REPORT 02 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Medicare Coverage of Dental, Vision, and Hearing Services
(Referred Resolve Clause of Alternate Resolution 113-A-22)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates partially referred Alternate Resolution 113, which asked the American Medical Association (AMA) to "support new funding that is independent of the physician fee schedule for Medicare coverage of 1) preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; 2) visual aids, including eyeglasses and contact lenses; and 3) aural rehabilitative services and hearing aids.

Expansion of Medicare coverage to new services has been debated extensively by Congress. Proponents of expanding Medicare coverage for dental, vision, and hearing services have frequently suggested that Congress could change the law to add dental, vision, and hearing coverage under traditional Medicare Part B; beneficiaries could enroll in Medicare Advantage (Part C) plans; a new, optional part of Medicare for dental, vision, and hearing coverage that would be similar to Medicare Part D for prescription drug coverage could be created; or some form of cash assistance or debit card for beneficiaries who do not have access to coverage for dental, vision, and/or hearing services could be established.

Nonetheless, while many believe that Medicare beneficiaries should have coverage for a wider range of services, significant obstacles remain. Given the current rate of inflation, the $358 billion projection from Congressional Budget Office in 2019 to include coverage for dental, vision, and hearing services in the Medicare program over the next decade would likely be substantially higher today. Further, given that Medicare is subject to statutory budget neutrality requirements, the Council believes it is impossible to consider this issue in a vacuum, and we must be sensitive to what implications adding these services could mean for payment and access to other current health care services for Medicare beneficiaries.

While the Council acknowledges the potential value of expanded Medicare benefits, it believes that the current options in place for beneficiaries to access these services are adequate. In terms of the current political environment, at the time that this report was written, Congress had failed to prevent a budget neutrality cut to the Medicare physician conversion factor and was facing a stalemate on how to move forward with managing the national debt. Broader Medicare physician payment reform remains one of the highest priorities of the AMA, under the AMA's Recovery Plan for America's Physicians.

The Council reemphasizes the importance of working with the American Dental Association regarding strategies to expand dental coverage to Medicare beneficiaries. The Council believes that the AMA can be most influential in addressing the need for hearing services by improving mechanisms already in place. Additionally, the AMA can encourage the United States Preventive Task Services Task Force to re-evaluate its decision not to recommend screening for hearing loss in asymptomatic adults over age 65, especially considering the new evidence that exists about the connection of hearing loss and dementia. Finally, the Council believes that AMA policy on vision coverage can be strengthened, and we recommend amendments to Policy H-25.990 to encourage programs and outreach efforts for affordable prescription eyeglasses.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 02-A-23

Subject: Medicare Coverage of Dental, Vision, and Hearing Services (Referred Resolve Clause of Alternate Resolution 113-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

At the 2022 Annual Meeting, the House of Delegates partially referred Alternate Resolution 113, which asked the American Medical Association (AMA) to "support new funding that is independent of the physician fee schedule for Medicare coverage of 1) preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; 2) visual aids, including eyeglasses and contact lenses; and 3) aural rehabilitative services and hearing aids.

Resolution 119 was combined with similar resolutions 113 and 114 to become Alternate Resolution 113, which was passed in part to become Policy D-185.972, "Increasing Patient Access to Hearing, Dental, and Vision Services." The policy states that the AMA will promote awareness of hearing impairment as a potential contributor to cognitive impairment later in life and encourage further research on this topic. This policy also encourages increased patient access to both vision and dental services.

There was mixed testimony heard on these related items. There were several calls for referral, but support for ensuring that patients have access to, and coverage for, essential hearing, dental, and vision services. Some testimony noted that some of the resolve clauses of the original resolutions did not align with the United States Preventive Task Services Task Force (USPSTF) recommendations for hearing and vision screening for older adults. Further testimony stressed that the expansion of health insurance coverage, and potentially Medicare benefits, for dental, vision, and hearing services needs to be considered not only from the patient perspective, but within the context of a Medicare payment infrastructure that is unsustainable for physician practices. In response to concerns regarding how coverage for these services would be paid for, an amendment was proffered to ensure that our AMA supports new Medicare funding that is independent of the Medicare Physician Payment Schedule to pay for these services. However, the Reference Committee noted in its report that expanding dental, vision, and hearing coverage would still require "pay-fors" in the current Congressional environment, pitting these coverage expansions against other AMA priorities that require funding. This referred clause was assigned by the Board of Trustees to the Council on Medical Service for study.

