Chair Sanders and Ranking Member Cassidy,

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

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

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

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

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

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

1. **Make an adult dental coverage a mandatory Medicaid benefit.**

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

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

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

2. **Medicare must cover dental care.**

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

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

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

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

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

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

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

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

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

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

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