ISSUE BRIEF
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How Medicare Could Provide Dental, Vision, and Hearing Care for Beneficiaries

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ABSTRACT

ISSUE: The Medicare program specifically excludes coverage of dental, vision, and hearing services. As a result, many beneficiaries do not receive necessary care. Those that do are subject to high out-of-pocket costs.

GOAL: Examine gaps in access to dental, vision, and hearing services for Medicare beneficiaries and design a voluntary dental, vision, and hearing benefit plan with cost estimates.

METHODS: Uses the Medicare Current Beneficiary Survey, Cost and Use File, 2012, with population and costs projected to 2016 values.

FINDINGS AND CONCLUSIONS: Among Medicare beneficiaries, 75 percent of people who needed a hearing aid did not have one; 70 percent of people who had trouble eating because of their teeth did not go to the dentist in the past year; and 43 percent of people who had trouble seeing did not have an eye exam in the past year. Lack of access was particularly acute for poor beneficiaries. Because few people have supplemental insurance covering these additional services, among people who received care, three-fourths of their costs of dental and hearing services and 60 percent of their costs of vision services were paid out of pocket. We propose a basic benefit package for dental, vision, and hearing services offered as a premium-financed voluntary insurance option under Medicare. Assuming the benefit package could be offered for $25 per month, we estimate the total coverage costs would be $1.924 billion per year, paid for by premiums. Subsidies to reach low-income beneficiaries would follow the same design as the Part D subsidy.

KEY TAKEAWAYS

- There is considerable unmet need for dental, vision, and hearing services among Medicare beneficiaries, and a high level of cost burden.
- A voluntary supplemental benefit, administered by Medicare, could cover preventive care visits at a total cost of $1.924 billion per year, paid for by $25 monthly premiums.
- This benefit could insure nearly 9 million beneficiaries if the policy included subsidies for people with low incomes.

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INTRODUCTION

Dental, vision, and hearing services are not covered under Medicare, although a small minority of beneficiaries have supplemental private coverage or Medicaid coverage for these benefits.[1] In 2012, 12 percent of all Medicare beneficiaries reported having coverage for dental services. More than four of five (85%) received these benefits under employer-sponsored health insurance.[2] (See Appendix.) Options for purchasing supplemental insurance for hearing and vision services are also very limited for Medicare beneficiaries; these services are available primarily through employer-sponsored health insurance or Medicare Advantage plans. For low-income Medicare beneficiaries who also have Medicaid, there is significant variation in what state Medicaid programs will cover; these services are often the first to be cut from a state's program when budgetary pressures surface.[3] Studies have shown that cost poses a significant barrier for older or disabled adults in obtaining dental, vision, and hearing services; half of older Americans reported that cost was their top reason for not visiting a dentist in the past year.[4]

Older adults who do not get the dental, vision, and hearing services they need or who have to delay needed treatment because of cost are at greater risk for avoidable emergency department visits, hospitalizations, skilled nursing facility visits, falls, isolation, depression, and greater dependence on family caregivers.[5] Those who do receive services have a high out-of-pocket cost burden. Medicare beneficiaries spend an average 39 percent of their total out-of-pocket health expenses on services not covered by Medicare.[6]

There have been legislative efforts to include dental, vision, and hearing services in Medicare to help protect beneficiaries against the high costs of care.[7] However, no progress has been made in meeting this goal. This brief describes the current access-to-care and cost challenges that Medicare beneficiaries face for dental, vision, and hearing services and outlines a policy option to close the gaps. It also considers the optimal design features that should be included in such a policy. This paper expands upon a "Viewpoint" published in the *Journal of the American Medical Association*.[8]