The Council has developed reports on these topics in recent years. In 2015, the Council authored CMS Report 6, "Hearing Aid Coverage" and concluded that a recommendation supporting adult hearing aid coverage mandates would conflict with Policies H-185.964 and H-165.856, which oppose new health benefit mandates unrelated to patient protections and which jeopardize coverage to currently insured populations, and supports the principle that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage

options. Given the policy, the Council did not recommend that the AMA support Medicare coverage for hearing aids.

In 2019, the Council authored CMS Report 3, "Medicare Coverage for Dental Services" and concluded that the AMA should continue to explore opportunities to work with the American Dental Association (ADA) to improve access to dental care for Medicare beneficiaries, support initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, explore optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and examine the impact of expanded dental coverage on health care costs and utilization.

BACKGROUND

The most recent enrollment data from the Centers for Medicare & Medicaid Services (CMS) show that over 65 million individuals are enrolled in Medicare. This includes 35 million individuals enrolled in traditional fee-for-service Medicare plans and a little over 30 million individuals enrolled in Medicare Advantage plans.[1] According to a 2019 Kaiser Family Foundation (KFF) poll, 16 percent of Medicare beneficiaries reported they could not get access to dental, vision, or hearing care. These numbers were higher amongst those with low incomes, in poor health, and/or in communities of color.[2]

Another 2019 KFF poll indicated that 90 percent of the American public supported expanding Medicare to include dental, hearing, and vision care as a "top" or "important" priority for Congress.[3] However, recent attempts at passing legislation in Congress have not been successful. In 2019, the House passed H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act. Title VI of this bill would have added new benefits for dental, vision, and hearing coverage under Medicare, such as dentures, glasses, hearing aids, and preventive services. The Congressional Budget Office (CBO) estimate for this bill was $358 billion over the next ten years ($238 billion for dental coverage, $30 billion for vision coverage, and $89 billion for hearing coverage).[4] In 2021, H.R. 4311, the Medicare Dental, Vision, and Hearing Benefit Act was introduced in the House and proposed repealing the statutory exclusion that restricts coverage of dental, vision, and hearing benefits, and expanding coverage to offer these services under Medicare Part B. Neither of these bills advanced out of Congress. In March 2023, Senators Bob Casey (D-PA) and Ben Cardin (D-MD) introduced a similar bill, S.842, The Medicare and Medicaid Dental, Vision, and Hearing Benefit Act. This bill would also repeal the statutory exclusion that restricts coverage of dental, vision, and hearing services and expand coverage to offer:

- Dental and oral care, including coverage of routine cleanings and exams, fillings and crowns, major services such as root canals and extractions, emergency dental care and other necessary services, and payment for both full and partial dentures.
- Vision care, including routine eye exams, procedures performed to determine the refractive states of the eyes and other necessary services, and payment for eyeglasses, contact lenses, and low-vision devices.
- Hearing care, including hearing exams, exams for hearing aids and other necessary services, and payment for hearing aids.

This bill also encourages states to provide these optional services to people with Medicaid by increasing the associated Federal Medical Assistance Percentage rate to 90 percent. At the time that this report was written, this bill was referred to the Senate Committee on Finance and the full text of the bill was not yet available.

