

SHINING THE LIGHT ON PEARLY WHITES: IMPROVING ORAL CARE FOR ELDERS IN A POST-AFFORDABLE CARE ACT WORLD

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Public policy has often overlooked oral health care, even in a political era marked by expanding access to otherwise comprehensive health care. Medicare and Medicaid offer dental coverage so limited and mired in administrative uncertainty that these programs fail to address the urgent need of the elder community. The most effective remedy for this problem is not in expanding governmental mandates, but in innovating the oral health field itself. This Note surveys how elders access oral care today and explores the barriers that exist to those services. This Note also examines the effects of Medicare and Medicaid policies that have contributed to the decline in the oral health of elders, as well as the murky judicial and administrative decisions defining those policies. This Note recommends expanding access to oral care services by widely implementing a new mid-level dental professional: the dental therapist. With specialized training in caring for the elder population, the dental therapist occupies a role similar to the nurse practitioner: focused services addressing the basic needs of dental hygiene. Existing within the present infrastructure of professional dentistry, the dental therapist increases access to services while lowering institutional costs.

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I. Introduction

If the eyes are the windows to one's soul, then the mouth is the door to one's health.¹ Yet oral health care, overlooked and misunderstood by many people, receives insufficient public awareness and funding because of the greater emphasis placed on human health outside the oral orifice.² Though often disregarded, oral hygiene provides indications of overall health, and poor oral care may result in detrimental problems.³ Poor oral hygiene and dental problems affect a substantial proportion of the elderly population,⁴ and the issues will continue to grow as the elderly population increases in number.⁵ Use of dental services has increased in recent decades, but elder Americans still face many oral health obstacles due to growing needs,⁶ larger aging populations,⁷ and sporadic dental visits.⁸ In fact, the United

1. Melinda Beck, *If Your Teeth Could Talk: The Mouth Offers Clues to Disorders and Disease; Dentists Could Play Larger Role in Patient Care*, WALL ST. J. (Dec. 27, 2011), <http://online.wsj.com/articles/SB10001424052970203686204577112893077146940>; *The Mouth as a Marker for Disease*, THE DR. OZ SHOW (Sept. 29, 2009), <http://www.doctoroz.com/article/mouth-marker-disease>; Minn N. Yoon & Catriona Steele, *The Oral Care Imperative: The Link Between Oral Hygiene and Aspiration Pneumonia*, 23 TOPICS IN GERIATRIC REHABILITATION 280, 280 (2007); see Louise Boyle, *Inventor Who Made \$40million for Hasbro When He Invented Classic Operation Game Can't Afford to Pay His Own Medical Bills*, DAILY MAIL (Oct. 29, 2014, 12:43 AM), <http://www.dailymail.co.uk/news/article-2812755/Creator-board-game-Operation-just-500-invention-t-afford-operation.html>.

2. Aubrey Sheiham, *Oral health, general health and quality of life*, 83 BULL. WORLD HEALTH ORG. 641, 644 (Sept. 2005), <http://www.who.int/bulletin/volumes/83/9/644.pdf?va=1>.

3. Mayo Clinic Staff, *Oral health: A window to your overall health*, MAYO CLINIC (May 11, 2013), <http://www.mayoclinic.org/healthy-living/adult-health/in-depth/dental/art-20047475>; *Senior Dental Problems & Underlying Health Issues*, A PLACE FOR MOM, <http://www.aplaceformom.com/senior-care-resources/articles/senior-dental-problems> (last updated Apr. 4, 2014).

4. *Oral Health in America: A Report of the Surgeon General – Executive Summary*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2000), <http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Report/ExecutiveSummary.htm> ("What amounts to 'a silent epidemic' of oral diseases is affecting our most vulnerable citizens-- . . . the elderly, and many members of racial and ethnic minority groups.").

5. Wan He et al., *65+ in the United States:2005*, U.S. CENSUS BUREAU 1 (Dec. 2005), <http://www.census.gov/prod/2006pubs/p23-209.pdf>; Jen Christensen, *Dental crisis could create 'State of Decay'*, CNN (Oct. 9, 2013, 11:40 AM), <http://www.cnn.com/2013/10/08/health/dental-health-care-coverage/>.

6. *Aging Statistics*, ADMIN. ON AGING, http://www.aoa.acl.gov/Aging_Statistics/index.aspx (last visited Nov. 11, 2015).

7. *Choosing a Nursing Home*, REAL SERVICES/ AREA 2 AGENCY ON AGING, https://www.realservices.org/_wp/wp-content/uploads/2015/06/Choosing_A_Nursing_Home.pdf (last visited Nov. 11, 2015).

8. Janet A. Yellowitz, *Access, Place of Residence, and Interdisciplinary Opportunities, in IMPROVING ORAL HEALTH FOR THE ELDERLY: AN INTERDISCIPLINARY APPROACH* 55, 55 (Ira B. Lamster & Mary E. Northridge eds., 2008).

States Surgeon General reports that the elderly are the most vulnerable population to poor dental care.⁹

Elder Americans tend to have low rates of dental insurance coverage, more severe chronic health issues, and are more likely to receive poor dental care.¹⁰ Current deficiencies in dental insurance coverage, access to care, and dental care delivery create problems for both the elderly and the general population.¹¹ In general, too few dental professionals actually treat elders, reasons being that “dental care is extremely expensive and it is really tough for seniors to go in and pay for dental care.”¹² Poor dental health among the elderly affects the physical and economic well-being of the nation as a whole, raising already burdensome medical care costs and weighing down the health care system.¹³ Public efforts and judicial decisions have had minimal impact, sometimes even increasing problems for elders.¹⁴ Instead, remedying problems and preventing further decay in elders’ oral care requires reforming the current system through new legislation that delivers more care at an affordable cost.¹⁵

This Note addresses the current state of elder Americans’ oral care, analyzing present policies and recommending a legislative alternative to improve oral care access and delivery. Part II of this Note provides background about oral care among the elderly population. Presenting relevant legislative and judicial decisions, Part III analyzes the impact of Medicare and Medicaid policies relating to the provision

9. Catherine Saint Louis, *Lack of Dental Care Poses Risk for Elderly: Neglecting Oral Hygiene Could Lead to Pain and Serious Illness*, INT’L HERALD TRIB. 15 (Aug. 7, 2013).

10. Jen Christensen, *Dental crisis could create ‘State of Decay’*, CNN (Oct. 9, 2013, 11:40 AM), <http://www.cnn.com/2013/10/08/health/dental-health-care-coverage/> (citing that only about two percent of elder Americans have any dental insurance at all); see also Janet A. Yellowitz, *Access, Place of Residence, and Interdisciplinary Opportunities*, in IMPROVING ORAL HEALTH FOR THE ELDERLY 55, 57 (Ira B. Lamster & Mary E. Northridge eds., 2008); NAT’L MEDICARE ADVOCATES ALLIANCE, CTR. FOR MEDICARE ADVOCACY, MEDICARE COVERAGE OF DENTAL SERVICES ISSUE BRIEF 1 (2009).

11. Chairman Bernard Sanders, *Dental Crisis in America: The Need to Expand Access*, U.S. S. COMM. ON HEALTH, EDUC., LABOR & PENSIONS 1, 4 (Feb. 29, 2012), <http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf> (finding that the lack of a dental safety net in the United States results in emergency room visits that are “costly to hospitals and taxpayers”).

12. Chris Hawkins, *Helpful Resources for Seniors Surviving on Social Security*, SENIORLIVING.ORG, <http://www.seniorliving.org/retirement/resources-surviving-social-security/> (last updated May 17, 2013).

13. Amanda McCluskey Schwob, Note, *Open Wide—I Meant Your Pocketbook: Repercussions of the Dental Exclusion to the Medicare Act*, 9 ELDER L. J. 83, 83-90 (2001).

14. *Id.*

15. Catherine Saint Louis, *Lack of Dental Care Poses Risk for Elderly: Neglecting Oral Hygiene Could Lead to Pain and Serious Illness*, INT’L HERALD TRIB. 15 (Aug. 7, 2013).

of oral care. Lastly, Part IV discusses a policy alternative to increase elders' access to oral care following the passage of the Patient Protection and Affordable Care Act (ACA). Calling for health professionals, policy makers, and the public to support improved access to oral care for elder Americans, this Note recommends extending policies that promote more cost-efficient care with dental therapists. Dental therapists, a class of mid-level dental professionals, may increase the provider population, increase access to dental care, and lower overall dental treatment costs.¹⁶ Expanding the role of dental therapists would fill the deep-rooted cavity of elders' oral health needs.

Because of the many methods by which elder Americans acquire and fund oral care, this Note focuses specifically on non-institutionalized adults age sixty-five and older. These adults live in the community rather than in institutionalized settings such as skilled nursing and long-term care facilities, where certain dental care is mandated under the Omnibus Budget Reconciliation Act of 1987.¹⁷ Individuals within this non-institutionalized population have similar health care access and financing arrangements in comparison to their institutionalized counterparts.¹⁸ The need for oral care is also very high among individuals in this population.¹⁹ One study about the barriers to dental care found that "almost ninety percent of the community-dwelling older adults . . . examined . . . needed dental care for untreated" oral conditions.²⁰ Despite the alarming need among elders, many conditions still go untreated.²¹

II. Background on Oral Care Amongst the Elderly

The United States Surgeon General states that "oral health and general health should not be interpreted as separate entities [because]

16. See *Early Impacts of Dental Therapists in Minnesota*, MINN. DEP'T OF HEALTH & MINN. BD. OF DENTISTRY 1-2 (Feb. 2014), <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf>; see also Mary Otto, *Lack of Access to Dental Care Leads to Expensive Emergency Room Care*, ASS'N HEALTH CARE JOURNALISTS (Apr. 8, 2014), <http://healthjournalism.org/blog/2014/04/lack-of-access-to-dental-care-leads-to-expensive-emergency-room-care/>.

17. Albert H. Guay, *The Oral Health Status of Nursing Home Residents: What Do We Need to Know?*, 69 J. DENTAL EDUC. 1015 (Sept. 2005), <http://www.jdentaled.org/content/69/9/1015.full.pdf.html>.

18. Theresa Montini et al., *Barriers to Dental Services for Older Adults*, 38 AM. J. HEALTH BEHAV. 781, 782 (2014).

19. *Id.*

20. *Id.* at 785.

21. *Id.*

oral health is integral to general health . . . [as one] cannot be healthy without oral health."²² Historically, however, society viewed dental care and health care as two individual entities, with a stronger emphasis on bodily health beyond a person's mouth.²³ This unfortunate disparity in concern for oral and general health results in a lack of coordination between providers of dental and medical care and little emphasis on oral hygiene in both elderly and general populations.²⁴ Policymaking decisions also often exclude or exercise indifference towards elder Americans' oral hygiene.²⁵

Most elder Americans "grew up during a time when preventive dental care was not emphasized. Some may not realize how important it is. They may believe that toothaches, bleeding gums, loose teeth or mouth pain are just part of getting older."²⁶ However, viewing oral hygiene as an optional part of health is particularly troubling for the elderly because of their weaker immune systems, other coexisting health conditions, and the challenges they may face in practicing personal oral care.²⁷ Elders grapple with dental care concerns that younger adults do not have.²⁸ The elderly population also carries a larger burden of oral illnesses due to medication side effects and the

22. *Oral Health in America: A Report of the Surgeon General—Executive Summary*, U.S. DEPT OF HEALTH & HUMAN SERVS. (2000), <http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Report/ExecutiveSummary.htm>.

23. *Choosing a Nursing Home*, REAL SERVICES/AREA 2 AGENCY ON AGING, https://www.realservices.org/_wp/wp-content/uploads/2015/06/Choosing_A_Nursing_Home.pdf (last visited Nov. 11, 2015); Teresa A. Dolan, Kathryn Atchison & Tri N. Huynh, *Access to Dental Care Among Older Adults in the United States*, 69 J. DENTAL EDUC. 961, 965 (Sept. 2005).

24. Martha Bebinger, *Put Back The Teeth? Why We Separate Dental And Medical Care*, WBUR'S COMMONHEALTH REFORM & REALITY (Feb. 4, 2014, 6:51 AM), <http://commonhealth.wbur.org/2014/02/dental-medical-health-care>.

25. Nathan Solheim, *PPACA pushes dental further into voluntary*, BENEFITSPRO (Jan. 22, 2014), <http://www.benefitspro.com/2014/01/22/ppaca-pushes-dental-further-into-voluntary>; see also Mary Otto, *Lack of Access to Dental Care Leads to Expensive Emergency Room Care*, ASS'N HEALTH CARE JOURNALISTS (Apr. 8, 2014), <http://healthjournalism.org/blog/2014/04/lack-of-access-to-dental-care-leads-to-expensive-emergency-room-care/>.

26. *Neglect, Not Age, Leads to Tooth Loss*, AETNA, <http://www.simplestepsdental.com/SS/ihtSS/r.==/st.35394/t.35762/pr.3.html> (last updated Jan. 22, 2012).

27. *Senior Dental Problems & Underlying Health Issues*, A PLACE FOR MOM, <http://www.aplaceformom.com/senior-care-resources/articles/senior-dental-problems> (last updated Apr. 4, 2014); *Dental Hygiene is Important for Seniors*, METROHEALTH & ST. LUKE'S FOUND., http://www.metrohealth.org/upload/docs/Medical%20Services/Closing%20the%20Gap/CtG_SeniorForum_DentalHygiene.pdf (last visited Nov. 11, 2015).

28. Healthwise Staff, *Dental Care for Older Adults*, UNIV. OF MICH. HEALTH SYS. (Nov. 14, 2014), <http://www.uofmhealth.org/health-library/ug3147>.

predisposed risks involved with aging.²⁹ Furthermore, elders, especially those with low income, experience disproportionately large financial impacts from health expenditures.³⁰ Without access to regular and preventive oral care, elders may only seek dental care when a need becomes urgent.³¹ At that point, dental treatment is often more dramatic and more costly.³² These issues raise even broader societal concern as the elder population in the United States grows and changes.

A. The Afflicted Elderly—Poorer Health

The aging process leads to an increased risk of illness, including higher susceptibility to oral diseases, and lower immune system responses.³³ Higher risk of infection and a slower ability to recover makes elders' oral hygiene maintenance especially important.³⁴ Elders need to keep good oral health because of the prevalence of oral disease and the mouth's role in maintaining proper nutrition.³⁵ Among the elderly, "the cause-and-effect relationships between poor oral health and other diseases . . . work[s] both ways. Poor oral health can increase the risk of systemic disease . . . or may result from systemic diseases."³⁶ Poor oral health may be symptomatic of diseases in an elder's body, and other health conditions may signal or contribute to-

29. Janet A. Yellowitz, *Access, Place of Residence, and Interdisciplinary Opportunities, in IMPROVING ORAL HEALTH FOR THE ELDERLY: AN INTERDISCIPLINARY APPROACH* 55 (Ira B. Lamster & Mary E. Northridge eds., 2008).