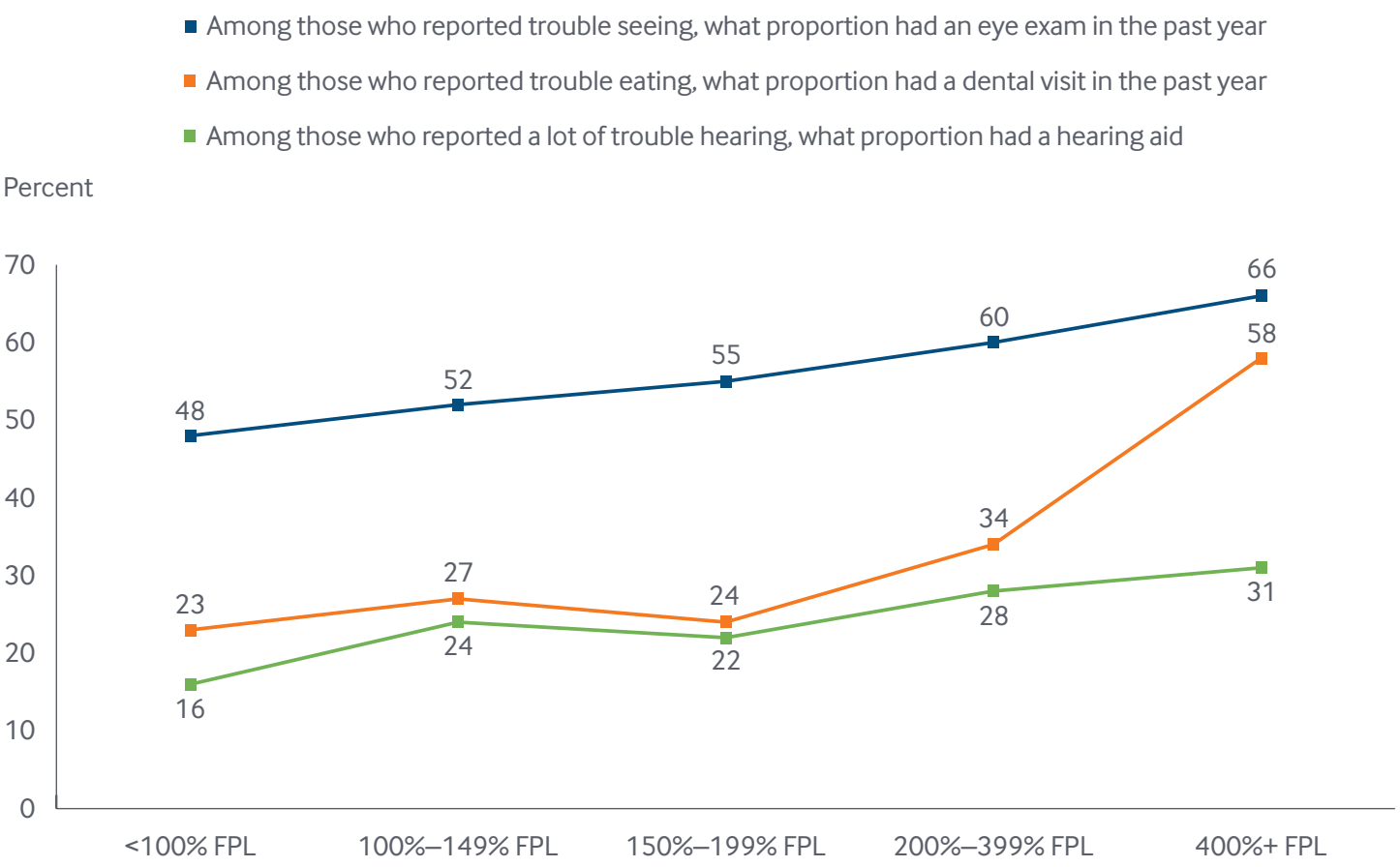
The policy option offered in this analysis is a voluntary supplemental Medicare benefit financed by premiums. The analysis examines the potential costs of including a subsidy to address unmet need among low-income Medicare beneficiaries, following the same design as the Part D low-income subsidy. All calculations are based on spending and utilization reported in the Medicare Current Beneficiary Survey (MCBS) Cost and Use File, 2012, projected to 2016. (For more detail, see How We Conducted This Study.)

DENTAL, VISION, AND HEARING: UNMET NEED AND HIGH COST BURDENS

The analysis reveals high unmet need for dental, vision, and hearing services, as well as cost burdens. Among all Medicare beneficiaries, of those who needed a hearing aid, 75 percent did not have one; of those who had trouble eating because of their teeth, 70 percent did not go to the dentist in the past year; and of those who had trouble seeing, 43 percent did not have an eye exam in the past year.