DENTAL CARE AND COVERAGE

The medical-dental coverage divide first began in the 20th century. In the early 1900s, oral health was widely thought to have little to no bearing on overall health and efforts to combine medical and dental fields were opposed by dentists. In the 1920s, William Gies, a biological chemist, insisted that oral health was directly related to overall health and recommended dentistry should be integrated into the medical field, but dentists again resisted this change. During the 1940s and 1950s, the AMA and the ADA joined efforts to oppose health insurance nationalization and/or expansion. During this same period, tap water fluoridation improved oral disease prevention among Americans, which some believed mitigated the need for some dental services and reduced demand for dental insurance coverage. Moreover, because dental service coverage began being widely included in employer-sponsored benefit packages later than medical health service coverage, it was considered a "perk" or cosmetic-only benefit, a perception that continues as dental care is still regarded by many as auxiliary to general health care even though current research clearly demonstrates the critical relationship between oral health and optimal overall health. When Medicare legislation was passed in 1965, oral health coverage was not included. As a result, the medical profession has frequently had to respond to the challenges of Medicare and Medicaid coverage and changes in payment policy over the years, while dentistry has not.[5]

A statutory exclusion in Section 1862(a)(12) of the Social Security Act expressly prohibits coverage for most dental services, specifically, "services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth" by Medicare for its beneficiaries.[6] Therefore, traditional Medicare regulations do not include coverage for routine oral health care including checkups, cleanings, and x-rays, or restorative procedures, tooth extraction, and dentures. To integrate dental benefits in Medicare, Congress would need to remove this exclusion, and add statutory changes, such as establishing the scope of dental services and a mechanism for provider payment that is independent from the Medicare Physician Payment Schedule.

As of 2018, almost half of Medicare beneficiaries did not have a dental visit within the past year (47 percent), with higher rates among those who are Black (68 percent) or Hispanic (63 percent), have low incomes (73 percent), or who are in fair or poor health (63 percent). Nonetheless, 94 percent of Medicare Advantage enrollees in individual plans are in a plan that offers access to some dental coverage. Nearly two-thirds of Medicare Advantage enrollees (64 percent) with access to preventive benefits, such as oral exams, cleaning and/or x-rays, pay no cost sharing for these services, though their coverage is typically limited to an annual dollar amount. Average out-of-pocket spending on dental services among Medicare beneficiaries (both traditional fee-for-service and Medicare Advantage) who had any dental service was $872 in 2019. Those enrolled in Medicare Advantage plans paid slightly less out-of-pocket than those enrolled in traditional Medicare ($729 vs. $995).[7] A February 2023 study published in *Health Affairs* found substantial declines in dental service use and worsened health outcomes after individuals became eligible for traditional Medicare at age 65. Additionally, this study found that there was also evidence of lower dental service use by those beneficiaries who opted for a Medicare Advantage plan and who likely have some coverage for these services. The authors suggest that benefit and plan design should not only offer coverage of these services, but also address barriers to access to necessary care beyond whether or not a beneficiary has coverage (i.e., out of pocket affordability for co-pays/coinsurance, lack of familiarity with covered benefits, or inability to find local dentists accepting Medicare or Medicare Advantage patients).[8]

Historically, Medicare has paid for dental services when they are integral and inextricably linked to treating a beneficiary's primary medical condition. However, the services Medicare paid for were

limited to those specified in sub-regulatory guidance, such as reconstruction of a ridge when performed as a result of and at the same time as the surgical removal of a tumor; stabilization or immobilization of teeth when done in connection with the reduction of a jaw fracture; extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; dental splints only when used in conjunction with medically necessary treatment of a medical condition; and dental services – including both examination and treatment – prior to organ transplants, cardiac valve replacements, and valvuloplasty.[9] Beginning in 2023, CMS formally codified these existing services in rulemaking and added additional services to the dental exclusion exception including dental examination and treatment when performed prior to a cardiac valve replacement and valvuloplasty or organ transplant procedures. In 2024, coverage will be expanded to include dental services to eliminate infection prior to treatment for head and neck cancers.

Additionally, the new regulation establishes an annual process to review public input and clinical evidence on other medical circumstances that may allow for payment of relevant dental services under the same exception.[10] Medical associations and their members are encouraged to participate in this annual review process by submitting their comments.

