of patients and communities. And it does not speak for all dentists. Some dentists and dental organizations have been vocal in supporting policy changes that would bring oral health to all, such as the National Dental Association.[51] Younger dentists are more likely to work outside the traditional owner-operator setting and are perhaps more likely to embrace the evolution of the field.[52,53] And even the American Dental Association has moved towards supporting some coverage for dental care within Medicare, producing a toolkit for member dentists[54] Yet overall, dentistry has been unable, or unwilling, to change itself to serve the needs of more Americans. Change will need to come from outside.

Both my medical and dental patients have asked me the same question: why is dentistry so separate? Why is it so hard for me to access and afford dental care? I tell them that there is no good reason. There is no good reason why we live in a country where low-income Americans are 16 times more likely to lose all their teeth than their wealthier neighbors. It simply isn't fair. My patients deserve better. Our country deserves better. Thank you for helping us achieve it.

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[SUMMARY STATEMENT OF LISA SIMON]

I speak in support of Senator Sanders' Comprehensive Dental Reform Act.

Practicing as a dentist in a community health center broke my heart. I will never forget the young woman my own age whose front teeth were so badly decayed that they all needed to be removed—this remarkable young mother gave me a gift (that she could barely afford) to thank me for trying to save them, even though she was left with a smile that would make it more difficult for her to eat, speak, or find work.

It was patients like her who inspired me to enter medical school and work on the crisis in oral health from "both sides of the aisle." Now as an internal medicine physician, I see even more unmet dental need than I did practicing dentistry—I see the patients who never make it to a dental office. I have cared for patients in the intensive care unit with life-threatening sepsis from a tooth infection. I have met patients who cannot start chemotherapy because they can't afford to remove their infected teeth. I have met patients with nutrient deficiencies from ill-fitting dentures. And I have met patients who, even knowing that I am a doctor and a dentist, are so ashamed of their teeth that they won't let me look in their mouths.

I wish to highlight the following policies that could dramatically improve oral health in the U.S.:

> First, make adult dental coverage a mandatory Medicaid benefit. These benefits are persistently threatened in times of budget shortfall due to their "optional" nature, even though data confirms that Medicaid dental coverage can increase access to jobs for beneficiaries, to say nothing of decreasing preventable suffering.
>
> Next, Medicare must cover dental care. A truly comprehensive Medicare dental plan has been estimated to cost less than a single Alzheimer's medication; and this does not include the cost savings of offering preventive care that keeps people healthy.
>
> Last, we must make the evolution of dental care a national priority through workforce expansion, increased research funding, CMS infrastructure and program evaluation, and better oral health data collection.

I should note that much of organized dentistry has repeatedly lobbied against these policies, dating back to 1965. It defends the status quo of small business owners, not the oral health of patients and communities. It does not speak for all dentists. Yet dentistry has been unable, or unwilling, to change itself to serve the needs of more Americans.

Both my medical and dental patients ask me the same question: Why is it so hard for me to get dental care? There is no good reason. There is no good reason why we live in a country where low-income Americans are 16 times more likely to lose all their teeth than their wealthier neighbors. It simply isn't fair. My patients deserve better. Our Country deserves better. Thank you for helping us achieve it.

The CHAIR. Dr. Simon, thank you very much. Our next witness is Dr. Myechia Minter-Jordan, the president, and CEO of the Care Quest Institute for Oral Health in Boston. Dr. Mitten-Jordan is a physician and researcher and leads the team to improve the oral health of all the research health improvement programs, policy, and education.

Dr. Minter-Jordan, thanks so much for being with us.

STATEMENT OF MYECHIA MINTER-JORDAN, M.D., MBA, PRESIDENT AND CEO CAREQUEST INSTITUTE FOR ORAL HEALTH, BOSTON, MA

Dr. MINTER-JORDAN. Thank you, Chairman Sanders, Ranking Member Cassidy, and Members of the Committee. Thank you for holding this hearing on a critical issue that deserves urgent action. It is encouraging that policymakers like yourselves are increasingly looking for ways to improve oral health policy. We are particularly grateful to you, Senator Sanders, for your leadership and reintro-

duction of the Comprehensive Dental Reform Act. And thank you Senator Cassidy, Greater Baton Rouge Community Clinic is a critical access point for oral healthcare.

My name is Dr. Myechia Minter-Jordan. I'm the president and CEO of the Care Quest Institute for Oral Health. Our mission is to create a more equitable, accessible, and integrated health system for everyone.

I'm here today to share my expertise as a physician and community leader dedicated to improving healthcare for all people. I'm an internist and previously served as Chief Medical Officer and CEO of the Demic Center, one of the largest community health centers in Massachusetts.

It was during my time at the Demic Center that I truly understood the impact of oral disease on people's lives. The severity of oral disease that several of our Head Start children experienced meant that children as young as 3 years old were put under anesthesia in order to remove decay and repair and stop the progression of their oral health disease.

Oral health is so much more than a nice smile. It has far-reaching impacts on overall health. Hypertension, diabetes, heart disease, dementia, and adverse birth outcomes all have a direct correlation to oral health.

Dental disease can also threaten family financial stability as well as state and Federal healthcare budgets. It can keep children home from school and adults from being able to work. It can cause pain so severe that people cannot eat or conduct their routine activities of daily living. In fact, lost work productivity time due to untreated dental disease cost the U.S. an estimated $45 billion each year.

Yet oral health remains siloed from the rest of the healthcare system. Millions of people cannot access their oral healthcare that they need most often because they cannot afford it. Delays in care likely cost the system far more than a routine preventative visit would have. Dental care is the No. 1 medical service skipped due to cost, even more than prescription drugs.

Nearly 70 million adults in the United States do not have dental insurance. Medicare does not cover routine dental care, leaving half of Medicare enrollees, nearly 25 million older Americans and people with disabilities without dental benefits. There is currently no financial support for adults to purchase dental insurance through the health insurance marketplace. And adult dental coverage is optional under state Medicaid programs, which means that coverage varies widely from extensive benefits to none at all.

Dental coverage gaps have exacerbated a nationwide oral health crisis that forces many people to forego critical dental care.

Quest Institute for Oral Health conducts an annual nationally representative survey on consumer access to, experience with, and knowledge about healthcare. Our findings continue to show that this crisis is widespread and disproportionately impacts low-income individuals, people in rural communities and racial and ethnic minorities.

For example, adults with lower incomes are significantly more likely than those with higher incomes to report costs as a barrier

to seeing a dentist. In the last 2 years, 34 percent of individuals living in a rural environment rate their oral health as fair or poor, which is about 10 percent higher than for people in urban and suburban areas. And Black adults are 68 percent more likely to have an unmet dental need than white adults. Prevalence of early childhood tooth decay in American Indian and Alaskan native communities is three times higher than it is for white children.

Progress is being made, private and public payers are increasingly recognizing the positive impact on overall health outcomes and reduction in the total cost of care that routine oral healthcare can offer.

Addressing coverage gaps is a foundational step toward a more integrated system that allows us to invest in prevention, bolster the oral health workforce, and improve the exchange of health information between medical and dental providers.

Integration not only improves the care experience, it reduces cost. For instance, care Quest Institute research shows that healthcare costs for adults with diabetes could be $3,000 less each year if they get periodontal treatment. Think about how much that would save if the nearly 40 million people in this country with diabetes all had access to integrated care that includes dental.

We have the model, look at the integration we achieve in many of our Nation's community health centers, and the progress we have made with primary care and behavioral health. It is time to bring that to oral health. The data continues to tell an unacceptable story, not only in terms of the impact on oral health status, but also on overall health outcomes.

It is time to change this story. It is up to all of us, the policymakers in this room, providers, educators, and advocates to create a more accessible, equitable and integrated healthcare system. Thank you for having me here today. It is an honor.

[The prepared statement of Dr. Minter-Jordan follows.]

PREPARED STATEMENT OF MYECHIA MINTER-JORDAN

Introduction

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee thank you for having me here today and holding this hearing on a critical issue that has been overlooked for far too long.

My name is Myechia Minter-Jordan, M.D., MBA, and I am the president and CEO of the CareQuest Institute for Oral Health. I previously served as chief medical officer and CEO of the Dimock Center, one of the largest community health centers in Massachusetts, and at Johns Hopkins Medicine as an attending physician and instructor of medicine. I am here today to share my expertise as a physician and community leader dedicated to improving health care for all people.

During my time at Dimock, I witnessed the devastating consequences of oral disease on children who were part of our Head Start/Early Head Start program. The severity of disease that our young participants were experiencing—some as young as 3 years old—meant that these children were sedated with anesthesia to perform the level of restorative care needed to remove tooth decay and halt the progression of the disease.

That was a moment of reckoning for me. It was unacceptable that a preventable disease was impacting our children in this way. This experience is what ultimately led me to my work at CareQuest Institute.

At CareQuest Institute, our dedicated team of experts is committed to creating a more accessible, equitable, and integrated health system for everyone. We are

championing a more equitable future where every person has access to high-quality oral health care and can reach their full potential through excellent health.

Right now, our health care system does not work for everyone because it was not built for everyone—people of color, people with lower incomes, those living in rural communities, people with disabilities, older adults, and other historically marginalized groups have been left behind. Further, our health care system and health insurance policies still largely treat the mouth as separate from the rest of the body, leaving oral health care unaffordable and out of reach for millions of Americans.

However, we are making progress.

Investments and advancements in research have ensured that today, we have a much stronger clinical understanding of all the ways oral health impacts our overall health and well-being. CareQuest Institute and other leaders in the field are leveraging this clinical knowledge to design, pilot, and scale validated models of integrated care.

Oral health is also increasingly part of health policy conversations. This hearing is proof of that.

Oral health has been more directly tied into policy discussions around lowering health care costs, improving health, and advancing equity than ever before. In fact, over the last 3 years, we've experienced some of the most productive and effective policy discussions in decades, including key improvements made by our current Administration regarding Medicare and the essential health benefits in the health insurance Marketplaces.

While this momentum is encouraging, the fact remains that we have an oral health crisis in this country. It is time to build on the recent momentum and identify opportunities to address the most significant barriers to oral health.

National Oral Health Crisis: Impact on American Families

CareQuest Institute for Oral Health conducts an annual, nationally representative survey on consumer access to, experience with, and knowledge about oral health care. Between this survey, our other consumer-focused research, and analyses by additional leaders in the field, findings continue to show that this crisis is widespread, and disproportionately impacts low-income individuals, older adults, people living with disabilities, people in rural communities, and racial and ethnic minorities. For example:

- Adults with lower incomes are significantly more likely than those with higher incomes to report cost as a barrier to seeing a dentist in the last 2 years. [1]
- When people from lower-income families are able to access dental care, they are paying over seven times more out-of-pocket for their dental care than higher-income families. [2]
- One in five adults aged 65 years or older have untreated tooth decay and about 2 in 3 (68 percent) have gum disease. [3], [4]
- Individuals in households experiencing disabilities are more frequently denied health care or oral health care due to discrimination—more than half (52.8 percent) compared to 36.9 percent in households not experiencing disability and visit the emergency department for dental care or pain three times more compared to households not experiencing disability. [5]

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- Thirty four percent of individuals living in a rural environment rate their oral health as fair or poor, which is about 10 percent higher than for people in urban and suburban areas. [6]
- Four in 10 adults in rural areas have not seen a dentist for over a year, which is about 10 percent higher than in urban and suburban areas. [6]
- Black adults are 68 percent more likely to have an unmet dental need than white adults, and the prevalence of early childhood tooth decay in American Indian and Alaska Native communities is three times higher than it is for white children. [7], [8]
- Black and Hispanic adults report that they have never been to a dentist at more than twice the rate of white adults. [9]

So much more than a nice smile, oral health has significant impacts [10] on overall health and well-being. Hypertension, diabetes, heart disease, dementia, and adverse birth outcomes all have a direct correlation with oral health.

Dental disease can also threaten family financial stability; it can keep children home from school and adults from being able to work; [11] it can cause pain so debilitating that people cannot eat or conduct routine activities of daily living.

For example:

- About half of adults with health care debt (49 percent) say dental bills caused some of their debt. [12]
- Adults in the U.S. miss more than 243 million hours of work or school each year due to oral health problems and children lose 34 million school hours each year because of unplanned (emergency) dental care. [13], [14]
- Lost work productivity time due to untreated dental disease costs the U.S. an estimated $45 billion each year. [15]
- Nearly 18 percent of all working-age adults and 29 percent of those with lower incomes report that the appearance of their mouth and teeth affects their ability to interview for a job. [16]

This crisis has far-reaching consequences for American families.

National Oral Health Crisis Stems from Barriers to Affordability and Lack of Coverage

The fact that dental coverage and care remain largely separate from medical has had a profound impact on affordability and access to services. Millions of people across the country cannot access the oral health care they need, most often because

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[17] CareQuest Institute for Oral Health. *Oral Disease is Common. Access to Care is Not*. Boston, MA:July 2021.

they cannot afford it.[17] In fact, dental care is the No. 1 medical service skipped due to cost, even more than prescription drugs.[18]

Nearly 70 million adults and nearly 8 million children in the United States do not have dental insurance.[19],[20] This is in large part because:

- Traditional Medicare doesn't cover dental services except under very specific and extreme circumstances. As a result, half of all Medicare enrollees don't have dental coverage, meaning nearly 25 million older Americans and people with disabilities lack access to this critical form of health care.[21] Around the same number of Medicare enrollees haven't visited a dentist in 12 months.[21] While people who have Medicare Advantage may get some dental coverage, the benefits can vary widely from plan to plan, and they may come with limited provider networks.[21]
- CareQuest Institute for Oral Health estimates that there are about 14.7 million people who purchase health insurance through the Marketplace, but still do not have or are not able to purchase dental coverage.[22] Many people have financial support to purchase health insurance coverage through their state's Marketplace but are not allowed to use that subsidy toward dental benefits for adults. While states can now change that through a new rule that allows adult dental services to be included as Essential Health Benefits, we know only some states will choose to do so.[23] Additionally, if an individual has health insurance but not dental insurance, (e.g. through their employer) they cannot independently purchase a dental plan through their state marketplace even if they can afford to do so.[24]
- Most states do not offer the extensive Medicaid dental benefits that adults need to maintain optimal oral health.[25] Adult dental coverage is optional for state Medicaid programs, and many states provide no, little, or emergency-only coverage.[26] Even when a state does provide adult dental coverage, the benefits are always at risk of reduction or elimination, especially during economic downturns when states face budget pres-

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[27] CareQuest Institute for Oral Health. *An Estimated 12 Million Children and Adults Lost Medicaid Dental Insurance After the COVID–19 Public Health Emergency Expired*. Boston, MA: CareQuest Institute, March 2024.

[28] Heaton, Lisa J., Tiwari, Tamanna, Tranby, Eric P. CareQuest Institute for Oral Health. *Oral-Systemic Interactions and Medical-Dental Integration: A Life Course Approach*. Boston, MA: CareQuest Institute, September 2023. *https://doi.org/10.35565/CQI.2023.2010*.

sures.[28] This patchwork approach creates uncertainty among patients and providers, reduces access, and impacts health outcomes. Moreover, the recent Medicaid redetermination process has resulted in millions of people losing their health coverage, including dental coverage, often unnecessarily. Our analysis shows that 12 million adults and children nationwide lost Medicaid dental coverage in 2023.[27]

The lack of dental coverage options exacerbates our national oral health crisis and forces many people to forgo critical dental care, leading to deep inequities in access and outcomes. Addressing these gaps is a critical and foundational step to realizing a health system that prioritizes prevention, bolsters the oral health workforce, integrates medical and dental care, and improves the exchange of health information between medical and dental providers.

The Economic and Health Benefits of Oral Health Prevention

If we want to truly improve overall health, we need to prevent oral health disease before it takes hold.

Access to dental care is critical for preventing oral disease and keeping other health conditions from worsening. Poor oral health has a direct link to a person's overall health, including greater risk of diabetes, hypertension, obesity, dementia, mental health issues, and adverse birth outcomes.[28] Given that there are persistent health inequities associated with many, if not all, of these conditions, preventing oral disease may also be key to tackling disparities that exist throughout our health care system.

For example, oral health prevention can have a significant impact on maternal health—another area of health care experiencing devastating disparities in outcomes. Research shows that maternal periodontal (gum) disease is associated with preterm birth, development of preeclampsia (maternal high blood pressure), and delivery of a small-for-gestational age infant.

Conversely, studies show that periodontal treatment for pregnant women can result in a nearly four-fold reduction in the rate of preterm delivery.[29]

Prevention also results in clear cost savings for the health system—including the Federal Government. For example, preventing and appropriately addressing oral disease keeps people out of emergency rooms. Dental-related ED visits nationwide cost an estimated $2.1 billion per year, but nearly 79 percent of those visits could've been addressed in a dental office, saving up to $1.7 billion per year.[30]

Similarly, appropriate oral health care can also improve overall health outcomes and lead to cost savings on medical expenses. For example, CareQuest Institute researchers found that periodontal treatment for people with diabetes can reduce overall health care costs by about $3000 annually, per person. This finding was applicable to both commercially insured and Medicaid enrollees with diabetes who had received periodontal treatment within the previous 2 years.[31]

There are nearly 40 million people in this country with diabetes. In Medicare alone, there is the potential to save up to $14.5 billion annually for patients with diabetes and up to $27.8 billion annually for patients with heart disease if these

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[27] CareQuest Institute for Oral Health. *An Estimated 12 Million Children and Adults Lost Medicaid Dental Insurance After the COVID–19 Public Health Emergency Expired*. Boston, MA: CareQuest Institute, March 2024.

[28] Heaton, Lisa J., Tiwari, Tamanna, Tranby, Eric P. CareQuest Institute for Oral Health. *Oral-Systemic Interactions and Medical-Dental Integration: A Life Course Approach*. Boston, MA: CareQuest Institute, September 2023. *https://doi.org/10.35565/CQI.2023.2010*.

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patients were to receive periodontal care.[32] Millions more people in this country have other comorbidities that can be improved or more effectively managed with proper oral health care resulting in significant health care savings if they all had access to necessary care.

Investing in prevention will keep oral disease from getting worse, make people healthier overall, and result in cost savings for the government.

Closing the Gap: Integrating Medical and Dental Care for Better Health Outcomes

A more integrated system allows us to invest in prevention, bolster the oral health workforce, and improve the exchange of health information between medical and dental providers. Medical-dental integration is a necessary approach to improving systems so that all providers have a full view of their patients' needs, connecting oral health care with primary care, behavioral health, and more.

Integration models can be adapted to meet the needs of communities, systems, and providers. These models include school-based dental programs, oral health screenings at a primary care visit, blood pressure screenings at a dental visit, and/or using technology like teledentistry and mobile dentistry to reach rural areas or dental deserts. Patients report wanting these kinds of integrated care options, though few have yet to experience them.[33]

Moreover, medical-dental integration can improve patients' care experiences and reduce costs. The CDC estimates that integrating basic health screenings into a dental setting could save the health care system up to **$100 million every year**.[34]

Medical-Oral Expanded Care (MORE Care) is an integration model that CareQuest Institute leads. This program builds effective interprofessional referral relationships between dentists and primary care providers.[35] For example, a pediatrician at nationwide Children's Hospital in Ohio is integrating oral health screenings into well-child visits as part of her participation in MORE Care, a practice that is surprisingly uncommon. Through this model, the pediatrician assesses the child's teeth for signs of cavities and checks to see if the child has seen a dentist or received a fluoride varnish application. When the screenings indicate that the patient needs more extensive oral health care, she can effectively refer her patients to a dentist at Midwest Dental Center in Toledo, Ohio.[36]

Oftentimes, this form of integrated care connects children to preventative oral health services sooner than if their parents waited until their next dental visit or until their condition worsened to seek care. This model also helps educate parents about the importance of oral health for children, even at an early age.

While integration can, and often should, take many different forms, an essential component of any integrated model must be the safe and secure sharing of relevant health information with a patient's full care team. This both encourages and enables providers to develop comprehensive care plans that address patients' needs in an interdisciplinary way.

We have the model for success. Just look at what we have achieved in so many of our Nation's community health centers and pilot programs, and how far we have come in connecting primary care and behavioral health. It is time to invest in and scale that model to include oral health.

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[32] Heaton, Lisa J., Leonin, Elizabeth, Schroeder, Kelly, Tranby, Eric P., Matthew, Rebekah. *Another Billion Reasons for a Medicare Dental Benefit*. Boston, MA: CareQuest Institute, September 2022. *https://doi.org/10.35565/CQI.2022.2006*.

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It's Time to Change the Story

Improvements are being made, but the data continue to tell an unacceptable story—not only in terms of the impact on oral health status but also on overall health outcomes.

The data demonstrates, and our experience tells us, that this is a systemic problem that requires a systemic solution.

No story better illustrates the tragic outcome of a fragmented and disjointed system than Deamonte Driver's.

Many of you may be familiar with Deamonte's story, but for those who are not, Deamonte Driver died from a toothache. He was 12 years old.

It sounds implausible, but that is exactly what happened.

Deamonte couldn't get the basic oral health care he needed to treat his tooth decay. Eventually, bacteria from his abscessed tooth spread to his brain, and that infection killed him after 6 weeks in the hospital.

That was 17 years ago, and while some things have changed in response to this unnecessary tragedy, particularly in children's oral health policy, we are still grappling with many of the same systemic issues that Deamonte and his family faced and continue to face today.

Social determinants of health, lack of consistent coverage, not being able to find a dental provider, and many more factors all contributed to Deamonte's death.

It's time to change the story. It's up to all of us—the policymakers in this room, providers, educators, and advocates to create a more accessible, equitable, and integrated oral health care system.

The time is now.

[SUMMARY STATEMENT OF MYECHIA MINTER-JORDAN]

I am the president and CEO of the CareQuest Institute for Oral Health, where our mission is to create a more accessible, equitable, and integrated health system for everyone. I am here today to share my expertise as a physician and community leader dedicated to improving health care for all people.

Oral health is so much more than just a nice smile. It has far-reaching impacts on overall health. Hypertension, diabetes, heart disease, dementia, and adverse birth outcomes all have a direct correlation to oral health. Dental disease can also threaten family financial stability as well as state and Federal health care budgets; it can keep children home from school and adults from being able to work; it can cause pain so severe that people cannot eat or conduct routine activities of daily living.

CareQuest Institute for Oral Health conducts an annual, nationally representative survey on consumer access to, experience with, and knowledge about oral health care. Our findings, as discussed in my oral and written testimonies, continue to show that this crisis is widespread, and disproportionately impacts low-income individuals, people in rural communities, and racial and ethnic minorities. These findings also show that dental coverage gaps have exacerbated a nationwide oral health crisis that forces many people to forgo critical dental care.

While the situation is dire, progress is being made, and that momentum is encouraging. Private and public payers are increasingly recognizing the positive impact on overall health outcomes and reduction in the total cost of care that routine oral health care can offer. Medical and dental providers are looking for ways to effectively collaborate. And encouragingly, policymakers are talking about these issues more than ever and taking steps toward change. It's up to all of us—the policymakers in this room, providers, educators, and advocates to create a more accessible, equitable, and integrated health care system that includes oral health.

The CHAIR. Thank you very much for your testimony and your work.

Our next witness is Dr. Brian Jeffrey Swann, a dentist who serves in the board of directors of Remote Area Medical, a volunteer organization that provides pop-up medical clinics around the United States offering dental, vision and general medical care at no

cost to patients. Dr. Swann is also co-chair of the global Oral health outreach at the National Dental Association.