Access to care and unmet need vary by income level. There is a 35-percentage-point difference in access to necessary dental care from the lowest- to highest-income quintile. More than three-quarters (77%) of people with incomes below 100 percent of the federal poverty level (i.e., less than $11,407 for an individual and $14,376 for a couple age 65 and older in 2016) did not have a dental visit in the previous year (Exhibit 1). High-income beneficiaries with hearing concerns were far more likely than those with low incomes (31% vs. 16%) to report having a hearing aid. Overall, access to hearing services was much lower across all income groups compared to dental and vision services, likely reflecting the high associated costs. Midlevel hearing aids cost approximately $4,500. The stigma or cosmetic concerns associated with hearing aids likely play a role as well.[9] Although there is less unmet need for vision services compared to dental and hearing, fewer than half of the low-income Medicare beneficiaries who report having trouble seeing had an eye exam in the previous 12 months.

Exhibit 1. Receipt of Needed Care for Dental, Vision, and Hearing Services, by Income, 2016



Note: FPL = federal poverty level.
Data: Authors' analysis of the Medicare Current Beneficiary Survey, Cost and Use File, 2012, projected to 2016.

Of those who did receive care for dental, vision, or hearing services in the previous 12 months, Medicare beneficiaries on average spent 4 percent of income on the out-of-pocket costs of these services (data not shown). For dental services, average total spending was $927 annually; it was $1,338 annually for those receiving hearing-related services. For both dental and hearing services, three-quarters of the total spending was paid for by beneficiaries. Average spending for vision services was $715, of which 60 percent was paid out of pocket (Exhibit 2).

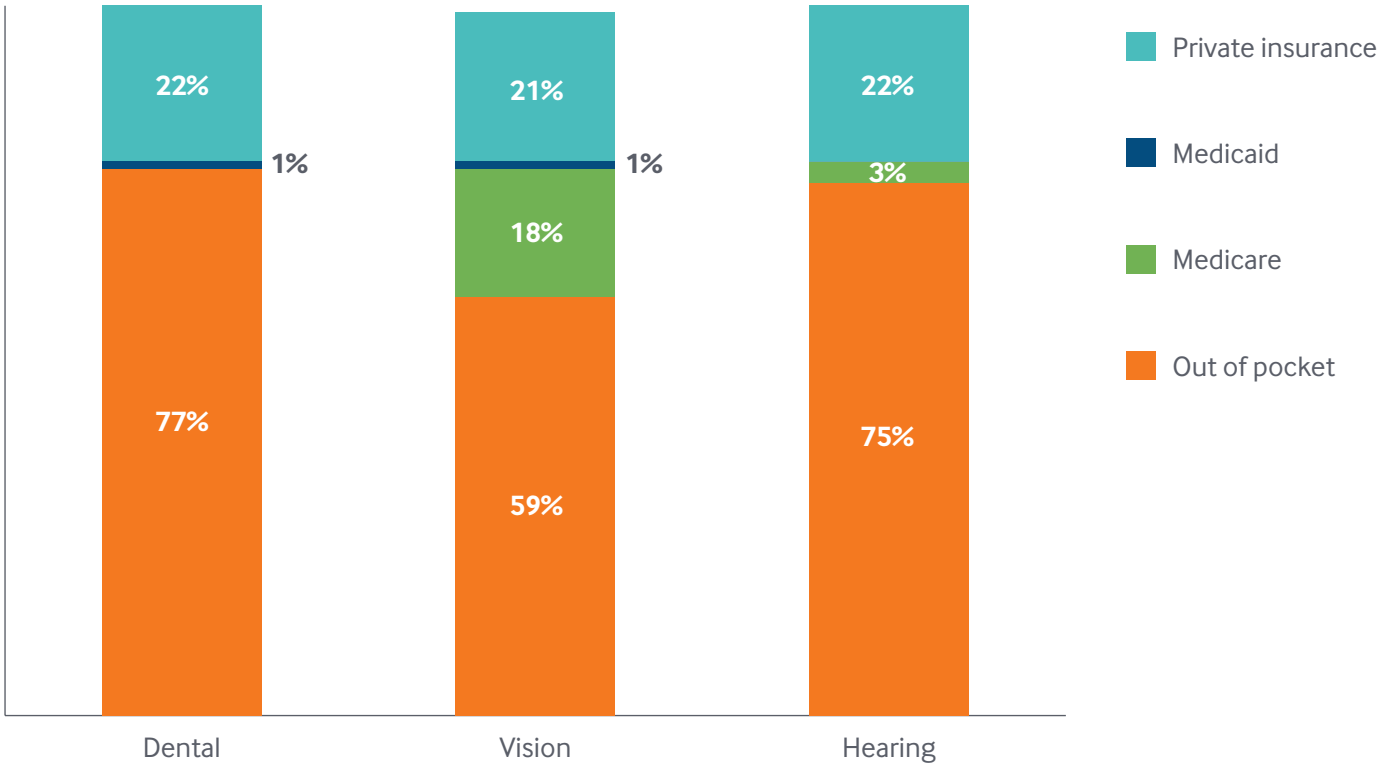
Across dental, vision and hearing services, private insurance financed approximately 22 percent of total spending (Exhibit 3). Medicare pays for some vision spending (18%); Part B covers a yearly eye exam for diabetic retinopathy, a glaucoma test for those who qualify because of a diabetes diagnosis or family history of glaucoma, and diagnostic tests for macular degeneration. Medicare does not cover routine eye exams for eyeglasses or contact lenses. Medicaid pays a negligible portion of reported costs for any of the three services.