ADA policy states that for the purpose of presenting potential legislation that includes dental benefits for adults age 65 and over in a tax payer-funded public program such as, Medicaid, Children's Health Insurance Program (CHIP), privately administered Medicare or other federal or state programs, the ADA supports a program that: 1) covers individuals under 300 percent FPL; 2) covers the range of services necessary to achieve and maintain oral health; 3) is primarily funded by the federal government and not fully dependent on state budgets; 4) is adequately funded to support an annually reviewed reimbursement rate such that at least 50 percent of dentists within each geographic area receive their full fee to support access to care; 5) includes minimal and reasonable administration requirements; and 6) allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit.[11] The full text of the policy can be found here: https://www.ada.org/about/governance/current-policies#medicare.

VISION CARE AND COVERAGE

Medicare Part B covers certain vision services including treatment for glaucoma, macular degeneration, cataract surgery (if done using traditional surgical techniques or using lasers), annual eye exams for diabetic retinopathy for patients with diabetes, and annual glaucoma tests for patients at high risk for developing glaucoma. However, traditional Medicare does not typically cover routine eye examinations or refractions for eyeglasses or contact lenses, nor does it cover eyeglasses or contact lenses themselves, other than eyeglasses following cataract surgery or corrective lenses if a patient has cataract surgery that implants an intraocular lens.[12,13]

Beneficiaries typically spend significantly less on vision coverage compared to dental and hearing services. Traditional Medicare does not generally cover routine eye exams. However, beneficiaries can seek supplemental vision coverage from Medicare Advantage or other private insurance coverage. As of 2021, 99 percent of Medicare Advantage enrollees have access to some vision coverage. 93 percent of Medicare Advantage enrollees are in plans that provide access to both eye exams and eyewear (contacts and/or eyeglasses). However, enrollees may be limited in terms of frequency of obtaining certain covered services and may be subject to annual dollar limits.[14]

Another option for seniors to receive an eye exam and eye health services is through EyeCare America, which connects eligible seniors 65 and older with local volunteer ophthalmologists who provide a medical eye exam often at no cost out-of-pocket, and up to one year of follow-up care for any condition diagnosed during the initial exam and for the physician services. To qualify, an

individual must be a U.S. citizen or legal resident, aged 65 or older, not belong to a Health Maintenance Organization or have eye care benefits through the Veterans Affairs, and not have seen an ophthalmologist in three or more years. Notably, EyeCare America does not directly cover the cost of eyeglasses, but can provide information to patients on where to get help paying for eyeglasses if they are needed.[15,16]

HEARING CARE AND COVERAGE

When Medicare was enacted in 1965, it did not include any coverage for hearing aids. Hearing aids were considered "not routinely needed and low in cost" and many Americans did not live long enough to need them. Today, hearing loss affects one-third of adults over the age of 65 and has a significant impact on health.[17] Traditional Medicare does not cover hearing exams, hearing aids, or aural rehabilitative services. Medicare Advantage charges additional premiums for hearing coverage, with out-of-pocket costs and annual limits varying across plans. Traditional Medicare covers medically reasonable and necessary hearing tests and treatments when ordered by a physician or a non-physician practitioner including diagnostic services related to hearing loss that is treated with surgically implanted hearing devices, and covers cochlear implants if a beneficiary meets specific hearing loss criteria.[18] Starting January 1, 2023 Medicare Part B expanded coverage of audiology services to allow beneficiaries to receive care from an audiologist without a physician or practitioner order once every 12 months for non-acute hearing assessments that are unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids.[19,20,21] AMA policy supports coverage of hearing tests administered by a physician or a physician-led team under Medicare's benefit (H-185.929).

In 2021, the USPSTF reviewed the need to screen asymptomatic adults over the age of 50 for hearing loss and concluded that the current evidence is insufficient to assess the balance of benefits versus the harms of screening for hearing loss in older adults. The USPSTF also stated that additional research was necessary.[22]

In 2022, the Biden Administration issued an executive order for the Food and Drug Administration (FDA) to allow over the counter (OTC) purchase of hearing aids for those with mild to moderate hearing loss. OTC purchase of hearing aids became available in October 2022 and provides an immediate, low-cost option for adults with mild to moderate hearing loss. OTC hearing aids range in price from $99 to $3400 per pair and are readily available at local pharmacies, large retailers, and online. By increasing competition among OTC hearing aid companies, the FDA rule is designed to create more options for those who experience hearing loss and who want to purchase affordable hearing aids.[23,24]