Dr. Swann, thanks a lot for being with us.

STATEMENT OF BRIAN JEFFREY SWANN, DMD, MPH, BOARD OF, DIRECTORS, REMOTE AREA MEDICAL (RAM), CO-CHAIR, GLOBAL ORAL HEALTH OUTREACH, NATIONAL DENTAL ASSOCIATION, ROCKFORD, TN

Dr. SWANN. It's my pleasure. Thank you, Chairman Sanders, and Ranking Member, Dr. Bill Cassidy. It's a pleasure to be here with the HELP Committee.

The CHAIR. If you could talk a little bit louder, it would be great.

Dr. SWANN. My name is Brian Swann. I'm testifying today as a former private and now public health trained oral physician practicing in Tennessee, North Carolina, and Massachusetts. My primary residence is East Tennessee in a small town called Greenback, not far from where I was born. When I was 7 years old, my family moved to California. Starting as a cleaning lady for affluent white families, my mother eventually enrolled and completed dental assisting courses. At age 12, I had my first general visit with my mother's employer, the only Black dentist in the area. He diagnosed me with 13 cavities. All in need of intervention.

I often ponder my complex pathway to oral healthcare and the sometimes torturous or frankly impossible path, many in this country are faced to navigate in search of dental care. Today I serve on the board of the Remote Area of Medical, as well as co-chair of the Committee on Global Health and Outreach for the National Dental Association.

RAM is a major nonprofit provider for these pop-up medical clinics, and the mission is to prevent pain and alleviate suffering by providing free dental, vision, medical and dental services to underserved and uninsured individuals. RAM's core is more than 200,000 humanitarian volunteers. Along with licensed dentist, vision, and medical professionals, they have treated more than 900,000 individuals and delivered more than $200 million worth of healthcare services. Today, RAM is nearing its 1400th clinic.

It also partners with organizations striving to make a positive change regarding access to care. One of these organizations, RAM partners with is the National Dental Association, whose mission is to serve marginalized and oppressed communities. And also, was the Dental Association in 1965 that argued that Medicare should include dental care.

The people that come to RAM for assistance often drive across two or three state lines, sleeping in their cars, wrapped in blankets to stay warm. Many people come days before the clinic just to ensure that they get a ticket. Patients suffer from cavities from gum disease, and this is concerning due to the interplay of gum disease and diabetes.

Nowhere can the necessity of RAM be more seen than the story of Jade, who I've had permission from her mother to talk about her case. She was a 27-year-old Appalachian woman with a history of type one diabetes that led to placement of a port after two thirds

of her right lung had been removed. She developed swelling called cellulitis under her chin and neck region from a decayed infected lower molar.

Due to the swelling and pain, lack of dental care, she did what many patients do, and that was to visit the emergency department at the local hospital. She was given antibiotics and pain medication, in the form of pills, and then went to seek dental care.

She went to see the local dentist who had recently extracted all of her mom's teeth and was told that $900 was the cost to remove this one offending tooth. Not having the cash, she decided to wait the anticipated refund check. The following month swelling had advanced and she was prescribed more of the same medications, which is an antibiotic and opioid which alleviated symptoms but not treat the problem. In the third month, she contracted COVID, which impaired her breathing even more. She was given yet more antibiotics and pain medication, which she could no longer swallow.

The following month, she returned to the hospital unable to swallow her neck, her neck had turned black. The doctors immediately put her in an ambulance and rushed her to a nearby university hospital, only 35 minutes away where she was given antibiotics through an IV and the tooth was removed. Sadly, 2 days later, she died. The cause of death was listed as sepsis from an infected tooth derived from a condition called Ludwig's angina.

As this is typical in the U.S. medical schools, the hospital doctors had not received even limited training in oral health, which may have contributed to Jade's death. Her mother and her husband of 1 year, who are now in therapy proclaimed, if they had only told us that a tooth infection could kill my daughter.

There is need to bring attention to the social determinants of health and begin the process of educating not only patients, but the community and all professionals on what is needed for sustainability and longevity of our oral and systemic health. RAM presents an immediate short-term solution to a long-term problem.

Prevention, education. A high percentage of our patients have low health IQ, not understanding what's happening to the oral cavity and how it's connected and contributes to what's happening in the rest of the body. Specific dental education should be provided to patients during all touchpoint, enhanced digitization as well.

We need to increase the number of states who provide non-emergency adult Medicaid services, which usually is medication and or an extraction. And the logistics for that needs to come from more dental associations, not only the NDA. RAM is also concerned about temporary state licenses for volunteer work, which would apply to dentist hygienists and assistants. This will resolve the dearth of state licensed healthcare providers and open the doors to healthcare providers licensed in other states to volunteer and provide care at RAM events.

I went to the dental field inspired by my mother. Over the years, working with RAM and the NDA, I have seen personally the human connection when a human being comes into these clinics for treatment, most often to escape pain and discomfort and is treated with respect. In the process, immense gratitude is felt, but not just

for the patient, for everyone involved. We all receive a blessing in this exchange, and this is work. The history can be made today, but there needs to be a shift.

[The prepared statement of Dr. Swann follows.]

PREPARED STATEMENT OF BRIAN SWANN

Greetings Chairman Sanders, Ranking Member Bill Cassidy, M.D., and Members of the Committee.

Thank you for this opportunity to appear before this Committee to discuss the causes and results of oral health shortages in The United States of America.

About Me

My name is Brian Jeffery Swann, testifying as an Oral Physician practicing in Tennessee, North Carolina, and Massachusetts in public health capacity. I am a board member of Remote Area Medicine (RAM), and a member and co-chair of the Committee on Global Oral Health Outreach for the National Dental Association. I provide clinical care as a volunteer with the RAM organization. Over 900,000 patients have received treatment at no cost.

I reside in an Appalachian town of Greenback, Tennessee not far from where I was born. I was inspired to become a dentist through my Mother, who was a dental assistant and a community advocate. After her passing in 2018, she was memorialized in the California House of Representatives for her contributions to health and education. At age 12, I had my first dental visit. I had 13 cavities and spent numerous days as a patient and for the exposure. The independence of the dentist and his contribution to the community resonated with me as a career choice and saved my dentition. I was not aware of the significance at the time, but it was a crossroad.

After her passing in 2018, she was memorialized in the California House of Representatives for her contributions to health and education.

About RAM

RAM is a major nonprofit provider of free pop-up medical clinics. The mission is to prevent pain and alleviate suffering by providing free, quality health care to those in need. We do this by delivering free dental, vision, and medical services to undeserved and uninsured individuals. RAM's Corps of more than 212,700 Humanitarian Volunteers along with licensed dental, vision, and medical professionals have treated more than 940,700 individuals, delivering over $200,000,000 worth of health care services. Today, RAM is nearing its 1400th clinic. RAM also partners with other organizations striving to make a positive change in access to care. One of the organizations RAM partners with is The National Dental Association.

NDA/Harvard School of Dental Medicine

Founded in 1913, The National Dental Association's mission is to serve the marginalized and oppressed communities. I co-chair the global outreach committee which focuses on those marginalized and oppressed communities that have a shortage of dental care. Our aim includes mobilizing students and practicing dentists to join forces with existing interventions and outreach programs to provide needed care. This also serves as a teaching opportunity for student members.

As an assistant professor at the Harvard School of Dental Medicine, my students and I were introduced to the Medicine Wheel. The wheel charts the ingredients of optimal health. This tool combined with the fact that John Harvard who started America's first college, also began one of its first Indian Schools. Revisiting these facts, we began a program with the Wampanoag tribe that historically greeted the Pilgrims on Cape Cod. Specifically, we were drawn to the Aquinnah Wampanoag tribe on Martha's Vineyard (MVI).

In addition to Martha's Vineyard being home to many wealthy families in America, its original inhabitants have lived there between 10 to 14,000 years. Relative to dental treatment, the Island represents a microcosm of how dentistry looks across the Nation. In 2013, the Martha's Vineyard hospital had a two (dental) operatory clinic which excepted dental benefits or insurances. All other dental offices on the island were cash only; they did not except any insurances. With the closure of the hospital dental clinic in 2020, a significant number of the year-round residents, including blue-collar workers and tribal members, had to go off island, a multiple hour, weather dependent journey each way, to seek affordable care. This neces-

sitates an entire day off from work or school for an appointment that might last an hour. This is a prime example of the issues surrounding the complexity and unavailability of access to care. The social determinants of health that apply to this example include, rural location, transportation, affordability, elderly age of the population and the limited workforce. Adding to the issues of cost, when providers do not accept dental insurance there is no regulation of fees charged to the patients. In some cases, prices exceed mainland averages by 30 percent.

The NEED

The need for organizations like RAM and its partners, are more than necessary to continue to make change, and to support human beings and their basic rights to be cared for. RAM provides opportunities for people to experience relief from various ailments that can be life changing. The people that come to RAM for assistance, often drive across multiple stateliness. They are advised to prepare to sleep in their cars, wrapped in blankets to stay warm. Many come days before the clinic opens to ensure that they receive a ticket to get the care they have come so far to obtain. Our patients suffer from the most prominent oral diseases, tooth decay and periodontal (gum) disease, which are the most prevalent diseases worldwide among children and adults according to the 2019 Global Burden of Diseases report. Also mentioned in this report is the connection between gum disease and Type 2 Diabetes along with other systemic illnesses including obesity, poor nutrition, kidney disease, lung disease, dementia, cancer, osteoarthritis, and heart disease. A high percentage of patients with a low health IQ, do not understand that what is happening in the oral cavity is connected to and may contribute to what is happening in the rest of their body. Preventive education is key.

Jade's Story

Jade was a 27-year-old, Appalachian woman with a history of type 2 diabetes that led to placement of a port after 2/3 of her right lung was removed. She developed swelling called cellulitis under her chin and neck region from a decayed and infected lower molar. Due to the swelling and pain and lacking a dental home, she did what many patients do and visited the emergency department at the local hospital for care. She was given antibiotics and pain medication in the form of pills and told to seek dental care. She went to the dentist (who had recently extracted all her mother's teeth) and was told that $900 was the cost to remove the one offending tooth. Not having the cash, she decided to wait for an anticipated refund check. The following month the swelling had advanced, and she was prescribed more of the same medications which alleviated symptoms but did not treat the problem. In the 3rd month she contracted COVID which impaired her breathing even more.

Jade was given yet more antibiotics and pain medication which she could no longer swallow. The following month, she returned to the hospital a fourth time, unable to swallow. Her neck had turned black. The doctors immediately put her in an ambulance and rushed her to a nearby university hospital only 35 minutes away where she was given an IV and the tooth was removed. Two days later, she died. The cause of death was listed as sepsis from an infected tooth derived from a condition called Ludwig's Angina. As is typical in U.S. medical schools, the hospital doctors had not received even limited training in oral health, which may have contributed to Jade's death. Her mother and husband of 1 year, who are in therapy, proclaimed, "If they'd only told us that a tooth infection could kill my daughter."

There is a need to bring attention to the social determinants of health and begin the process of educating not only patients, but the community and all health professionals on what is needed for sustainability and longevity of our oral and systemic health.

PREVENTION:

RAM represents an immediate short-term solution to a long-term problem. It creates a community template that could potentially become a sustainable entity. Prevention is the long-term solution. When the community begins to provide health access, care, and education for marginalized communities, the potential for that community to become healthier and more productive is attainable. RAM essentially provides a blueprint for change and positive impact.

RAM clinics go where they are invited. Volunteers from that community, are mobilized to provide the staffing services, which includes processing of patients, dispensing of medications and related information, controlling the influx of patients, sterilization of instruments, and most importantly greeting patients at the entrance

with a warm and welcoming hello. Due to the lack of portability of licensed providers, sometimes services are hindered. There is often a lack of state-licensed healthcare providers in a given community. If we were able to open the doors to healthcare providers licensed in neighboring states, it would save time and more patients could be treated. A possible solution to this would be to allow temporary licenses for voluntary dentists, hygienists, and assistants.

My Own Experience with RAM

From my own experience working onsite, the first encounter between a RAM volunteer or provider and the patient, is most important. That moment is where the healing begins. I've had several encounters with patients who are overjoyed to see their smiles for the first time in years, or even to get a tooth or teeth pulled after a long battle of aches and pains.

Farmer's Story

I had a patient who was a disabled farmer, as it is the second most dangerous profession in America. He'd driven across 3 states to get to us. He was self-conscious about possibly having an odor due to sleeping in his car. He needed to have several broken teeth removed and a few teeth filled. We anesthetized him and used a technique that made the injection relatively painless. He seemed surprised; his worry and fear around this visit had dissipated. We didn't have to pull as many teeth as he thought. He was happy that some of his teeth could be saved. When the procedure was over, he shook my hand. He was so grateful that he had such a good encounter that he offered up a prayer to give thanks for the experience. He said he appreciated being validated and not condemned. We all shed a tear.

Human Connection

When a human being comes to these clinics for treatment, most often to escape pain or discomfort, and is treated with respect in the process, immense gratitude is felt. But not just for the patient, for everyone involved. We all receive a blessing in this exchange and in this work.

[SUMMARY STATEMENT OF BRIAN SWANN]

Greetings Chairman Sanders, Ranking Member Bill Cassidy, M.D., and Members of the HELP Committee. Thank you for this opportunity to appear before this Committee to discuss the results of oral health shortages in The United States of America.

My name is Brian Jeffery Swann, testifying today as a public health trained Oral Physician practicing in Tennessee, North Carolina, and Massachusetts. My primary residence is in east Tennessee in a small town called Greenback, not far from where I was born. When I was 7 years old, my family moved to California. Starting as a cleaning lady for affluent white families, my mother eventually enrolled and completed dental assisting courses. At age twelve, I had my first dental visit with my mother's employer, the only Black dentist in the area. He diagnosed me with 13 cavities all in need of intervention. I often ponder my complex pathway to oral health care and the sometimes torturous or frankly impossible path many in this country are forced to navigate in search of dental care.

Today, I serve on the board of Remote Area Medicine (RAM), as well as co-chair of the committee on global outreach for the National Dental Association. RAM is a major nonprofit provider of free pop-up medical clinics. The mission is to prevent pain and alleviate suffering by providing free dental, vision, and medical services to undeserved and uninsured individuals. RAM's Corps of more than 212,700 Humanitarian Volunteers along with licensed dental, vision, and medical professionals have treated more than 940,700 individuals, delivering over $200,000,000 worth of health care services. Today, RAM is nearing its 1400th clinic. RAM also partners with other organizations striving to make a positive change regarding access to care. One of the organizations RAM partners with is The National Dental Association.

The people that come to RAM for assistance, often drive across 2 or 3 states, sleeping in their cars, and wrapped in blankets to stay warm. Many people come days before the clinic opens, just to insure they receive a ticket. Patients suffer from cavities as well as gum disease, concerning due to the interplay of gum disease and Type 2 Diabetes. No where can the necessity of RAM be seen more than in the story of Jade.

Jade was a 27-year-old, Appalachian woman with a history of type 2 diabetes that led to placement of a port after 2/3 of her right lung was removed. She developed swelling called cellulitis under her chin and neck region from a decayed and infected lower molar. Due to the swelling and pain and lacking a dental home, she did what many patients do and visited the emergency department at the local hospital for care. She was given antibiotics and pain medication in the form of pills and told to seek dental care. She went to the dentist (who had recently extracted all her mother's teeth) and was told that $900 was the cost to remove the one offending tooth. Not having the cash, she decided to wait for an anticipated refund check. The following month the swelling had advanced, and she was prescribed more of the same medications which alleviated symptoms but did not treat the problem. In the 3rd month she contracted COVID which impaired her breathing even more. Jade was given yet more antibiotics and pain medication which she could no longer swallow. The following month, she returned to the hospital a fourth time, unable to swallow. Her neck had turned black. The doctors immediately put her in an ambulance and rushed her to a nearby university hospital only 35 minutes away where she was given an IV and the tooth was removed. Two days later, she died. The cause of death was listed as sepsis from an infected tooth derived from a condition called Ludwig's Angina. As is typical in U.S. medical schools, the hospital doctors had not received even limited training in oral health, which may have contributed to Jade's death. Her mother and husband of 1 year, who are in therapy, proclaimed, "If they'd only told us that a tooth infection could kill my daughter."

There is a need to bring attention to the social determinants of health and begin the process of educating not only patients, but the community and all health professionals on what is needed for sustainability and longevity of our oral and systemic health.

RAM represents an immediate short-term solution to a long-term problem.

What is the long-term solution?

1. Prevention

   (a). Education: A high percentage of our patients have a low health IQ, not understanding what's happening in the oral cavity is connected to and may contribute to what is happening in the rest of their body. Specific dental health education should be provided to patients during all medical touch points.

   (b). Prevention: Increase in the number of states who provide non-emergency adult Medicaid benefit.

2. RAM associated policy change.

   (a). Allow temporary state licenses for voluntary work which would apply to dentists, hygienists, and assistants. This would resolve the dearth of state-licensed healthcare providers and open the doors to healthcare providers licensed in others states to volunteer and provide care at RAM events.

I went into the dental field because of inspiration from my mother. Over the years working with RAM, I have seen the deeply personal and human connection. When a human being comes to these clinics for treatment, most often to escape pain or discomfort, and is treated with respect in the process, immense gratitude is felt. But not just for the patient, for everyone involved. We all receive a blessing in this exchange and in this work.

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The CHAIR. Dr. Swann, thank you very much. Senator Cassidy, introduce the next witness.

Senator CASSIDY. I'll allow Senator Tuberville to.

Senator TUBERVILLE. Thank you, Senator Cassidy. It's my honor today to introduce Dr. Gordon Isbell, from Gadsden, Alabama. Dr. Isbell went to Auburn University for his bachelor's degree and then to UAB for his degree in dental medicine. And since 1981, he's been serving the people of Gadsden area through his practice, Isbell Dental. Over the years, Dr. Isbell has been very active with the Academy of General Dentistry, and he served in a variety of leadership roles with the organization, both at the state and National level.

He was also president of the Alabama Dental Association from 2017 to 2018. Dr. Isbell has had a distinguished career full of honors and awards from entities across the State of Alabama and across the country. He spent years advocating for dentists, their patients, and their communities, and he's managed to accomplish this all while raising five children with his wife, Cindy, who is by the way, an Alabama graduate.

[Laughter.]

Today, Dr. Isbell will bring an important perspective to this hearing. In that of a practicing dentist in a community and state with many wide-ranging healthcare challenges. Dr. Isbell provides charitable care to his community through his involvement with Donated Dental Services Mission of Mercies and Regional Access Mission programs. He will speak to the efforts of private dentist across the country and their efforts to reach underserved population.

Dr. Isbell, thank you for being here.

STATEMENT OF GORDON ROSWELL ISBELL, III, DMD, MAGD, PAST TRUSTEE, ACADEMY OF GENERAL DENTISTRY, GADSDEN, AL

Dr. ISBELL. Thank you, Senator Tuberville. Chairman Sanders, Ranking Member Cassidy, thank you for the opportunity to testify on behalf of the Academy of General Dentistry. The AGD is the only professional association that exclusively represents general dentist. The nation is paying more attention to oral healthcare. Research continues to highlight the importance of dental care, overall well-being, but also shows the inequities in excess.

AGD is committed to addressing these inequities by leveraging the abilities of private practice general dentists. We must protect private practice dentistry and ensure the longevity and resilience of the dental profession by supporting fully trained and licensed dentist and comprehensive services only they can provide.

I am Dr. Gordon Isbell and I've practiced general dentistry for 43 years. My son and I practice together. My practice cares for many underserved populations. It is a true honor to serve so many of our veterans when they have difficulty receiving care.

I have a daughter with spinal muscular atrophy and understand the barriers that patients with disabilities face. She lives her life in an electric wheelchair. It is up to the provider community to come together to help.

Research estimates over 100 systemic diseases have oral manifestations. Illnesses related to oral health result in 6.1 million days of bed disability, 12.7 million days of restricted activity and 20.5

million lost work days each year. Most oral health conditions are avoidable through the oral health literacy, sound hygiene and preventative care.

Private practice dentists can detect and treat oral health problems as early as possible, avoiding expensive emergency room visits and complications that may rise from subsequent medical conditions.

Yet, we are challenged with increased governmental paperwork and regulations. Reimbursements have continually decreased as the cost of doing business has escalated, making it challenging for individual practitioners to provide care.

Workforce shortages remain a significant challenge.

All six of the hygienists in our practice are near retirement age, but I'm here to talk about solutions. Foremost, AGD care too deeply about ensuring every American has access to oral healthcare and strives to ensure governmental policies are properly targeted for optimal effectiveness. While AGD supports Federal programs that increase access to care and address disparities, it is important these programs fill the gaps that truly exist.

We have written to HHS that the data used to calculate health professional shortage areas may be out of date, resulting in inaccurate information. Increasing governmental services and locations already being served by private practice can harm small independent dentists.

We must also address workforce strains. AGD strongly supports the reauthorization of the Action for Dental Health, which provides critical state grants to support dental health workforce initiatives in areas with shortages.

We also support Title VII, which administers grants to both postdoctoral dental programs, advanced dental education, and offer loan repayments for dentists. Such grants play a pivotal role in addressing the scarcity of dental school professors and also diversity within our dental field. Our members feel the dental insurance industry forces independent dentists into unfair contracts.

The AGD urges Congress to pass the Doc Act, which would prohibit dental insurers from acquiring providers to charge patients a mandated fee for non-coverage services, over 40 states prohibit this practice.

The AGD sincerely thanks to Committee, especially Senator Collins, for her efforts to include AGD as an improved provider of continued education for prescribers of opioids, in the reauthorization of the support act. The AGD also appreciates Senator Lujàn, and Senator Collins efforts on oral health literacy and awareness act.

In conclusion, advancing access to the delivery of oral healthcare to all will require swift intentional action. Progress will require partnership. And we urge your support for policies that prioritize oral health, well-being, in conjunction with the dental profession, including private, independent practices.

AGD strongly believes every person deserves a dental home and access to routine, safe, reliable, quality, oral healthcare provided by trained and licensed professionals led by dentists. Thank you for

the opportunity to appear before the Committee today, and I look forward to your questions.

[The prepared statement of Dr. Isbell follows.]

PREPARED STATEMENT OF GORDON ISBELL

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee: I thank you for the opportunity to testify before you on behalf of the Academy of General Dentistry (AGD) to discuss access to and the issues facing the delivery of oral health care in the United States. The AGD is the only professional association that exclusively represents the needs and interests of general dentists, advancing general dentistry through quality continuing education and advocacy. The AGD provides its more than 40,000 members with the resources and support to provide the best dental care and oral health education.

The good news is that the Nation is paying more attention to oral health. Research continues to highlight the importance of dental care to overall well-being, but also shows the inequities in access to dental care. The AGD is committed to addressing these inequities by leveraging the abilities of private practice general dentists. I recognize that the Committee has a broad jurisdiction with many important issues to focus on, and so I applaud you for your focus on oral health care. However, let me be clear, we must ensure that the private practice of dentistry is protected and that in our efforts to find solutions to common problems, we do not diminish the care we provide, make it harder to enter into and survive in private dental practice, or dilute the level of services that only fully trained and licensed dentists can and should provide.

I am Dr. Gordon Isbell, III. I have practiced general dentistry in Gadsden, Alabama for 43 years. My son, Dr. Ross Isbell, and I have two practices in Gadsden and have 20 employees. We are a small business and a family restorative dental practice serving our patients and our community.