30. Fidelity Viewpoints, *Retiree Health Costs Hold Steady*, FIDELITY BROKERAGE SERVS. LLC (June 11, 2014), http://retirementresource.nationwide.com/sites/default/files/Retiree_health_costs_hold_steady-Fidelity%20June11_14.pdf.

31. Chairman Bernard Sanders, *Dental Crisis in America: The Need to Expand Access*, U.S. S. COMM. ON HEALTH, EDUC., LABOR & PENSIONS 1, 4 (Feb. 29, 2012), <http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf>.

32. *Id.*

33. *Aging changes in immunity*, MEDLINEPLUS, <https://www.nlm.nih.gov/medlineplus/ency/article/004008.htm> (last updated Oct. 27, 2014); see Kenneth L. Minaker, *Common Clinical Sequelae of Aging*, in GOLDMAN'S CECIL MEDICINE (Lee Goldman & Andrew Schafer eds., 24th ed., 2011).

34. Daniel Gati & Alexandre R. Vieira, *Elderly at Greater Risk for Root Caries: A Look at the Multifactorial Risks with Emphasis on Genetics Susceptibility*, 2011 INT'L J. DENTISTRY 1, 3 (May 2011).

35. *Id.*; Harold C. Slavkin, *Maturity and Oral Health: Live Longer and Better*, 131 J. AM. DENTAL ASS'N 805, 806 (June 2000); Chris Hawkins, *Helpful Resources for Seniors Surviving on Social Security*, SENIORLIVING.ORG, <http://www.seniorliving.org/retirement/resources-surviving-social-security/> (last updated May 17, 2013).

36. Harold C. Slavkin, *Maturity and Oral Health: Live Longer and Better*, 131 J. AM. DENTAL ASS'N 805, 806 (June 2000).

wards problems in an elder's mouth.³⁷ Prevalence of oral diseases increases even more with declining general health, cognitive function, and physical function.³⁸

The status of elderly Americans' oral health directly affects aspects of daily life. While good dental care "can restore oral function, alleviate pain and discomfort, and improve one's appearance," poor oral health, pain, or discomfort due to oral problems impacts quality of life in even the simplest of activities.³⁹ Shoddy overall well-being, communication, and social interaction are all associated with oral pain, poor facial aesthetics, and impaired chewing.⁴⁰ In some cases where "people are faced with the difficult decision to remove their teeth because extractions are considerably cheaper than the cost of treatments to save them," elders must face the negative health and social impacts of missing teeth.⁴¹ Elders may withdraw from speaking or interacting with others due to the level of discomfort or pain involved with speaking.⁴² Others may not be able to participate in daily activities or may require greater assistance due to the inability to complete basic functions independently without oral pain.⁴³ More importantly, elders with poor dental health or oral pain may not receive proper nutrition.⁴⁴ Poor oral health complicates conditions that

37. *Senior Dental Problems & Underlying Health Issues*, A PLACE FOR MOM, <http://www.aplaceformom.com/senior-care-resources/articles/senior-dental-problems> (last updated Apr. 4, 2014).

38. Kay Bensing, *Oral Care in Elderly Patients*, ADVANCE HEALTHCARE NETWORK FOR NURSE PRACTITIONERS & PHYSICIAN ASSISTANTS (Jan. 18, 2013), <http://nurse-practitioners-and-physician-assistants.advanceweb.com/Features/Articles/Oral-Care-in-Elderly-Patients.aspx>.

39. Janet A. Yellowitz, Access, *Place of Residence and Interdisciplinary Opportunities*, in *IMPROVING ORAL HEALTH FOR THE ELDERLY: AN INTERDISCIPLINARY APPROACH* 55, 61 (Ira B. Lamster & Mary E. Northridge eds., 2008).

40. *Id.*

41. Chairman Bernard Sanders, *Dental Crisis in America: The Need to Expand Access*, U.S. S. COMM. ON HEALTH, EDUC., LABOR & PENSIONS 1, 2 (Feb. 29, 2012), <http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf>.

42. *Oral Health in America: A Report of the Surgeon General – Executive Summary*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2000), <http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Report/ExecutiveSummary.htm> (identifying, in Part 3, self-reported impacts of oral conditions on social function include limitations in verbal and nonverbal communication, social interaction, and intimacy).

43. *Id.*

44. *Id.* at Part 3 (explaining how "oral and craniofacial diseases and conditions contribute to compromised ability to bite, chew, and swallow foods; limitations in food selection; and poor nutrition. These conditions include tooth loss, diminished salivary functions, oral-facial pain conditions such as temporomandibular disorders, alterations in taste, and functional limitations of prosthetic replacements.").

elders may already suffer and opens the door for more serious illnesses and negative impacts to affect their lives.⁴⁵

Compared to the general population, elders “consume a disproportionately large percentage of health care resources” and face many more health challenges due to aging.⁴⁶ Medications that cause dry mouth and arthritis make brushing and flossing difficult, and dentures that lead to gum shrinkage are just some of the cyclical oral problems that the elderly face.⁴⁷ Gingival recession, when gum tissue pulls away from the teeth it surrounds,⁴⁸ affects almost all middle and older aged people to some degree.⁴⁹ The recession may be caused by any number of issues such as periodontal disease, hormonal changes, a history of smoking tobacco, the cumulative effects of aggressive brushing, and other causes that tend to increase with age.⁵⁰ These causes may also be compounded by the fact that most elders grew up before preventive care policies, such as widespread water fluoridation, thus resulting in more fillings that weaken and crack over time.⁵¹ Without fluoridation and education about proper personal oral care, elders have very high rates of dental root caries, cavities that form at the root of the teeth, and other forms of tooth decay.⁵² The National Institute of Dental and Craniofacial Research estimates that ninety-three percent of seniors ages sixty-five and older have had dental caries in their permanent teeth.⁵³ Other statistics show that fifty percent of older adults have untreated dental caries, thirty percent of older

45. *Oral Health for Older Americans: Adult Oral Health*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/OralHealth/publications/factsheets/adult_oral_health/adult_older.htm (last updated July 10, 2013).

46. Shoshana H. Bardach & Graham D. Rowles, *Geriatric Education in the Health Professions: Are We Making Progress?*, 52 *GERONTOLOGIST* 607, 607 (Mar. 2012), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3463419/pdf/gns006.pdf>.

47. Chris Hawkins, *Helpful Resources for Seniors Surviving on Social Security*, SENIORLIVING.ORG, <http://www.seniorliving.org/retirement/resources-surviving-social-security/> (last updated May 17, 2013).

48. Michael Friedman, *Oral Care: Receding Gums*, WEBMD MED. REFERENCE (Oct. 26, 2014), http://www.webmd.com/oral-health/guide/receding_gums_causes-treatments.

49. *Id.*

50. Koppolu Pradeep et al., *Gingival Recession: Review and Strategies in Treatment or Recession*, 2012 *CASE REPORTS IN DENTISTRY* 1, 1-2 (2012), <http://www.hindawi.com/journals/crid/2012/563421/>.

51. Mouth Health, *Decay*, AM. DENTAL ASS'N, <http://www.mouthhealthy.org/en/az-topics/d/decay> (last visited Nov. 11, 2015).

52. *Dental Caries (Tooth Decay) in Seniors (Age 65 and Over)*, NAT'L INST. OF DENTAL & CRANIOFACIAL RESEARCH, <http://www.nidcr.nih.gov/DataStatistics/FindDataByTopic/DentalCaries/DentalCariesSeniors65older.htm> (last visited Nov. 11, 2015).

53. *Id.*

adults lose their teeth, and twenty-three percent have severe gum disease.⁵⁴ These dental health issues may lead to nutritional deficiencies, pain, and other systemic diseases that create even greater problems for elders.⁵⁵

Conditions such as gingivitis and dental caries may stem from non-contagious infections in the body, but the compromised immune systems of elders battling oral infections can also heighten susceptibility to other opportunistic infections and systemic conditions.⁵⁶ Poor dental health in elderly individuals also aggravates diabetes, cardiovascular diseases, and other infections.⁵⁷ In this way, neglecting treatable oral infections may result in spreading contagious illnesses or exacerbating conditions that require more medical resources and more serious treatment.⁵⁸ Aside from physical conditions, other chronic psychological and mental conditions such as dementia are also linked to tooth loss.⁵⁹ For elders, recognizing the value of oral health is imperative because of the potential consequences that “may result in the deterioration of overall physical health. . . . Older adults suffer from the cumulative toll of oral diseases over their lifetime. This results in extensive oral disease.”⁶⁰ This troubling cycle of disease and affliction

54. *Older Adults' Oral Health in a State of Decay*, ORAL HEALTH AM. (2013), http://b.3cdn.net/teeth/83b738de97bca9baec_jdm6bj8py.pdf; see Kay Bensing, *Oral Care in Elderly Patients*, ADVANCE HEALTHCARE NETWORK FOR NURSE PRACTITIONERS & PHYSICIAN ASSISTANTS (Jan. 18, 2013), <http://nurse-practitioners-and-physician-assistants.advanceweb.com/Features/Articles/Oral-Care-in-Elderly-Patients.aspx>.

55. Kay Bensing, *Oral Care in Elderly Patients*, ADVANCE HEALTHCARE NETWORK FOR NURSE PRACTITIONERS & PHYSICIAN ASSISTANTS (Jan. 18, 2013), <http://nurse-practitioners-and-physician-assistants.advanceweb.com/Features/Articles/Oral-Care-in-Elderly-Patients.aspx>.

56. Janet A. Yellowitz, *Access, Place of Residence, and Interdisciplinary Opportunities*, in *IMPROVING ORAL HEALTH FOR THE ELDERLY: AN INTERDISCIPLINARY APPROACH* 55, 56 (Ira B. Lamster & Mary E. Northridge eds., 2008).

57. See Denise Reynolds, *8 Health Effects of Poor Dental Hygiene that Extend Beyond Your Mouth*, EMAXHEALTH (May 28, 2013), <http://www.emaxhealth.com/1506/8-health-effects-poor-dental-hygiene-extend-beyond-your-mouth>; *Poor oral care may aggravate heart disease risk and diabetes*, DENTALPLANS.COM, <http://www.dentalplans.com/dentalhealtharticles/58154/poor-oral-care-may-aggravate-heart-disease-risk-and-diabetes.html> (last updated Mar. 22, 2012).

58. Yousef S. Khader et al., *Periodontal Diseases and the Risk of Coronary Heart and Cerebrovascular Diseases: A Meta-Analysis*, 75 J. PERIODONTOLOGY 1046, 1046 (2004), <http://www.joponline.org/doi/abs/10.1902/jop.2004.75.8.1046?prevSearch=allfield%253A%2528risk%2Bfactor%2529%2BAND%2B%2528periodontal%2Bdisease%2529&searchHistoryKey=>.

59. *Understanding and preventing tooth loss*, HUMANA, <https://www.humana.com/learning-center/health-and-wellbeing/healthy-living/tooth-loss> (last updated Feb. 2014).

60. *A State of Decay: The Oral Health of Older Americans*, ORAL HEALTH AM. & CAMPAIGN FOR ORAL HEALTH PARITY 2 (2003), <https://c.ymcdn.com/sites/www>.

will continue growing as long as the current system of oral care finance and delivery remain the same.⁶¹

B. Barriers to Accessing Care

Presently, finance and delivery of dental care for the elderly takes place primarily through private means because few public options exist.⁶² Elder Americans with limited income and insurance coverage are disproportionately affected by poor oral health and less able to obtain treatment.⁶³ Educational achievement, occupation, and income are some of the most significant predictors of oral care use among elders.⁶⁴ One study found that educational attainment correlates with the likelihood that an elderly individual would visit the dentist.⁶⁵ The same study also found that “blue collar workers [were] only half as likely as other occupational levels to have made dental visits in the past year. [Yet, blue] collar workers were 2.5 times more likely to have had an extraction at their last visit than those in managerial or professional occupations.”⁶⁶ Thus, the cumulative effects of poor dental care access over one’s lifetime can result in more severe dental problems in old age.⁶⁷ Poor access to oral care also leaves low-income elders with limited education in poorer health than the general population.⁶⁸ Not only do these elders have greater dental care needs as their health conditions accumulate, but they also face greater barriers to obtaining proper oral care when they seek treatment.⁶⁹

Dental care is expensive, and dental care insurance coverage remains primarily a voluntary benefit for those who can afford the re-

chronicdisease.org/resource/resmgr/Healthy_Aging_Critical_Issues_Brief/State_of_Decay_b.pdf.

61. *Id.*

62. *Id.*

63. See *A State of Decay: Are Older Americans Coming of Age Without Oral Healthcare?*, DENTISTRYIQ, http://www.dentistryiq.com/content/dam/diq/online-articles/documents/2013/10/OHA_State_of_Decay_2013.PDF (last visited Nov. 11, 2015).

64. H. Asuman Kiyak & Marisa Reichmuth, *Barriers to and Enablers of Older Adults’ Use of Dental Services*, 69 J. DENTAL EDUC. 975, 977-78 (2005).

65. *Id.* at 978.

66. *Id.*

67. See *id.*

68. See *A State of Decay: Are Older Americans Coming of Age Without Oral Healthcare?*, DENTISTRYIQ, http://www.dentistryiq.com/content/dam/diq/online-articles/documents/2013/10/OHA_State_of_Decay_2013.PDF (last visited Nov. 11, 2015).

69. See H. Asuman Kiyak & Marisa Reichmuth, *Barriers to and Enablers of Older Adults’ Use of Dental Services*, 69 J. DENTAL EDUC. 975, 978 (2005) (discussing physical barriers for frail elder adults in obtaining oral care).

sources required to seek out and pay for care.⁷⁰ “Older adults often have special oral health needs. . . . Older Americans without private dental insurance have no means of accessing care unless they are able to pay out-of-pocket. This is difficult or impossible for millions of older Americans who suffer from poor oral health.”⁷¹ A report by the Health Policy Institute of the American Dental Association found that finances and dental insurance are the main reasons for not obtaining needed dental care.⁷² Those surveyed who were aged sixty-five and older were second most likely to indicate that they needed dental care, but could not obtain it, just behind individuals aged twenty-one to sixty-four.⁷³ The population of elders ages sixty-five and older is growing significantly,⁷⁴ making these cost barriers more significant problems because of the more extensive dental care elders will likely require as the cohort expands.⁷⁵ Generally, high costs and minimal insurance coverage impacts elders’ willingness to seek health care, including dental care.⁷⁶ In a survey analyzing the financial challenges faced by an individual if he or she lives to age 100, the largest percentage (thirty-seven percent) of respondents reported running out of money as their primary concern.⁷⁷ Twenty-three percent of respondents reported managing the costs of health care as their biggest potential challenge, the second-most common response.⁷⁸ Both running out of money and managing health care costs are closely linked concerns

70. Nathan Solheim, *PPACA pushes dental further into voluntary*, BENEFITSPRO (Jan. 22, 2014), http://www.benefitspro.com/2014/01/22/ppaca-pushes-dental-further-into-voluntary?page_all=1.