MEDICARE PART B AND BUDGET NEUTRALITY

Medicare law requires that increases and decreases in payment rates by CMS must be budget neutral – i.e., any changes resulting from regulatory changes made by CMS must have no impact on total Medicare spending. Typically, this is done by lowering the Medicare "conversion factor." Increases in total Medicare spending are set by law. Unlike hospitals and nursing homes, Medicare physician payments lack an automatic annual update. As a result, Medicare payments have failed to keep pace with rising inflation.

The Statutory Pay-As-You-Go Act of 2010 (PAYGO) requires that all new legislation changing taxes, fees, or mandatory expenditures, when assessed together, must not increase projected deficits. If legislation is enacted that cuts taxes or increases expenditures without fully offsetting the cost, PAYGO applies a budget enforcement mechanism called sequestration. Sequestration is

the automatic reduction of certain types of spending in the federal budget, generally by a uniform percentage.[25,26]

If Congress adjourns at the end of a session with net costs on the Office of Management and Budget scorecard, the President is required to issue a sequestration order implementing across-the-board cuts to a select group of federal mandatory programs in an amount sufficient to offset the net costs. There are some exemptions from sequestration, such as Social Security, most unemployment benefits, interest on the national debt, federal retirement, and low-income entitlements (i.e., Medicaid, Supplemental Nutrition Assistance Program, and Supplemental Security Income). However, the major remaining mandatory programs are subject to sequestration – including Medicare. If sequestration is ordered, each non-exempt mandatory program is reduced for one year by the same percentage, with one notable exception: Medicare payments subject to sequestration cannot be reduced by more than four percent. If sequestration would require a percent reduction greater than four percent, other non-exempt mandatory programs must make up the difference. To date, a sequester pursuant to PAYGO has not been applied, as Congress has either exempted legislation from PAYGO requirements or otherwise deferred the application of such requirements.[27]

POTENTIAL MEDICARE COVERAGE OPTIONS FOR DENTAL, VISION, AND HEARING SERVICES

Expansion of Medicare coverage to new services has been considered and debated extensively. While many believe that Medicare beneficiaries should have coverage for a wider range of services, there are significant challenges to expanded coverage. Proponents of expanding Medicare coverage for dental, vision, and hearing services have suggested the following:

- Congress could change the law to add dental, vision, and hearing coverage under traditional Medicare Part B. The benefits of this option are that it would impact all 65 million Medicare beneficiaries and could lead to enhanced benefits that are integrated into other Medicare-covered services. The challenges facing this option include determining new claims systems and payment schedules that are independent of the Medicare Physician Payment Schedule. Perhaps the largest challenge to this approach is the price tag assigned by CBO: $358 billion over the next ten years is an enormous sum, especially when the current level of inflation is added to this previous score. Another major challenge involves budget neutrality requirements. If these services were covered under Medicare Part B, the conversion factor would need to be significantly reduced to balance the increased spending, thereby reducing payment for other Medicare Part B services. Alternatively, if the conversion factor were to remain the same and the new funding was independent of the Medicare Physician Payment Schedule, the pool of money allotted for Medicare Part B would still have to increase substantially, which is also untenable. Under either of these scenarios, funding for this option would be diverted from another program and there is potential risk for competing federal priorities for the AMA (i.e., the AMA's Recovery Plan for America's Physicians).

- Beneficiaries could enroll in Medicare Advantage (Part C) plans. Coverage for dental, vision, and hearing services under Medicare Advantage is already an option for most beneficiaries. These services are often offered through supplementary coverage under Medicare Advantage plans. Most Medicare Advantage enrollees are in plans that offer dental (96 percent), vision (99 percent), and hearing (98 percent) coverage. Medicare Advantage plans can vary, but most plans cover both preventive and extensive dental services, access to eye exams and eyewear (contacts and/or glasses), and hearing exams

and hearing aids. Medigap plans may also cover dental, vision, and hearing services to supplement traditional Medicare coverage.