We have strived during these years to stay state-of-the-art technologically, as we believe our patients deserve to be treated with the highest standard of care possible.

I have sought to hone my skills for my entire career and have achieved Fellowships and Masterships in the AGD. I believe in the importance of lifelong learning in our profession. I have also served my profession as state president of the Alabama Academy of General Dentistry and the Alabama Dental Association.

I have served in multiple capacities in organized dentistry from Regional Director to Trustee of the AGD Board to serving as Chairman of the American Dental Association's Council on Dental Practice, as well roles in many state and local societies.

The AGD believes that every American should have access to oral health care. Our practice cares for many underserved populations by working to treat patients through Donated Dental Services, Mission of Mercy, and Regional Access Missions programs. In particular, it has been an honor to serve so many of our veterans that have needed oral health care after they have served our Nation and kept us free when they have had difficulty receiving all the care they need.

I have been a Physician Staff member at two local hospitals to help with our special needs populations. Our practice treats special needs patients as well as the elderly population in our community. I have a daughter with Spinal Muscular Atrophy who lives in an electric wheelchair, thus I understand and have lived knowing those with special needs have barriers that must be understood and the provider community as a whole must come together to help overcome these barriers to access. I would note that in our practice, we have safety protocols for our patients and staff. Our staff has access to emergency training opportunities. General dentistry is here to serve our patients safely and effectively.

Private practice dentists treat oral health care problems as early as possible. This helps ensure that patients will not need to go to an emergency room for treatment or develop subsequent medical issues. This type of early treatment saves patients and the health system money and improves overall health and quality of life for our fellow Americans. This is why it is critical to protect private practice dentistry, as only dentists can provide consistent, preventative oral health care and serve these needs.

Small businesses, including general dentistry, are challenged with increased governmental paperwork and regulations. Reimbursements have continually decreased as the cost of doing business has escalated over the past 43 years during my time practicing. These barriers make it challenging for individual practitioners to continually serve our citizens.

Additionally, workforce shortages are a continual challenge for small businesses like mine in private practice dentistry. Finding quality well-trained personnel to assist dentists in taking care of our patient population has been an issue for years and has only been exacerbated since COVID–19. Unfortunately, the outlook going forward is not promising. All six of the hygienists in our practice are at or near retirement age, but I am here to not just talk about challenges, but solutions as well.

Introduction and Landscape

Oral Health is Critical to Overall Well-being

Studies have long documented the importance of an individual's oral health to their overall well-being. One journal from 2017 stated "the oral cavity is the intersection of medicine and dentistry and the window into the general health of a patient".[1] This holds true for patients across their lifespan, from birth to early youth, to women who are pregnant or postpartum, to those at the end of life. Research estimates that over 100 systemic diseases have oral manifestations.[2] For example, the Mayo Clinic states that poor oral health may contribute to various diseases and conditions, including: (1) endocarditis when bacteria from the mouth spreads through the bloodstream; (2) cardiovascular disease which may be linked to infections caused by oral bacteria; (3) birth complications; and (4) pneumonia. Additionally, poor oral health can also be an indicator of diseases such as diabetes, HIV/AIDS, osteoporosis, and Alzheimer's disease. Research also shows other conditions that might be linked to poor oral health, including eating disorders, poor nutritional intake, rheumatoid arthritis, certain cancers, and immune system disorders.[3]

Dentists like myself often identify illnesses and conditions before they are diagnosed by a physician. Patients tend to visit their dentists more regularly than their physicians. This may be due to the fact that many medical issues are asymptomatic, and patients therefore do not see a need to visit their physicians as frequently. Optimization of a patient's health through both primary and dental health care can alleviate many of these disease burdens on individuals and on the health care system as a whole.

Although dentistry accounts for just 4 percent of total national health expenditures,[4] dental health care can help prevent worsening of certain illnesses and ultimately save costs to both the individual patient and the overall health care system. For example, illnesses related to oral health result in 6.1 million days of bed disability, 12.7 million days of restricted activity, and 20.5 million lost workdays each year.[5] Additionally, data indicates that costs associated with emergency room visits for dental procedures may exceed $2 billion per year.[6] Therefore, it is important to note that unlike medical treatments, the vast majority of oral health conditions are avoidable through the prevention model of oral health literacy, sound hygiene, and preventative care. Doing so will help the patient avoid worsening health conditions and prevent them and the health care system from incurring great costs. For example, general dentists can help identify early signs of tooth decay, which can help patients avoid developing cavities or infections which can be costly and painful to treat. If patients develop oral infections, particularly those with preexisting conditions such as diabetes or certain cardiovascular conditions, they can experience severe health complications that result in emergency room visits.

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[1] Patricia Alpert. *Oral Health: The Oral-Systemic Health Connection*. SAGE Journals. *https://journals.sagepub.com/doi/abs/10.1177/1084822316651658*.

[2] Shawn F. Kane. *The Effects of Oral Health on Systemic Health*. General Dentistry Research Brief. *https://www.agd.org/docs/default-source/self-instruction-(gendent)/gendent-nd17-aafp-kane.pdf*.

[3] Mayo Clinic Staff. *Oral Health: A Window to Your Overall Health*. May Clinic. *https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475*.

[4] Centers for Medicare & Medicaid Services. *National Health Expenditures 2017 Highlights*. *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf*.

[5] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000. NIH publication 00–4713. *https://www.nidcr.nih.gov/sites/default/files/201710/hck1ocv%40www.surgeon.fullrpt.pdf*.

[6] Owens, P., Manski, R., Weiss, A., *Emergency Department Visits Involving Dental Conditions, 2018*. Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, Statistical Brief #280, August 2021. *https://www.ncbi.nlm.nih.gov/books/NBK574495/pdf/Bookshelf-NBK574495.pdf*.

Challenges Facing Dentistry and Oral Health

Given the importance of oral health to the Nation's overall health and well-being, it is critical to address the numerous challenges facing dentistry. As I will discuss in greater detail later in my testimony, some of the biggest challenges in dentistry include inadequate access to oral health care, workforce shortages, significant dental student loan debt, low reimbursement from government programs, and anti-competitive insurance and governmental practices.

The AGD cares deeply about ensuring that every American has access to oral health care. Good oral health care is critical to peoples' health and well-being. Unfortunately, many communities lack access to oral health care services, especially those in rural and underserved communities and those individuals without insurance.

Inadequate access to dental care is further exacerbated by the acute workforce issues plaguing the dental profession. There are severe dental auxiliary shortages across the country, particularly in rural and underserved areas. Furthermore, due to the dental student loan crisis, many dentists are forced to practice in specific geographic areas to make ends meet. Without policies that support the dental workforce, dentists are unable to provide care for their patients and access to care is reduced. This leaves the patients who are most in need of care without sufficient access to dental providers.

Dentists are committed to serving each and every individual with the best possible care, but simply are unable to because of a lack of adequate policy. Policies that may help advance access to care include supporting increasing the workforce and improving oral health literacy. These policy proposals will be discussed later in this testimony.

Finally, the private dental insurance industry is increasingly putting heightened pressure on dentists and patients through anti-competitive insurance tactics and inadequate reimbursement. Notably, insurance companies often force dentists to charge patients the maximum fee for "non-covered" services, rather than allowing dentists to charge patients a usual and customary fee. This practice harms the critical relationships between patients and dentists, and forces private-pay patients to absorb the additional out-of-pocket costs incurred by the dentist.

To address these challenges and more, the AGD supports a variety of policy solutions to enhance access to oral health services, strengthen the dental workforce, and promote small and independent dental practice owners.

Priority Issues of Concern

In addition to ensuring access to dental health care and strengthening the private practice of dentistry, the AGD would also like to bring focus to four priorities we urge this Committee, and Congress, to act on:

I. Supporting increased workforce in dentistry

II. Promoting equitable relationships between dentists and insurers

III. Including the AGD as an approved provider of opioid training under the *Medication Access and Training Expansion (MATE) Act*

IV. Promoting oral health literacy

The AGD cares deeply about ensuring every American has access to oral health care. As discussed previously, oral health care is a critical predictor and indicator of overall well-being. Unfortunately, not everyone has access to dental health care, and these rates of access are significantly worse for underserved populations. For example, people who are located in rural areas, have lower incomes, and are Hispanic and non-Hispanic Black are less likely to have had a dental visit within the last year, according to 2019 data from the Centers for Disease Control and Prevention (CDC).[7] Additionally, those without insurance are also less likely to seek or re-

[7] AE Cha AE, RA Cohen. *Urban-Rural Differences in Dental Care Use Among Adults Aged 18–64*. NCHS Data Brief, no 412. National Center for Health Statistics. 2021. *https://www.cdc.gov/nchs/data/databriefs/db412-H.pdf*.

ceive dental health care.[8] Further, a 2021 survey found that nearly half of all Americans with insurance skipped a dental visit because of cost.[9]

That said, while the AGD supports Federal programs aimed at addressing some of these disparities, such as community health centers (CHC), and recognizes that they can help increase access to care, we are concerned that increasing the number of CHCs where existing dental practices are already serving a population harms these small and independent dental practices. This unfair Federal subsidization of such competition, including allowing the cherry picking of patients that already have a dental home and coverage, can force existing practices to close. There is also no guarantee that once private practice dentists are forced out of an area, that federally subsidized sites can care for the whole of the community. This, in turn, potentially worsens the access issue that we all want to solve. Many dentists, myself included, are small business owners and our independent practices are critical to the communities we serve. The AGD recognizes that CHCs can expand access to dental services in areas facing true workforce shortages, but we must work together and in coordination to fill the gaps that truly exist. We urge Congress and the Health Resources and Services Administration (HRSA) to consider the impact that changes to CHC policies and funding will have on the viability of independent dental practices. Furthermore, the AGD strongly supports CHC boards partnering with local dental societies in order to contract with locally practicing dentists to more adequately identify and reach underserved patients. In addition, the AGD has recently expressed concern through formal written communication to HRSA that the data used to calculate Health Professional Shortage Areas (HPSAs) may be out of date and is not updated expeditiously, resulting in inaccurate information and misallocation of needed resources. This inaccurate data can contribute to the problem I noted earlier, of establishing CHCs in areas where the need for them is not the greatest. I have attached the letter to my testimony and we are happy to submit this letter for the record.

I. Promoting a Strong Workforce

The AGD is deeply concerned about issues related to workforce strains, particularly the student loan debt burden impacting our members. Without policies that support the dental workforce, dentists are unable to provide care for their patients. Thus, the AGD strongly supports policies that will help the current workforce as well as the pipeline of future workers.

For example, we support programs such as dental loan repayment programs, which place new graduates in underserved areas. Dental organizations also host large annual campaigns to fund care for children from underserved communities.

We also support programs that help with student loan relief, particularly for dentists practicing in underserved areas, and workforce policies that will support staffing and operational needs of dental practices. Let me be clear, all members of the dental team play an important role in providing care, but nothing can substitute for the training and skill required to become a dentist and any efforts to substitute care by those with less training or qualifications only increases the risk of harm and further complications to patients.

The AGD strongly supports the reauthorization of the *Action for Dental Health Act*, which would reauthorize critical state grants to support dental health workforce initiatives in areas with dental health provider shortages from fiscal years (FY) 2024 to 2028. These grants are managed by HRSA and provide $13.9 million in annual funding for oral health workforce grants. Grants authorized by the *Action for Dental Health Act* improve the oral health workforce's capacity and increase access to dental health services. These grants are especially important in rural and underserved areas that face severe workforce shortages which affect access to dental care. Funding from these grants could be used for a variety of important workforce initiatives, including, but not limited to: (1) recruiting and retaining dental professionals; (2) establishing or expanding dental residency programs in coordination with accredited dental training institutions in states without dental schools; (3) providing grants or low-interest and no-interest loans to help dentists who participate in the Medicaid program to establish or expand dental practices in geographic areas with dental shortages; and (4) contributing to loan forgiveness and repayment programs.

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[8] Chad D. Meyerhoefer, Irina Panovska, and Richard J. Manski. *Projections Of Dental Care Use Through 2026: Preventive Care to Increase While Treatment Will Decline*. Health Affairs. *https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0833*.

[9] Michelle Lambright Black. *Nearly Half of Insured Americans Skip Dental Visits, Procedures Due to Cost*. Value Penguin. *https://www.valuepenguin.com/dental-survey*.

The *Action for Dental Health Act* would support rural and underserved communities by bolstering the oral health workforce in these areas and improving access to crucial dental services.

Furthermore, the AGD supports Title VII of the *Public Health Services Act* (PHSA). Section 748, entitled *Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene*, administers grants through HRSA to bolster postdoctoral dental and dental hygiene programs, advance dental education, and offer loan repayments for a spectrum of dental specialties, including general dentistry. Such grants play a pivotal role in broadening the accessibility of oral health care services, especially in rural and underserved regions. Moreover, Section 784 grants address the scarcity of dental school professors by facilitating faculty loan repayment programs and professional development courses. These initiatives also champion diversity within the dental field through programs like the Health Careers Opportunity Program (HCOP), Centers of Excellence (COE), and Minority Faculty Fellowship Program (MFFP). Through fiscal year 2025, HRSA commits an annual investment of $14 million to postdoctoral training in general, pediatric, and public health dentistry residency programs, aimed at fostering the evolution and enhancement of novel care delivery models in underserved areas. The AGD strongly advocates for the reauthorization of these pivotal programs well beyond 2025.

As in many sectors throughout the health care industry and beyond, workforce strains among dentists were greatly exacerbated during the COVID–19 pandemic. Some practices had many of their employees quit during the pandemic due to the additional stress and fear resulting from the virus. Stressors and strains on the workforce like this ultimately decrease access to oral health care and exacerbate the burden on dental practices.

Additionally, the AGD strongly supports solutions to address the dental student loan crisis, including through the *Resident Education Deferred Interest (REDI) Act*. The average dental school student graduates with over $262,000 in debt. With dental school tuition nearly doubling since 2000, new dentists are faced with staggering amounts of debt after graduation, which can limit their ability to choose a preferred career path. Most dental students rely on Federal student loans to finance their education. In addition, with the passage of the *Budget Control Act of 2011*, graduate students lost access to federally subsidized loans. Under this program, the Federal Government pays the interest while students are in school, during a grace period, and during periods of deferment. The loss of this benefit has increased the debt burden on graduate and professional students, including dental students.

Unfortunately, education costs can be a disincentive to practicing in underserved areas after graduation. The REDI Act would bolster the workforce and increase access to care by allowing dental and medical students to defer their student loans interest-free while working in an internship or residency program. Dentists frequently earn modest salaries during their residency, while their student loan debt rapidly increases due to accruing interest. The REDI Act would allow more dentists to practice in underserved or rural areas where salaries may be lower.

Some argue that to address access to care issues, we need to create a new mid-level dental provider. The AGD disagrees. Oral health will not be optimized by introducing a less-educated practitioner who is authorized to perform non-reversible surgical procedures. This model will create a system where those with more critical oral and medical health issues will be treated by practitioners with less training. Enacting policies, like those outlined above, to eliminate disincentives to practice in underserved areas will allow citizens to find a dental home led by a general dentist. The AGD looks forward to working with the Committee to reach that common goal.

II. Equitable Insurance Practices

Many dentists, myself included, independently own our small dental practices. Independent dental practices are integral to the communities we serve, especially in rural and underserved areas that have limited access to providers. Unfortunately, we have regularly heard from members who feel the dental insurance industry forces independent dentists into unfair contracts that harm their practices and their patients. Currently, dental insurers often require providers to charge patients the maximum fee for non-covered services, rather than allowing dentists to charge patients a usual and customary amount for non-covered services, or independently negotiating a price with the patient. This practice, known as fee capping, disrupts long-standing patient-dentist relationships and forces private-pay patients to absorb the additional costs incurred by the dentist.

It is also incredibly challenging for small, independent dental practices to negotiate with large, consolidated dental insurance companies as the two negotiating

parties are on vastly unequal playing fields. This is especially problematic in communities with a limited number of dental insurers, as providers are forced to accept contracts that may disadvantage their practices and their patients. The AGD urges Congress to pass the *Dental and Optometric Care Access Act of 2023* (DOC Access Act), which would prohibit fee capping. This practice also relieves carriers' obligation to provide coverage for a wider range of services. Dentists and patients should be allowed to agree on payment terms that fit the patient's needs, while allowing the dentist to operate a successful practice and provide the best possible care. While over 40 states have enacted legislation prohibiting this practice, many plans are regulated federally and can circumvent these protections. The DOC Access Act is critical to banning fee capping at a Federal level. The bill would allow providers to charge a fair and customary amount for non-covered services rather than be subjected to an insurer's mandated fee schedule. The DOC Access Act would promote fairness in contracts between providers and insurers, increase the quality of care for patients, and protect consumers from anti-competitive practices.

III. Safe Opioid Prescribing Practices

The AGD sincerely thanks the Chair and Ranking Member, as well as Senator Collins on this Committee and Senator Bennet, for their efforts to include the AGD as an approved training provider for prescribers of opioids in the reauthorization of the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act* (SUPPORT Act). This training, as required by the *MATE Act*, is essential to educate providers on safe opioid prescribing practices. We especially appreciate Senator Collins' tireless work to ensure that general dentists can readily access essential prescribing training.

The AGD recognizes that the dire opioid epidemic continues to plague American communities. Recent studies have found that while opioid prescribing by dentists is decreasing,[10] dentists still prescribe 8.6 percent of all opioids.[11] As general dentists continue to prescribe opioids for pain management, the AGD will continue to educate them on safe opioid prescribing, opioid addiction, and alternative treatment options that may be used.

IV. Oral Health Literacy

In addition, the AGD greatly appreciates Senator Lujàn's and Senator Collins' efforts on the *Oral Health Literacy and Awareness Act of 2023*. We strongly believe that by improving oral health literacy, we further everyone's access to dental health care, particularly among underrepresented populations including rural populations. Unfortunately, studies show that dental care visits declined drastically during the early phases of the COVID–19 pandemic, and although they have rebounded since, rates of dental care visits remain below pre-pandemic levels.[12] Further, some populations require more regular or intensive visits to their dentists but are unaware of this need or the consequences of foregoing this care. For example, pregnant women may experience worse oral health due to hormonal fluctuations, and it is critical they see their dentist regularly to ensure any infection does not pass onto the fetus. Other barriers to access and utilization that patients report include transportation issues, lack of oral health literacy,[13] fear, and anxiety. In summary, educating the public about the importance of maintaining good oral health should be a top concern—as oral disease left untreated can result in pain, disfigurement, loss of school and workdays, nutrition problems, expensive emergency room use for preventable dental conditions, and even death.

Conclusion

The AGD continues to advance its mission to promote and advance oral health for all by advocating for improved oral health literacy and a regulatory environment that supports general dentists' practice of primary oral health care. In conclusion,

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[10] H. Yan Connie et al, *Trends in Opioid Prescribing by General Dentists and Dental Specialists in the United States*, 2012–2019. Am J Prev Med. 2022 Jul; 63(1): 3–12. *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9233039/*.

[11] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *Dental Pain Care*. *https://www.cdc.gov/opioids/healthcare-professionals/prescribing/dental-pain.html*.

[12] Ashley M. Kranz, Annie Chen, Grace Gahlon, and Bradley D. Stein. *2020 Trends in Dental Office Visits During the COVID–19 Pandemic*. The Journal of the American Dental Association. *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7942140/*.

[13] Institute of Medicine, Board on Population Health and Public Practice. *Oral Health Literacy*. *https://www.ncbi.nlm.nih.gov/books/NBK207122/*.

successfully advancing access to, and delivery of, oral health care to all Americans will require swift and intentional action. This action will need to support both the workforce, so they are able to care for patients across the United States regardless of where they are located or patients' ability to pay, and the patients, by educating them on the importance of healthy oral habits and expanding their access to care. Progress will require partnership across all stakeholders, including government and industry, and we urge your support for policies that prioritize oral health and well-being in conjunction with the dental profession across all practice locations, including private, independent practice. The AGD strongly believes every person deserves a dental home and access to routine, safe, reliable, and quality oral health care provided by trained and licensed professionals, led by dentists.

Thank you for the opportunity to appear before the Committee today, and I look forward to your questions.

[SUMMARY STATEMENT OF GORDON ISBELL]

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee: I thank you for the opportunity to testify before you on behalf of the Academy of General Dentistry (AGD) to discuss access to and the issues facing the delivery of oral health care in the United States. The AGD is the only professional association that exclusively represents the needs and interests of general dentists, advancing general dentistry through quality continuing education and advocacy. The AGD provides its more than 40,000 members with the resources and support to provide the best dental care and oral health education.

My name is Dr. Gordon Isbell, III. I have practiced general dentistry in Gadsden, Alabama for 43 years. My son, Dr. Ross Isbell, and I have two practices in Gadsden and have 20 employees. We are a small business and a family restorative dental practice serving our patients and our community. We strive to stay state-of-the-art technologically, as we believe our patients deserve to be treated with the highest standard of care possible. I have sought to hone my skills for my entire career and have achieved Fellowships and Masterships in the AGD. Additionally, I have served my profession as state president of the Alabama Academy of General Dentistry and the Alabama Dental Association. I have also served in multiple capacities in organized dentistry from Regional Director to Trustee of the AGD Board to serving as Chairman of the American Dental Association's Council on Dental Practice, as well roles in many state and local societies.

Research continues to highlight the importance of dental care to overall well-being, but also shows the inequities in access to dental care. The AGD is committed to addressing these inequities by leveraging the abilities of private practice general dentists. Our practice cares for many underserved populations by working to treat patients through Donated Dental Services, Mission of Mercy, and Regional Access Missions programs. Successfully advancing access to, and delivery of, oral health care to all Americans will require swift and intentional action for both the workforce, so they are able to care for patients across the United States regardless of where they are located or patients' ability to pay, and patients, by educating them on the importance of healthy oral habits and expanding their access to care. Progress will require partnership across all stakeholders, including government and industry. The AGD supports legislation to advance these aims, including the *Dental and Optometric Care Access Act of 2023* (DOC Access Act), the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act* (SUPPORT Act), and the *Oral Health Literacy and Awareness Act of 2023*. We urge your support for policies that prioritize oral health and well-being in conjunction with the dental profession across all practice locations, including private, independent practice.

Thank you for the opportunity to appear before the Committee today, and I look forward to your questions.

The CHAIR. Dr. Isbell, thank you very much for your testimony and for your work. I think every one of the panelists has indicated that we have a serious dental crisis in America. You've all made the connection between dental health and physical health.

Let me start off with a simple question. In the richest country, in the history of the world, why are we experiencing the kind of

dental crisis that we have, where tens and tens of millions of people, can't afford to go to a dentist? Can't find a dentist, or if they do find a dentist, there are waiting lists for 6 months or a year. That's the crisis. How do we solve it? Dr. Simon?

Dr. SIMON. Dentistry has been separated from medicine since the first dental school was founded in Maryland in the 1840's. And since then, the separation of medicine and dentistry has spun off and continued to cause problems. By the way, it's upheld within our insurance structures, our education system, and the ways healthcare is delivered. When things are separate, it makes it harder to get through a second door. Americans already struggle to get healthcare in the first place. If we make it that they have to walk through one door and get to a smaller locked one, they are going to have a hard time moving in.

The CHAIR. Bottom line is dental care is healthcare and should be available to all as a right.

Dr. SIMON. Dental care is healthcare and healthcare is a human right. Okay.

The CHAIR. Dr. Minter-Jordan, what's your thoughts?