71. *A State of Decay: Are Older Americans Coming of Age Without Oral Healthcare?*, DENTISTRYIQ, http://www.dentistryiq.com/content/dam/diq/online-articles/documents/2013/10/OHA_State_of_Decay_2013.PDF (last visited Nov. 11, 2015).

72. Thomas Wall et al., *Most Important Barriers to Dental Care Are Financial, Not Supply Related*, AM. DENTAL ASS’N (Oct. 2014), http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_2.ashx.

73. *Id.* at 4.

74. Sandra L. Colby & Jennifer M. Ortman, *The Baby Boom Cohort in the United States: 2012 to 2060*, U.S. CENSUS BUREAU (May 2014), <http://www.census.gov/prod/2014pubs/p25-1141.pdf>.

75. Jen Christensen, *Dental Crisis Could Create ‘State of Decay’*, CNN (Oct. 9, 2013), <http://www.cnn.com/2013/10/08/health/dental-health-care-coverage/>.

76. Wyatt Myers, *The Top 7 Reasons We Avoid the Dentist*, EVERYDAY HEALTH, <http://www.everydayhealth.com/dental-health/the-top-reasons-we-avoid-the-dentist.aspx> (last updated July 11, 2012).

77. Lavonne Kuykendall, *Making the Case to Buy an Annuity*, WALL ST. J. (Mar. 8, 2011, 12:01 AM), <http://www.wsj.com/articles/SB10001424052748703954004576089761660773344>.

78. *Id.*

because of the high and sometimes unpredictable costs of elders' health care.⁷⁹

The high cost and lack of dental coverage provides elders who despise dental dealings with a painless excuse to evade the dentist without understanding the need for routine oral care.⁸⁰ Because they grew up in times of less advanced dental technology and low awareness about the importance of good oral hygiene, elders may avoid seeking out dental care or place it as a low priority.⁸¹ "[T]he older you are, the more likely you are to have had a dental procedure when anesthesia was less effective, or not used, and when dentists focused less on patient comfort."⁸² Lacking an understanding about the need for routine dental care and the neglect of oral health results in sometimes tragic consequences.⁸³

Aside from personal barriers to oral care such as finances or a lack of understanding of the value of dental care,⁸⁴ elders also face external challenges from the current system including restrictions in access to transportation and limitations in the dental workforce.⁸⁵ Many elders have special needs due to chronic conditions or medications, and "being disabled, medically compromised, homebound, or institutionalized increases the likelihood of serious dental problems and limited access to dental care."⁸⁶ Physical mobility limitations can make

79. See Fidelity Viewpoints, *Retiree Health Costs Hold Steady*, FIDELITY BROKERAGE SERVS. LLC (June 11, 2014), http://retirementresource.nationwide.com/sites/default/files/Retiree_health_costs_hold_steady-Fidelity%20_June11_14.pdf.

80. Krisha McCoy, *Anxiety in the Dentist's Chair*, EVERYDAY HEALTH, <http://www.everydayhealth.com/dental-health/you-and-your-dentist/dental-anxiety.aspx> (last updated Aug. 5, 2011) (discussing dental anxiety, including the fact that "dental anxiety is more common in older people, who may have experienced dental care when technologies were not as advanced").

81. See Wyatt Myers, *The Top 7 Reasons We Avoid the Dentist*, EVERYDAY HEALTH, <http://www.everydayhealth.com/dental-health/the-top-reasons-we-avoid-the-dentist.aspx> (last updated July 11, 2012) (discussing how dental technology has improved over time).

82. Krisha McCoy, *Anxiety in the Dentist's Chair*, EVERYDAY HEALTH, <http://www.everydayhealth.com/dental-health/you-and-your-dentist/dental-anxiety.aspx> (last updated Aug. 5, 2011).

83. Paul Glassman & Matthew Newman, *Policy Brief: The Costs of Neglect of Dental Disease and the Impact of the Virtual Dental Home*, PAC. CTR. FOR SPECIAL CARE 1 (Apr. 7, 2013), http://dental.pacific.edu/Documents/community/special_care/acrobat/VirtualDentalHome_CostOfNeglect_PolicyBrief_2013_0407.pdf.

84. Sharyn Alden, *Seniors Face Barriers to Critical Dental Care*, CTR. FOR ADVANCING HEALTH (CFAH) (Aug. 26, 2014), <http://www.cfah.org/hbns/2014/seniors-face-barriers-to-critical-dental-care>.

85. *Id.*

86. Naomi Levy et al., *Geriatrics Education in U.S. Dental Schools: Where Do We Stand, and What Improvements Should Be Made?*, 77 J. DENTAL EDUC. 1270, 1270 (2013); A

obtaining dental care difficult.⁸⁷ Accommodations for transportation add an additional expense, and such “factors exponentially increase the risk for oral infection and tooth decay among the elderly.”⁸⁸ The hardships driving up elders’ opportunity costs to receiving care may even make a dentist visit not worth their while.⁸⁹

Additionally, dental workforce limitations may also play a role in the lack of access to oral care for elder Americans.⁹⁰ One study reports that thirty-three million elderly individuals live where dentists and clinics are scarce,⁹¹ and the dentists who have comprehensive training in treating the elderly are even rarer.⁹² Studies cite a lack of geriatric training and discomfort with elderly patients as barriers to dentists providing care to elders.⁹³ Studies also report that “dentists significantly overestimated their older patients’ reluctance to receive dental treatment. . . . [and almost] one-fourth also felt unprepared for treating frail older patients.”⁹⁴ Compounding these problems is the

State of Decay: Are Older Americans Coming of Age Without Oral Healthcare?, DENTISTRYIQ, http://www.dentistryiq.com/content/dam/diq/online-articles/documents/2013/10/OHA_State_of_Decay_2013.PDF (last visited Nov. 11, 2015).

87. Naomi Levy et al., *Geriatrics Education in U.S. Dental Schools: Where Do We Stand, and What Improvements Should be Made?*, 77 J. DENTAL EDUC. 1270, 1270 (2013).

88. Lerin Madole, *A new way of looking at dental care for the elderly through “Dentists for Della,”* DENTISTRYIQ, <http://www.dentistryiq.com/articles/2013/06/a-new-way-of-looking-at-dental-care-for-the-elderly-through--den.html> (last visited Nov. 11, 2015).

89. Nancy Volkers, *Dental Visits “Not Worth It” to Some Elderly*, INTELIHEALTH NEWS SERV. (Nov. 13, 2013), <https://www.dentalaegis.com/news/2013/11/22/Dental-Visits-Not-Worth-It-to-Some-Elderly>.

90. Lerin Madole, *A new way of looking at dental care for the elderly through “Dentists for Della,”* DENTISTRYIQ, <http://www.dentistryiq.com/articles/2013/06/a-new-way-of-looking-at-dental-care-for-the-elderly-through--den.html> (last visited Nov. 11, 2015).

91. Inst. of Med. & Nat’l Research Council, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*, HUMAN RES. & SERV. ADMIN. 1, <http://www.hrsa.gov/publichealth/clinical/oralhealth/improvingaccess.pdf> (last visited Nov. 11, 2015).

92. Naomi Levy et al., *Geriatrics Education in U.S. Dental Schools: Where Do We Stand, and What Improvements Should Be Made?*, 77 J. DENTAL EDUC. 1270, 1270 (2013).

93. See Michael J. Helgeson et al., *Dental Considerations for the Frail Elderly*, 22 SPECIAL CARE DENTIST 40S, 46S (2002), <http://www.mohc.org/files/SCD%20Frail%20Elderly%209-11-02%20Helgeson%20%282%29.pdf>; Anthony M. Iacopino, *Maintaining Oral Health in the Aging Population: The Importance of the Periodontal-Systemic Connection in the Elderly*, DENTISTRYIQ, <http://www.dentistryiq.com/articles/gr/print/volume-1/issue-3/original-article/maintaining-oral-health-in-the-aging-population-the-importance-of-the-periodontal-systemic-connection-in-the-elderly.html> (last visited Nov. 11, 2015) (stating that the “inclusion of other healthcare disciplines in geriatric dental practice or oral health education for non-dental health professions is inadequate and lacks uniformity.” In this way, not only are dentists not receiving training in how to treat the elderly, geriatric dentists who specialize in treating elders are not providing education and training to others.).

94. Asuman Kiyak & Marisa Reichmuth, *Barriers to and Enablers of Older Adults’ Use of Dental Services*, 69 J. DENTAL EDUC. 975, 982–83 (2005).

perception by some dentists “that older adults generally are uninterested in maintaining their teeth or that they cannot afford dental care” which discourages providers from caring for these patients.⁹⁵

Even where dentists have significant geriatric training, exclusions for the coverage of services and low overall reimbursement rates may drive dentists away from treating elders.⁹⁶ Some dentists cite confusion about coverage and exclusions over procedures as a reason for rejecting elderly patients.⁹⁷ In terms of low reimbursement rates, dentists may be discouraged from treating the more expensive conditions common to elderly patients because many dentists face personal challenges in paying for a practice and dental school tuition loans.⁹⁸ On average, “educational debt from public dental schools was \$192,299; for private dental schools it was \$263,382.”⁹⁹ The cost at some schools “could be as high as \$400,000.”¹⁰⁰ Facing high educational debts, treating elder populations with costly medical conditions or other complications for very little compensation may appear highly unattractive to a dentist.¹⁰¹ In these ways, elder Americans may face hardships that prevent them from obtaining necessary oral care, which may be important now that more of the elderly retain their permanent teeth into old age.¹⁰²

C. The Changing Face of Affected Elderly—The Baby Boomers

The United States Surgeon General reported that “[o]ne of the more dramatic discoveries in biomedical science in the [twentieth] century has been the realization that tooth loss is not an inevitable consequence of aging, but the result of disease or injury.”¹⁰³ Develop-

95. *Id.* at 982.

96. *Id.* at 980.

97. Naomi Levy et al., *Geriatrics Education in U.S. Dental Schools: Where Do We Stand, and What Improvements Should Be Made?*, 77 J. DENTAL EDUC. 1270, 1270-85 (2013).

98. Erick Cutler, *What does the high cost of dental school mean for the profession?*, GOLDIN PEISER & PEISER, LLP, http://dental.gppcpa.com/2014/07/31/what_does_the_high_cost_of_dental_school_mean_for_the_profession (last visited Nov. 11, 2015) (citing the American Student Dentist Association’s statistics for the cost of a dental education).

99. *Id.*

100. *Id.*

101. Naomi Levy et al., *Geriatrics Education in U.S. Dental Schools: Where Do We Stand, and What Improvements Should Be Made?*, 77 J. DENTAL EDUC. 1270, 1270 (2013).

102. Jen Christensen, *Dental Crisis Could Create ‘State of Decay’*, CNN (Oct. 9, 2013, 11:40 AM), <http://www.cnn.com/2013/10/08/health/dental-health-care-coverage/>.

103. Kay Bensing, *Oral Care in Elderly Patients*, ADVANCE HEALTHCARE NETWORK FOR NURSE PRACTITIONERS & PHYSICIAN ASSISTANTS (Jan. 18, 2013), <http://nurse->

ments in health and dental care led to only “[thirty percent] of older Americans [losing] their teeth, compared to [forty-six percent twenty] years ago.”¹⁰⁴ Prevention and treatment of oral diseases has been effective in improving oral health.¹⁰⁵ Coupled with technological advances such as dental implants, Americans entering old age have experienced better oral health than their predecessors.¹⁰⁶ The evidence points to the effectiveness of preventive dental care in reducing disease, decreasing instances of decay, and improving overall health.¹⁰⁷ Studies note that preventive dental care in adults impacts medical costs, resulting in cost-savings and fewer serious medical procedures.¹⁰⁸

[A]n analysis of health insurance claims data found that, for diabetic patients with an average of one to two preventive procedures in a year, total per member per month (PMPM) health care costs were eleven percent lower relative to those without periodontal and prophylaxis procedures. A similar analysis of Maine’s all-insurer database found that patients with cardiovascular disease and one periodontal visit in the year had overall medical costs . . . lower relative to those without a visit.¹⁰⁹

However, the advantages brought about by the developments in preventive care may not last in the face of emerging dental problems among elders and the increased size of the elder population. As the Baby Boomers age, many more keep “their natural teeth [and, as a result], could be facing some serious oral health problems over the next decade. . . . [Teeth] that have been in use for [fifty] or [sixty] or [seven-

practitioners-and-physician-assistants.advanceweb.com/Features/Articles/Oral-Care-in-Elderly-Patients.aspx.

104. *Id.*

105. Paul Glassman & Matthew Newman, *Policy Brief: The Costs of Deglect of Dental Disease and the Impact of the Virtual Dental Home*, PAC. CTR. FOR SPECIAL CARE 1, 2 (Apr. 7, 2013), http://dental.pacific.edu/Documents/community/special_care/acrobat/VirtualDentalHome_CostOfNeglect_PolicyBrief_2013_0407.pdf.

106. Jen Christensen, *Dental Crisis Could Create ‘State of Decay’*, CNN (Oct. 9, 2013, 11:40 AM), <http://www.cnn.com/2013/10/08/health/dental-health-care-coverage/>.

107. Paul Glassman & Matthew Newman, *Policy Brief: The Costs of Deglect of Dental Disease and the Impact of the Virtual Dental Home*, PAC. CTR. FOR SPECIAL CARE 1, 2-3 (Apr. 7, 2013), http://dental.pacific.edu/Documents/community/special_care/acrobat/VirtualDentalHome_CostOfNeglect_PolicyBrief_2013_0407.pdf.

108. Chairman Bernard Sanders, *Dental Crisis in America: The Need to Expand Access*, U.S. S. COMM. ON HEALTH, EDUC., LABOR & PENSIONS 1, 2 (Feb. 29, 2012), <http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf>.