Exhibit 2. Total and Out-of-Pocket Spending for Dental, Vision, and Hearing Services, by Income, 2016

		Federal poverty level				
	All Medicare beneficiaries	<100%	100%–149%	150%–199%	200%–399%	400%+
Total dental spending among those with spending	$927	$706	$718	$869	$949	$1,039
Total dental out-of-pocket spending among those with spending	$714	$519	$550	$728	$744	$779
Total vision spending among those with spending	$715	$517	$496	$819	$809	$744
Total vision out-of-pocket spending among those with spending	$426	$222	$297	$445	$502	$471
Total hearing spending among those with spending	$1,338	$907	$1,128	$1,493	$1,392	$1,390
Total hearing out-of-pocket spending among those with spending	$1,001	$528	$837	$1,114	$1,017	$1,109

Data: Authors' analysis of the Medicare Current Beneficiary Survey, Cost and Use File, 2012, projected to 2016.

Exhibit 3. How Dental, Vision, and Hearing Services Are Paid, by Insurance Source, 2016



Note: Segments may not sum to 100 percent because of rounding.
Data: Authors' analysis of the Medicare Current Beneficiary Survey, Cost and Use File, 2012, projected to 2016.

BENEFIT DESIGN CONSIDERATIONS

We propose a voluntary supplemental Medicare benefit, based on the precedent set by Part D to allow supplemental benefits to be obtained with no federal subsidy. Unlike Part D, we envision that Medicare would directly administer the services rather than provide them through private plans. This approach has the advantage of maximizing Medicare's purchasing power on behalf of beneficiaries, simplifying choice by using one benefit design, and reducing administrative overhead.

The benefit design follows the model of private insurance that often limits total plan payments for supplemental dental, vision, and hearing benefits, yet ensures access to essential preventive care. To encourage the use of preventive dental services, the benefit includes one oral health exam and cleaning per year, which is not subject to a deductible or coinsurance.

The cost of hearing aids is an important consideration. A pair of hearing aids can range from $2,000 to as much as $7,000.[10] Current Medicare Advantage plans that provide some financial coverage for hearing aids pay between $400 and $500 per ear every three years, which only covers half of the lowest-cost alternative.[11] In 2015, the President's Council of Advisors on Science and Technology recommended that the U.S. Food and Drug Administration allow for certain basic hearing aids to be made available for purchase over the counter for the treatment of mild-to-moderate hearing loss.[12] Under the illustrative supplemental policy option, Medicare would put the hearing device up for competitive bids. The benefit would cover the cost of the lowest bid for a high-quality device as is current practice in the Veterans Health Administration, which only pays $400 per device on average.[13] There is evidence that high-quality devices could be much less expensive if Medicare used its purchasing power through competitive bids.[14] Beneficiaries could opt to pay more for alternatives but would be covered only for the reference price. Given the high price of hearing aids, providing access to a lower-cost option may have a substantial impact on reducing the access barriers, particularly for poorer beneficiaries. Medicare Part B covers a diagnostic hearing exam prescribed by a physician only if it is for the purposes of medical treatment. This benefit also would cover routine hearing exams prescribed by a physician for the purposes of prescribing, fitting, or changing hearing aids.[15] Evidence supporting preventive hearing exams for asymptomatic adults age 50 and older is limited.[16]

For vision care, a basic policy could cover an annual exam and one pair of corrective lenses up to a negotiated price, providing there was a significant change in vision. If no significant change in vision, the policy could limit the frequency of purchasing new corrective lenses, for example once every three years.