Dr. MINTER-JORDAN. I think there's been a lack of recognition of the cost savings that we could have if we were able to integrate oral health and medical, and certainly agree with Dr. Simon. We know, again, that periodontal treatment for people with diabetes has been shown to reduce overall health costs, and Medicare, we know that there's a potential to save up to $14 billion annually by providing appropriate oral healthcare with people with diabetes, with heart disease, we could save almost $30 million.

The CHAIR. Let me jump in. We've heard this story a thousand times.

Dr. MINTER-JORDAN. That's correct.

The CHAIR. That, what did you say, Senator Cassidy? An ounce of prevention, cure for all. We hear this over and over again. We're pretty good at spending zillions of dollars, treating people on death's door, but we don't prevent the cavities that little kids have.

Dr. MINTER-JORDAN. That's right.

The CHAIR. Dr. Swann.

Dr. SWANN. Well, I agree with the prevention issue. We also start looking at the fact that if we have to train across disciplines, everybody should know what the risk factors are. There should be no entity that's not advocating for healthy societies. So, we need to put our money where our mouth is.

The CHAIR. Dr. Isbell.

Dr. ISBELL. Senator, all I can tell you is what we do in our world. We have free clinics in our practice and have for many years, and now we have a free clinic in our town. We work with RAM, and I applaud Dr. Swann, for his RAM program. We were there to take care of our people.

I'll tell you about a student that came, who was going to nursing school. All of her front teeth were rotten. She came and was concerned and whatever. So we rebuilt her mouth. We did it. She went to nursing school and a successful practitioner today. We did it for

her for nothing. And dentists do that all over the country. And you're not telling that story, Senator. Because there are dentists that are out there that are helping people and there is more. There's always more.

The CHAIR. I'm saying, doctor, there certainly are, and I thank you very much for what you do. And many dentists do it. We have a crisis. Millions of people cannot find a dentist, cannot afford dental care. I don't think that is under debate. I think that's the reality.

Let me ask all of you another question, and I was kind of shocked to learn this a few years ago. I talked to dentists who have graduated dental school, $300,000–$400,000 in debt. So, we talk about not getting dentists out into rural areas, lower income areas. It's hard to make money in lower income areas. What does the cost of dental school and dental school debt have impact where dentists go? Dr. Simon.

Dr. SIMON. The average dental school graduate graduates with almost a hundred thousand dollars more debt than the average medical school graduate around $300,000, as you say. I think it absolutely influences where they practice.

The CHAIR. Okay. Yes, Dr. Minter-Jordan.

Dr. MINTER-JORDAN. I mean, I would agree with Dr. Simon. There's a crisis as to how we can afford education and the impact of the cost of education on the choices that professionals make when they go to provide care. It certainly impacts dentists and their ability to accept patients with Medicaid because of the low reimbursement rates, as well as the multifactorial costs that are inherent in having a dental practice. So part of what we have to address is the use of ancillary providers as well as a means of expanding access to care.

The CHAIR. Dr. Swann.

Dr. SWANN. I agree with the statements that have been made. NYU's tuition right now for 4 years is $700,000, where the medical school tuition is zero because of some donation. So, we see these students getting out. I had talked with the young doctors, been practicing 7 years, he's got $600,000 in debt, he's frustrated. He doesn't know what to do. He can barely make it.

I think that's one issue. Another issue is putting more emphasis on reimbursement rates, especially around prevention.

The CHAIR. Dr. Isbell.

Dr. ISBELL. Yes. I agree with that statement too. It's, it's scary. The average right now, they say it's 262,000, but I know many students with much higher than that. So, it's a challenging situation. Then where do they go? The big deal is to give them an opportunity into residencies.

If we could have some form, and there's legislation in front of you to possibly, there could be just a halt on it—They're not asking for forgiveness, they're asking for just to be able to go to residency and train where they can have access to care and treat patients. And they really, if we could develop programs to get our dentist into rural areas, I know in our state, that's something we've worked hard at and we're having some success, but getting students from

the beginning that are planning to go back into the rural areas to take—because our citizens deserve that. Senator.

The CHAIR. Well, let me just—my time has expired, but I would also think not only if I graduated dental school with hundreds of thousands debt, that's one thing. But if I'm a young person, a working-class kid, thinking about going into dental school, do I really want to go into a profession where I am going to end up with 300—500,000 in debt? I suspect that's a deterrent for a lot of young people going to dental school. Is that right?—seeing head's being nodded here. Okay. My time's expired. Senator Cassidy.

Senator CASSIDY. Thank you all for being here. Dr. Isbell, I'm also married to an Alabama grad, which I rarely mention on the campaign trail, being from Louisiana, so something like that.

[Laughter.]

She was a couple years after you at the UAB. I just had my teeth done. And Senator Sanders talks about the expense. He just touched on the cost of tuition. But I was amazed at the technology in a dental office. They don't put the little x-rays up as they did when I was a child. It's all digitalized, and I can imagine it's fairly expensive.

I also understand it's a highly regulated industry. We want to make sure it's sanitary, but there's a cost of compliance. And then as you mentioned, there's workforce shortage, which I presume that you pay the hygienist more. That hygienist was out that day, so I had the dentist wife taking care of me, which we had a great conversation.

All that to say like, what percent of a typical dentist practice goes to overhead. And then if they're just out, and Dr. Swann, you can answer this too, please. What percent of their income would be dedicated toward paying back student loans?

Dr. ISBELL. That's a good question, Senator. Overhead has increased exponentially over the last 43 years. The cost of having quality individuals for my patients of all income levels which we treat, the very poorest to the people that do better, I want them to be able to understand the care they need. So, we have intraoral cameras, we have monitors to be able to show them what's there to where they can make choices to have quality healthcare, every individual disorder.

Senator CASSIDY. What percent of your like—like a dentist back home told me that like he's got a 60 percent overhead.

Dr. ISBELL. I think it's higher than that. I'd say 70 percent at this time.

Senator CASSIDY. Is that, would that include the student loan payments to go back?

Dr. ISBELL. It does not.

Senator CASSIDY. Being higher, Dr. Swann, would you kind of agree with that?

Dr. SWANN. Totally agree with that. It does not include student loan payments. And people just getting out of school, it's going to take them five to 7 years before they start breaking even in business.

Senator CASSIDY. I've never been to a dentist in Mexico, but I could imagine they might still have those little x-rays and not the digital that we've become familiar with. I just say that because, there is a quality of care that you two provide, which is quite remarkable.

Let me move on. Dr. Swann, if a hundred percent of an average dentist payer mix was at Medicaid rates, could that dentist stay in business?

Dr. SWANN. Most likely not, but that dentist could mix it.

Senator CASSIDY. I get that. So, it's a payer mix. Dr. Isbell, well, you're actually in practice and Alabama's like Louisiana. You've got a lot of poor folks. Do you see pediatrics?

Dr. ISBELL. We do.

Senator CASSIDY. You got some Medicaid patients in there?

Dr. ISBELL. We don't.

Senator CASSIDY. You don't. If you had a hundred percent of Medicaid, I'm suspecting that you could not keep your doors open.

Dr. ISBELL. We could not.

Senator CASSIDY. Now, to point out Dr. Senator—I don't know if I demoted you or elevated you. I was about to say Dr. Sanders.

Senator Sanders sometimes refers to being poorly insured, but that's a euphemism for Medicaid. I was just in California and there's a hospital going out of business. They think because they got so many Medi-Cal patients and Medi-Cal pay so poorly. So I just want to point out that whenever we talk about mandating through Medicaid, if you mandate the dentist to see the patient, then you are going to end up with a bankrupt dentist.

The other thing I've been told by private dentists, the section of Baton Rouge, principally African-American has African-American dentist. And they don't tell me this, but my colleagues do, the folks that were my colleagues in our free clinic for the working uninsured. That when a community health center brought in dental services, they put those two dentists out of business because they could, they basically had their practice underwritten by the CHC, and they get a higher Medicaid rate. They get 1.5 times.

These guys were saying we just lost two dentists in a bad section. Poor section of town, bad dental healthcare do you know what I'm trying to say. And so, is that a perverse effect of the CHC? I'm not criticizing the CHC, I'm just kind of pointing that out. What I've observed. Dr. Swann, your thoughts?

Dr. SWANN. Yes. I don't think it's necessarily a general reverse effect. I think that's an isolated issue. What I do feel in my practice, when I was doing private practice, I looked at the demographics. 25 percent of the population was on dental care. So, I accepted that we were able to make ends meet. But it also meant building social capital.

Senator CASSIDY. Well, you must have had another mix. You had a better off patient with commercial insurance or able to pay private dollars.

Dr. SWANN. We had a mix.

Senator CASSIDY. Because I'm suspecting your dental cow was paying you below cost?

Dr. SWANN. Right.

Senator CASSIDY. Dr. Isbell.

Dr. ISBELL. Yes. In that particular situation in our community, it's called Quality of Health, our community health center. And for 40 years I've worked with the dentist there. They've co worked with our societies, and it's really been a collegial situation. It's been wonderful for the citizens of our community. And the dentist there have been helpful in our free clinic that we've started also. And also building the community. College programs mean working a workforce with building dental assistants and hygienists there. So it can be there together.

But I know other areas of our state where it didn't work so well. And there were dentists that it was unfair competition, and they basically end up closing and moving. So, it's important to communicate, just like for you guys, it's about communication. It's about sharing, but always, always putting your patient first and taking care of your patients. And I think the doctors here will agree with that.

Senator CASSIDY. Thank you all. Thank you.

Senator Baldwin.

Senator BALDWIN. Thank you, Chair Sanders, and Ranking Member, for holding this hearing today. And to our witnesses, I really appreciate your testimony. I want to sort of start where Dr. Cassidy left off with a focus on community health centers.

Dr. Simon, I think you said in your testimony that's kind of where you first started encountering some of the huge challenges that we're discussing here today. And it seems to me in Wisconsin that the community health centers and their dental clinics are really stepping up and in various communities, really helping create access that's affordable. Can you talk about your experience in the role that community health centers play in improving access to care for underserved populations?

Dr. SIMON. Certainly, and I'm proud to do so alongside two other former community health center clinicians. I think one thing that community health centers can do is a matter of scale, which is that if you are a dental department within a health center, that provides not only medical care, but pharmacy, all sorts of services, all of that administrative burden that Dr. Isbell mentions, does not fall exclusively on the backs of a few dentists. It's something that's distributed.

I think that makes it much more satisfying and meaningful to practice dentistry because those sorts of concerns aren't ones that you need to deal with alone.

On top of that, a federally qualified health center is required to have at least 50 percent of its boards composed of community members, which means that you are in direct service to the community and listening to your neighbors and the people that you are hoping to serve and following their lead. And I will say that usually their lead includes dental care.

When it comes to the things we're able to do in a community health center, it is very dependent currently on what state Medicaid programs will cover. And while there is some amount of free care or sliding scale care, it's almost always insufficient. On top of that, there are not enough community health centers and not enough community health center dentists. So, the people who are trying to get in often can't.

When I was training in internal medicine residency, my primary care clinic was at an FQHC in Boston the entire time. I trained there all 3 years, our dental clinic was never able to accept new patients, and none of my medical patients saw a dentist at our FQHC, even though the dental clinic was down the hall.

Senator BALDWIN. Wow. Dr. Minter-Jordan you, you noted in your testimony that maternal care and oral health are linked. When a mother has poor oral health or can't access the dental care she needs, she and her child may face worse health outcomes. And I know our Country is currently facing a maternity care crisis. What policies would you recommend to improve maternal oral healthcare?

Dr. MINTER-JORDAN. Thank you for the question, Senator Baldwin. Just as you've said we know that studies show that periodontal treatment for pregnant women can result in a nearly fourfold reduction in the rate of preterm delivery. We also know that between 60 and 75 percent of pregnant people experience oral healthcare issues that raise the likelihood of major complications and poor birth outcomes.

One of the things that we did at the community health center that I led in Boston, we led a centering pregnancy program that incorporated our dentists into the program to provide oral healthcare to pregnant mothers. So as from a policy perspective, it would be important for maternal health to be inclusive of oral health and to ensure that policies support mom getting access to oral health during her pregnancy and the education that goes along with that.

Senator BALDWIN. Thank you. In this conversation, it's important that we recognize that children must have access to dental care at a young age to ensure a healthy life. One way to improve access, which has happened in my home state, is to provide school-based oral health prevention care. Dr. Simon, how does reaching people where they are with programs in schools or other community settings improve access and trust?

Dr. SIMON. As I mentioned to Senator Sanders, I think a lot about this in terms of making dentistry a separate door that's harder to get through. And what you're describing is eliminating that problem, not only in schools, but for adults in nursing homes or homes for people with developmental disabilities and inclusive of the pediatricians or primary care physicians' office.

I give these talks a lot to my fellow primary care physicians, and they're always so excited because right now what they feel is helpless. They, like me, are seeing dental patients and not able to do anything for them. So I think being expansive, not only of our workforce, but also the things we think about doing in various places are really important. Just like what you described.

Senator BALDWIN. Thank you, Mr. Chairman.

The CHAIR. Thank you.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman. And thank you to the panelists. I'm sorry that I wasn't able to hear your opening statements, but had an opportunity to look at the background. I want to focus on access to oral health, dental care in rural areas, because it's really hard.

I grew up in a part of the state where if you needed to go to the dentist, you got in an airplane or you got on a ferry. And more often than not, you went to Seattle. And that was not a cheap trip, but that was how we got our healthcare. We have improved dramatically since then, but we still have far too many communities where access is an issue.

Far as I know, you can't fill a cavity through dental through telehealth. And so, how we have been able to address this requires a little bit of thinking outside the box.

The dental health aid therapist program, the DHAT program, is something that we put in place in Alaska. We got a lot of pushbacks from the American Dental association who thought that this was going to be encroaching on their territory. And I said, you send me all the dentists that you want to come out to rural Alaska and for more than just a couple weeks stint, because these kids don't need health dental care just 1 week or 2 weeks out of the year, we need somebody.

We'll take a mid-level, we'll take somebody who will work with kids to encourage them on simple dental Hygienics. And so, we have made some good progress, but there is still so, so much more that we need to do to address access to dental care in our rural communities.

I think Dr. Swann, you may have mentioned the DHAT Program, but share with me, if you will, what more we can do, what more we must do in our more rural and remote areas. Because we are seeing overall health outcomes that have been impacted negatively because it began with poor oral healthcare.

Dr. SWANN. I agree with you. And I think that in the State of Alaska, you've been a prime example, with a state that large and being able to get a program that is seeing people. And I read just last year, in the 10 or 12 years you've had this program, there hasn't been one malpractice lawsuit. So, it's working. And I think that we have to address those rural areas.

We need more role models in the schools of education where we're teaching young people to become doctors. They need to see people who are able to function and work in rural areas. And we don't see that necessarily in our faculty. There needs to be incentives. I think that would help people. And just really innovative business models, General Practice Residency Programs, GPR Programs, those type of programs. I think work like in the State of New York where it's a requirement to get a license that you spend 1 year doing public work. I think that works. And I just think that the rural communities would benefit from that.

Senator MURKOWSKI. Other comments?

Dr. MINTER-JORDAN. Just to underscore and thank you Senator Murkowski, for raising this. Just to underscore some of what you said. Our research shows that over one third of rural residents do not have dental insurance coverage. 4 in 10 adults in rural areas have not seen a dentist in over a year, which is about 10 percent higher than suburban and urban areas.

We also know that 67 percent of rural areas are health professional shortage areas. And so, when I think about solutions, it is generally what Dr. Swann has said in terms of incentivizing providers, but also to your point, creating greater opportunities for ancillary providers to provide services in rural areas and expanding the scope of practice in order to be able to do that.

Senator MURKOWSKI. One of the things that we see is a great disparity. I'm talking about rural, but so many of our rural communities are predominantly Alaska native. And so, our native population just suffers disproportionately when it comes to negative health outcomes related to dental health.

It's not an issue of insurance. I can tell you, I go around to the small regional or sub-regional clinics, and we will have a dental chair, but it's practically brand spanking new, great equipment because we can't get the providers that are out there. So everything that we can be doing to focus on training those who will take on, it's a challenge. It's hard. It's not easy when you're moving around, when you really don't have the place to stay in these small communities.

But it's an experience that ought to count for some level of support for the training. And I would urge us all to think about how we fully connect all these dots. It's one thing to make it available with the chairs and the equipment. It's another thing to get the providers that are out there, whether they are the dentists or the mid-levels like we have with the DHATs. Thank you, Mr. Chairman.

The CHAIR. Thank you, Senator.

Senator Hassan.

Senator HASSAN. Thanks so much, Mr. Chairman, and thanks to you and Ranking Member Cassidy for this hearing. To our witnesses, thank you all not only for being here, but for the very important work that you do.

Dr. Swann, I want to start with a question to you. Just taking a step back. A lack of affordable dental options can result in patients skipping visits to the dentist, which can ultimately lead to even more expensive long-term healthcare challenges. So what is the impact on a patient's long-term oral health when they skip regular visits to the dentist?

Dr. SWANN. Well, we see that actually from COVID, the problem exacerbates. It just gets worse. And so, therefore, the amount of money that's going to take to save a tooth is going to quadruple or it's going to end up with an extraction, which has been the solution for a lot of people. Just take it out because I have 28 or 32 of them, right?

Senator HASSAN. Yes. Okay. So worse oral health, more expensive remediation once they do come to the doctor.

Dr. SWANN. Not just worse oral health, but systemic health.

Senator HASSAN. Right. Okay. Dr. Minter-Jordan, some employers don't offer dental benefits and Medicare and Medicaid often provide little to no dental coverage for adults. As a result, nearly 70 million adults in the United States don't have dental coverage. Many families who have health insurers through their employers want to purchase standalone dental coverage through their state's insurance marketplace.

However, while this is possible with some state-run marketplaces, depending on the design that the state decided to use. Families can't purchase stand-alone dental coverage in New Hampshire and the 31 other states that use the healthcare.gov Federal marketplace.

Understanding that the dental programs that are on the marketplace are vetted and people can actually compare what coverage is actually there. What would be the impact of allowing adults in New Hampshire and 31 other states to enroll in standalone dental plans on healthcare.gov?

Dr. MINTER-JORDAN. Thank you, Senator Hassan for the question. It is clear that when people have access to dental coverage, they use it. And so, what we would expect from that increased access through the marketplace and the ability for individuals and families to purchase it through the marketplace, is increased access to care, increased access to prevention and reduction in overall healthcare costs, given the correlation between oral health and overall health.

Senator HASSAN. Well, thank you for that. I have a bill with Senator Marshall, called the Increasing Access to Dental Insurance Act. It has eight bipartisan co-sponsors, including Senator Braun, which would help fix this problem, allowing people across the country to access the vetted dental plans offered on healthcare.gov.

Mr. Chairman, I know there's a markup next week that's focused on reauthorizations, but I would just urge us to see if we can fit this bill into an upcoming markup because it's a straightforward way to improve coverage around the country.

Last, I wanted to just build on what Senator Murkowski was talking about. Last year, New Hampshire expanded Medicaid benefits to include dental coverage for adults. However, I'm hearing, on a smaller scale, obviously, than Alaska, but New Hampshire has its rural places too. It is still really hard for people to find a dentist who takes Medicaid and is seeing new patients, especially in rural areas of New Hampshire.

Dr. Simon, building on what the conversation you all just were having with Senator Murkowski, what can we do to help dentists practice in places where they are most needed?

Dr. SIMON. As many people have said, of course, Medicaid reimbursement is a big important issue for dentists trying to care for Medicaid patients. But across the country, if you look at the rates of Medicaid reimbursement in different states, it is not correlated with the number of dentists who accept Medicaid. So I would argue there's also something else going on. Providing more funding is always great, but there has to be a culture shift as well. To a certain

extent, rural dentists are graying. There are actually decreased rates of rural dentists because dentists in my generation are less likely to practice there.

I think that DHAT model is an amazing one that has shown that listening to communities and letting them lead the way is absolutely how we should be providing healthcare. And we know that this can work in the lower 48 for sovereign tribal communities, but also for Americans all over the place. We also know that for private practice dentists who choose to work in these areas, employing a dental therapist, can increase their bottom line and allow them to care for more Medicaid beneficiaries.

I think it's a very amazing free market solution to this problem. On top of that, I would argue that having better infrastructure in our community health centers and recruiting more dental students from rural areas as the West Virginia has done, does show that it can make a small dent in making these communities better served.

Senator HASSAN. Well, thank you very much for that. I have talked to dentists in New Hampshire who are graying and want to retire, but they don't know who's going to follow in their practice. So they're keeping at it because they care about their patients, but at some point, we have to find better ways to solve this problem. So I thank you all for your work, and thank you, Mr. Chairman.

The CHAIR. Senator Tuberville.

Senator TUBERVILLE. Thank you, Mr. Chairman. Dr. Isbell, in your professional opinion, what do you think are the driving causes of skyrocketing health dental care costs in this country? In your opinion, what's driving that?

Dr. ISBELL. It is workforce, Senator. It's the cost of competition. You will train somebody and then they're bought down the street from somebody else. And just really keeping individuals in our practice. We want quality healthcare, and the cost of supplies, equipment, even at the basic level to have, because our patients deserve quality care at all levels.

The cost of doing business today is tremendously different than it used to be. Where reimbursement levels are very different in our world today. So it is challenging to be able to make it work today, to take care of our patients, and our patients deserve quality. So we sit down with every patient, spend time, we teach our patients. We believe so much in oral health literacy and teaching patients from the bottom level, getting involved in the schools and in every state.

I think it's important that we really educate people on the need for oral healthcare. And I think all the panelists will side with that. But the cost of doing business has gone up tremendously, especially since COVID. It's really made it challenging for practitioners to be able to—but we want to do what's best for our patients. It's all about the patients, always.

Senator TUBERVILLE. To me too, it's about educating kids at a younger age.

Dr. ISBELL. Absolutely.

Senator TUBERVILLE. I educated 130 kids a year from all areas. And it's shocking to me, some kids that came from really no house-

hold that had very little money, but they had perfect teeth. A lot of it it's hereditary. It's got to be a lot of—because they had nothing. They had no clue what a dentist was. But then you have other people come in, it's just totally different. And of course, a lot of that has to do with our diet? So what can we do on a Federal level to incentivize more people to get in the dentist business and hygiene business?

Dr. ISBELL. I think it comes down to communication. I think it comes down to educational process and giving people the opportunity. But I think it comes to actually teaching at an early level that the importance of dental care, and then it's a profession that they can be proud of what they do. They get to work with patients every day, and it's fulfilling what we do.

Like the story I told earlier of the young lady going to nursing school with all of her front teeth decayed out, and we built veneers and gave her a smile. The man that was in my office on Monday, I practice dentistry every day. And the male is in there 20 years. He hadn't been since COVID. Walked in. He came, and got his teeth cleaned, and about our vintage. And 20 years ago, came in with his teeth rotted out, and he said, what can I do?

We rebuilt his mouth 20 years ago, and he said, it's been fantastic for 20 years. He said, my family's love it. He said, I still feel good about my smile. I feel good about who I am. And thank you so much for, yes, he's got some periodontal issues, because that's partly genetic. That's partly he's 70 years old like I am. And that happens with time and age.

Senator TUBERVILLE. Well, as you know, nobody likes to go to the dentist though.

Dr. ISBELL. No, sir.

Senator TUBERVILLE. I'll be honest with you, I'm 2 months late on my next cleaning, and I get a call every day.

[Laughter.]