109. Paul Glassman & Matthew Newman, *Policy Brief: The Costs of Deglect of Dental Disease and the Impact of the Virtual Dental Home*, PAC. CTR. FOR SPECIAL CARE 1, 3 (Apr. 7, 2013), http://dental.pacific.edu/Documents/community/special_care/acrobat/VirtualDentalHome_CostOfNeglect_PolicyBrief_2013_0407.pdf.

ty] years will have problems.”¹¹⁰ Without regular visits to a dental provider, “older adults often present with extensive oral disease, the cumulative effects of oral diseases throughout their lifetime.”¹¹¹ The elder population is expected to grow to seventy million by 2030 and elders age sixty-five and older will account for one-fifth of the American population.¹¹² This exponential growth in the elder population means that dental problems will not only be compounded by larger numbers of remaining natural teeth, but will also be multiplied by the larger number of individuals needing access to dental care.¹¹³

Direct dental care needs of today’s elderly cover the spectrum of oral health issues.¹¹⁴ Some may include relatively small issues such as minor tooth decay or gum disease, but they can also involve temporomandibular joint disorders from muscle problems or arthritis, dentures, and edentulism (tooth loss).¹¹⁵ In the United States, one-fourth of adults age sixty-five and older have lost all of their teeth.¹¹⁶ While regular cleanings and proactive preventive care can diagnose and treat these issues with relative ease, many elders still do not have regular dental examinations, nor do they have the means to access community-based dental practices.¹¹⁷

The environment is ripe for government policy and new legislation to fill gaps in elders’ oral care. Poor health, low levels of insurance coverage, high costs of oral care, limited transportation, and barriers within the dental workforce can create cyclical problems that

110. Jen Christensen, *Dental Crisis Could Create ‘State of Decay’*, CNN (Oct. 9, 2013, 11:40 AM), <http://www.cnn.com/2013/10/08/health/dental-health-care-coverage/>.

111. Janet A. Yellowitz, *Access, Place of Residence, and Interdisciplinary Opportunities*, in *IMPROVING ORAL HEALTH FOR THE ELDERLY: AN INTERDISCIPLINARY APPROACH* 55, 61 (Ira B. Lamster & Mary E. Northridge eds., 2008).

112. Michael J. Helgeson et al., *Dental Considerations for the Frail Elderly*, 22 *SPECIAL CARE DENTIST* 40S, 40S-55S (2002), <http://www.mohc.org/files/SCD%20Frail%20Elderly%209-11-02%20Helgeson%20%282%29.pdf>.

113. *Id.* at 485.

114. Connie Lambert, *The Unexpected Crisis of Caring for Aging Parents*, OUR GENERATIONS (Mar. 14, 2014, 4:28 PM), <http://www.ourgenerationsllc.com/the-unexpected-crisis-of-caring-for-aging-parents/>.

115. *Temporomandibular Joint Disorders (TMD, TMJ)*, WEBMD, <http://www.webmd.com/oral-health/guide/temporomandibular-disorders-tmd> (last visited Nov. 11, 2015).

116. Chairman Bernard Sanders, *Dental Crisis in America: The Need to Expand Access*, U.S. S. COMM. ON HEALTH, EDUC., LABOR & PENSIONS 1, 1 (Feb. 29, 2012), <http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf>.

117. Janet A. Yellowitz, *Access, Place of Residence, and Interdisciplinary Opportunities*, in *IMPROVING ORAL HEALTH FOR THE ELDERLY: AN INTERDISCIPLINARY APPROACH* 55, 57 (Ira B. Lamster & Mary E. Northridge eds., 2008).

may burden overall physical health among the elderly.¹¹⁸ The growing costs of elder Americans' poor dental health burden the general population both financially and socially.¹¹⁹ The effects of poor oral health on both the elderly and general populations are well-documented.¹²⁰ The risks of doing nothing are great.¹²¹ However, public systems including Medicare and Medicaid continue to fall short in providing proper oral care to the elderly.¹²²

III. Analysis of Current Policies and Their Impacts on Elders' Oral Care

Although elder Americans have a high oral disease burden and significant dental needs,¹²³ those who cannot pay dental care providers or afford insurance coverage are often left without meaningful public alternatives to access care.¹²⁴ The Centers for Medicare & Medicaid Services and state Medicaid programs are some of the largest federal and state payers for health care in the United States, yet most programs only have minimal coverage for elders' dental services, if at all.¹²⁵ Even though the ACA modified insurance, Medicaid, and other areas of health care provision, discussions about oral care remained paltry at best.¹²⁶ In most cases, coverage remained the same—

118. *A State of Decay: The Oral Health of Older Americans*, ORAL HEALTH AM. & CAMPAIGN FOR ORAL HEALTH PARITY (2003), http://www.oralhealthamerica.org/wp-content/uploads/2003_StateofDecayFinal.pdf.

119. *Oral Health in America: A Report of the Surgeon General—Executive Summary*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2000), <http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Report/ExecutiveSummary.htm> (Part 6).

120. *Id.* (finding that oral and craniofacial diseases and their treatment place a burden on society in the form of lost days and years of productive work).

121. Catherine Watkins et al., *Putting Teeth Into Elder Health Care*, 15 FALL NAELA Q. 22 (2002).

122. Kay Bensing, *Oral Care in Elderly Patients*, ADVANCE HEALTHCARE NETWORK FOR NURSE PRACTITIONERS & PHYSICIAN ASSISTANTS (Jan. 18, 2013), <http://nurse-practitioners-and-physician-assistants.advanceweb.com/Features/Articles/Oral-Care-in-Elderly-Patients.aspx>.

123. *A State of Decay: The Oral Health of Older Americans*, ORAL HEALTH AM. & CAMPAIGN FOR ORAL HEALTH PARITY (2003), http://www.oralhealthamerica.org/wp-content/uploads/2003_StateofDecayFinal.pdf.

124. *Id.*

125. CMS *Roadmaps Overview*, CTRS. FOR MEDICARE & MEDICAID SERVS. (CMS), http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/downloads/RoadmapOverview_OEA_1-16.pdf (last visited Nov. 11, 2015).

126. Janet L. Dolgin, *Who's Smiling Now?: Disparities in American Dental Health*, 40 FORDHAM URB. L.J. 1395, 1410 (2013).

minimal.¹²⁷ As a result, low-income, older Americans suffering from poor oral health find no safe harbor to receive oral care through public health systems.¹²⁸ This leaves many elders without any consistent means to access oral care.¹²⁹

A. Where is Medicare?

The Medicare exclusion of coverage for dental services epitomizes oral health care inadequacies in the current system and the low prioritization of oral health.¹³⁰ Congress specifically excluded coverage for dental care initially when drafting legislation for the Medicare program in 1965.¹³¹ Aside from an amendment in 1980 for “patient hospital services when the dental procedure itself made hospitalization necessary,” the law remains unchanged.¹³² This exclusion exists even after the many health care reforms brought about by the ACA.¹³³ The law excludes coverage of primary dental care services, regardless of cause or complexity, “provided for the care, treatment, removal, or replacement of structures directly supporting the teeth.”¹³⁴

Likewise, secondary dental services are not covered if they are related to “teeth or structure[s] directly supporting the teeth unless it is incident to and an integral part of a covered primary service that is necessary to treat a non-dental condition.”¹³⁵ To be covered, the dental services must be “performed at the same time as the covered primary service and by the same primary care professional.”¹³⁶ At most, Medicare pays for secondary services without covering the dental appliances, preparation of the mouth for the appliance, or the repair of

127. *A State of Decay: The Oral Health of Older Americans*, ORAL HEALTH AM. & CAMPAIGN FOR ORAL HEALTH PARITY (2003), https://c.ymcdn.com/sites/www.chronicdisease.org/resource/resmgr/Healthy_Aging_Critical_Issues_Brief/State_of_Decay_b.pdf.

128. *Id.*

129. *Id.*

130. 42 U.S.C. § 1395 (2014); § 1862(a)(12), Social Security Amendments of 1965, Pub.L. No. 89-97, 79 Stat. 286, 325 (1965).

131. *Fact Sheet: Medicare at a Glance*, KAISER FAMILY FOUND. (Sept. 2, 2014), <http://kff.org/medicare/fact-sheet/medicare-at-a-glance-fact-sheet/>.

132. *Medicare Dental Coverage*, CTRS. MEDICARE & MEDICAID. SERVS., <http://www.cms.gov/Medicare/Coverage/MedicareDentalCoverage/index.html?redirect=/MedicareDentalcoverage/> (last updated Nov. 19, 2013).

133. *Id.*

134. *Id.*

135. *Id.*

136. *Id.*

teeth and structures directly supporting the teeth.¹³⁷ In this way, these provisions in Medicare allow payment only for exceptions under very specific hospital, in-patient circumstances under Medicare Part B, regardless of a dental treatment's necessity or connection to other medical conditions.¹³⁸ The ambiguity of Medicare with regard to the conditions when these specific circumstances for payment are met has been well-documented.¹³⁹ Courts have interpreted the exclusion of services broadly against the payment of services with very few exceptions, leaving few alternatives for elder Americans.¹⁴⁰

Courts have also found that the Medicare statute's dental coverage is unclear as to coverage for oral care services "in connection with" medically necessary care where unmentioned in the exceptions to the exclusion.¹⁴¹ Because of the ambiguity, courts reviewing the decisions denying coverage made by the Secretary of the Department of Health and Human Services need only find a "permissible" interpretation of the statute by administrative agencies based on *Chevron* deference.¹⁴² The Supreme Court has held that where a statute is ambiguous, courts should defer to agency interpretations unless they are unreasonable.¹⁴³ These deferential decisions by the courts result in narrow interpretations of the Medicare statute to cover very few dental services.¹⁴⁴

In 2001, the Court of Appeals for the Seventh Circuit held in *Wood v. Thompson* that necessary dental services prior to a necessary health procedure were not covered under Medicare Part B.¹⁴⁵ Wood, an elderly patient in need of surgery to replace a heart valve, sought

137. *Id.*

138. *Wood v. Thompson*, 246 F.3d 1026, 1035-36 (7th Cir. 2001) (holding that although the dental services Wood received were a necessary precursor to his heart surgery and that the Health Care Financing Administration did not unreasonably interpret the statute barring Medicare Part B coverage for dental services by not providing coverage) (noting that Wood should seek redress through lobbying for legislation rather than adjudication).

139. Amanda McCluskey Schwob, Note, *Open Wide—I Meant Your Pocketbook: Repercussions of the Dental Exclusion to the Medicare Act*, 9 ELDER L. J. 83, 83-90 (2001).

140. *Wood*, 246 F.3d at 1035-36; see generally Amanda McCluskey Schwob, Note, *Open Wide—I Meant Your Pocketbook: Repercussions of the Dental Exclusion to the Medicare Act*, 9 ELDER L. J. 83 (2001).

141. *Wood*, 246 F.3d at 1031; *Fournier v. Sebelius*, 718 F.3d 1110, 1119 (9th Cir. 2013); *Born v. Sebelius*, 968 F.Supp.2d 1109, 1112 (D. Colo. 2013).

142. *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984).

143. *Chevron Deference*, LEGAL INFO. INST., http://www.law.cornell.edu/wex/chevron_deference (last visited Nov. 11, 2015).

144. Amanda McCluskey Schwob, Note, *Open Wide—I Meant Your Pocketbook: Repercussions of the Dental Exclusion to the Medicare Act*, 9 ELDER L. J. 90 (2001).

145. *Wood*, 246 F.3d at 1035-36.

dental care because “his cardiologist determined that Wood’s severe periodontal disease presented a significant risk of bacterial infection to his artificial heart valve.”¹⁴⁶ The cardiologist recommended that Wood undergo dental extractions prior to surgery.¹⁴⁷ Wood’s dentist submitted a claim for the extractions, but it was denied by Wood’s Medicare carrier, and denied again by both an agency hearing officer and an Administrative Law Judge.¹⁴⁸

On appeal, the court did not dispute the necessity of Wood’s dental treatment.¹⁴⁹ However, the Court of Appeals found that the ambiguity of the dental exclusion in the Medicare provisions provided the agency with wide deference in interpreting the statute.¹⁵⁰ This led the court to hold that the Health Care Financing Administration, the precursor to the Centers for Medicare & Medicaid Services, did not unreasonably interpret the statute barring Medicare Part B coverage for dental services by not providing coverage.¹⁵¹ Thus, the court denied coverage for Wood’s medically necessary dental services, noting that Wood should seek redress through lobbying for legislation rather than adjudication.¹⁵²

More recently, in *Fournier v. Sebelius*, the Ninth Circuit affirmed a lower court’s decision denying Medicare coverage to beneficiaries for primary dental care services.¹⁵³ The appellants, both elderly individuals, suffered from conditions which left them unable to produce saliva.¹⁵⁴ The inability of one of the appellants, Berg, to produce saliva was due to Sjogren’s Syndrome, a rare condition causing her to lose her teeth and gums and making her “prone to gum infections that put her at risk of a life-threatening heart infection.”¹⁵⁵ She received treatment in response to the serious risks the Sjogren’s Syndrome caused.¹⁵⁶ Appellant DiCecco also suffered from a serious condition, but his inability to produce saliva took place due to graft-versus-host disease after receiving an allogenic bone-marrow transplant to treat

146. *Id.* at 1028.

147. *Id.*

148. *Id.*

149. *Id.* at 1031-33.

150. *Id.*

151. *Id.* at 1035-36.

152. *Id.* at 1036.

153. *Fournier v. Sebelius*, 718 F.3d 1110, 1110 (9th Cir. 2013).

154. *Id.* at 1113.

155. *Id.*

156. *Id.*

chronic myelogenous leukemia.¹⁵⁷ He lost his teeth to decay so severe that he was forced to use a feeding tube.¹⁵⁸ After treatment, both appellants' claims were denied by Medicare Part B.¹⁵⁹

Both appellants challenged the broad exclusions of the Medicare statute for primary dental services received on an outpatient basis.¹⁶⁰ As with *Wood*,¹⁶¹ the court determined that "Congress did not speak directly on the precise question at issue" and deferred to the agency's interpretation of the statute.¹⁶² In finding that the appellants' procedures were not covered,¹⁶³ these cases highlight the severe consequences of the Medicare exclusion on the vulnerable elderly population. Elders cannot rely upon Medicare for oral care coverage, and this remains the same despite the passage of the ACA and its significant impact on other areas of health care.¹⁶⁴

B. Amidst the Need for Aid, What is Up with Medicaid?

Medicaid, a joint and voluntary program funded and administered by the federal government and individual states,¹⁶⁵ also provides limited oral care for certain portions of the elderly population.¹⁶⁶ Although Medicaid primarily provides health insurance coverage for low-income parents, pregnant women, disabled individuals, and children,¹⁶⁷ some elders are dually eligible for Medicare and Medicaid.¹⁶⁸

157. *Id.* at 1113-14.

158. *Id.* at 1114.

159. *Id.*

160. *Id.* at 1118-19.

161. *Wood v. Thompson*, 246 F.3d 1026, 1031 (7th Cir. 2001).