POTENTIAL COSTS OF SUPPLEMENTAL BENEFIT

To explore the potential costs of a voluntary supplemental benefit, we designed a benefit that has a $150 deductible for beneficiaries, 20 percent coinsurance, and a $1,500 annual total benefit limit on covered services (Exhibit 4). Preventive care visits (as described in the previous section) would be covered in full. The policy would be administered by Medicare and paid for through voluntary premiums.

To enhance affordability, low-income beneficiaries with incomes up to 150 percent of poverty (approximately $17,110 per year for an individual) could receive premium subsidies and reduced cost-sharing (Exhibit 4). The design follows Part D low-income provisions for premium subsidies. In addition, eligible low-income beneficiaries would not pay a deductible and would only be subject to 10 percent coinsurance for expenses up to the $1,500 total benefit limit. Individuals who apply for Part D low-income support would automatically qualify for the low-income subsidies for this supplemental plan.

Exhibit 4. Voluntary Supplemental Benefit Design for Dental, Vision, and Hearing Services Under Medicare

	Supplemental insurance option	Supplemental insurance option with low-income subsidies
Deductible	$150	$0 for <150% FPL
Coinsurance	20%	10% for <150% FPL
Total benefit limit	$1,500	$1,500
Premium subsidy	None	<135% FPL receives 100% subsidy 135%–139% receives 75% subsidy 140%–144% FPL receives 50% subsidy 145%–149% FPL receives 25% subsidy 150%+ FPL receives no subsidy
Participation assumption	70% of Medicare beneficiaries (excluding people with Medicaid, employer-sponsored benefits, Medicare Advantage, and those with incomes below 150% of poverty)	70% of Medicare beneficiaries (excluding people with Medicaid, employer-sponsored benefits, and Medicare Advantage)

Note: FPL = federal poverty level.
Data: Authors' analysis of the Medicare Current Beneficiary Survey, Cost and Use File, 2012.

Calculating the cost of a dental, vision, and hearing services benefit is challenging and depends on many assumptions. (See How We Conducted This Study.) As a starting point, we assume a monthly premium of $25, determined by the average dental, vision, and hearing spending of Medicare beneficiaries with incomes at or above 200 percent of the federal poverty level. The premium would need to be higher if only the highest-need beneficiaries participated.

We then calculate the total coverage costs using several simplified assumptions. For instance, people with existing access to coverage through Medicaid, employer benefits, and Medicare Advantage would be unlikely to take up the option. In addition, low-income beneficiaries (i.e., those with incomes below 150% of poverty) would be unable to afford a voluntary option without subsidies. We assume 70 percent participation by the remainder of the Medicare population — beneficiaries with incomes over 200 percent of poverty enrolled in Medigap supplemental plans or in traditional Medicare only.[17] Given these assumptions, we calculate the total coverage costs to be $1.924 billion per year paid for by premiums.

Including the low-income premium and cost-sharing subsidies would cost approximately $1.05 billion per year to the federal government (Exhibit 5), assuming 70 percent of low-income beneficiaries without Medicaid participate.

If these assumptions are accurate, the voluntary option would insure an estimated 6.4 million Medicare beneficiaries without the low-income subsidies, and nearly 9 million Medicare beneficiaries with the low-income subsidies. This policy option can be used as a starting point for further discussion and more extensive modeling.