That's just part of it. But Dr. Swann, what do you think? What do we need to do federally to get more dentists? Have more dentists? I know it costing a fortune now in our universities that are gone up 800 percent in terms of tuition cost in the last 10 years is ridiculous. But what do we need to do to get more people involved?

Dr. SWANN. I think the younger generation responds to social media and there are ways in which you can start educating people, as Dr. Harris said, to be able to catch them at an earlier age, to talk about the pros and cons of being in this profession.

We also need to make sure that we are training in more of an interdisciplinary way. We need to work on our patients as a team so that every entity of healthcare is actually promoting optimal health.

We also need to think about the business of dentistry as well as our patient's care. And sometimes they are interwoven, sometimes they're separate. We need to bring that together. The majority of dentists in America are general dentists, but 90 percent or more is private practices. That's fine, but it needs to be a win-win situation.

If you took the State of Massachusetts that has 7,000 dentists, if each one of those just said, I will see five mass health patients a year, just to say I'll do it. That would mean that everybody along with the FQHCs would have a dental home.

Then if you cross train in medical schools, nursing schools, and pharmacy schools about all the systemic illnesses that come out of oral health, most medical nursing schools don't do anything around oral health. We are trained in silos and that's archaic. So there has to be a shift toward inclusion and being able to make sure that as healthcare, that we are all given the same message that is accurate. Its research proven, and we are actually educating our patients about preventing dental disease, which most of it can be prevented.

Senator TUBERVILLE. Thank you.

The CHAIR. Senator Hickenlooper.

Senator HICKENLOOPER. Thank you, Mr. Chairman. And thank all of you for being here. I had the funny experience of seeing kind of a full circle. 52 years ago, I helped a kind of wild rebellious young man named Mark Sally. Started a community health center in Middletown, Connecticut, called the Community Health Center, Inc. And he started with a single dentist. And he had one afternoon a week, where people could come in and get their teeth done from the low-income communities around north Main Street in Middletown, Connecticut. And then he got two afternoons a week. Now he's got 220 locations, I think. But they don't have dental care everywhere. In other words, he's that pendulum swung——

[Laughter.]

Let's stick to dentistry here. It's come round full circle so that obviously we're not getting the appropriate level of dental hygiene to our entire country. So, Dr. Simon, how can we share best practices of what we've seen in health centers to improve the integration of dental care with primary care and expand access for patients?

Dr. SIMON. I think we have a model for that, which is the many large consolidated health systems that provide the bulk of medical care in our Country. They employ vast numbers of healthcare providers, but very rarely have dental providers as part of that mix, even though they are receiving subsidies that are related to oral healthcare. For example, for all of the emergency department visits where by the way, Senator Cassidy, you can't get a tooth extracted. The emergency department can't even do that for you, for the most part.

Senator CASSIDY. I got a friend that does it, but I'll leave it.

[Laughter.]

Dr. SIMON. That's amazing. I wish all EDs had that, but most of them don't. So I think we have a lot of work to do of using existing health infrastructure in a more efficient way. If we could build a clinic into every hospital, that's one less location people have to go to, to get their dental care.

They would note that while there are amazing private practice physicians like Dr. Isbell, the younger generation of dentists is more interested and more likely to work in different locations. And

I think a lot of young dentists would jump at the chance to work alongside their medical colleagues in a setting like that.

Senator HICKENLOOPER. Yes, I think you're exactly right. And I think we should have a sense of urgency about this more than what we see. And again Mr. Marcelli, was a community organizer is how he got into this. But he was constantly bringing together persuasive arguments about this.

One of the things I remember vividly 40 years ago at least and Dr. Minter-Jordan, maybe I'll ask you as well, they saw and heard alarming stories of kids from disadvantaged backgrounds who had real self-image problems having to do with their dental hygiene, and felt they didn't want to go to school. They didn't feel comfortable in the neighborhood. Is there research on that demonstrates how valuable that is?

Dr. MINTER-JORDAN. There is research that—and Senator Hickenlooper, thank you so much for raising the very real fact that there are so many children who go without oral health disease prevention. And therefore, and I shared this story in our opening, young children, as young as 3 years old, need to be put under anesthesia in order to fix some of those cavities that cannot be fixed in a dental chair.

They certainly impact their ability to participate in their education, to feel, to have, self-esteem, and then as they become adults, to be able to seek employment. I am so happy to share additional information with your office on this important topic. Just underscoring the real need for prevention and for education.

Senator HICKENLOOPER. Thank you. And last question. All of you have talked about the dental workforce shortage. And, and what that means. I think Colorado's been working very hard to lead in this effort to educate the next generation of dental hygiene professionals. We've got Community College of Denver and the Front Range Community College, Colorado Mountain College, Peak Community College. I can go down the list of all these institutions that committed to expand their programs by 2025, because we're asking them, we're reaching out and providing some funding.

This is going to certainly help expand the workforce capacity, especially in diverse and underserved communities. But I'd love each of you, and I can just do this quickly because I've only got 38 seconds. What else can we do to help foster the growth of dental support professional programs like the ones we're talking about in Colorado? At more schools, more training programs, more states.

Dr. SIMON. People have to believe that they can be in this field. If they don't see anyone that looks like them or aren't able to visit a dentist themselves, then they won't be able to. When I was in dental school, I was one of the very few people there that didn't have a parent who was a dentist. If that's the only way you can enter this field, we are not going to do a good job of diversifying it.

Dr. MINTER-JORDAN. I would quickly add, we need to continue to remove the siloing between oral health and medical health, and ensure that we're cross training and create the idea of interdisciplinary teams that are focused on the patient and their families.

Dr. SWANN. We need to incentivize people from underserved communities to actually go in to get the training to who are culturally sensitive and return to those communities.

Dr. ISBELL. We are doing that in Alabama. We're trying to develop programs where students that are in high school from rural areas. It's really hard if for this, even with a social media, as Dr. Swann's mentioned, to get students once they've gone to Birmingham, Atlanta or Nashville to dental school, they've got student debt to get them to go back.

We have probably six counties in Alabama that there's some of my guys that are still there, but there's not any young dentists there. So really get them there. So really giving opportunities from the financial base of it, of them going to school with contracts, they understand what dentistry means and why it's so important to the patients. Because those patients in those areas deserve quality care is really important.

Then open access to when they're in our hospitals. Like I'm serving two hospital staffs for 43 years, but guess what? All the dental equipment's gone. It's dead. All my down syndrome, all my special need, all my nursing home patients. Guess what? There's not an operating room that I can go into for those very apprehensive, for those very severe.

I have a daughter that lives in an electric wheelchair that has SMAI understand disabilities, I understand barriers. So we bring stretchers into our office and gas and Alabama with ambulances bring them to us to take care of those people's deserve care. But some of those people, it would be really great if we worked across medical borders and we had an opportunity to seal whether, one Friday a month or whatever to see those patients general dentist are doing that. General dentist have done that for 50 years. And general dentist can do that in your state and mine, but that's not happening anymore. But we've got to educate young people the importance of high grade profession. Dentistry's a wonderful profession. I think everybody needs.

Senator HICKENLOOPER. The Chairman is going to come down on me. I'm already 2 minutes over, but anyway, I think this is one of our best panels. Okay.

The CHAIR. Good. Thanks.

Senator Kaine.

Senator KAINE. Thanks, Chairman Sanders, thanks to the panel. Dr. Swann, I want to talk to you about a part of the world that you and I both love. You're from Appalachian, Tennessee, and I appreciate your continued dedication to the region. I'm going to be in Appalachian, Virginia tomorrow visiting the Allegheny Highlands Dental Center, a dental center that serves folks in Appalachia that we were able to receive a significant congressionally directed expenditure to help them.

But in particular, I want to thank you for your work on Remote Access Medical. So just to paint the picture for my colleagues and those who are here. Remote Access Medical does dental clinics and other medical clinics in remote areas. One of the first sites that, and continuous sites, annual sites for RAM is the Virginia Ken-

tucky Fairgrounds in Wise County, Virginia. And beginning when I was Lieutenant Governor, I would often go to volunteer on this 3-day weekend of service.

What happens is people start arriving about Tuesday or Wednesday to park their car in a dusty county fairgrounds parking lot to get a number so that when it opens Friday morning, they can go in and get medical care.

The first time I came, I was struck when I walked through the parking lot, I would've expected to see vehicles from Virginia and Kentucky and Tennessee and West Virginia and North Carolina. But I was surprised to see vehicles with license plates from Georgia and Florida and Alabama, and even Oklahoma because low-income people at that point, beginning in 2002, 2003, had to drive that far to get medical care.

The clinic offers all kinds of medical care, but by far the most significant usage of the clinic are folks who are seeking dental care. And the most significant thing is teeth extraction. If you just look at the bucket where the teeth are extracted at the end of each day, I mean, it's just staggering the number of people who have to drive state through state, through state, just to have that happen.

The numbers of people going to the RAM Clinic declined when Virginia embraced Medicare expansion, Medicaid expansion, excuse me, that was positive. But because it's a border community and many of the surrounding states haven't done Medicaid expansion, there's still a lot of folks. But the numbers didn't decline on the people coming to seek dental care for a variety of reasons, dental care not being part of the essential health benefits yet.

Virginia has embraced in 2022 a Medicaid expansion for dental care. And Virginia has also done a salary supplement under Medicaid for those who are serving. And yet still only 27 percent of our dentists except Medicaid patients.

It's clear that we have an awful lot to do. Medicaid expansion has really helped the folks who came to that clinic and come every year. But on the dental side, we need more operations like the Allegheny Highland Center that I'm going to tomorrow and others.

I just appreciate the role that RAM has played in this safety net. It's kind of the first rung of the safety net and then free clinics and community health centers.

But in the Nation, that's probably the most powerful and wealthiest nation on the world, the fact that you'd have to drive through three or four states and park in a dusty parking lot and wait 3 days to get in line, so you can have your teeth pulled. I mean, I was a missionary in Honduras when it was one of the poorest countries in the western hemisphere next to Haiti. This was in 1980 and 1981. And it's not that different from what you might see in the dusty parking lot in Wise County, Virginia, which is the area of the state that my wife is from.

You said something Dr. Simon, I wanted to follow-up with you on, which is, it's not just reimbursement, there's a cultural thing. Because you're right, if Virginia, we embraced Medicaid for dental services, we expanded it. And then the legislature put more money into increased reimbursement rates, and that's showing some suc-

cess. But we still only have 27 percent of our dentists that accept Medicaid patients.

How do you view this cultural shift, any of you? And what, what might we do in addition to reimbursement increases to try to change that? I like who said, if we can just get each dentist to take five Medicaid patients, right? And then that plus the safety net would help. But what can we do?

Dr. SIMON. I'd also point out that the 27 percent number doesn't even paint the whole picture because only 5 percent of Virginia dentists see more than a hundred Medicaid patients a year. Yes. So you have an extraordinarily small workforce who's really doing the work.

A hundred Medicaid patients is not very many when the average dentist has a patient panel of 1,500-plus patients. So really, it's an incredibly small group.

I think understanding from that group themselves, how they're able to do that. I would imagine many of them work in community health centers or other settings where they have sort of more infrastructural support in order to provide this amazing care. But understanding the dentists were able to do it is probably the first thing.

The other thing, more big picture, would be to make a shift between fee for service to a value-based care model. Right now, dentists feel like they're not getting enough money for each procedure they do. But patients would benefit if they didn't need any procedures, and dentists make nothing if that's the case. Yes. So, a model that aligns patient and provider perspectives and lets dentists actually practice in a way that's more meaningful and preventive focused, I think is also part of that.

Senator KAINE. Other nations do that and they have much better health outcome than we do. Any others that might want to comment on this issue about the culture shift? If my Chairman would enable me now that I'm over time to hear the answer.

Dr. SWANN. Part of the culture shift is to shift more toward prevention. But to be able to teach people how to prevent disease and how disease are interacting with one another really requires increasing health IQ, and it means that you have to do it in a culturally sensitive way, even in Appalachia.

That's a culture. And you have to be able to use that as a way to be able to educate people about prevention. If we don't do that, we're never going to be able to fix and put band-aids on all these situations.

Senator KAINE. Dr. Minter-Jordan.

Dr. MINTER-JORDAN. I certainly would agree with everything that's been said. The focus on prevention and increasing and leveraging the use of ancillary providers within dental practices so that the dentist is focused on working at the top of their licensure and aided by ancillary providers in the office that helps provide more Access to Medicaid patients.

Senator KAINE. Then Dr. Isbell.

Dr. ISBELL. I think it comes down to education, Senator. I think it's about treating every patient that we can. In a practice like he's had, and I have, there's only so many patients you can see.

One of my associates treats the patients in the jail. Who wants to go do that? I mean, you, if you were a dentist, you're not going to want to do that, but guess what? They deserve care. How about our nursing home patients? We treat numerous nursing home. We bring them in and stretchers into our office, to take care of them. And many of our elder care, they're coming in wheelchairs, but having the structure where it can be there.

It gets down to how much you can do for our children. We see so many of our children, we go into the grammar schools and teach oral health literacy to our children, and then we send brochures home to try to get to the parents. How do you get to the parents? Because guess what? They weren't raised with that Senator, and the parents don't understand.

It starts from the bottom level, teaching the child, teaching the parent in every access that we can, to give them an opportunity to understand what Dr. Swann, has said. If there's so many things that we do in dentistry that by education and getting on there with just simple prevention, we can save so much for every family and prevent the catastrophic stories that we're all telling.

Senator KAINE. Well, I appreciate your service, your testimony, and thanks Mr. Chairman. I yield back.

The CHAIR. I would be remiss Dr. Swann, not mentioning Stan Brock. I met Stan. Well, Stan is the founder of RAM, I believe. And when you talk Senator Kaine about those, I remember seeing those photographs and it really, you're quite right, did not look like this was taking place in America. And Stan did a great job, I think, in raising consciousness of providing care with that. Senator Cassidy, do you want to introduce something into the record?

Senator CASSIDY. First, I want to point out Dr. Swann, did you notice that when Dr. Isbell said something earlier, like our vintage, and he nodded toward you, that he was kind of roping you into——

Dr. ISBELL. He is probably younger than me.

[Laughter.]

A lot better looking too, but yes.

Dr. SWANN. No, not, not really. But I am not younger than you. Class of 1975, UCSF.

Senator CASSIDY. Oh, wow. On behalf of Senator Paul, who could not be here today, I ask unanimous consent that this statement for the record from the American Dental Association, be submitted into the record.

The CHAIR. Without objection. That ends our hearing. And I want to thank each of our panelists. This is an enormously important issue. You raise consciousness on it. I thank you all very much for the work that you do personally and in advocating the need for quality dental care for all.

For any Senators who wish to ask additional questions, questions for the record will be due in 10 business days. I ask anonymous

consent to enter into the record five statements in support of dental health.

[The following information can be found on page 58 in Additional Material:]

The CHAIR. The Committee stands adjourned. Thanks again.

ADDITIONAL MATERIAL

United States Senate
Health, Education, Labor, and Pensions Committee
Bernard Sanders, Chair

The American People on the Dental Care Crisis

May 16, 2024

Llalla, from Randolph, VT
I shattered some of my teeth due to a calcium and potassium deficiency. My muscles locked up, even in my face. I'm losing bone in my jaw so with missing teeth and teeth about to fall out, I'm making soups and stews and puree meat in order to get nutrients I need. I'm trying to get back in the work force and I'm just not presentable with teeth that are now sideways, missing and jutting forward. I can't get a job that might give me dental as a benefit because my dental situation. I was told too many of my teeth were still good so I couldn't get them all removed and then get a nice set of dentures. Braces to fix these "good teeth" are way more expensive than dentures. I have Medicare and Medicaid and would love to be able to eat without the need to puree everything.

Lindsey, from Georgia
I broke my two front teeth mostly out in a bad fall in middle school, and had temporary caps put on the remnants at an emergency dentist until they could be replaced with permanent ones. I'm 29 now—but I still have those "temporary" caps. They flake off into my food when I eat.

Tany, from Minnesota
My mother quit taking me to the dentist at the age of 10. Due to lack of health insurance in my 20s I had to have an emergency impacted wisdom tooth extraction with only local anesthesia. It took almost 10 years of having dental health insurance to have all my teeth issues resolved.

Michelle, from Pennsylvania
I went years with chipped and broken/jagged teeth because I couldn't afford the repair. I just had them taken out last year. My daughter's father had a workplace accident that busted out all his teeth and he's not been able to have them repaired. Dental is healthcare!!

Mel
I didn't see a dentist for nearly 10 years, which included most of my teens and early 20s, due to having no health insurance. Since having health insurance I've managed to get a few pulled and a few filled but have literally racked up over $1500 in credit card debt from it.

Pati, from Idaho
Dental care for seniors on limited income is very expensive! And, at a time in life when we're most likely to need it. I have put off work that needs to be done because of the cost & so has my husband.

Anonymous, from Ohio
I definitely put off getting my wisdom teeth pulled until they rotted out and broke because I couldn't afford the procedure even with "dental insurance" that covered basically nothing but cleanings. Had to get a "dental credit card" when I did, the payments were back breaking.

Antonio, from Texas
Both my wife and I have had to travel numerous times to Mexico for our dental care due to exuberant prices even though we have "dental insurance".

Noelle, from California
Haven't been to the dentist in probably at least 15 years. Too expensive. Only went when it was an emergency. Just got Medicare Scan that had dental. Even with insurance paying I had to pay out enough to have bought a car, in some states a house. I basically depleted my savings!

Tim, from Wisconsin
I currently have three cracked and broken teeth. I have had this issue over a year now, and even with insurance it will cost me $1000 per tooth to crown. I don't have 3000 in a lump sum, but they have collected $50 a month to be "insured" for 22 years…

Merrie, from Louisiana
I've been waiting since before covid and a breast cancer diagnosis in 2021. I'm on Medicare now but they only covered half the cost of my crown. My mother passed away last year without being able to afford the dentist in the last 10 years of her life.

Gayle, from Plainfield, VT
My husband and I started going to Thailand for dental care 20 years ago because dental work is so expensive in the US and we needed implants and caps. Plus, we get a great vacation for what our dental work would cost us in the US. We'd like to have our teeth cleaned twice a year but paying $200-300 for a cleaning is ridiculous. Now that we are 80, our enamel is not great any more. We Americans have not been taught how important good teeth and clean tongues and gums are in terms of our healthcare. Why not?

Anonymous, from Michigan
I live in Michigan I have a full bottom denture and a top partial plate I broke my partial n I lost my bottom denture n I have to wait five years for my insurance to pay for new teeth

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Anonymous, from Arizona
I have been grinding my teeth most of my life, now 73. At 50 years old most of them fell apart. I have been living on SSDI since 1993 and no way to pay for dental care. A few months ago I traveled to the nearest city and to a dentist that can do dental surgery for an estimate of restoring my mouth. I have many teeth broken off at the gum line. 7,500.00 to restore my mouth and fit me with dentures. Now I am poor and in hospice but wanted to tell my story even though I live in Arizona. I know I am not alone in this situation.

Anonymous, from Maryland
I have a dental issue that needs to be taken care of but I do not have the funds to have the procedure because my insurance only covers 15% leaving me with a bill that I cannot afford to pay. In the meantime, I use the temporary filling and Tylenol to ease my pain.

Stephanye, from Mississippi
I have had to wait months to get into a lower cost dental clinic for root canals, fillings, and crowns. I am 70 years old.

Wanda, from Idaho
I've been blessed to have a Union job and was covered by insurance. A unexpected medical retirement left me without dental insurance for a couple years. I couldn't get a cleaning done as preventive, because I was due for x-ray and couldn't afford the $400! Ended up with having to have a lot of work done, when I was finally covered again.

Amanda, from New Hampshire
My mom is in excruciating pain most of the time because of her teeth. She needs so much work done. Dental care is health care and should be as accessible as such. She is on disability. At first she was on Medicaid and they paid for quite a bit, but when she reached a certain age she was switched to Medicare and now barely anything is covered. And it's very hard to find a dental practice that takes her insurance.

Meagan, from Minnesota
When I moved out of state, I lost my insurance and my new job didn't offer affordable coverage, so I went without. I haven't been to the dentist in over 8 years. I finally have an appointment in a few weeks and I'm pretty nervous about the damage that was done in that time.

Mary, from Illinois
Medicare and Medicaid dental coverage is a complete joke in my area. Our local health department will accept it but they only do cleanings and fillings. If you need anything else there isn't a single dentist within 100 mile radius that will accept it. And forget about finding a pediatric dentist. I have a friend that took out a loan and is paying out of pocket for her daughter to get the dental care she needs. It's ridiculous.

Nicole
I am 60 years old and I have never had dental insurance my entire life! I have worked in childcare centers for over 40 yrs and it is not offered, and if it is, it's too costly. The last time I was at the dentist was when I was 12. I am not even joking.

Anonymous, from Delaware
I went for 10 years without dental care, because I could not afford dental insurance, and the prices for regular care were too expensive. Eventually, I found a dental school in my area that had reduced cost procedures for low income patients. It took over a year worth of appointments, and still several thousand dollars, to get all the fillings, root canals, oral surgeries, and crowns I needed to have done. Then again, a few years later, during the COVID-19 pandemic, one of those crowns broke. Because I now made slightly more than the upper limit of what that dental school considered "low income", I did not qualify for their reduced cost services, but I still couldn't afford dental insurance or full cost dental procedures. I wound up forgoing treatment on that tooth for 2 years. I have dental insurance now, because of the Obamacare health insurance marketplace, but coverage for major procedures still won't start until 6 months into the coverage year, meaning I have to wait another month before I can have what's left of that now unsaveable tooth pulled. It may be years before I can afford to get implants.

Donna, from Virginia
As a small business owner from 2012 to 2022, I could not afford insurance for me or my employees. I sustained broken teeth due to cavities, two of which I just elected to have pulled because I couldn't afford repairs. You learn to just chew on your good side and hope for the best. In 2022 I was diagnosed with stage 3 breast cancer; luckily I had applied under the ACA during Covid and received Virginia Medicaid so my cancer treatment was covered. To prevent breast cancer from spreading to my bones, I need a medicine called Zometa. Due to side effects, this requires your teeth to be in good health before it's administered, and I had not been able to afford any dental care for years (long ago I had enjoyed coverage under my ex-husband's wonderful federal employee benefits). Unable to work during & after cancer treatment, I was broke and my only option was our local community health (formerly "free") dental clinic. I still had to pay $75 and more per visit and appointments are hard to get but I got my teeth fixed and am now able to receive the Zometa, which will hopefully prevent the cancer from progressing to my bones. I believe Virginia Medicaid has since added dental coverage but it is very hard to find a provider.

Dr. Havaleh Gagne, from South Burlington, VT
I am a Radiation Oncologist, with interest in geriatric oncology. I have many retired patients who cannot afford, or have difficulty paying for their dental care after head and neck radiation. The problem is similar for those with Medicaid. It is a struggle for patients to find a dentist, or oral surgeon who takes Medicaid, for what little Medicaid pays, out of pocket expenses are beyond most people's budget. When people have dental problems, they lose teeth, when they lose teeth they can't chew, when they can't chew, they eat poor quality food, when they eat poor quality food they are not as healthy. This is compounded when teeth are infected and cause other severe health problems when not addressed in a timely manner. Also, in our American culture, having nice teeth is more socially acceptable. I have patients who are missing front teeth, are embarrassed and don't speak or smile in public this results in social isolation which is a risk factor similar to smoking in predicting early death. I can probably find patients to share their story, but would need their permission before passing along contact info. It is ridiculous in this age to single out one part of the body that gets sick and doesn't get care.