162. *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984).

163. *Fournier v. Sebelius*, 718 F.3d 1110, 1124 (9th Cir. 2013).

164. Jan Schakowsky, *A Healthy Future for America's Seniors: The Benefits of Obamacare*, U.S. HOUSE OF REPRESENTATIVES 3 (2012), <http://obamacarefacts.com/wp-content/uploads/2014/10/obamacare-seniors.pdf>; Nathan Solheim, *PPACA pushes dental further into voluntary*, BENEFITSPRO (Jan. 22, 2014), <http://www.benefitspro.com/2014/01/22/ppaca-pushes-dental-further-into-voluntary>.

165. *Seniors & Medicare and Medicaid Enrollees*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.medicaid.gov/medicaid-chip-program-information/by-population/medicare-medicare-enrollees-dual-eligibles/seniors-and-medicare-and-medicare-enrollees.html> (last visited Nov. 11, 2015).

166. Theresa Montini et al., *Barriers to Dental Services for Older Adults*, 38 AM. J. HEALTH BEHAV. 781, 781 (2014).

167. *Seniors & Medicare and Medicaid Enrollees*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.medicaid.gov/medicaid-chip-program-information/by-population/medicare-medicare-enrollees-dual-eligibles/seniors-and-medicare-and-medicare-enrollees.html> (last visited Nov. 11, 2015); *Eligibility*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html> (last visited Nov. 11, 2015).

Medicaid provides insurance to approximately 4.6 million dually eligible elder Americans, individuals who can be covered for both optional and mandatory categories of care under the programs.¹⁶⁹ However, there are no minimum requirements for adult dental services and states may choose whether dental coverage is included at all.¹⁷⁰

The Centers for Medicare & Medicaid Services reports that “while most states provide at least emergency dental services for adults, less than half of the states currently provide comprehensive dental care.”¹⁷¹ In fact, a report by Oral Health America grading the fifty-one United States jurisdictions on the level of elder adult dental Medicaid coverage reported a D+ overall for providing little coverage beyond emergency care.¹⁷² The report found that twenty states received D-grades for only offering emergency dental care to elders, and six states received F-grades for providing no dental benefits to adults at all.¹⁷³ Fifteen states earned a C-grade for providing limited benefits, and five states providing “comprehensive” benefits that did not reach full coverage received a B-grade.¹⁷⁴ Only five states provided full dental benefits under Medicaid to the eligible elder adult population.¹⁷⁵ These policy and program shortcomings in Medicaid play a large role in the minimal access elders have to dental care.¹⁷⁶

Because of these limitations in the public system of dental care coverage, most elders must either pay separately for dental care coverage or pay dental care providers out of pocket.¹⁷⁷ “The legal system in the United States has never focused vigorously on ensuring access

168. *Seniors & Medicare and Medicaid Enrollees*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.medicaid.gov/medicaid-chip-program-information/by-population/medicare-medicaid-enrollees-dual-eligibles/seniors-and-medicare-and-medicaid-enrollees.html> (last visited Nov. 11, 2015) (stating that “8.3 million people are ‘dually eligible’ and enrolled in both Medicaid and Medicare, composing more than 17% of all Medicaid enrollees.”).

169. *Id.*

170. *Dental Care*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html> (last visited Nov. 11, 2015).

171. *Id.*

172. *A State of Decay: The Oral Health of Older Americans*, ORAL HEALTH AM. & CAMPAIGN FOR ORAL HEALTH PARITY (2003), https://c.ymcdn.com/sites/www.chronicdisease.org/resource/resmgr/Healthy_Aging_Critical_Issues_Brief/State_of_Decay_b.pdf.

173. *Id.*

174. *Id.*

175. *Id.*

176. *Id.*

177. *Id.*

to dental care for low-income people.”¹⁷⁸ This disproportionately affects the low-income elderly population, and “almost seventy percent of Americans age sixty-five and older do not have dental coverage.”¹⁷⁹ Furthermore, some elderly individuals may not have the cognitive or physical ability to seek out dental care, and others may require additional assistance with transportation.¹⁸⁰ These issues create significant increases in financial and search costs, further burdening the process of obtaining oral care.

In situations where existing conditions are aggravated by dental problems or where dental problems become serious enough to do extensive damage, individuals will seek treatment in hospitals.¹⁸¹ Due to the Emergency Medical Treatment and Labor Act (EMTALA), hospitals which receive government reimbursements for Medicare and operate emergency room departments must agree to screen and stabilize any person who comes to a hospital asking for emergency treatment.¹⁸²

This appropriate screening and stabilization applies to individuals entering an emergency department with a severely neglected dental disease as well.¹⁸³ However, these hospital-related expenses for dental care cost significantly more than prevention or even treatment in a dental practice.¹⁸⁴

The Pew Center on the States estimates that there were over 830,000 visits to ERs nationwide for preventable dental conditions

178. Janet L. Dolgin, *Who's Smiling Now?: Disparities in American Dental Health*, 40 FORDHAM URB. L. J. 1395, 1397 (2013).

179. Mary McGinn-Shapiro, *Medicaid Coverage of Adult Dental Services*, NAT'L ACAD. FOR ST. HEALTH POL'Y 1, 1 (2008).

180. Janet A. Yellowitz, *Access, Place of Residence, and Interdisciplinary Opportunities*, in IMPROVING ORAL HEALTH FOR THE ELDERLY: AN INTERDISCIPLINARY APPROACH 55, 61 (Ira B. Lamster & Mary E. Northridge eds., 2008); Pamela S. Stein, *Poor Oral Hygiene in Long-Term Care: Nurses Must Provide Better Care to Older Adults and Patients with Severe Disabilities*, 109(6) AM. J. NURSING (June 2009). See Monit Cheung, *Long-Term Care Service Utilization Among Low-Income Older Adults*, https://kb.osu.edu/dspace/bitstream/handle/1811/32430/1/3_Cheung_paper.pdf (last visited Nov. 11, 2015).

181. Janet A. Yellowitz, *Access, Place of Residence, and Interdisciplinary Opportunities*, in IMPROVING ORAL HEALTH FOR THE ELDERLY: AN INTERDISCIPLINARY APPROACH 55, 61 (Ira B. Lamster & Mary E. Northridge eds., 2008); Pamela S. Stein, *Poor Oral Hygiene in Long-Term Care: Nurses Must Provide Better Care to Older Adults and Patients with Severe Disabilities*, 109(6) AM. J. NURSING (June 2009). See Monit Cheung, *Long-Term Care Service Utilization Among Low-Income Older Adults*, https://kb.osu.edu/dspace/bitstream/handle/1811/32430/1/3_Cheung_paper.pdf (last visited Nov. 11, 2015).

182. 42 U.S.C. § 1395dd (2012).

183. *Baber v. Hospital Corp. of Am.*, 977 F.2d 872 (4th Cir. 1992) (discussing an appropriate screening under EMTALA).

184. Mary Otto, *Lack of Access to Dental Care Leads to Expensive Emergency Room Care*, ASS'N HEALTH CARE JOURNALISTS (Apr. 8, 2014), <http://healthjournalism.org/blog/2014/04/lack-of-access-to-dental-care-leads-to-expensive-emergency-room-care/>.

in 2009—a sixteen percent increase from 2006. In 2007, more than 10,000 visits to Iowa emergency rooms were related to dental issues with a cost to Medicaid and other public programs of nearly five million dollars. In Florida, there were more than 115,000 hospital ER visits for dental problems in 2010 with costs of more than eighty-eight million dollars. These numbers would not be nearly as high if people had access to the basic and preventive care they need.¹⁸⁵

The general public pays for these costs through federal and state taxes when the elderly and other individuals use hospital facilities for treatment.¹⁸⁶ The 830,000 visits to the emergency rooms around the country in 2009 “could have been prevented if the patients had seen a dentist earlier.”¹⁸⁷ Consequently, “financially stressed states have been required to bear the cost of expensive emergency treatment for decay, abscesses and other dental ailments.”¹⁸⁸

Insufficient efforts to care for the mouths of the elderly population cause a myriad of problems, as observed by the Medicare exclusion and the limited oral care delivery through state Medicaid programs.¹⁸⁹ “Health care options provided by the government are often available, but do not include dental care.”¹⁹⁰ This shortage of public options for dental care coverage may leave elders in a difficult position. Retirement can be costly already, and for “many Americans, health care is likely to be one of their largest expenses in retirement.”¹⁹¹

185. Chairman Bernard Sanders, *Dental Crisis in America: The Need to Expand Access*, U.S. S. COMM. ON HEALTH, EDUC., LABOR & PENSIONS 1 (Feb. 29, 2012), <http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf>.

186. Mary Otto, *Lack of Access to Dental Care Leads to Expensive Emergency Room Care*, ASS'N HEALTH CARE JOURNALISTS (Apr. 8, 2014), <http://healthjournalism.org/blog/2014/04/lack-of-access-to-dental-care-leads-to-expensive-emergency-room-care/>.

187. Editorial Board, *Licensing 'dental therapists' could give Americans the care they need*, WASH. POST (July 14, 2014), http://www.washingtonpost.com/opinions/licensing-dental-therapists-could-give-more-americans-the-care-they-need/2014/07/14/42aa7620-07b7-11e4-8a6a-19355c7e870a_story.html.

188. Mary Otto, *Lack of Access to Dental Care Leads to Expensive Emergency Room Care*, ASS'N HEALTH CARE JOURNALISTS (Apr. 8, 2014), <http://healthjournalism.org/blog/2014/04/lack-of-access-to-dental-care-leads-to-expensive-emergency-room-care/>.

189. *Medicare Dental Coverage*, CTRS. MEDICARE & MEDICAID. SERVS. (Nov. 19, 2013, 8:03 AM), <http://www.cms.gov/Medicare/Coverage/MedicareDentalCoverage/index.html?redirect=/MedicareDentalcoverage/>.

190. Lerin Madole, *A new way of looking at dental care for the elderly through "Dentists for Della"*, DENTISTRYIQ, <http://www.dentistryiq.com/articles/2013/06/a-new-way-of-looking-at-dental-care-for-the-elderly-through--den.html> (last visited Nov. 11, 2015).

191. Fidelity Viewpoints, *Retiree Health Costs Hold Steady*, FIDELITY BROKERAGE SERVS. LLC (June 11, 2014), http://retirementresource.nationwide.com/sites/default/files/Retiree_health_costs_hold_steady-Fidelity%20June11_14.pdf; see Lerin Madole, *A new way of looking at dental care for the elderly through "Dentists for Della"*, DENTISTRYIQ, <http://www.dentistryiq.com/articles/2013/06/a-new-way-of-looking-at-dental-care-for-the-elderly-through--den.html> (last visited Nov. 11, 2015).

In 2014, Fidelity Benefits Consulting estimated that an average couple retiring at age sixty-five would need an average of \$220,000 to cover their medical expenses.¹⁹² These financial estimates do not even include additional hassles, such as limited mobility or availability of transportation options to receive medical or dental care.¹⁹³

Given the significant challenges that the elderly must overcome to obtain dental care, new policies should help increase access to care.¹⁹⁴ Small, preventable cavities will only spawn into exponentially greater problems as the elder population's growth and worsening conditions of dental care strain the limited available resources.¹⁹⁵ The legislature should quickly remedy the health care system's deficiencies in dental care.¹⁹⁶ Health care reform through the ACA may have expanded Medicaid and other aspects of health care access in some states, but dental care is still lacking.¹⁹⁷ Dental health care for the elderly remains largely in the shadows of legislative discussions.¹⁹⁸ While some adults gain dental care through Medicaid, oral care for elders is largely untouched by the ACA.¹⁹⁹

192. Fidelity Viewpoints, *Retiree Health Costs Hold Steady*, FIDELITY BROKERAGE SERVS. LLC (June 11, 2014), http://retirementresource.nationwide.com/sites/default/files/Retiree_health_costs_hold_steady-Fidelity%20June11_14.pdf.

193. Lerin Madole, *A new way of looking at dental care for the elderly through "Dentists for Della"*, DENTISTRYIQ, <http://www.dentistryiq.com/articles/2013/06/a-new-way-of-looking-at-dental-care-for-the-elderly-through--den.html> (last visited Nov. 11, 2015).

194. See Janet A. Yellowitz, *Access, Place of Residence, and Interdisciplinary Opportunities*, in *IMPROVING ORAL HEALTH FOR THE ELDERLY: AN INTERDISCIPLINARY APPROACH* 55, 57 (Ira B. Lamster & Mary E. Northridge eds., 2008); see also Lerin Madole, *A new way of looking at dental care for the elderly through "Dentists for Della"*, DENTISTRYIQ, <http://www.dentistryiq.com/articles/2013/06/a-new-way-of-looking-at-dental-care-for-the-elderly-through--den.html> (last visited Nov. 11, 2015).

195. *A State of Decay: The Oral Health of Older Americans*, ORAL HEALTH AM. & CAMPAIGN FOR ORAL HEALTH PARITY (2003), https://c.ymcdn.com/sites/www.chronicdisease.org/resource/resmgr/Healthy_Aging_Critical_Issues_Brief/State_of_Decay_b.pdf.

196. H. Asuman Kiyak & Marisa Reichmuth, *Barriers to and Enablers of Older Adults' Use of Dental Services*, 65 J. DENTAL EDUC. 975 (2005).

197. Cassandra Yarbrough et al., *More than 8 Million Adults Could Gain Dental Benefits through Medicaid Expansion*, AM. DENTAL ASS'N (Feb. 2014), http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0214_1.ashx.

198. Nathan Solheim, *PPACA pushes dental further into voluntary*, BENEFITSPRO (Jan. 22, 2014), <http://www.benefitspro.com/2014/01/22/ppaca-pushes-dental-further-into-voluntary>; see also H. Asuman Kiyak & Marisa Reichmuth, *Barriers to and Enablers of Older Adults' Use of Dental Services*, 65 J. DENTAL EDUC. 975 (2005).

199. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified in scattered sections of 42 U.S.C.); see Cassandra Yarbrough et al., *More than 8 Million Adults Could Gain Dental Benefits through Medicaid Expansion*, AM. DENTAL ASS'N (Feb. 2014), http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0214_1.ashx (noting that Medicaid has increased access to dental benefits for eight million non-elderly adults).