- A new, optional part of Medicare for dental, vision, and hearing coverage that would be similar to Medicare Part D for prescription drug coverage could be created. Beneficiaries would have the option to sign up, likely for an additional premium. While this new part would not be subject to the specific budget neutrality requirements of adding coverage for these services under Medicare Part B, the challenge of how to pay for this coverage still remains. This solution could also further complicate the Medicare system and is largely redundant for Medicare Advantage beneficiaries since the vast majority of Medicare Advantage (Part C) plans already offer coverage for dental, vision, and hearing services for an additional premium. Again, there is also the risk that advocacy for this option would be in competition with other AMA priorities.

- A form of cash assistance or debit card for beneficiaries who do not have access to coverage for dental, vision, and/or hearing services could be established. While this option could be less costly than the others presented, there is still a funding challenge present. Other outstanding questions include the amount of money offered to each beneficiary, the impact on beneficiaries who already have some sort of supplemental coverage, and how government officials would ensure this assistance was only being utilized for covered services. More research would need to be completed before consideration of this option.

AMA POLICY

AMA Policy D-160.925 affirms the importance of oral health care. Policy H-330.872 affirms that the AMA supports continued opportunities to work with the ADA and other interested national organizations to improve access to dental care for Medicare beneficiaries. The policy goes on to affirm AMA support for initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.

Policy H-25.990 states that the AMA encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients.

Policy H-185.929 states that the AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the cost of hearing aid purchases, hearing-related exams and related services; supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's benefit; supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly; encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids; and supports the availability of over the counter hearing aids for the treatment of mild-to-moderate hearing loss.

Policy D-185.972, established with the adoption of Alternate Resolution 113-A-22, affirms that the AMA will promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment or dementia later in life and encourage other stakeholders to promote the conduct and acceleration of research into specific patterns of hearing loss to determine those most linked to cognitive impairment or dementia and amenable to correction. The AMA will work with interested national medical specialty societies and state medical associations to encourage and

promote research into hearing loss as a contributor to cognitive impairment, and to increase patient access to hearing loss identification and remediation services; and promote research into vision and dental health and to increase patient access to vision and dental services.

More broadly, Policy H-185.964 states that the AMA opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations. Additionally, Policy D-390.946 affirms that the AMA will work towards the elimination of budget neutrality requirements within Medicare Part B; will eliminate, replace, or supplement budget neutrality in Merit-based Incentive Payment System with positive incentive payments; and will advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option.

Other related policies include D-330.935 and H-425.988, which state that the AMA will collaborate with relevant stakeholders to actively promote the value of the Welcome to Medicare Visit, the Tobacco Cessation Benefit, and other Medicare-covered preventive services, as well as work with the federal government and other stakeholders to support providing preventive service coverage for seniors.

As part of its Recovery Plan for America's Physicians, the AMA has dedicated an entire strategic pillar to reforming the Medicare physician payment system. In February 2023, the AMA led nearly 100 organizations in asking Congress to explore long-term solutions to the Medicare physician payment problems. The AMA is encouraging the 118th Congress to "work with us on long-term, substantive payment reforms and urge congressional hearings as soon as possible to begin exploring potential payment solutions to ensure America's seniors continue to receive access to the high-quality care they deserve."[28]

DISCUSSION

There are several aspects to consider when exploring ways to expand coverage for dental, vision, and hearing services to Medicare beneficiaries, including cost, access, the current political environment, the relevance of these services to overall health, existing AMA efforts to improve Medicare payment to physicians, and the scope of the AMA's influence.

Given the current rate of inflation, the $358 billion projection from CBO in 2019 to include coverage for dental, vision, and hearing services in the Medicare program over the next decade would likely be substantially higher today. In an environment in which Medicare is subject to statutory budget neutrality requirements, the Council believes it is impossible to consider this issue in a vacuum and the AMA must acknowledge the likely impact that adding these services would mean for payment and access to current health care services for Medicare beneficiaries. At the time that this report was written, the bill recently introduced by Senators Casey and Cardin did not have a CBO score nor was the full text of the bill available.