Anonymous
I have never understood why dental or vision is not considered regular health care all covered under health insurance hearing also.

Makes no sense to me

Deborah
My 28 year old granddaughter, mother of a 9 month old, has no dental insurance and is now adding additional medical debt in addition to birthing debt because she has an abscess tooth: 1200. Root canal. 1100 crown. Only in America can a young family become indebted to the point of poverty because of healthcare.

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May 16, 2024

The Honorable Bernie Sanders
Chair
Committee on Health, Education,
Labor & Pensions
United States Senate
Washington, DC

The Honorable Bill Cassidy, MD
Ranking Member
Committee on Health, Education,
Labor & Pensions
United States Senate
Washington, DC

Dear Chairman Sanders and Ranking Member Cassidy:

AARP, which advocates for the more than 100 million Americans age 50 and older, thanks you for holding a hearing on Examining the Dental Care Crisis in America. We share your commitment to making dental care more affordable and more available. Lack of access to affordable dental care can have profound health consequences across populations. Older Americans, in particular, know that oral health affects all aspects of their health and wellbeing. Poor oral health can cause complications for people with chronic conditions, hasten cognitive decline, lead to social isolation, and increase overall health care expenses.

We believe the most straightforward and impactful action to increase dental care access across the country is to include dental coverage as a standard benefit in Medicare. As the largest health care payor in the country, Medicare coverage decisions often influence coverage decisions in the private market. Including comprehensive dental coverage in traditional Medicare as a Part B benefit would establish oral health as essential to overall health, and prompt other payors to follow suit. Currently, Medicare does not cover routine dental care. By law, Medicare does not pay for preventive or diagnostic services such as teeth cleanings or x-rays. It also does not cover basic restorative procedures like fillings, nor more complex restorative care like dentures or implants. Medicare Advantage plans may voluntarily offer some dental coverage, but it is not guaranteed and varies greatly.

Fortunately, Medicare is taking some steps to recognize the medical importance of oral health. In 2023, the Centers for Medicare & Medicaid Services revised their policy to allow Medicare coverage for "medically necessary" dental care that is integral and inextricably linked to the success of a covered health service. This policy change will allow Medicare beneficiaries to receive the prerequisite oral care needed for organ transplants, cancer treatment, or many other health services. Before this change, the lack of coverage for oral care created a barrier preventing access to life-saving health care treatments.

Despite this advancement, the continued separation of dental care from medical care is reflected throughout our health care system and across insurers. Only recently has oral health care begun to be more incorporated into medical insurance coverage. Medicare Advantage plans are able to offer supplemental dental benefits; CMS recently proposed allowing adult dental services to be included in state Marketplace plans as an Essential Health Benefit; and more state Medicaid plans are including dental coverage. These are important steps in the right direction, but more must be done. For instance, the Committee and Congress should consider a robust minimum standard of dental benefits for inclusion in

health insurance coverage. Additionally, states should be encouraged to take up adult dental coverage as an essential health benefit, and reimbursement rates for public payors should appropriately reflect costs and encourage provider participation.

However, increased dental coverage itself does not equal access to care. AARP recognizes that there is a lack of dental providers in many parts of the country. As with other parts of the health care workforce, interest in using health professionals in more flexible ways is growing as emerging models of health care delivery seek to improve coordination and efficiency. For example, evidence indicates that dental therapists in independent practice provide safe, competent care for many services that is comparable to that provided by dentists. Allowing dental therapists to provide the full array of services for which they are qualified based on their education and training could help alleviate care gaps in areas with little or no access to oral health care.

Maine, Minnesota, Vermont, and tribal lands in Alaska, Oregon, and Washington state utilize dental therapists to provide basic dental services, such as fillings and extractions. Other states are also considering doing so. The services they provide have been rigorously evaluated and found to be safe and of a quality comparable to that of licensed dentists. Allowing these practitioners to work in areas currently underserved by dentists — particularly in geographically isolated and rural areas — will enable many more people, including older adults, to obtain high-quality oral health care.

Every American deserves accessible and affordable health care — from head to toe. AARP thanks the Committee for examining oral health coverage and looks forward to working with you to ensure more Americans have access to the care they need. If you have any questions, feel free to contact me or have your staff contact Andrew Scholnick on our Government Affairs team at ascholnick@aarp.org.

Sincerely,

Bill Sweeney
Senior Vice President
Government Affairs

Testimony for the Record
Submitted to the Committee on Health, Education, Labor, and Pensions
United States Senate
May 16th, 2024

In response to a hearing on **Examining the Dental Care Crisis in America: How Can We Make Dental Care More Affordable and More Available?**

Prepared by Annaliese Cothron, DHSC, MS, CPH
Co-founder and Executive Director of The American Institute of Dental Public Health

Introduction
Chairman Sanders, Ranking Member Cassidy, and Members of the Committee: let me begin by thanking you for conducting a hearing on this important topic and inviting the American Institute of Dental Public Health to submit written comments in response to this critical issue. The dental care crisis in America is profound, requiring a nuanced policy discussion to elucidate the issues and identify equitable solutions for improving access and affordability of dental care.

The American Institute of Dental Public Health (AIDPH) is a 501c(3) nonprofit organization that empowers our community to advance oral health through research, education, and advocacy. AIDPH believes it is our responsibility to address individual, institutional, and systemic barriers that keep communities from achieving optimal oral health across the lifespan. As part of our community-engaged approach, AIDPH builds the capacity of the oral health workforce to improve the quality, access, and affordability of dental care in historically excluded, marginalized, and underserved communities. AIDPH predominantly concentrates these efforts within our four core communities of focus: LGBTQIA+, rural, veterans, and people with disabilities.

The purpose of our testimony is to highlight the pervasive oral health inequities experienced within the US healthcare system and offer policy recommendations that address this gap. The dental care crisis in America is not just a failure of health; it is a failure of justice. Across the country, millions of people, especially within rural, veteran, disabled, and LGBTQIA+ communities, face substantial barriers to receiving basic dental care. These barriers not only perpetuate disparities but also exacerbate other health conditions, leading to a cycle of health inequity that is financially shouldered by patients, providers, and payers. Our testimony will define these challenges and illuminate the pathways toward policy solutions to ensure no community is left behind in accessing affordable dental care.

An Overview of Dental Care Access and Affordability
A person cannot have good health without good oral health. Oral health and overall health are inherently linked through the oral-systemic connection.[1] As a function of this

[1] American Dental Association. "Oral-Systemic Health." American Dental Association. Accessed May 2024. https://www.ada.org/en/resources/ada-library/oral-health-topics/oral-systemic-health.

connection, the inability to access high-quality and affordable dental care threatens a person's overall health and well-being. There are 7,651 dental healthcare professional shortage areas (DPHSA) in the US, impacting over 79 million residents.[2] Roughly two-thirds of working-age adults in the US see a dentist annually, a number that has remained virtually unchanged among the total population for over 15 years.[3] When examining the same time period and evaluating the cost of healthcare, the results are sobering. Americans have experienced an 88% increase in personal healthcare expenses since 2005, with out-of-pocket expenditures rising by 53%.[4] Dental service expenditures have increased by 64.2% since 2005, with approximately 42% of total dental expenditures paid out-of-pocket by consumers. While out-of-pocket costs for dental care have slowly decreased over time, consumers are still personally paying 41 cents of every dollar spent on dental care throughout the US, the highest among all healthcare costs - including hospital expenditures, physician and clinical expenditures, home healthcare expenditures, nursing care facilities, and prescription drug costs. Americans consistently report delaying medically necessary dental care due to cost, with 17% of working-age adults forgoing dental treatment in the past year because they couldn't afford care.[5] Taken together, these data suggest that Americans pay more each year for their healthcare, and in the case of dental care, accessing services at the same rate for significant costs.

The chronic lack of access to affordable dental care strains other aspects of the healthcare system, creating unnecessary and costly emergency department visits. In 2019, more than 2 million emergency department visits occurred for non-traumatic dental conditions (NTDCs) or issues that could have been averted through adequate access to dental care in a routine setting.[6] These visits resulted in treatment costs of over $3.4 billion, a rate that has steadily increased over time despite an overall reduction in ED visits since 2010. These ED visits and resulting costs are more significant for low-income, rural, and younger working-age adults, an alarming trend when considering the exacerbating socioeconomic conditions experienced among these marginalized groups.[7]

Oral Health and Chronic Disease Conditions

Adverse oral healthcare outcomes are exacerbated through poorly managed chronic disease conditions - and vice-versa. One in ten Americans (11%) are living with diabetes, and roughly 6% of adults have been diagnosed with heart disease – resulting in millions of Americans experiencing high-risk, high-cost chronic disease conditions that increase their poor oral health outcomes. [8] Among this population, 45% of adults

[2] County Health Rankings. Dentists – 2024 Annual Data Release. Available at: https://www.countyhealthrankings.org/health-data/health-factors/clinical-care/access-to-care/dentists?year=2024
[3] National Center for Health Statistics. Health, United States, 2020-2021. Table DentAd. Hyattsville, MD. 2022. Available from: https://www.cdc.gov/nchs/hus/data-finder.htm.
[4] National Center for Health Statistics. Health, United States, 2020-2021. Table HExpPers. Hyattsville, MD. 2022. Available from: https://www.cdc.gov/nchs/hus/data-finder.htm.
[5] American Dental Association Health Policy Institute. National Trends in Dental Care Use, Dental Insurance Coverage, and Cost Barriers. Chicago, IL: March 2024. Available from: https://www.ada.org/resources/research/health-policy-institute/coverage-access-outcomes
[6] CareQuest Institute for Oral Health. Recent Trends in Hospital Emergency Department Visits for Non-Traumatic Dental Conditions. Boston, MA: May 2022. Copyright © 2022 CareQuest Institute for Oral Health, Inc.
[7] CareQuest Institute for Oral Health, Inc. Healthy Mouths: Why they matter for adults and state budgets. Boston, MA; February 2020. DOI:10.35565/CQI.2020.1001 Copyright ©2021 CareQuest Institute for Oral Health, Inc.
[8] Centers for Disease Control and Prevention. Diabetes by the Numbers. Available at: https://shorturl.at/hjGNZ

with heart disease did not visit a dentist in the past year [9] Similarly, 42% of adults with diabetes did not visit a dentist in the past year. Substantial evidence supports the connection between oral health, diabetes, stroke, and heart disease, indicating access to preventive and comprehensive dental care reduces the cost of medical treatment for these chronic diseases.[10] Improved access to oral health care for Americans with these chronic disease conditions not only improves quality of life and health outcomes but also reduces the financial burden of the patient and the payer through more effective and holistic treatment.

The Impact of Poor Oral Healthcare Access Among Marginalized, Underserved, and Historically Excluded Communities

An Overview of Veteran Oral Health: There are approximately 18 million veterans in the US, of which roughly half are eligible for medical care administered through the Veteran Health Administration.[11] Among these veterans, 22.5% meet the eligibility requirements for dental care outlined in Title 38 of the Federal Code.[12] Of the 22.5% eligible for dental care, approximately 32% of veterans utilized their dental benefit through the VA in FY 2024. This is a steady trend of low utilization despite a 7% recent increase in eligibility due to the PACT Act. In short, most veterans are not eligible for dental care through the VA, or don't utilize their benefit if they are eligible, resulting in a chronically underserved community. Veterans have more caries experience, gum disease, and edentulism compared to nonveterans.[13] These oral health outcomes are often related to chronic disease conditions like heart disease and diabetes, of which veterans experience higher prevalence rates compared to nonveterans.[14] The cost savings associated with treating veterans with heart disease and diabetes in an integrated care environment average roughly $3.4 billion annually – over a billion dollars more than the FY 2025 VHA budget request for dental services.[15] A report published by AIDPH revealed these chronic disease issues are complicated by intersecting inequities like income, education, and rurality. Rural veterans experience poorer oral health outcomes compared to their urban counterparts.[16] Rural veterans pay higher out-of-pocket costs for dental care, have poorer self-reported oral health, and experience edentulism at higher rates than nonrural veterans.[17] In summary, all available data indicate that veterans not only encounter poorer oral health outcomes and access compared to nonveterans but that factors like rurality and high prevalence of chronic disease conditions make oral health worse for subgroups of this community. Veteran stories shared with AIDPH underscore the human impact of poor access to dental care:

[9] Centers for Disease Control and Prevention. BRFSS Web Enabled Analysis Tool. 2020. Available at: https://nccd.cdc.gov/weat/#/analysis
[10] Cigna Healthcare. Improved Health and Lower Medical Costs: Why Good Dental Care is Important. June 2016. Available at: https://legacy.cigna.com/assets/docs/business/large-employers/dental-white-paper.pdf
[11] Veterans Affairs. About the VHA. Available at: https://www.va.gov/health/aboutvha.asp
[12] US Department of Veterans Affairs FY 2024 Budget Submission. March 2024. Available at: https://www.va.gov/opa/docs/remediation-required/management/fy2025-va-budget-volume-ii.pdf
[13] The American Institute of Dental Public Health and CareQuest Institute for Oral Health. Veteran Oral Health: Expanding Access and Equity. Boston, MA: December 2021. DOI: 10.35565/CQI.2021.2041.
[14] The American Institute of Dental Public Health and CareQuest Institute for Oral Health. Veteran Dental Care Stimulates the Economy and Improves Overall Health. Boston, MA: April 2022.
[15] US Department of Veterans Affairs FY 2024 Budget Submission. March 2024. Available at: https://www.va.gov/opa/docs/remediation-required/management/fy2025-va-budget-volume-ii.pdf
[16] Cothron, A., Shaver, A., Boynes, SB. Chronic Disease and Rurality Impacts Veteran Oral Health Outcomes: A Behavioral Risk Factor Surveillance System Analysis. J Am Col Dent 2022; 89 (2): 1-60. Available at: https://bit.ly/3UKvpYx
[17] The American Institute of Dental Public Health and CareQuest Institute for Oral Health. Improving the Oral Health of Rural Veterans Through Policy, Data Collection, and Care Delivery. Boston, MA: November 2022.

"If I pay for this, I'm positive I'd end up homeless. As it is, I barely can afford food. I never go anywhere except to VA appointments. It's a 2-hour drive, and gas isn't cheap." 71-year-old retired Army Veteran from Delaware who has undergone chemo treatment and lost the majority of her teeth as a result.

"Dental care is vital for us veterans that have disability designations but [are] not [at] 100%. We should have access to dental care even if at a discounted rate. It is critical to our health and I know my mouth situation affects me greatly." Working-age army veteran from Massachusetts

An Overview of Oral Health for People with Disabilities: According to the CDC, more than a quarter of adults in the US report having some kind of disability.[18] Most commonly, these disabilities are related to mobility and cognitive functioning. Adults with disabilities are more likely to experience heart disease, diabetes, and stroke – chronic disease conditions with strong influences on oral health outcomes. Notably, adults with intellectual, acquired, or developmental disabilities report seeing a dentist less frequently, often going two or more years without accessing dental care, with cost reported as the most common barrier.[19] The result of this lack of access to care is profound oral health disparity: more extractions, greater prevalence of gum disease, more cavities, and significant edentulism.[20] People with a disability also experience stigma and discrimination in healthcare settings, with more than half reporting having been refused dental care in connection to their disability.[21] This personal experience is best described by Jackie Kancir, Policy Director, National Council on Severe Autism and Patient Advocacy Director, SynGAP Research Fund, who shares her history finding dental care for her child with disabilities:

"Here's a child that was in excruciating pain, face was swollen. And you had these doctors who took an oath to do no harm who were just sending her out without even an antibiotic, without any pain medicine [because they would not treat her with her disability.] I've said all along: I have a German Shepherd. Most vets hate dealing with German Shepherds, but it's easier for me to get my dog humane treatment than it is my daughter. And it just absolutely breaks my heart. It really does."

An Overview of Rural Oral Health: People living in rural areas experienced intersecting inequities facilitated by geographic barriers to accessing dental care. As a result of these barriers, rural people sustain poorer oral health outcomes, including gum disease, edentulism, and cavities.[22] More than 1/3 of people in rural areas do not have dental

[18] Centers for Disease Control and Prevention. Disability and Health Data System (DHDS) [Internet]. [updated 2023 May; cited 2023 May 15]. Available from: http://dhds.cdc.gov
[19] Chavis SE, Macek M. Impact of disability diagnosis on dental care use for adults in the United States: Status matters. J Am Dent Assoc. 2022 Aug;153(8):797-804. doi: 10.1016/j.adaj.2022.03.002. Epub 2022 May 5. PMID: 35527037; PMCID: PMC9339456.
[20] Wilson, N. J., Lin, Z., Villarosa, A., & George, A. (2019). Oral health status and reported oral health problems in people with intellectual disability: A literature review. *Journal of Intellectual & Developmental Disability*, *44*(3), 292–304. https://doi.org/10.3109/13668250.2017.1409596
[21] CareQuest Institute for Oral Health. Family Affair: A Snapshot of Oral Health Disparities and Challenges in Individuals in Households Experiencing Disability. Boston, MA: October 2022
[22] Mitchell J, Bennett K, Brock-Martin A. Edentulism in high poverty rural counties. J Rural Health. 2013 Winter;29(1):30-8. doi: 10.1111/j.1748-0361.2012.00440.x. Epub 2012 Oct 22. PMID: 23289652.

insurance coverage, and 2/3 live in a dental health professional shortage area.[23] Rural people report higher rates of chronic disease conditions like heart disease and diabetes, even when controlling for other contributing factors like education and income, which exacerbate poor oral health outcomes and the lack of access to dental care.[24] Socioeconomic and structural factors like high rates of poverty, increased substance use, and steady closures of rural healthcare clinics not only complicate dental care access in rural communities but impact the overall quality of life. As a result of these systemic inequities, rural oral health is dire, and policy solutions require a multi-directional approach that considers both upstream and downstream effects. Alan Morgan, CEO of the National Rural Health Association, shares his perspective on the complex challenges experienced by rural Americans:

> *"Rural America is often a story about workforce shortages, vulnerable populations, and chronic poverty. Let's be honest: the truth lies in between. The challenges that we face in Rural America drive innovation and that's an important starting point. People living in rural areas are often sicker, older, and poorer. It's not a smaller version of urban living, it's a unique healthcare delivery environment that requires an asset-based approach to policy change."*

An Overview of LGBTQIA+ Oral Health: LGBTQIA+ people experience stigma and discrimination in the healthcare system, including dental care. Roughly 2/3 of LGTBTQIA+ adults report experiencing some level of discrimination during a recent healthcare visit.[25] These encounters with discrimination often leave LGBTQIA+ patients feeling unempowered to support health recommendations and treatment plans – and, in some cases, can create long-term feelings of stress and anxiety that impact future health visits. Recent survey research indicated that 43% of LGBTQIA+ dental patients report feeling uncomfortable during appointments, and over 1/3 of those surveyed reported unfair treatment by dental providers.[26] The result of these negative experiences is delayed dental care, with LGBTQIA+ people being 77% more likely to visit an emergency department to address a dental need.[27] While oral health outcomes among LGBTQIA+ people are under-researched, available literature indicates queer people often rate their oral health more poorly than their non-queer peers and express trouble both accessing and financing their dental care.[28]

Policy Recommendations to Address Oral Health Inequity in Underserved Populations

Building on our community-engaged research and information framework, AIDPH has developed a series of policy recommendations that make dental care more affordable

[23] Martin, Paige, Santoro, Morgan, Heaton, Lisa J., Preston, Rebecca, and Tranby, Eric P. Still Searching: Meeting Oral Health Needs in Rural Settings. Boston, MA: November 2023. DOI: 10.35565/CQI.2023.2007.
[24] Cothron, A., Shaver, A., Boynes, SB. Chronic Disease and Rurality Impacts Veteran Oral Health Outcomes: A Behavioral Risk Factor Surveillance System Analysis. J Am Col Dent 2022; 89 (2): 1-60. Available at: https://bit.ly/3UKvpYx
[25] Montero A., Hamel L., Artiga S., Dawson, L. LGBT Adults' Experiences with Discrimination and Health Care Disparities: Findings from the KFF Survey of Racism, Discrimination, and Health. Kaiser Family Foundation. April 2024. Available at: https://www.kff.org/report-section/lgbt-adults-experiences-with-discrimination-and-health-care-disparities-findings/
[26] Tharp G, Wohlford M, Shukla A. Reviewing challenges in access to oral health services among the LGBTQ+ community in Indiana and Michigan: a cross-sectional, exploratory study. PLoS One. 2022;17(2):e0264271.
[27] CareQuest Institute for Oral Health. "Oral Health and the LGBTQ+ Community: A Snapshot of Disparities and Discrimination." Boston, MA: June 2022..
[28] Gupta A, Salway T, Jessani A. Cost-related avoidance of oral health service utilization among lesbian, gay, and bisexual individuals in Canada. J Public Health Dent. Published online June 16, 2023. doi:10.1111/jphd.12574.

and accessible. While these recommendations focus on underserved, marginalized, and historically excluded communities – particularly within our four communities of focus – we recognize that effective policy change ultimately helps all Americans access more affordable and high-quality dental care.