C. Other State Programs and Donated Services

State governments have addressed dental care for the elderly through a few different means outside of Medicare and Medicaid, but most present options for the elderly are limited at best.²⁰⁰ Similar to dental care for children in Medicaid and State Child Health Insurance Programs, these focused attempts sought to bring more regular dental care to vulnerable populations in recognition of the importance of good oral health.²⁰¹ Unfortunately, even these programs are few and far between because they are much more costly.²⁰² In most cases, policymakers appear to neglect the oral and overall health of elders in comparison to policies written for children's health.²⁰³

Some states provide comprehensive dental care for individuals who need medical assistance equivalent to the level of care provided in a nursing home setting.²⁰⁴ Massachusetts provides this dental care through Programs of All-Inclusive Care for the Elderly (PACE).²⁰⁵ Where plans are available, "PACE provides comprehensive medical care and supportive services . . . [that] include . . . primary and specialty medical care; specialty care, including . . . dentistry. . . ; social services;" and other benefits to elders.²⁰⁶ Unfortunately, only twelve states give elder Americans the option to receive dental care through a coordinated care program, giving such programs very limited penetration.²⁰⁷ Moreover, the level of coordinated care provided is limited by the coverage of services in each state's Medicaid program.

Aside from a scarcity in state programs, the lack of government-funded dental coverage often leaves elder Americans at the mercy of

200. *If Medicare will not pay for my dental care, what other resources could help me pay?*, MEDICARE INTERACTIVE, http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=1592 (last visited Nov. 11, 2015).

201. *Oral Health Topics: Medicaid and Medicare*, AM. DENTAL ASS'N, <http://www.ada.org/en/member-center/oral-health-topics/mcicaid-and-medicare> (last visited Nov. 11, 2015).

202. *Id.*

203. *Id.*

204. *If Medicare will not pay for my dental care, what other resources could help me pay?*, MEDICARE INTERACTIVE, http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=1592 (last visited Nov. 11, 2015).

205. *Id.*

206. *Which Services are Covered by PACE?*, MASS. EXEC. OFFICE OF HEALTH & HUMAN SERVS., <http://www.mass.gov/eohhs/consumer/insurance/pace/which-services-are-covered-by-pace.html> (last visited Nov. 11, 2015).

207. *If Medicare will not pay for my dental care, what other resources could help me pay?*, MEDICARE INTERACTIVE, http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=1592 (last visited Nov. 11, 2015).

donated services and overflowing health care centers.²⁰⁸ Some of these options such as Community Health Centers, hospital dental clinics, or pro bono dental work performed by students and professionals may vary greatly in cost and availability.²⁰⁹ For example, the Dental Lifeline Network is a non-profit organization that connects approximately 15,000 volunteer dentists to elders, the medically fragile, and to individuals with disabilities.²¹⁰ However, eligibility and services vary by state, all of which require an application process.²¹¹ Moreover, sites may have “lengthy wait lists” preventing the admission of new patients.²¹² Another non-profit organization, Dentistry from the Heart, also provides donated services.²¹³ Unlike the Dental Lifeline Network which operates at regular locations,²¹⁴ Dentistry from the Heart serves groups of individuals during organized events.²¹⁵ While these efforts are meaningful, none of the non-profit or clinic options provide sustainable dental care to elders over long periods of time.²¹⁶ Additionally, elders visiting non-profits, Community Health Centers, or other pro bono clinics may not see the same dental professional during each visit, introducing extra challenges into care coordination and treatment plans.²¹⁷ These patchwork alternatives of “pop-up” and local clinics do not provide elders with the necessary stability or consistency.

208. *Id.*

209. *Id.*

210. *About Us*, DENTAL LIFELINE NETWORK, dentallifeline.org/about-us/ (last visited Nov. 11, 2015).

211. *Our State Programs*, DENTAL LIFELINE NETWORK, <http://dentallifeline.org/our-state-programs/> (last visited Nov. 11, 2015) (listing the programs in different states with information about qualifications and applications).

212. *See Illinois State Program*, DENTAL LIFELINE NETWORK, <http://dentallifeline.org/illinois/> (last visited Nov. 11, 2015) (stating that applications are closed in certain counties due to lengthy waiting lists); *see New York State Program*, DENTAL LIFELINE NETWORK, <http://dentallifeline.org/new-york/> (last visited Nov. 11, 2015) (stating that applications are closed in all counties due to lengthy waiting lists).

213. *About Dentistry From The Heart*, DENTISTRY FROM THE HEART, <http://www.dentistryfromtheheart.org/about.php> (last visited Nov. 11, 2015).

214. *Our State Programs, Illinois*, DENTAL LIFELINE NETWORK, <http://dentallifeline.org/illinois/> (last visited Nov. 11, 2015).

215. *Packages*, DENTISTRY FROM THE HEART, <http://www.dentistryfromtheheart.org/packages.php> (last visited Nov. 11, 2015) (noting that in “2010, Dentistry From The Heart [had] more than 200 events scheduled across North America - bringing free dental care events to communities in 48 states and Canada.”).

216. News Release, Am. Dental Ass’n, Mission of Mercy free dental clinic to treat 1,000 underserved patients in San Antonio (Oct. 7, 2014) (stating that “charity is not a sustainable health care system.”).

217. *A State of Decay: The Oral Health of Older Americans*, ORAL HEALTH AM. & CAMPAIGN FOR ORAL HEALTH PARITY (2003), https://c.ymcdn.com/sites/www.chronicdisease.org/resource/resmgr/Healthy_Aging_Critical_Issues_Brief/State_of_Decay_b.pdf.

cy required for proper oral care.²¹⁸ With the courts' narrow reading of Medicare's dental care coverage and legislative efforts that fall short of creating a robust plan to care for the elders' oral issues, reform is necessary.²¹⁹

This Note discusses a policy alternative: the expansion of the dental therapy profession to increase elders' access to oral care. Based on existing programs and policies used among different settings and populations, this policy alternative may resolve some of the larger issues surrounding the provision of comprehensive oral care to elders.²²⁰ Because of the seriousness of oral care issues among the elderly, doing nothing is not an option. Thus, this Note uses the status quo as a comparison in reference to the alternatives, but does not actually support existing programming through Medicare and Medicaid as a viable option for financing and delivering oral care to elders.

IV. A Policy Alternative in Light of the ACA

The passage of the ACA leaves gaps in oral care, yet elders continue to be at higher risk for oral problems such as gum disease, tooth loss, tooth decay, dry mouth, and oral cancers.²²¹ "Age in and of itself is not a dominant or sole factor in determining oral health," but medical conditions such as heart disease and arthritis may heighten these risks.²²² Coupled with a reduced ability to perform daily personal oral care and chew properly, elders may suffer a great deal.²²³ Because simple tasks such as brushing and flossing may be difficult for an elderly individual, a means of receiving comprehensive and sustainable oral care is important. An ideal system of oral care provision maximizes elders' access to dental providers while remaining efficient and cost-effective.

218. H. Asuman Kiyak & Marisa Reichmuth, *Barriers to and Enablers of Older Adults' Use of Dental Services*, 65 J. DENTAL EDUC. 975 (2005).

219. *See id.* at 978-79.

220. *Early Impacts of Dental Therapists in Minnesota*, MINN. DEP'T OF HEALTH & MINN. BD. OF DENTISTRY (Feb. 2014), <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf>.

221. Brooke Wheeler, *What's Your Risk for Oral Health Problems?*, DELTA DENTAL, <http://oralhealth.deltadental.com/Adolescent/Adolescent/22,DD206?PrinterFriendly=true> (last visited Nov. 11, 2015); *Concerns*, AM. DENTAL ASS'N, <http://www.mouthhealthy.org/en/adults-over-60/concerns> (last visited Nov. 11, 2015).

222. Michael Friedman, *Oral Care: Dental Care for Seniors*, WEBMD (May 22, 2014), <http://www.webmd.com/oral-health/guide/dental-care-seniors?page=1>.

223. *Id.*

Legislators and agencies making decisions about the design and implementation of a policy must weigh several factors.²²⁴ Cost-benefit analyses, scientific data, and other elements are taken into consideration.²²⁵ Any policy alternative that policymakers use to treat shortfalls in elders' oral care access should fulfill specific characteristics including effectiveness, cost-efficiency, political feasibility, and administrative feasibility.²²⁶ These elements are relatively common in public policy analyses, and help to assess the advantages and shortcomings associated with a given policy option.²²⁷

- 1. *Effectiveness* for an oral care policy includes the population reached and the quality of care provided.²²⁸ Policy options maximizing effectiveness reach larger populations of elders and provide high quality care.

- 2. *Cost-efficiency* factors costs to the federal government, state governments, and individual elders receiving care. An ideal policy alternative would minimize the short-term, financial burdens of creating a new program while providing dividends in long-term savings through avoided treatments.

- 3. *Political feasibility* evaluates the support and opposition for a policy alternative based on the parties it concerns.²²⁹ In this case, these groups likely involve health care providers (oral and general) to the elderly, policymakers, and elder Americans affected by a program.

- 4. *Administrative feasibility* relates to the infrastructure, manpower, and regulations that exist to implement a policy alternative. Policies with higher administrative feasibility optimize existing resources to create and implement new programs.

The policy alternative introduced here will be measured against these factors. The policy alternative will also be compared with the status quo.²³⁰

A. The Alternative—Dental Therapists

One policy option in light of the ACA's oral care shortfalls involves expanding the role of dental therapists to improve elders' ac-

224. JOHN W. KINGDON, AGENDAS, ALTERNATIVES, AND PUBLIC POLICIES 143 (Longman Classics eds., 2d ed. 2003).

225. LISA S. BRESSMAN ET AL., THE REGULATORY STATE 322 (2d ed. 2013).

226. JOHN W. KINGDON, AGENDAS, ALTERNATIVES, AND PUBLIC POLICIES 143-144 (Longman Classics eds., 2d ed. 2003).

227. *Id.*

228. *Id.* at 138-39.

229. *Id.* at 146.

230. Cost is the limiting factor in all of these policies because of the high cost of care and the limited funding appropriated by the government, as evidenced by the current budgets for dental care public programs.

cess to oral care. Dental therapists work under the supervision of dentists, examining, preventing, and treating oral diseases in certain groups of individuals.²³¹ Usually working in public clinics, private practices, or schools, dental therapists can examine individuals' mouths, diagnose oral conditions, and call attention to serious problems that require a dentist.²³² Their work in oral disease prevention consists of educating individuals and the community on oral hygiene methods, applying sealants that cover the chewing surfaces of teeth, and advising on food health.²³³ In terms of treatment, dental therapists perform dental examinations, cleanings, fillings, simple extractions, fluoride therapy, and impressions for mouth-guard construction.²³⁴ "They can perform routine dental work such as filling cavities . . . [and they] could fill a crucial gap in the United States where, in contrast to many nations, there are almost no mid-level providers in dentistry."²³⁵ While dental therapists are scarce in the United States, other nations such as Australia, New Zealand, and the United Kingdom have highly developed programs.²³⁶ In those countries, dental providers are divided into several strata based on pay and training.²³⁷ The creation of a mid-level dental professional workforce creates more robust competition amongst providers, and could result in lower prices for consumers.²³⁸

The role of a dental therapist can be quite extensive. In New Zealand, for instance, dental therapists prepare treatment plans, per-

231. *Dental Therapist*, AUSTL. DENTAL ASS'N, <http://www.ada.org.au/dental-professionals/therapist.aspx> (last visited Nov. 11, 2015).

232. *Id.*

233. *Id.*

234. *Id.*

235. Janet L. Dolgin, *Who's Smiling Now?: Disparities in American Dental Health*, 40 *FORDHAM URB. L.J.* 1395, 1413 (2013).

236. David Bornstein, *Looking a Dangerous Disease in the Mouth*, *N.Y. TIMES* (Oct. 30, 2014, 8:00 PM), http://opinionator.blogs.nytimes.com/2014/10/30/looking-a-dangerous-disease-in-the-mouth/?_r=0.

237. Kaihaumanu Niho, *Dental Therapist- How to enter the job*, *CAREERS NZ* (June 4, 2015), <http://www.careers.govt.nz/jobs/health/dental-therapist/how-to-enter-the-job>.

238. Letter from Andrew L. Gavil, Dir. of Office of Policy Planning, Francine Lafontaine Dir. of Bureau of Econ. & Deborah Feinstein, Dir. of Bureau of Competition, to Sherin Tooks, Dir. of Comm'n on Dental Accreditation (Nov. 21, 2014) (on file with the author); Letter from Andrew I. Gavil, Dir. of Office of Policy Planning, Martin S. Gaynor, Dir. of Bureau of Econ. & Deborah Feinstein, Dir. of Bureau of Competition, to Sherin Tooks, Dir. of Comm'n on Dental Accreditation (December 2, 2013) (on file with the author); See generally Erik Bruce Smith, Note, *Dental Therapists in Alaska: Addressing Unmet Needs and Revising Competition in Dental Care*, 24 *ALASKA L. REV.* 105, 105 (2007).

form routine treatments, and advise patients.²³⁹ Individuals seeking dental therapy positions in New Zealand must obtain an undergraduate degree, that is either a Bachelor of Oral Health or a Bachelor of Health Science in Oral Health.²⁴⁰ The Dental Council of New Zealand handles licensing and registration.²⁴¹ Although these individuals are paid significantly less than dentists for similar work, they can earn their degree in two to four years and there is a high demand for their services.²⁴² In the United States, compensation ranges from approximately \$30,000 (USD) to \$46,000, but those with more experience and duties may earn up to approximately \$72,000.²⁴³ In 2011, New Zealand had a population of approximately 4,405,000, and there were 807 dental therapists.²⁴⁴ The number of dental therapists increases each year by about thirty workers.²⁴⁵

In the United States, dental therapists currently provide mostly preventive care, which can reduce costs and may be more effective than treatments.²⁴⁶ Dental therapists in Alaska and Maine provide lower-cost dental care for basic procedures that private practice dentists usually perform.²⁴⁷ Dental therapists acquire more training than dental hygienists, but it is not as extensive as the training for dentists.²⁴⁸ Recently, a Pew Charitable Trusts report examined dental therapists in private dental practices and in three public health dental operations.²⁴⁹ Researchers found that with dental therapists perform-

239. Kaihaumanu Niho, *Dental Therapist- How to enter the job*, CAREERS NZ (Jan. 5, 2015), <http://www.careers.govt.nz/jobs/health/dental-therapist/how-to-enter-the-job>.

240. *Id.*

241. *Id.*

242. *Id.*

243. See District Health Boards/PSA, *Allied, Public Health and Technical Multi-Employer Collective Agreement (MECA) expires 30 April 2015*, EMIGRATE N.Z., www.psa.org.dmsdocument/133 (last visited Nov. 11, 2015).

244. Kaihaumanu Niho, *Dental Therapist- How to enter the job*, CAREERS NZ (Jan. 5, 2015), <http://www.careers.govt.nz/jobs/health/dental-therapist/how-to-enter-the-job>.