The Council acknowledges the potential value of expanded Medicare benefits. Nonetheless, dental, vision, and hearing services already are frequently offered through supplementary coverage under Medicare Advantage (Part C) or Medigap plans. Veterans can receive coverage for these services through Veterans Health Administration (VHA) plans (including free hearing aids), and low-income individuals can often receive coverage through Medicaid. Other beneficiaries have private coverage offered through an employer or an individually purchased plan.

In terms of the current political environment, at the time that this report was written, Congress had recently failed to prevent a budget neutrality cut to the Medicare physician conversion factor and was facing a stalemate on how to move forward with managing the national debt. At a time when physicians are already fighting to keep practices open amid continued payment cuts due to lack of an annual inflation-based update, frozen Medicare payment rates under the Medicare Access and CHIP Reauthorization Act, and budget neutrality restrictions, pursuing broader Medicare coverage expansions would be extremely challenging. Enacting Medicare physician payment reform remains one of the AMA's highest priorities under our Recovery Plan for America's Physicians.

The Council also reemphasizes the importance of working with the ADA when it comes to strategies to expand dental coverage to Medicare beneficiaries. It is crucial for the ADA and the AMA to work together to navigate the current policy landscape regarding infringements on the Medicare Physician Payment Schedule. While the Council acknowledges that oral health care is a critical part of overall health care, we believe that our dental colleagues are best positioned to assess the payment structures that work best for their needs. Notably, in 2020, the ADA enacted new policy to address dental coverage under Medicare. The AMA will continue to work closely with the ADA to share data on oral health care's impact on overall health, as stated in AMA policy.

The Council believes that the AMA can be most influential in addressing the need for hearing services through improving mechanisms already in place. Physicians should educate and encourage their patients on lower cost hearing aids that are now available over the counter for mild to moderate hearing loss. Additionally, the AMA can encourage the USPSTF to re-evaluate its decision not to recommend screening for hearing loss in asymptomatic adults over age 65, especially considering the new evidence that exists about the connection of hearing loss and dementia. Hearing loss caught and treated early could prevent the onset of dementia and improve quality of life for the aging population.

Finally, the Council believes that AMA policy on vision coverage could be strengthened, and we recommend amendments to Policy H-25.990 to encourage programs and outreach efforts for affordable prescription eyeglasses.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of the referred Resolve clause of Alternate Resolution 113-A-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support physician and patient education on the proper role of over the counter hearing aids, including the value of physician-led assessment of hearing loss, and when they are appropriate for patients and when there are possible cost-savings. (New HOD Policy)

2. That our AMA encourage the United States Preventive Services Task Force to re-evaluate its determination not to recommend preventive hearing services and screenings in asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss to dementia. (New HOD Policy)

3. That our AMA amend Policy H-25.990 by addition to read as follows:

   Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations <u>and access to affordable prescription eyeglasses</u> for elderly

patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings. (Amend HOD Policy)

4. That our AMA reaffirm Policy D-160.925, which recognizes the importance of managing oral health and the importance of dental care to optimal patient care and supports the exploration of opportunities for collaboration with the American Dental Association (ADA) on comprehensive strategy for improving oral health care and education for clinicians. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-330.872, which supports the American Medical Association's continued work with the ADA to improve access to dental care for Medicare beneficiaries and supports initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-185.929, which supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's benefit and policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly and supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-390.946, which supports the American Medical Association's work towards the elimination of budget neutrality requirements within Medicare Part B. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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APPENDIX

Policies Recommended for Amendment or Reaffirmation

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

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

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

Hearing Aid Coverage H-185.929
1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. (CMS Rep. 6, I-15; Appended: Res. 124, A-19)

Sequestration D-390.946
Our AMA will: (a) continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; (b) seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; (c) ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; (d) work towards the elimination of budget neutrality requirements within Medicare Part B; (e) eliminate, replace, or supplement budget neutrality in MIPS with positive incentive

payments; (f) advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; and (g) advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services. (Res. 212, I-21; Reaffirmed: Res. 240, A-22)