1. **Expand Medicaid and Medicare to require a comprehensive adult dental benefit.**
   - Expanding Medicaid to include a comprehensive dental benefit for all enrollees saves money. The cost averages roughly $4.64 per member per month, with a resulting net cost savings of over $836 million.[29] Data also indicate that states ultimately spend less money by offering comprehensive dental benefits vs. a limited or emergency benefit.[30]
   - Nearly half of Medicare beneficiaries do not have dental coverage, and the same percentage of beneficiaries haven't visited a dentist in the past year.[31] Of those who did see a dentist, one in five spent over $1,000 out-of-pocket on dental treatments. Several policy options exist, including an expansion under Part B and Part D, that increase access to dental care and make coverage more affordable for beneficiaries and taxpayers.[32]
   - Medicaid does not extend uniform, comprehensive coverage to adults with disabilities in all states. People with disabilities, particularly those with intellectual and developmental disabilities, rely heavily on Medicaid and Medicare for dental care coverage. Extensions of coverage could create a cost savings of at least $7 million annually with additional implications for reductions in emergency department costs.[33]
2. **Increase the oral health workforce to meet the needs of underserved communities.**
   - Roughly 79 million Americans live in a D-HPSA with inadequate access to an oral health provider. At least 13,000 additional dental practitioners are needed to meet the current dental care demand.[34] Over 62% of DHPSAs are located in rural areas, although many low-income urban areas are also designated as DHPSAs.[35] Increasing eligibility and funding for existing workforce accelerators, such as loan repayment programs, facilitates the entry of dental providers into low-income and underserved areas. Additional financial incentives should be given to dental providers from rural backgrounds and historically excluded communities.
   - All dental providers should work at the top of their scope and licensure, with pay commensurate with their skills and abilities. Care delivery solutions that facilitate access to oral health, like dental therapists and expanded-function

[29] Burroughs A, Reusch, C. New Data: Medicaid Adult Dental Coverage is Wise Investment for Economic Recovery. Families USA. July 2021. Available at: https://rb.gy/lql3v5
[30] Lyu W, Wehby GL. The effects of Medicaid expansions on dental services at federally qualified health centers. J Am Dent Assoc. 2023;154(3):215-224.e10. doi:10.1016/j.adaj.2022.11.005. Published online January 10, 2023.
[31] Freed M, Ochieng N, Sroczynski N, Damico A, Krutika A. Medicare and Dental Coverage: A Closer Look. Kaiser Family Foundation. July 2021. Available at: https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/
[32] Freed M, Potetz L, Jacobson G, Neuman T. Policy Options for Improving Dental Coverage for People on Medicare. Kaiser Family Foundation. Published September 18, 2019. Available at: https://rb.gy/278xvb
[33] National Council on Disability. Medicaid Oral Health Coverage for Adults with Intellectual & Developmental Disabilities – A Fiscal Analysis. Published March 9, 2022. Available at: https://rb.gy/800wxt
[34] Kaiser Family Foundation. Dental Healthcare Professional Shortage Areas. November 2023. Available at: https://rb.gy/5gzscu
[35] Rural Health Information Hub. Health Professional Shortage Areas: Dental Care, by County, April 2024. Available at: https://www.ruralhealthinfo.org/charts/9

dental assistants, should be covered by Medicare and Medicaid.[36] Expanded function assistants and hygienists should be eligible for loan repayment programs to reduce education costs and incentivize care delivery in underserved and rural areas. Maximizing care delivery of the entire oral health workforce improves access and is a cost-effective solution to dental workforce shortages.[37]

3. **Finance dental care delivery models that are integrated and value-based.**
   - Dental care delivery exists in a fee-for-service (FFS) model that financially incentivizes the quantity of procedures vs. the quality of oral health outcomes. The divergence of this FFS payment model from many other primary care systems that utilize value-based care reinforces a siloed approach to dental care. Patients in value-based systems access prevention more frequently, require less costly treatment, like hospitalization, and save millions in out-of-pocket and insurer expenditures annually.[38] Data underscore the ability to increase affordability and accessibility in a value-based payment model for both Medicaid and Medicare.[39,40]
   - Federally Qualified Health Centers (FQHCs) are a best-practice model for integrated and holistic healthcare delivery, often serving as a conduit for value-based and alternate payment models.[41] Patients seen in integrated settings, like FQHCs, are more likely to have medical issues, like chronic diseases, managed in conjunction with their oral health needs. The result of this integrated care delivery system is a reduction in medical costs and improved oral health outcomes. Moreover, FQHCs serve as a crucial care access point for underserved and historically excluded communities, including people with disabilities, veterans, LGBTQIA+ people, and people in rural areas. Federal policy should support expansion and increased funding for FQHCs – and FQHCs that support historically excluded communities, like LGBTQIA+ people, should receive additional funding designations to improve access to dental care for these populations.
4. **Expand VA dental eligibility to include the highest-risk, highest-cost veterans.**
   - The VA is the largest integrated healthcare system in the United States. As such, the VA can appreciate the highest cost savings by expanding dental care eligibility to veterans with heart disease and diabetes. The financial benefits of expanding care to veterans through the VA are such that for every dollar spent on dental care for veterans with diabetes, a dollar is saved in medical care treatment. For heart disease, this cost savings increases to two dollars. As a result, the VA can save up to $3.4 billion in taxpayer dollars by

[36] Cooper M. Dental Therapists: A Solution to Dental Deserts. Georgetown J Policy Law. January 29, 2023. Available at: https://www.law.georgetown.edu/poverty-journal/blog/dental-therapists-a-solution-to-dental-deserts/
[37] Kim FM. Economic Viability of Dental Therapists. Prepared for Community Catalyst. May 2013. Available at: https://www.communitycatalyst.org/wp-content/uploads/2022/11/economic-viability-dental-therapists.pdf
[38] Humana Healthcare. Value-Based Care Annual Report. 2023. Available at: https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=5413213
[39] McLeod C, Mathews R, Tranby E, Leonin E, Holloway D, Sonnek A. Value-based payment alignment: A case study for oral health. October 2022. Dental Economics. Available at: https://rb.gy/xqblf1
[40] Centers for Healthcare Strategies. Moving Toware Value-Based Payment in Oral Health. 2021. Available at: https://www.chcs.org/media/Moving-Toward-VBP-in-Oral-Health-Care_021021.pdf
[41] National Association of Community Health Centers and DentaQuest Partnership for Oral Health Advancement. August 2020. Oral Health Value-Based Care: The Federally Qualified Health Center (FQHC) Story. Boston, MA. DOI: 10.35565/DQP.2020.2013

expanding eligibility for veterans with heart disease and diabetes to receive dental care.

- Veterans are disproportionately located in rural areas, complicating access to dental care for the 22% of veterans who are eligible for care through the VA.[42] Increasing care through the Community Care Network as the VA bolsters its oral health workforce allows veterans in underserved areas to access dental care. Increasing care coverage and care delivery through teledentistry and mobile dentistry facilitates access to dental care for rural veterans and all rural communities.

Conclusion

In closing, we reiterate our appreciation to Chairman Sanders, Ranking Member Cassidy, and HELP committee members for recognizing the critical role of oral health in our nation's broader healthcare landscape. AIDPH is committed to dismantling the barriers that perpetuate oral health disparities, and we urge Congress to take bold, decisive action to ensure equitable policy solutions, like those outlined in our remarks, to make dental care more accessible and affordable. Our testimony has outlined the dire state of oral health in our nation and its disproportionate impact on our most vulnerable populations, including rural communities, veterans, LGBTQIA+ people, and individuals with disabilities. These disparities are not just alarming; they are a clear indication of our current system failures and a clear call to action for policy solutions. AIDPH and our community partners look forward to working with each of you to make these necessary changes a reality.

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Brief Biography

Dr. Annaliese Cothron is the Co-Founder and Executive Director of the American Institute of Dental Public Health (AIDPH). She holds a Doctor of Health Sciences (DHSc) from AT Still University, specializing in Leadership and Organizational Behavior, and a Master of Science in Experimental Psychology with a focus on Applied Statistics from Mississippi State University. Dr. Cothron specializes in mixed-methods research using a community-engaged approach to advancing oral health equity. As a nonprofit leader and oral health researcher, she has received more than five million dollars in federal, foundation, and private funding. Dr. Cothron's work is driven by a commitment to the mission, vision, and values of AIDPH, focusing on advancing oral health equity and education while dismantling barriers to care.

[42] The American Institute of Dental Public Health and CareQuest Institute for Oral Health. Improving the Oral Health of Rural Veterans Through Policy, Data Collection, and Care Delivery. Boston, MA: November 2022.

AMERICA'S PEDIATRIC DENTISTS
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Examining the Dental Care Crisis in America: How Can We Make Dental Care More Affordable and More Available?

Testimony of Scott W. Cashion, DDS, President, American Academy of Pediatric Dentistry

May 16, 2024

Chairman Sanders, Ranking Member Cassidy and Members of the Committee:

The American Academy of Pediatric Dentistry (AAPD) appreciates the opportunity to submit a statement for the record for the United States Health Education Labor and Pensions Committee's hearing on "Examining the Dental Crisis in America: How Can We Make Dental Care More Affordable and More Available." The Committee has an important role to play in addressing dental workforce issues, supporting dental access in rural and other communities, ensuring dental coverage and access within the health exchange marketplaces and broader health plan coverage, and supporting the authorization of important and needed dental programs across federal agencies, notably the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), and the Centers for Medicare and Medicaid Services (CMS).

While we have seen the prevalence of tooth decay nationally decrease in the U.S., nearly one-in-five children under the age of five has experienced dental decay. Dental decay IS NOT an equal opportunity disease. Children living in poverty are twice as likely to suffer tooth decay and two-times as likely to go untreated as compared to more affluent peers. This disparity is also prominent in the disability community. We know that tooth decay compromises the health, development, and quality of life of children, affecting such factors as eating, sleeping, self-esteem, speech development and school performance.

The AAPD and other dental and medical professional groups endorse the importance of having the child's first visit dental visit on or before age one to establish a dental home. The Academy defines a dental home as an ongoing relationship between the dentist and a patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.[1] A dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A dental home addresses anticipatory guidance and preventive, acute and comprehensive oral health care and includes referrals to dental specialists when appropriate. Early dental visits can prevent suffering from dental pain and/or disease, reduce dollars spent on future surgical and emergency dental services, and maximize the chances for children to grow up with healthy, happy smiles.

[1] American Academy of Pediatric Dentistry. Definition of Dental Home. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2022:15.

Young children are more vulnerable to oral disease and its consequences given that they depend on others to receive care. We also know that children living in poverty have a higher risk of dental decay.[2] Non-Hispanic black and Hispanic children are almost three times more likely to live in poverty than white children. Dental caries (decay) prevalence varies with family income. In 2014–2015, 52 percent of children and youth aged 2–19 from families living below the federal poverty level had any dental caries experience, compared to 34 percent of children from families with income levels greater than 300 percent of the federal poverty level.[3]

We have an epidemic of dental caries in many of our youngest children. Poor diet and low overall health literacy affect these disparities. Dentists observe children with diets high in sugar and refined carbohydrates and without the benefit of early preventive care, contributing to early childhood caries.

Disparities in dental disease exist based on race and ethnicity as well. Among children and youth aged 2–19 years, the prevalence of total dental caries was highest for Hispanic youth (52 percent) compared with black (44 percent), Asian (43 percent), and white youth (39 percent). The prevalence of untreated dental caries was highest among black children (17 percent) compared with Hispanic (14 percent), white (12 percent), and Asian children (11 percent). [4] Often times, children seen in the emergency room for dental pain attributed to decay are predominantly minority children from low-income families.[5]

Dental Workforce

Pediatric dentists are the backbone of the pediatric oral health care delivery system, helping to ensure all children have access to high quality comprehensive dental services. Access to dentists is especially critical for underserved populations that face health disparities. The Centers for Disease Control and Prevention (CDC) reports that tooth decay affects 1 in 4 children under age five, half of children ages 6-11, and nearly 60 percent of adolescents ages 12-19. Untreated decay is more than twice as likely for children in low-income families, compared to those in higher-income households. Left untreated, decay can cause pain and infection that undermines eating, speaking, and learning during critical stages of childhood development. Dental decay is preventable if children have access to pediatric dentists.

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[2] Vargas CM, Ronzio CR. Disparities in Early Childhood Caries. BMC Oral Health 2006;6(Suppl 1):S3. Available at: "http://www.biomedcentral.com/1472-6831/6/S1/S3". Accessed March 27, 2023.
[3] Fleming E, Afful J. Prevalence of Total and Untreated Dental Caries Among Youth: United States, 2015-2016. NCHS Data Brief 2018;(307):1-8.
[4] Ibid.
[5] Hill BJ, Meyer BD, Baker SD, et al. State of Little Teeth Report. 2nd ed. Chicago, IL: Pediatric Oral Health Research and Policy Center, American Academy of Pediatric Dentistry; 2019.

HRSA Title VII Program

Title VII, section 748 of the Public Health Service Act (PHSA) supports pediatric dentistry health care workforce education and training through grants to and contractual agreements with institutions to support predoctoral (dental school) education and postdoctoral residency programs and a Dental Faculty Loan Repayment Program (DFLRP), among other efforts. A dentist trainee learns advanced diagnostic and surgical procedures, along with unique care techniques and skills for dealing with children such as child psychology and behavior guidance; child development; and caring for patients with disabilities. Since children's oral health is an important part of overall health, pediatric dentists often work with pediatricians, other physicians, and dental specialists.

The Title VII program is an essential resource in meeting the unmet oral health needs for many families and addressing the national shortage of pediatric dentists. The program serves to build a diverse, culturally competent health professions pipeline and a workforce that meets the needs of individuals in both rural and urban underserved communities. As we face nationwide shortages in the health professions, investment through Title VII programs in the dental workforces creates a robust network of providers who are trained to serve some of the most vulnerable patients in our country.

Title VII provides pediatric dentistry training programs, supporting more dental and dental hygiene students to enter the field prepared to serve and support the unique needs of children in underserved communities throughout the country. In addition to directly supporting dental residency training and placement of dentists in underserved communities, the program also supports a dental faculty loan repayment program, incentivizing dental professionals to train future practitioners who are able to then meet the needs of underserved communities. The program may support loan repayment contracts over five years to recruit and retain faculty. Full-time faculty members are eligible for repayment of 10, 15, 20, 25 and 30 percent of their student loan balance (principal and interest) for each year of service while they provide dental care in an underserved community.

Title VII is supporting the growth and placement of the dental workforce in multiple ways, and the program will be up for reauthorization in 2025. During the Academic Year (2022-2023), oral health training programs provided support to 5,540 dental and dental hygiene students and professionals. Recent reports indicate that 69 percent of graduates serve in medically underserved communities, with an additional 20 percent contributing to primary care settings, such as Federally Qualified Health Centers, following their completion of the oral health training program. **We encourage the Committee to support the Title VII program's authorization and**

to ensure its timely reauthorization in 2025, recognizing that the program is making an impact in the recruitment of dentists to serve underserved communities as well as developing new pediatric dental faculty.

S. 747 – Resident Education Deferred Interest (REDI) Act

To address geographic and other disparities in accessing oral health care, we must work to enhance the dental workforce and to ensure dentists and their teams are able to practice in underserved communities. The average student loan debt for a dentist to complete four years of dental school and an additional two-to-three years of pediatric dental residency training is roughly $300,000.[6] The significant loan debt a dentist-in-training accrues makes it near impossible for new pediatric dentists to make any payments on school loans while they are in training. Dental students may qualify to have their school payments halted during residency through two options: deferment or forbearance. However, like medical school residents, dental school residents accrue interest on their loans even if they qualify for deferment or forbearance during residency, compiling their debt owed.

When pediatric dentists graduate, they face significant economic challenges while managing their debt and trying to set up a dental practice. This economic reality significantly limits their options as they look for communities to practice in, as they have to be able to afford to operate a practice and simultaneously pay down their debt.

We encourage the Committee to advance S. 747, the bipartisan REDI Act during this congressional session in an effort to support the dentist workforce and encourage dentists and their teams to practice in underserved communities.

Rural Oral Health – Geographic and Economic Disparities

Children living in rural communities generally have poorer oral health outcomes than their urban or suburban peers. A myriad of factors accounts for this oral health disparity. First and foremost, rural areas face a critical shortage of dental providers. With rural communities accounting for two-thirds of the nation's Health Professional Shortage Areas, many children residing in these communities lack reliable, comprehensive, ongoing, high-quality dental care. Other factors contributing to poor oral health include limited availability of and accessibility to healthy foods and a lack of optimally fluoridated water.

Medicaid is the most common payor for dental treatment for low incomes families, and a disproportionate share of rural populations have Medicaid coverage. In some states,

[6] Dentists of Tomorrow 2022. American Dental Education Association. September 2022. Available at https://www.adea.org/Seniors2022/.

reimbursements by Medicaid dental programs fail to cover the costs associated with delivering dental care. As a result, many dentists choose not to participate in Medicaid, while some of those choosing to participate may be doing so at a financial loss.

Another barrier to optimal oral health in children is limited or low parental health literacy. Lack of awareness and/or knowledge in parents and caregivers of the importance of oral health has profound implications for their children's health and development. This can contribute to poor oral hygiene at home, high frequency of snacks and sweetened drinks and high sugar diets, and lower utilization of dental services including preventive visits, potentially resulting in more visits to the Emergency Department for non-urgent dental conditions. Children living in rural communities deserve access to dental care to help achieve and maintain optimal oral health.

The AAPD issued a rural health call to action in 2023[7] and believes the following actions hold promise for improving the oral health of children living in rural communities, and recommends that the Committees focus on policy reforms and initiatives that would support the following efforts:

- **Recruit dentists to rural communities by offering incentives and the ability for pediatric and other dental providers to choose to and succeed in having a sustainable and successful practice in a rural community.**
- **Address social determinants of health by covering and supporting payment for care coordination and transportation support in dental insurance plans.**
- **Facilitate partnerships between medical providers, schools and community organizations, religious organizations, dentists and others to develop oral health solutions that serve a community.**
- **Support community water fluoridation.**
- **Ensure food security and accessibility to healthy and nutritious foods.**
- **Improve individual oral health literacy and the understanding of the integration of oral health and overall health and well-being.**

Dental Coverage and Access

The Affordable Care Act (ACA) requires all health insurance plans available through the individual and small-group marketplaces to include essential health benefits in non-grandfathered health plans. Pediatric dental is considered an essential health benefit under the ACA within the health exchange marketplace. However, these benefits are considered to be optional coverage benefits, unlike every other essential health benefit. This means that the

[7] American Academy of Pediatric Dentistry, Research and Policy Center. "Hidden Crisis: Pediatric Oral Health in Rural America." Chicago, Illinois. April 2023.

purchase of dental coverage is not required for people who are 18 and younger, despite it being available.

Currently, dental benefit coverage for adults is not considered an essential health benefit. However, with new rules finalized this year, CMS is allowing states the option, beginning in 2027, to add routine adult dental services as an essential health benefit by updating the state essential health benefit-benchmark plans.

Over the years, the AAPD has offered recommendations to CMS on improvements that should be made to the ACA to best promote children's oral health and assure that children receive the oral health care they need, as follows:

a) Make pediatric oral health coverage mandatory for families with children, either through an appropriately structured stand-alone dental plan (SADP) or embedded medical plan.

b) Exempt preventive dental services from any cost sharing (deductibles or co-pays) in embedded medical plans and SADPs, and require separate dental deductibles in embedded plans.

c) Include any separate dental premium cost under the calculation of a tax subsidy for low-income families.

We encourage the Committee to engage CMS on its efforts to improve access to dental care for children and adults and to better understand the limitations of this access given the construct of the dental benefits offered through the exchange marketplaces.

Dental Public Health

Centers for Disease Control and Prevention (CDC) – Division of Oral Health Reauthorization: S. 3597, Promoting Dental Health Act

The CDC Division of Oral Health administers critically important federal dental public health programs and activities that successfully prevent cavities, gum disease, and other serious oral health conditions. The Division provides vital support for state and territorial health departments to monitor oral disease across populations and implement evidence-based oral health interventions. The CDC Division is responsible for supporting health departments to develop, maintain, and upgrade their community water fluoridation systems and dental sealant programs benefitting low-income children. The Division of Oral Health has developed infection control guidelines to protect dental patients and funded specialty training for dental public health professionals and supported public education campaigns to encourage good oral hygiene. Additionally, the Division supports public health data systems to support the use of

preventive oral health services. This data is used to measure the Nation's progress in advancing the public's oral health.

At a time when the Committee is wanting to address health inequities and support access to care, the work of the CDC Division of Oral Health is paramount to these goals. **We urge the Committee to advance S. 3597, the bipartisan Promoting Dental Health Act during this congressional session to reauthorize the oral health promotion and disease prevention activities of the CDC through 2028 and support communities nationwide.**

Centers for Medicare and Medicaid Services – Chief Dental Officer

Recognizing that dental health is vital to overall health, in 2021, CMS appointed its first-ever Chief Dental Officer in the Office of the Administrator. A board-certified pediatric dentist, policy expert and public health advocate, Dr. Natalia Chalmers, supports the agency in advancing its oral health programs and policies across the CMS centers and through all of the health care marketplaces the agency oversees.

There has been a tremendous effort undertaken by CMS to address oral health coverage and access in federal and state health exchange markets and in broader markets during Dr. Chalmers' tenure. Over the last two years, CMS has worked to expand medically necessary dental coverage under Medicare and has taken strong steps toward improving access to dental surgeries for Medicare and Medicaid-eligible patients. As referenced earlier, the agency has also provided authorization for states to provide adult dental services as an essential health benefit within the health care exchange marketplace.

As the oral health efforts within the federal agency grow, the AAPD is hoping as will the resources provided to support Dr. Chalmers and the agency's oral health objectives. **The AAPD encourages the Committee to engage CMS to understand its plans for expanding dental offices and resources within CMS to support the work of the Chief Dental Officer and to be responsive to the expansion of oral health activities within the agency's centers. The Committee should understand from CMS what additional authorization support is needed to help implement, oversee and monitor CMS' oral health efforts.**

Conclusion

AAPD looks forward to working with the Committee to advance and address these important programs, issues and challenges. From working to ensure that every child in America – no matter where they live or their circumstances - has a dental home, to strengthening our dentist

and dental team workforce to reauthorizing oral health programs and strengthening oral health positions and resources that are critical to our oral health programmatic infrastructure, we stand ready to work with the Committee. For questions or further discussion, please contact AAPD's government relations representative, Julie Allen at Julie.allen@powerslaw.com.

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Statement for the Record

Senate Committee on Health, Education, Labor, and Pensions

Hearing on "Examining the Dental Care Crisis in America: How Can We Make Dental Care More Affordable and More Available?"

Prepared by Families USA

May 16, 2024

FamiliesUSA.org
1225 New York Avenue, NW, Suite 800
Washington, DC

Chair Sanders and Ranking Member Cassidy, Families USA would like to thank you and the entire Health, Education, Labor, and Pensions (HELP) Committee for this important and timely hearing, and to offer our sincere appreciation to all of today's witnesses for lifting up the critical need to improve our oral health care system. Oral health care is key to overall health and wellness, employment opportunities, economic stability, and social connectedness. Families USA supports addressing the disparities in access to oral health care and finding solutions to ensure all families have access to affordable and quality oral health.

Oral Health Care is Health Care

The Centers for Disease Control[1] and the World Health Organization[2] have both declared that oral health is a key indicator of overall health, well-being, and quality of life. Additionally, longstanding evidence shows that poor oral health harms our physical, mental, and economic well-being.

When people cannot access the care they need, oral health problems can prevent them from eating, working, securing employment, and staying healthy. A recent survey of middle-aged adults revealed that nearly four in ten had dental problems within the past two years that caused pain, difficulty eating, and work absences.[3]

When oral disease goes untreated, people are at a higher risk for diabetes, heart disease, stroke, COVID-19, and even death.[4] If people already have these health conditions, poor oral health can make them worse. This can be a particularly acute problem for our nation's older adults, over two thirds of whom have untreated gum disease and roughly a fifth of whom have untreated tooth decay.[5]

Additionally, lack of access to oral health care during pregnancy can lead to poor health outcomes for both the mother and baby.[6] Poor oral health raises the risk of high blood pressure during pregnancy, which can lead to major complications and even maternal death.[7] It also increases the risk of poor birth outcomes, such as low birth weight or premature birth.[8] Moreover, children are three times more likely to have dental disease if their mother was not able to receive dental care during pregnancy.[9]

Oral Health Remains Out of Reach

Oral health care is central to overall health, yet for far too many people, access to affordable and high-quality dental care is out of reach. Americans are roughly four times more likely to lack dental insurance than medical insurance, with the greatest rates of uninsurance among racial and ethnic minorities.[10] Without insurance, oral health care is too expensive for many people to afford. For example, the average cost of a root canal is between $750 and $1,200.[11] Dental care remains the number one medical service families skip due to cost.[12]

Even those with insurance still struggle to afford oral health coverage. Recent polling found that 37% of marketplace enrollees delayed dental care because of the cost, as well as 25% of those with employer sponsored insurance.[13]

These disparities are even greater for communities of color, rural communities, and people with disabilities. Black and non-white Hispanic adults are more likely to face cost barriers to dental care than White adults, and this gap has been increasing over time.[14] Among Black older adults, the

percent of individuals who have lost of all their natural teeth is 31% — almost double the national average — with minimal change over the past decade.[15] Additionally, the CareQuest Institute found that Black and Hispanic respondents reported that they had never been to a dentist at more than three times the rate of white respondents.[16]

Residents in rural America face major difficulties in access, coverage, and geography that limit their ability to obtain good oral health care. An analysis of 2016 Behavioral Risk Factor Surveillance System data found that 20% of rural older adults have not seen a dentist or visited a dental clinic for more than five years, compared to 14% of non-rural older adults.[17] In rural areas, unmet oral health needs can exacerbate other health problems that are common in these communities – studies show strong links between oral health and diabetes, a disease with much higher mortality rates in rural areas than in more urban locations.[18]

Now is the Time for Congress to Act

It is clear that millions of people in America do not have affordable access to oral health care — and are suffering as a result — so it is no wonder that there is broad public support to address this problem. Polling shows that 85% of Americans support federal legislation that helps expand access to dental benefits for all Americans. One poll earlier this year found that 92% supported expanding Medicare to provide a comprehensive dental, vision, and hearing benefit.[19]

Congress can and should take action right now to improve affordable access to oral health care. That includes ensuring comprehensive benefits for people who rely on Medicare or Medicaid for their health care, and creating opportunities to improve affordable access to oral care for people who have private insurance as well. One such bill, the *Comprehensive Dental Reform Act of 2024* introduced by Senator Sanders, expands dental coverage through Medicare, Medicaid, the Affordable Care Act, and the Department of Veterans Affairs. Specifically, the bill would finally make oral health an essential health benefit within the Affordable Care Act for adults in the private marketplace. In doing so, it would ensure greater access to oral health coverage for those with private insurance.