245. *Id.*

246. *Preventive care can reduce costs*, DELTA DENTAL, <http://www.deltadentalins.com/individuals/guidance/preventive-care.html> (last visited Nov. 11, 2015); Heaven Stubblefield, *Preventive Dentistry*, HEALTHLINE (Jan. 21, 2014), <http://www.healthline.com/health/preventative-dentistry#Overview1>.

247. *Early Impacts of Dental Therapists in Minnesota*, MINN. DEP'T OF HEALTH & MINN. BD. OF DENTISTRY (Feb. 2014), <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf>; Joe Lawlor, *Dental therapist position approved by Maine Senate*, PORTLAND PRESS HERALD (Apr. 18, 2014), http://www.pressherald.com/2014/04/18/dental_therapist_position_approved_by_maine_senate/.

248. Janet L. Dolgin, *Who's Smiling Now?: Disparities in American Dental Health*, 40 FORDHAM URB. L.J. 1395, 1413 (2013).

249. *Licensing 'dental therapists' could give Americans the care they need*, WASH. POST (July 14, 2014), <http://www.washingtonpost.com/opinions/licensing-dental-therapists>

ing relatively simple procedures, “[the] number of patients serviced jumped. With more of the basic work taken care of, dentists could focus on complicated procedures, which also allowed them to bill more. Overall, the private practices brought in more than enough revenue to cover the dental therapists’ salaries.”²⁵⁰

In Minnesota, dental therapists can also provide nitrous oxide, an inhaled anesthetic and analgesic drug that can help prevent patients from suffering anxiety associated with dental care.²⁵¹ This may be especially helpful with the elderly who may have conditions that require sedation, such as Alzheimer’s disease or fear from previous dental procedures.²⁵² Dental therapists may also dispense and administer certain medications that fall within their scope of practice.²⁵³ This may be useful in cases where additional medications are necessary because elders generally have multiple conditions and more chronic illnesses.²⁵⁴ These additional services also highlight how dental therapists can be specifically trained to cater to the needs of elderly patients.²⁵⁵ Although dental therapists in the United States and other countries typically treat schoolchildren, geriatric training may allow dental therapists to focus on working with elders.²⁵⁶ As many dentists prefer not to work with elders, increasing access to oral care for elders may also open up unreached markets.²⁵⁷

Dental therapists could provide a great deal of basic care to elder Americans, and more states are looking to expand their role.²⁵⁸ By increasing the presence of dental therapists, policy can introduce a new

-could-give-more-americans-the-care-they-need/2014/07/14/42aa7620-07b7-11e4-8a6a-19355c7e870a_story.html.

250. *Id.*

251. MINN. R. 3100.3600 (2015); see Emmanuel Nicolas & Claire Lassauzay, *Interest of 50% nitrous oxide and oxygen premix sedation in gerodontology*, 4 CLINICAL INTERVENTIONS IN AGING 67, 69 (May 14, 2009), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2685227/pdf/cia-4-067.pdf>.

252. Emmanuel Nicolas, *Interest of 50% nitrous oxide and oxygen premix sedation in gerodontology*, 4 CLINICAL INTERVENTIONS IN AGING, 67, 67 (2009).

253. *Dental Therapist Scope of Practice*, MINN. BD. OF DENTISTRY (2009).

254. *Understanding and preventing tooth loss*, HUMANA, <https://www.humana.com/learning-center/health-and-wellbeing/healthy-living/tooth-loss> (last updated Feb. 2015).

255. See *Dental Therapist Scope of Practice*, MINN. BD. OF DENTISTRY (2009).

256. *Id.*

257. Naomi Levy et al., *Geriatrics Education in U.S. Dental Schools: Where Do We Stand, and What Improvements Should Be Made?*, 77 J. DENTAL EDUC. 1270, 1270-85 (2012).

258. Joe Lawlor, *Dental therapist position approved by Maine Senate*, PORTLAND PRESS HERALD (Apr. 18, 2014), http://www.pressherald.com/2014/04/18/dental_therapist_position_approved_by_maine_senate/ (discussing the passage of a bill approving dental therapists as providers in Maine and noting their scarcity in the United States).

class of caretakers that can provide education and basic oral care to elder Americans. Education may involve teaching elders about basic oral care and providing tools for personal oral care, similar counseling that would require costly reimbursements if it came from a dentist.²⁵⁹ Teaching about the importance of brushing, flossing, and maintaining one's teeth stresses the connection between oral health and overall well-being, and it also encourages the elderly to value oral health.²⁶⁰ Dental therapists can work in a number of settings to provide day-to-day care and individual examinations.²⁶¹ Although the dental care provided by a dental therapist is not as comprehensive as a dentist's, it can still increase awareness about dental care needs and give elders the opportunity to receive focused attention on their oral health.²⁶²

In this way, policies promoting dental therapists are both effective and relatively cost-efficient in improving oral care treatment among elders. Such policies would increase access to care. The mid-level dental professionals can increase the number of people treated with minimal additional infrastructure.²⁶³ Where dental therapists work under dentists, few or no additional facilities may be necessary due to the use of shared tools and machinery. In terms of administrative feasibility, reimbursement and other claim filing infrastructures may already be in place based on existing dentists' and hygienists' rates.²⁶⁴ In fact, Minnesota used the same reimbursement rates for services performed by dental therapists and dentists.²⁶⁵ However, despite these potential advantages in elderly oral care through the addition of

259. *Early Impacts of Dental Therapists in Minnesota*, MINN. DEP'T OF HEALTH & MINN. BD. OF DENTISTRY (Feb. 2014), <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegrspt.pdf>.

260. *Oral Health*, ADMIN. ON AGING, http://www.aoa.acl.gov/AoA_Programs/HPW/Oral_Health/index.aspx (last visited Nov. 11, 2015).

261. *Dental Therapist*, AUSTL. DENTAL ASS'N, http://www.ada.org.au/dental_professionals/therapist.aspx (last visited Nov. 11, 2015).

262. Janet L. Dolgin, *Who's Smiling Now?: Disparities in American Dental Health*, 40 *FORDHAM URB. L.J.* 1395, 1411 (2013).

263. Michelle Healy, *Dental therapists aim to fill dental-care gap*, *USA TODAY* (Jan. 2, 2013), <http://www.usatoday.com/story/news/nation/2012/12/21/dental-therapists-minnesota/1731979/>.

264. *Early Impacts of Dental Therapists in Minnesota*, MINN. DEP'T OF HEALTH & MINN. BD. OF DENTISTRY (Feb. 2014), <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegrspt.pdf>.

265. *Id.*

dental therapists, such policies experience a significant degree of backlash as well.²⁶⁶

B. Weighing the Options—Advantages and Shortcomings

Despite the strengths of policies promoting dental therapists, some concerns about political feasibility, cost-effectiveness, and legal issues still remain. For instance, the American Dental Association (ADA) opposes all bills licensing dental therapists.²⁶⁷ The ADA “released a plan to improve access to dental care, and it left out dental therapists. Instead, the dentists’ group favors more community coordinators who can counsel patients on oral health and help them find a dentist.”²⁶⁸ In Maine, the ADA “lobbied hard against the dental therapy bill” on both economic and quality merits.²⁶⁹ The ADA released a statement stating that “[the] ADA does not consider the one-size-fits-all mid-level dental provider model to be a viable solution to the diverse set of barriers that impede millions from getting dental care.”²⁷⁰ The ADA also contended “that only licensed dentists are technically qualified to” perform “irreversible procedures” like extractions and suggested increasing the numbers of dentists.²⁷¹ However, this is unrealistic given that programs such as Medicare and Medicaid already refuse to cover care in many cases.²⁷² More dentists would not increase access for elders who cannot pay out-of-pocket if the costs of procedures remains high.²⁷³

Some opposition will likely continue to voice objections, but agencies such as the Federal Trade Commission (FTC) have urged the

266. Joe Lawlor, *Access to dental care in rural Maine center of dental therapists debate*, PORTLAND PRESS HERALD (Feb. 16, 2014), http://www.pressherald.com/2014/02/16/access_to_dental_care_in_rural_maine_center_of_dental_therapists_debate/.

267. *Licensing ‘dental therapists’ could give Americans the care they need*, WASH. POST (July 14, 2014), http://www.washingtonpost.com/opinions/licensing-dental-therapists-could-give-more-americans-the-care-they-need/2014/07/14/42aa7620-07b7-11e4-8a6a-19355c7e870a_story.html.

268. *Id.*

269. Michelle Healy, *Dental therapists aim to fill dental-care gap*, USA TODAY (Jan. 2, 2013), <http://www.usatoday.com/story/news/nation/2012/12/21/dental-therapists-minnesota/1731979/>.

270. *Id.*

271. Erik Bruce Smith, Note, *Dental Therapists in Alaska: Addressing Unmet Needs and Reinvigorating Competition in Dental Care*, 24 ALASKA L. REV. 119-20 (2007).

272. *National Health Expenditures 2013 Highlights*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2013), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>.

273. *Id.*

adoption of dental therapy education accreditation standards.²⁷⁴ The FTC states that such a move would encourage competition in dentistry.²⁷⁵ The lack of competition in the field was known long before dental therapists began working in the United States. One student note from 1974 points out that restrictive licensing by dentists of “dental auxiliaries,” paraprofessionals such as hygienists and dental assistants, inhibited increases on the supply of dental care and increased the price of dental care.²⁷⁶ In Alaska, licensing dental therapists increased competition for dental services and gave Alaskan Natives and Native Americans greater access to care.²⁷⁷ Elder Americans may also benefit from such policy programs through increased access to care. Policies allowing dental therapists to treat elderly patients still require dentists for supervision and complex treatments, but dental therapy is effective in increasing access to care and ensuring oral care maintenance.²⁷⁸ Trained dental therapists already have knowledge about “human anatomy, physiology, physiologic changes associated with aging, signs of inflammation, infection and disease, pharmacology, adverse side effects of medications, and the association with general health.”²⁷⁹ Their background and education make them good candidates to fill the gaping need for mid-level dental professionals that can treat elderly populations.²⁸⁰

274. *Antitrust News: FTC Staff Urges Finalization of Dental Education Accreditation Standards*, FED. TRADE COMM’N (Nov. 21, 2014), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-commission-dental-accreditation-concerning-proposed-accreditation-standards-dental/141201codacomment.pdf; *Antitrust News: FTC Staff Urges Revisions to Dental Therapist Accreditation Standards to Encourage Growth of Profession*, FED. TRADE COMM’N (Dec. 2, 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-commission-dental-accreditation-concerning-proposed-accreditation-standards-dental/131204codacomment.pdf

275. *Antitrust News: FTC Staff Urges Revisions to Dental Therapist Accreditation Standards to Encourage Growth of Profession*, FED. TRADE COMM’N (Dec. 2, 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-commission-dental-accreditation-concerning-proposed-accreditation-standards-dental/131204codacomment.pdf.

276. Yale Law Journal Company, Inc., *Restrictive Licensing of Dental Paraprofessionals*, 83 YALE L.J. 806, 809-11 (Mar. 1974).

277. Erik Bruce Smith, Note, *Dental Therapists in Alaska: Addressing Unmet Needs and Revising Competition in Dental Care*, 24 ALASKA L. REV. 108 (2007).

278. *Id.*

279. Janet A. Yellowitz, *Access, Place of Residence, and Interdisciplinary Opportunities*, in *IMPROVING ORAL HEALTH FOR THE ELDERLY: AN INTERDISCIPLINARY APPROACH* 55, 67 (Ira B. Lamster & Mary E. Northridge eds., 2008).

280. Michelle Healy, *Dental therapists aim to fill dental-care gap*, USA TODAY (Jan. 2, 2013), <http://www.usatoday.com/story/news/nation/2012/12/21/dental-therapists-minnesota/1731979/>.

Increasing the number of mid-level dental professionals through policies that promote dental therapists will not likely cut down dental care costs, at least in the initial phases.²⁸¹ Because the policy intends to increase access to care, some investment upfront will be necessary. In terms of overall cost-effectiveness, increasing the number of mid-level dental professionals would likely address issues of funding and cost-savings in the long-term as individuals require less emergent care and fewer costly treatments.²⁸² Even the most developed program in Minnesota has not existed long enough to identify long-term cost-savings through preventive treatments and care given by dental therapists.²⁸³ The Minnesota policy was just drafted in 2009,²⁸⁴ and more time passage is necessary to evaluate the program as existing conditions receive treatment and the elder cohort receiving dental therapy care ages. Countries such as New Zealand pay dental therapists at lower reimbursement rates than dentists, thus cost-savings may be more readily identifiable.²⁸⁵ In Minnesota, because “public program reimbursement rates for dental therapist services [are] the same as the rates for dentist services, there is not necessarily an immediate savings . . . on each claim paid.”²⁸⁶ A report on the program notes that the “differential between [the Department of Health Services’] rates and clinics’ lower personnel costs for dental therapists appears to be contributing to more patients being seen.”²⁸⁷ In the long-term, preventative treatment by dental therapists will likely result in cost-savings through fewer dental emergencies, and ultimately, fewer taxpayer dollars wasted on otherwise preventable care.²⁸⁸ Nonetheless, a state

281. *Early Impacts of Dental Therapists in Minnesota*, MINN. DEP’T OF HEALTH & MINN. BD. OF DENTISTRY (Feb. 2014), <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf>.

282. Chairman Bernard Sanders, *Dental Crisis in America: The Need to Expand Access*, U.S. S. COMM. ON HEALTH, EDUC., LABOR & PENSIONS 1 (Feb. 29, 2012), <http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf>.

283. *Early Impacts of Dental Therapists in Minnesota*, MINN. DEP’T OF HEALTH & MINN. BD. OF DENTISTRY (Feb. 2014), <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf>.

284. *Id.*

285. Kaihaumanu Niho, *Dental Therapist- How to enter the job*, CAREERS NZ (Jan. 5, 2015), <http://www.careers.govt.nz/jobs/health/dental-therapist/how-to-enter-the-job>.

286. *Early Impacts of Dental Therapists in Minnesota*, MINN. DEP’T OF HEALTH & MINN. BD. OF DENTISTRY (Feb. 2014), <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf>.