Conclusion

Millions of individuals and families lack access to affordable, quality oral health coverage. Congress has both the power and the responsibility to enact policy changes that acknowledge the reality that good oral health is central to overall health and financial stability. We appreciate the focus from Chair Sanders and Ranking Member Cassidy on this critical issue, and we look forward to continuing to work closely with the Finance Subcommittee on Health Care to bring to light the deep disparities in oral health care, to advance solutions to ensure that our health doesn't depend on our wealth, and to finally ensure that oral health care is appropriately treated as equally critical to our overall health and wellbeing as other kinds of medical care.

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PAN Foundation

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Written Testimony Of
Kevin L. Hagan
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For the U.S. Senate Committee on Health, Education, Labor and Pensions Hearing

"Examining the Dental Care Crisis in America: How Can We Make Dental Care More Affordable and More Available?"

May 16, 2024

Chairman Sanders, Ranking Member Cassidy, and members of the Committee, thank you for convening this hearing to put a spotlight on the challenges in access to oral health care. We urge the HELP Committee and the Senate to take action on this important issue that impacts people's overall health, ability to work and ability to attend school.

PAN is an independent, national 501(c)(3) organization dedicated to helping federally and commercially insured people living with life-threatening, chronic, and rare diseases with the out-of-pocket costs for their prescribed medications. PAN provides patients with direct assistance through nearly 70 disease-specific programs and collaborates with national patient advocacy organizations to provide patients with education and additional support. Since 2004, we have helped more than 1 million underinsured patients gain access to their lifesaving prescriptions.

PAN supports improving oral health and hygiene as an integral part of health care. As you know, poor oral health and hygiene can cause tooth decay, gum disease and tooth loss among a variety of other health complications. Populations with a greater oral health risk include individuals with chronic diseases and weakened immune systems. Insufficient or inadequate dental care can worsen chronic health problems like diabetes and cardiovascular disease, hinder timely diagnosis of severe medical conditions, and lead to avoidable complications that may require costly emergency room visits.[i]

Former US Surgeon General David Satcher said more than 20 years ago that "you cannot be healthy without oral health.[ii]" While access to oral health has improved for many Americans there continues to be disparities in access. In the United States, people are more likely to have poor oral health if they are low-income, uninsured, and/or members of racial/ethnic minority, immigrant, or rural populations who have suboptimal access to quality oral health care. These inequities extend throughout the life course and include differences in access to affordable healthy foods, professional dental prevention and treatment services, and dental insurance.[i] These same groups are less likely to afford to pay out-of-pocket for dental care, do not have private or public dental insurance, or can't get time off from work to get to dental care. Dental expenses constitute more than a quarter of overall health care out-of-pocket (OOP) expenditures and are reported to present higher financial barriers than medical, prescription pharmaceuticals, and mental health care.[iii]

<u>Dental Coverage and the Affordable Care Act (ACA)</u>

PAN was pleased that the Centers for Medicare and Medicaid Services (CMS) recently removed the prohibition on issuers of most plans under the ACA from including routine non-pediatric dental services as an Essential Health Benefit (EHB). This allows states to add routine adult dental services as an EHB by

updating their EHB-benchmark plans. Removing the regulatory prohibition on non-pediatric dental services aligns state EHB-benchmark plans more closely with the private marketplace.

Importantly, states now have the opportunity to improve adult oral health and overall health outcomes, which could help reduce health disparities and advance health equity since these health outcomes are disproportionately low among marginalized communities. People of color are less likely than whites to receive dental care, in part because of lack of coverage. Moreover, lack of access to dental services also leads to other serious conditions, including cardiovascular disease and low birthweights, which are more prevalent in underserved communities.

While the policy change set out in the final 2025 Notice of Benefits and Payment Parameters is an important step, states must now take action to voluntarily decide to include adult dental benefits. Further, this will not address the variability among states that will result in inequities from state to state. HHS can and should establish minimum standards that all states must meet in how they cover EHBs, including dental coverage, which should be reviewed and updated regularly.

Dental Coverage and Medicare

As you know, the Medicare program covers a majority of all Americans age 65 and older and plays a vital role in the quality and longevity of their lives. However, the program has also long fallen short in providing those beneficiaries with sufficient coverage for essential oral and dental treatment. Two-thirds of Medicare beneficiaries lack oral health coverage, and 49% of Medicare beneficiaries have not seen a dentist in the last 12 months (as of 2017).[iv] A recent study found that use of dental services fell at age 65 for both enrollees in tradition fee-for-service and Medicare Advantage. [v] As a result, medical problems and treatment that can be proactively addressed with such care have instead gone unchecked, delayed, or cancelled, resulting in serious clinical, human, and fiscal implications.

All too often, limited or no dental insurance coverage can result in high OOP or foregone oral health care. High OOP costs are a barrier to dental care as more than 15 million older adults live on incomes below 200% of the federal poverty level, and 4.7 million live below poverty. Forgoing dental care, however, can worsen underlying conditions. Untreated cavities and gum disease can exacerbate certain diseases, such as diabetes and cardiovascular disease, and lead to chronic pain, infections, and loss of teeth.

Congress should adopt legislation to authorize a dental benefit in Medicare so that millions of beneficiaries on fixed incomes will be able to maintain their oral health that is critical to their overall health. Importantly, Congress must structure the benefit to included routine preventive procedures and limit out-of-pocket spending for more invasive dental care, including restorative procedures such as fillings, crowns and root canals. High levels of coinsurance have proven to be cost prohibitive and results in a drop in utilization of dental services.[iii]

In the absence of a dental benefit, PAN is pleased that (CMS) has clarified that Medicare can pay for some dental services as part of coverage for certain medical treatments. CMS has established an annual process to identify for consideration and review submissions of additional dental services that are inextricably linked and substantially related and integral to the clinical success of other covered medical services. On that basis, CMS specifically recognized payment for dental services in the context of organ transplant surgery, cardiac valve replacement, valvuloplasty procedures, head and neck cancers and other covered services used to treat cancer—chemotherapy services, Chimeric Antigen Receptor T-

(CAR-T) Cell therapy, and the use of high-dose bone modifying agents (antiresorptive therapy). While this is an important step forward, a dental benefit under Medicare should be adopted.

PAN lauds you for your continued leadership to increase access and affordability of oral health care. We welcome the opportunity to work with the Committee as they develop legislation to address this important issue. For further information, please reach out to Amy Niles, Chief Mission Officer at aniles@panfoundation.org.

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Statement for the Record

American Dental Association

to the

Health, Education, Labor and Pensions (HELP) Committee
United States Senate

on

Examining the Dental Care Crisis in America: How Can We Make Dental Care More Affordable and More Available?

May 16, 2024

On behalf of the American Dental Association, thank you Chairman Sanders and Ranking Member Cassidy for the opportunity to submit a statement for the record and share data-driven insights at the May 16th hearing: "*Examining the Dental Care Crisis in America: How Can We Make Dental Care More Affordable and More Available?*"

The American Dental Association is pleased that the Senate HELP Committee has selected the topic of the dental care crisis in America and see this as a testament of not only the important link between oral health and overall health and well-being, but a recognition that there is a need for action. We can and should do better when it comes to our nation's oral health.

Our statement is focused around three main themes: the state of oral health in America, including dental workforce; the policy choices we have made along the way; and considerations as we move forward.

The State of Oral Health in America – Key Trends to Highlight from the Data

Among U.S. children, oral health is improving. Over the past two decades, rates of untreated dental disease have been declining; dental care utilization has been increasing, particularly for key preventive services (e.g., dental sealants); and more and more children are covered by some form of dental benefits.[1] These improvements have been most dramatic for low-income children and non-White children. In fact, in several states, including Texas, Hawaii, and Wyoming, dental care utilization rates for Medicaid-insured children are comparable to those of privately-insured children.[2] New analysis shows that the mix of dental care services being provided to Medicaid-insured children is similar to those being provided to privately-insured children.[3] When it comes to children's oral health in America, disparities by income and by race have been narrowing over time.

For working-age adults (age 19-64) and seniors (age 65 and older), the trends are different. For example, rates of untreated disease among working-age adults have not changed significantly over the past two decades, and disparities by income and race are persistent and much wider than for children. The percent of working-age adults who visit a dentist in the course of a year is actually slightly lower today than two decades ago. Access to dental care for Medicaid beneficiaries continues to be fraught with significant hurdles. Despite sufficient numbers of Medicaid providers located near Medicaid populations, as shown by our geo-analytics, beneficiaries still face considerable difficulties in accessing these providers. The complexity of the system often requires beneficiaries to contact multiple offices before finding an available appointment.

For seniors, dental care utilization rates have increased over time, but the disparities by income and by race have been stable. In fact, gains in some oral health measures, such as reductions in tooth loss, are concentrated among high-income seniors.[4] Overall, disparities in oral health are stable for working-age adults and seniors.[5] In any given year, less than half of the U.S. population visits a dentist.[6] But oral

health in America is a two-part story. We have seen two decades of steady improvements among children, particularly the most vulnerable, in tandem with much less progress among working-age adults and seniors. The ADA has been supportive of the Department of Health and Human Services' recent rules aimed at expanding payment for dental services and appreciates their efforts in resolving operational issues. We continue to believe that maintaining an adequate provider base as well as adequate reimbursement is essential, especially for this vulnerable population.

On the dental workforce, it has shown signs of recovery with first-year enrollment numbers for dental assistants and hygienists returning to pre-pandemic levels. Although this recovery marks a positive development, the effect on the healthcare system will require time to manifest due to the duration needed for training and assimilation into the workforce. Furthermore, our earlier prediction that the workforce shortage would continue for at least five years is proving accurate, highlighting an ongoing challenge that affects service delivery, particularly in rural and underserved areas. Additionally, we face a discrepancy in data quality that impacts our strategic planning, with less accurate and comprehensive information available for dental assistants compared to dental hygienists.

The Policy Choices We Have Made Along the Way

The trends in oral health we observe are a result of how dental care is handled in federal and state health policy, particularly the different policy approach for children compared to working-age adults and seniors. Comprehensive dental coverage is a requirement in Medicaid and CHIP programs and is part of the essential health benefit under the Affordable Care Act. As a result, over 90% of U.S. children are covered by dental insurance and this percentage has been increasing steadily the past two decades. Because dental care is an essential service, there are checks and balances in place to ensure a comprehensive basket of dental care services is covered for children with minimal cost-sharing among beneficiaries.

For working-age adults and seniors, the policy approach has been very different. Dental care is not considered a mandatory essential health benefit. Medicaid programs do not mandate coverage for adult dental services, and only some Medicare beneficiaries have dental benefits through primarily Medicare Advantage plans. The Affordable Care Act did not include adult dental care as an essential health benefit, but recently the prohibition on states including non-pediatric dental services within their essential health benefit benchmark plans was removed.

As a result, there is considerable variation, for example, in adult dental coverage within state Medicaid programs. As of October 2022, only half of states provide comprehensive dental coverage to adults in their Medicaid programs.[7] However, more and more states have added dental coverage for adults over the past several years, including all state Medicaid programs now providing dental coverage during pregnancy and for at least 60 days post-partum.[8]

For seniors, dental coverage is an optional benefit within Medicare Advantage, with 94% of enrollees having some form of dental coverage as part of their plan. However, the range of dental care services covered within these plans varies considerably, with some covering only preventive services. Most plans have considerable coinsurance rates (e.g., 50%) for dental care services beyond routine check-ups and cleanings.[9] There is very little data available on utilization rates for supplemental benefits, including dental care, among Medicare Advantage enrollees.[10] However, a recent study found that dental care utilization rates and certain measures of oral health decline when people reach Medicare eligibility and, more significantly, there were no differences between enrollees in traditional Medicare compared to Medicare Advantage.[11] Of all the supplemental benefits, Medicare Advantage enrollees report the most confusion and dissatisfaction about dental coverage.[10]

Due to the very different policy approaches taken toward dental care for children compared to working-age adults and seniors, we see vastly different degrees of financial barriers to dental care. A much larger share of working-age adults and seniors report they cannot access needed dental care services due to affordability issues compared to children.[12] Moreover, 'cost' is the top reason working-age adults and seniors are not able to access dental care, and financial barriers are more severe for dental care than any other health care service (e.g., prescription drugs, mental health, physician services). This is a direct consequence of policy choices.

Essentially, our health policy approach disconnects the mouth from the body when you become an adult.

Key Considerations for Policy Makers Moving Forward

As policymakers consider ways to address the oral health issues facing the nation, there are some important findings from the data and evidence that we wish to highlight.

The Economic and Fiscal Dividend of Improved Oral Health

Beyond the fact that you cannot be healthy without a healthy mouth,[13] there is compelling empirical evidence of the economic benefits associated with improved oral health. Oral health issues limit job prospects, hinder workplace productivity, and limit employee earnings. An estimated 29% of low-income adults in the U.S. report that the appearance of their mouth and teeth affects their ability to interview for a job.[14] For low-income adults living in states that do not provide adult dental coverage in their Medicaid program, this figure jumps to 60%. When states provide comprehensive adult dental coverage in their Medicaid program, the job prospects of Medicaid beneficiaries improve and the effect is most significant for Black Medicaid beneficiaries.[15] Investing in oral health improves job prospects and helps narrow economic disparities.

There is compelling research linking improved oral health with reduced overall health care spending. These links are strongest for certain medical conditions like diabetes, heart disease, and pregnancy. One study shows that newly diagnosed people with diabetes see reductions in health care spending if they receive certain dental care treatments while those that go without dental care do not.[16] Among pregnant women, when dental care is included as part of routine prenatal care, overall medical care costs associated with the pregnancy are lower.[17]

Every 15 seconds in America, someone shows up at a hospital emergency department because of a dental issue. The estimated 2.1 million emergency department visits for dental conditions cost the U.S. health care system $2.7 billion each year, with Medicaid accounting for the largest share of this spending.[18] This is an example of inefficient spending that could be avoided if more Americans had access to a dental home for routine care and prevention. Ensuring that states provide comprehensive dental services to adult Medicaid beneficiaries is a sound economic investment. The ADA strongly supports S.570, the Medicaid Dental Benefit Act of 2023, to make comprehensive dental care a mandatory component of Medicaid coverage for adults in every state.

The American Dental Association's Health Policy Institute has developed a quantitative model to estimate the fiscal impact of alternative adult dental coverage policies in Medicaid on state budgets. In addition to estimating additional dental care spending, the model incorporates the fiscal offsets associated with reduced emergency room costs as well as reduced medical care costs. The net cost of adding comprehensive adult dental benefits into all state Medicaid programs that currently do not provide such benefits is estimated at $836 million per year[19]. Detailed analysis has been provided to state legislatures in Maine, Hawaii, Virginia, and Florida.[20-23]

The inefficiency in accessing dental services for Medicaid beneficiaries highlights the urgent need for improved scheduling technologies. We suggest an advanced, user-friendly, app-based scheduling tool akin to "OpenTable," which could revolutionize how beneficiaries access care. This app would feature real-time availability viewing, easy appointment booking and management, multilingual support for diverse beneficiaries, and customized provider searches based on specific needs. These features could be designed to reduce the challenges faced by patients, such as lengthy phone calls and scheduling frustrations, thereby enhancing overall patient engagement and adherence to dental health care schedules.

Beyond the introduction of scheduling technologies, there is need for a comprehensive overhaul of state Medicaid programs to include modern digital tools that enhance both accessibility and efficiency. Integrating these technologies can significantly reduce administrative burdens, lower the costs associated with missed appointments, and improve overall patient and provider satisfaction. These proposed

innovations are not merely enhancements but are essential steps towards modernizing our healthcare infrastructure to better serve all stakeholders involved, particularly our most vulnerable populations.

Investing in oral health also impacts the local economy beyond reduced health care costs, improved job prospects, and overall wellbeing. Each dental practice is estimated to contribute $2.3 million annually to the local economy when the various direct and indirect effects are taken into consideration.[24] Overall productivity losses associated with untreated oral disease were estimated to be $45.9 billion per year in the U.S., much higher than any other country.[25]

As a nation, we are paying an economic penalty for how we address dental care within health policy.

A Dental Workforce that is Sufficient, Diverse, Healthy and Located Where it is Needed Most

As in much of health care, the COVID-19 pandemic significantly disrupted the labor market for dental team members. Dental practices are having a tough time finding qualified staff, particularly dental hygienists and dental assistants. As of March 2023, 96% of dentists report it is extremely or very difficult to fill vacant dental hygienist positions and 86% of dentists report the same for dental assistant positions.[26] Enrollment in dental hygiene programs has only recently recovered to pre-pandemic levels while enrollment in dental assisting programs has been on a steady decline since before the pandemic.[27] As a result, the current staffing shortage for dental hygienists and dental assistants is likely to persist for several years. In the interim, there are strategies for employers to effectively recruit and retain staff[28] and for state and federal policymakers to boost training capacity.[29]

Like many other health care professions, the pandemic took a toll on the mental health and wellbeing of dental team members. Levels of anxiety and depression spiked mid-2020 and then steadily decreased through 2021.[30]

Beyond the disruptions associated with the COVID-19 pandemic, the supply of dentists per capita is predicted to be steady through 2025 and then to increase significantly after that.[31] However, between 2011 and 2021, the number of dentists per 100,000 population increased from 60.8 to 62.8 in urban areas while decreasing from 37.3 to 36.5 in rural areas. This is an important issue to highlight, as geographic access to dental care providers in rural areas is much lower than in urban areas.[32] There are several policy options to consider to attract and retain more dental care providers in rural areas, including loan forgiveness programs tied to geographic areas, education pathway programs, enhanced mobile clinics, alternative workforce models and scope of practice, and targeted visa programs, to name a few.[33] Reauthorizing the Action for Dental Health Act (S. 2891) aims to mitigate workforce challenges and enhance access to care in rural areas.

Related to geographic access to dentists, it is important to note that conventional methods of designating 'shortage areas' for dental care providers – including the methodology used by HRSA – are significantly flawed. Much has been written about the drawbacks, including a concise two-page summary,[34] and the American Dental Association's Health Policy Institute has developed an alternative, peer-reviewed methodology that addresses these shortcomings. The American Dental Association's Health Policy Institute has offered, and continue to offer, to assist government agencies in any way to improve the data and methods for assessing provider adequacy. In the meantime, the analysis for every state, including a separate analysis for Medicaid beneficiaries, can be accessed on the American Dental Association's Health Policy Institute website.[35]

Among Medicaid beneficiaries, particularly adults, finding a dentist who participates in the Medicaid program is an important barrier to care in many states. One out of three dentists in the U.S. sees at least one Medicaid patient in the course of a year. A mere 18% of dentists see at least 100 Medicaid patients per year. There is significant variation in these kinds of statistics by state and dentist characteristics. At the state level, Vermont, Missouri, and Montana have the highest shares of dentists seeing a high volume of Medicaid patients.[36]

Policymakers have a considerable body of evidence at their disposal to design effective policies that can boost provider participation in Medicaid. These 'good practices' are well documented and include streamlined credentialing and broader administrative practices, sufficient fees, patient navigation assistance to reduce missed appointments, and expanded scope of practice for dental team members. What has been studied less is the role of individual dentist characteristics and practice modalities in the Medicaid participation decision. New research[37] indicates that, all else equal, racially and ethnically diverse dentists are far more likely to see a high volume of Medicaid patients. Dentists in large group practices are also more likely than solo practitioners to see a high volume of Medicaid patients. As dental school enrolment diversifies[38] and more dentists practice in larger groups,[39] this could lead to more dentists, in aggregate, participating in Medicaid.

The dentist workforce does not reflect the U.S. population when it comes to racial and ethnic diversity. The latest data indicate that Black and Hispanic dentists are significantly under-represented in relation to the U.S. population overall.[40] For example, 3.8% of dentists are Black compared to 12.4% of the U.S. population. Similarly, 5.9% of dentists are Hispanic compared to 18.4% of the U.S. population. Dental school enrollment data indicate a slight increase in diversity. For the 2021-22 school year, 7.3% of first-year dental students were Black and 10.7% were Hispanic, meaning we can expect a more diverse workforce in the future. Increased funding for training and recruitment programs like the Health Careers Opportunity Program, HRSA's Title VII Primary Care Training Program, National Health Service Corps and Teaching Health Centers are crucial to the supply, distribution and diversity of the dental workforce.

The Importance of Addressing Cost Barriers to Dental Care

The evidence is compelling that the most important barriers to dental care for working-age adults and seniors relate to affordability, particularly for those of low income. Lack of dental coverage as well as shortcomings in the status quo model of dental insurance for working-age adults and seniors are key factors driving up financial barriers to dental care. There are a host of policy approaches that could be explored to address affordability. These include improving transparency and accountability within the private dental insurance market through, for example, applying medical loss ratios (MLR) to dental insurance plans, setting out-of-pocket payment limits for patients or, even more simply, requiring better data reporting.[41] The private dental insurance model as it currently operates is not true insurance, as it almost universally has an annual maximum benefit and significant coinsurance rates for services beyond prevention. Policymakers could explore broader reforms such as classifying dental care as an essential benefit for all age groups, using the key policy parameters around children's dental care as a framework.

Currently, patients are being adversely impacted by provisions in dental and vision plans that dictate how much a doctor may charge a plan enrollee, even though the services provided to the enrollee are not "covered" (i.e., paid for) by the plan. The ADA supports S. 1424, the Dental and Optometric Care (DOC) Access Act, to prohibit dental and vision plans from setting the fees network doctors may charge for services not covered by the insurers. Even though 42 state governments have taken action, many dental plans are federally regulated, so insurers claim they are exempt from having to follow state laws. This insurer loophole means some enrollees and doctors face undue confusion in how their plans work.

Furthermore, we propose the introduction of measures that would simplify the administrative aspects of dental care provision. This includes the implementation of uniform credentialing processes, attachment standardization, and standardized Explanation of Benefits. These changes would significantly reduce the administrative burden on dental care providers, making it easier for them to participate in various insurance programs without the hassle of navigating through disparate requirements from different insurers.

Chairman Sanders and Ranking Member Cassidy, thank you again for bringing attention to oral health care in America. The American Dental Association looks forward to working with the Senate HELP Committee to continue to address how to make dental care more affordable and more available.

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[Whereupon, at 11:32 a.m., the hearing was adjourned.]

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