287. *Id.*

288. Chairman Bernard Sanders, *Dental Crisis in America: The Need to Expand Access*, U.S. S. COMM. ON HEALTH, EDUC., LABOR & PENSIONS 1 (Feb. 29, 2012), <http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf>.

implementing a dental therapy program will need to consider that such policies may not result in savings or may only lead to savings several years later. Costs may even increase if greater access leads to higher utilization rates. States must reconcile both funding and access problems simultaneously in order to fully remedy the problem of shortfalls in elders' oral care. However, the seriousness of consequences due to a lack of dental care for elders should confirm the need for quick legislative action and increased access to oral care.²⁸⁹

Aside from responding to funding concerns and questions about political feasibility, states considering dental therapist programs also need to create infrastructure and policies to handle licensure and malpractice. In Minnesota, dental therapists must work under the supervision of a dentist by way of a "collaborative management agreement."²⁹⁰ They are limited to settings that "serve primarily low-income, uninsured, and underserved patients or in dental health shortage areas."²⁹¹ Currently, no court cases have been filed against dental therapists in any state.²⁹² Consequently, it is unclear how courts will view liability in malpractice suits. However, in foreign countries, they may be treated as independent contractors or employees of the dentists who supervise them depending on their professional setting.²⁹³

Although some questions remain with regard to issues such as dental therapists' scope of practice and licensing, there is strong evidence that policies creating positions for dental therapists can increase access to care for elders and ease the burdens of dental care.²⁹⁴ No state policy formally discusses the use of dental therapists to treat the elderly population. However, the application of dental therapy programs to elders is logical, especially in light of the types of procedures that dental therapists can perform.²⁹⁵ Dental therapists are equipped

289. *Oral Health in America: A Report of the Surgeon General – Executive Summary*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2000), <http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Report/ExecutiveSummary.htm>.

290. MINN. STAT. § 150A.105 (2015).

291. *Id.*

292. No cases or filings found based on WestlawNext and LexisAdvanced search performed on July 20, 2015.

293. *Dental Therapist*, AUSTL. DENTAL ASS'N, <http://www.ada.org.au/dental-professionals/therapist.aspx> (last visited Nov. 11, 2015).

294. *Early Impacts of Dental Therapists in Minnesota*, MINN. DEP'T OF HEALTH & MINN. BD. OF DENTISTRY (Feb. 2014), <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf>.

295. *Dental Therapist Scope of Practice*, MINN. BD. OF DENTISTRY (2009).

to treat children,²⁹⁶ and most dental therapists in other countries treat children in schools as part of their work.²⁹⁷ In the same way that dental therapists receive training to work with children,²⁹⁸ they may receive training to work with elderly patients with special needs.²⁹⁹ While the administration of dental therapy programs for elders requires care coordination, licensing, regulation, and additional curriculum guidelines at the tertiary level, the results may reap significant benefits for the overall population.³⁰⁰ With the shortage of geriatric dental professionals, policies licensing dental therapists can meet needs and ensure that dental issues are diagnosed, treated, and referred to specialists more quickly.³⁰¹

C. Recommendation

This Note recommends creating policies that facilitate increasing the role of dental therapists to address shortcomings in oral health care for the elderly. As evidenced by states such as Alaska and several other countries, dental therapists can effectively reach a geographically widespread cohort, such as the elderly, and provide care at lower costs more efficiently.³⁰² A larger pool of dental therapists would also resolve some of the transportation issues that elders face by increasing access to dental professionals.³⁰³ Recognizing the effectiveness of similar programs in three states and other countries in provid-

296. Kaihaumanu Niho, *Dental Therapist- How to enter the job*, CAREERS NZ (Jan. 5, 2015), <http://www.careers.govt.nz/jobs/health/dental-therapis/how-toenter-the-job>.

297. Kaihaumanu Niho, *Dental Therapist- How to enter the job*, CAREERS NZ (Jan. 5, 2015), <http://www.careers.govt.nz/jobs/health/dental-therapist/how-to-enter-the-job>; *Dental Therapist*, AUSTL. DENTAL ASS'N, <http://www.ada.org.au/dentalprofessionals/therapist.aspx> (last visited Nov. 11, 2015).

298. Kaihaumanu Niho, *Dental Therapist- How to enter the job*, CAREERS NZ (Jan. 5, 2015), <http://www.careers.govt.nz/jobs/health/dental-therapist/how-to-enter-the-job>.

299. *Id.*

300. *Dental Therapist*, AUSTL. DENTAL ASS'N, <http://www.ada.org.au/dentalprofessionals/therapts.aspx> (last visited Nov. 11, 2015).

301. Michelle Healy, *Dental therapists aim to fill dental-care gap*, USA TODAY (Jan. 2, 2013), <http://www.usatoday.com/story/news/nation/2012/12/21/dental-therapists-minnesota/1731979/>.

302. Erik Bruce Smith, Note, *Dental Therapists in Alaska: Addressing Unmet Needs and Reviving Competition in Dental Care*, 24 ALASKA L. REV. 108 (2007); Janet L. Dolgin, *Who's Smiling Now?: Disparities in American Dental Health*, 40 FORDHAM URB. L.J. 1395, 1413 (2013).

303. *Early Impacts of Dental Therapists in Minnesota*, MINN. DEP'T OF HEALTH & MINN. BD. OF DENTISTRY (Feb. 2014), <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf>.

ing greater access to care, policymakers and public administrators can help the elderly access oral care using dental therapists.³⁰⁴

The growing budget deficit and rising costs of public health care programs make cost-containment a matter of great importance in any policy alternative.³⁰⁵ Under better economic circumstances, training more dentists and creating comprehensive programs may garner enough support to pass the legislature; yet, until the budget balances, the option is not viable. Therefore, this recommendation does not encourage increasing spending for insurance coverage or expanding Medicare and Medicaid. Such a policy alternative likely would not hold water with policymakers. Instead, this policy option aims to side-step coverage issues by using the market and increased competition amongst service providers to expand access to oral care for elders. While dental therapists have less training than dentists and cannot offer as many services, they can be trained much more quickly to do simple, routine procedures under indirect supervision by a dentist.³⁰⁶ Because of their shorter training time, dental therapists would not graduate saddled with a dental student's educational debts, justifying the policies that allow them to work with a specified range of patients and settings at lower reimbursement rates.³⁰⁷ Unlike Minnesota, most jurisdictions pay dental therapists less than dentists for the procedures that they perform.³⁰⁸ Therefore, the programs in those jurisdictions are likely to be more cost-effective.³⁰⁹

While certain Medicaid programs provide some oral care to elder Americans, their reach and effectiveness cannot compare to programs that open up a class of dental professionals who can specifically treat elderly patients.³¹⁰ Most Medicaid programs only provide emergency treatment, often when it is too late to preempt preventable dis-

304. *Id.*

305. *National Health Expenditures 2013 Highlights*, CTRS. MEDICARE & MEDICAID SERVS. (2012), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>.

306. Kaihaumanu Niho, *Dental Therapist- How to enter the job*, CAREERS NZ (Jan. 5, 2015), <http://www.careers.govt.nz/jobs/health/dental-therapist/how-to-enter-the-job>.

307. Erick Cutler, *What does the high cost of dental school mean for the profession?*, GOLDIN PEISER & PEISER, LLP, http://dental.gppcpa.com/2014/07/31/what_does_the_high_cost_of_dental_school_mean_for_the_profession (last visited Nov. 11, 2015).

308. Kaihaumanu Niho, *Dental Therapist- How to enter the job*, CAREERS NZ (Jan. 5, 2015), <http://www.careers.govt.nz/jobs/health/dental-therapist/how-to-enter-the-job>.

309. Joanna Manning, *Health Care Law Part 2 – Legislative Developments*, 2004 NZ L. REV. 385, 396 (2004).

310. *Id.* at 397.

eases.³¹¹ During these instances, cultivating an awareness of good oral hygiene becomes a very low priority.³¹² Moreover, individuals struggling with mobility or mental capacity may not have the knowledge or ability to seek out oral care.³¹³ Many elders may not have the cognitive or physical ability to perform the necessary functions without assistance.³¹⁴ Instead, the widespread implementation of dental therapy policies can help elders gain greater access to oral care.³¹⁵ In this way, dental therapists may meet deficiencies and manage preventive oral care needs among elders that dental care professionals have not yet reached.³¹⁶

Dental therapists can provide more effective care at a lower cost than existing policy programs.³¹⁷ Some program development will be necessary to implement and expand dental therapy policies, but much of the infrastructure already exists to educate and train personnel.³¹⁸ In time, program evaluation may highlight other elder oral care needs and lead to the amendment of policies to provide training for additional procedures. This is analogous to the developments in the medical field observed through the growth of nurse practitioners' and physician assistants' roles.³¹⁹ Allowing mid-level professionals to play a role in dentistry makes oral care more accessible to the elderly.³²⁰ Flexibility in cost and program development would also give health care

311. *Id.*

312. *Id.*

313. Melinda Beck, *If Your Teeth Could Talk: Dentists Could Play Larger Role in Patient Care*, WALL ST. J. (Dec. 27, 2011), <http://online.wsj.com/articles/SB10001424052970203686204577112893077146940>.

314. Pamela S. Stein, *Poor Oral Hygiene in Long-Term Care: Nurses must provide better care to older adults and patients with severe disabilities*, 109(6) AM. J. NURSING 44, 45 (June 2009); see Melinda Beck, *If Your Teeth Could Talk: Dentists Could Play Larger Role in Patient Care*, WALL ST. J. (Dec. 27, 2011), <http://online.wsj.com/articles/SB10001424052970203686204577112893077146940>.

315. Melinda Beck, *If Your Teeth Could Talk: Dentists Could Play Larger Role in Patient Care*, WALL ST. J. (Dec. 27, 2011), <http://online.wsj.com/articles/SB10001424052970203686204577112893077146940>.

316. *Early Impacts of Dental Therapists in Minnesota*, MINN. DEP'T OF HEALTH & MINN. BD. OF DENTISTRY (Feb. 2014), <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf>.

317. *Id.*

318. Erik Bruce Smith, Note, *Dental Therapists in Alaska: Addressing Unmet Needs and Reviving Competition in Dental Care*, 24 ALASKA L. REV. 105, 117-21 (2007).

319. Michelle Healy, *Dental therapists aim to fill dental-care gap*, USA TODAY (Jan. 2, 2013), <http://www.usatoday.com/story/news/nation/2012/12/21/dental-therapists-minnesota/1731979/>.

320. Janet L. Dolgin, *Who's Smiling Now?: Disparities in American Dental Health*, 40 FORDHAM URB. L.J. 1395, 1411 (2013).

facilities, dental practices, and public clinics the option to implement scaled programs to accommodate their objectives.³²¹

At the same time, federal and state governments should issue standards based on population, performance, and care practices. Standards would create benchmarks for facilities to ensure compliance, and they would also benefit program evaluation to isolate best practices for future models.³²² The program requires a significant amount of action on the part of the legislature and substantial efforts from health care professionals in training and care-taking positions. Ultimately, however, dental therapists can fill the professional cavity in mid-level dentistry and provide elders with necessary access to oral care.³²³

V. Conclusion

Society must seriously consider the costs of inaction with regard to the elderly and oral care because of the ever-growing burdens on the physical and financial health of the nation. More than an issue that resides within the mouths of aging Americans, elders' oral care is a decaying hole which affects all taxpayers and every person who associates with the elderly. Providing care and treating elders' dental needs positively impacts the wider population by saving on expensive emergency care costs and decreasing overall disease burdens.³²⁴

Much can be done to increase access to oral care for the elderly by growing the number of dental therapists in the United States. Policies that promote a new class of professionals to care for the elderly may provide the elderly population with oral hygiene in a sustainable way.³²⁵ Receiving regular dental examinations decreases the likelihood of unattended oral health issues, prevents costly treatments to preventable diseases, and increases awareness about the importance

321. *Early Impacts of Dental Therapists in Minnesota*, MINN. DEP'T OF HEALTH & MINN. BD. OF DENTISTRY (Feb. 2014), <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf>.

322. *Id.*

323. Michelle Healy, *Dental therapists aim to fill dental-care gap*, USA TODAY (Jan. 2, 2013), <http://www.usatoday.com/story/news/nation/2012/12/21/dental-therapists-minnesota/1731979/>.

324. Chairman Bernard Sanders, *Dental Crisis in America: The Need to Expand Access*, U.S. S. COMM. ON HEALTH, EDUC., LABOR & PENSIONS 1 (Feb. 29, 2012), <http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf>.

325. David Bornstein, *Looking a Dangerous Disease in the Mouth*, N.Y. TIMES (Oct. 30, 2014, 8:00 PM), http://opinionator.blogs.nytimes.com/2014/10/30/looking-a-dangerous-disease-in-the-mouth/?_r=0.

of oral hygiene among elders.³²⁶ Still, some current oral care providers such as dentists and hygienists may express resistance to the idea of dental therapists.³²⁷ Opening doors to a relatively new class of dental care professionals brings questions of licensure, cost, and reimbursement.³²⁸ However, states such as Minnesota already have working models.³²⁹ Dental therapists can also be equipped with the geriatric care training necessary to care for elders with specific needs or co-existent conditions, directly targeting the threat of elders' dental decay.³³⁰

In economic analysis, researchers and policymakers ask what people would be willing to pay for a particular good or service. "In the case of risks that we must bear, the concern shifts from our willingness to pay for added safety to the amount that we require to bear the risk, . . . our willingness-to-accept amount."³³¹ This Note asks decision-makers and the public to view the issue of elders' current oral health status as an inevitable risk. Oral hygiene will affect the physical well-being of the elderly, as well as the overall health of the country.³³² To counter this growing problem among all populations, elders need improved access to oral care.³³³ With the high probability of elders' oral health affecting us in the long-term, how much more are we willing to accept? If the mouth is the door to health, we should stop the risk at the threshold.

326. *Oral Warning Signs Can Indicate Serious Medical Conditions*, ACAD. OF GEN. DENTISTRY, <http://www.knowyourteeth.com/infobites/abc/article/?abc=O&iid=320&aid=9433> (last visited Nov. 11, 2015).

327. David Bornstein, *Looking a Dangerous Disease in the Mouth*, N.Y. TIMES (Oct. 30, 2014, 8:00 PM), http://opinionator.blogs.nytimes.com/2014/10/30/looking-a-dangerous-disease-in-the-mouth/?_r=0.

328. *Id.*

329. *Early Impacts of Dental Therapists in Minnesota*, MINN. DEP'T OF HEALTH & MINN. BD. OF DENTISTRY (Feb. 2014), <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf>.

330. David Bornstein, *Looking a Dangerous Disease in the Mouth*, N.Y. TIMES (Oct. 30, 2014, 8:00 PM), http://opinionator.blogs.nytimes.com/2014/10/30/looking-a-dangerous-disease-in-the-mouth/?_r=0.

331. LISA S. BRESSMAN ET AL., *THE REGULATORY STATE* 580 (2nd ed. 2013) (quoting W. Kip Viscusi on Fatal Tradeoffs, 17-19 (1992)).

332. Melinda Beck, *If Your Teeth Could Talk: Dentists Could Play Larger Role in Patient Care*, WALL ST. J. (Dec. 27, 2011), <http://online.wsj.com/articles/SB10001424052970203686204577112893077146940>.

333. *Oral Health in America: A Report of the Surgeon General – Executive Summary*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2000), <http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Report/ExecutiveSummary.htm>.