Exhibit 5. Estimated Costs of Coverage and Premiums for Voluntary Benefit Design

	Supplemental insurance option	Supplemental insurance option with low-income subsidies
Total population of beneficiaries (millions)	6.44	8.83
Cost of coverage, including 5% administration fee (millions)*	$1,924	$3,067
Federal costs of low-income subsidy and the premium contribution (millions)	n/a	$1,052
Income level of beneficiaries:	Monthly premium	
<135% FPL	n/a	$0
135%–139% FPL	n/a	$6
140%–144% FPL	n/a	$13
145%–149% FPL	n/a	$19
150%+ FPL	$25	$25

* Net costs do not include 20% cost-sharing or deductible to be paid by beneficiaries.
Note: FPL = federal poverty level.
Source: Authors' analysis of the Medicare Current Beneficiary Survey, Cost and Use File, 2012, projected to 2016.

Medicaid Alternative

To provide benefits for more seniors, Medicaid could be required to cover dental, vision, and hearing services for low-income adults. Currently such services are optional. In 2012, 34 state and territory Medicaid programs covered hearing aids with either price limits or service day limitations such as frequency of replacements, fittings, or repairs, whereas 22 state and territory Medicaid programs did not provide any coverage.[18] Forty-six state and territory Medicaid programs provided coverage for eyeglasses.[19] Dental coverage varies widely. Eighteen states and territories do not provide coverage for dentures; approximately half the states and territories provide emergency dental care only.[20] Further, Medicaid payment rates are so low for dental care that few dentists participate — thus coverage does not ensure access. Expanding service coverage under Medicaid could address unmet needs and cost barriers facing low-income Medicare beneficiaries with incomes up to the poverty level. Reaching those with incomes up to 150 percent of poverty would require expanding Medicaid, which would be challenging in the current environment. The costs for expanding service coverage in the Medicaid program have not been modeled as part of this analysis.

CONCLUSIONS

The Medicare program could offer a voluntary, supplemental insurance benefit for dental, vision, and hearing services that would begin to alleviate the unmet need for services and the financial pressure currently experienced by beneficiaries. This approach has the advantage of maximizing Medicare's purchasing power on behalf of beneficiaries to provide affordable options for these services, specifically hearing aids. It also will simplify choice by using one benefit design and reduce administrative overhead. We calculate the total coverage costs would be $1.924 billion per year to insure an estimated 6.4 million Medicare beneficiaries, assuming a $25 per month premium and no federal subsidies. Including the low-income subsidies would cost Medicare an additional $1.052 billion per year and insure an estimated additional 2.4 million beneficiaries. As the population ages, these coverage needs will only continue to grow. If they are not addressed, the overall health of older people will suffer and the use of costly and avoidable services will increase.

HOW WE CONDUCTED THIS STUDY

This brief uses the Medicare Current Beneficiary Survey (MCBS) Cost and Use File from 2012 with population and spending projected to 2016 levels using the National Health Expenditures tables from the Centers for Medicare and Medicaid Services. The MCBS Cost and Use File provides claims data on a nationally representative sample of Medicare beneficiaries and complements the claims data with survey questions that explore health and health care needs, insurance coverage, out-of-pocket-costs, and utilization. The assumed premium to cover the specified dental, vision, and hearing benefits derives from use and spending patterns self-reported by a subset of beneficiaries. Since Medicare does not cover these benefits, administrative data from Medicare for claims are not available. To calculate the cost of the benefit, we assume average spending on dental, vision, and hearing services for individuals with incomes at or above 200 percent of the federal poverty level as the benchmark. As reported through the MCBS, beneficiaries with incomes at or above 200 percent of poverty spend on average $479 a year on dental, vision, and hearing services. We used this level to assume spending of all those who purchase the benefit along with assumptions about hearing aid and dental use, subject to an annual ceiling on plan paid benefits. By using the higher-income benchmarks, we in effect increased use and cost levels for those participating to these levels, reducing the gaps by income.

We assume that those most likely to purchase the benefit would be individuals with traditional Medicare only and a supplemental Medigap plan. We also assume that individuals with employer-sponsored insurance and Medicare Advantage would be unlikely to participate because they more likely would have more coverage for these services. Although some employers might drop coverage if Medicare were to offer a voluntary benefit, we did not estimate the potential impact. Medicare Advantage, however, would be likely to continue offering partial dental, hearing, and vision coverage as this is an incentive for beneficiaries to enroll in Medicare Advantage plans. Finally, we assume that beneficiaries with Medicaid would not participate and that others with incomes below 150 percent of the federal poverty level would be unable to afford the voluntary option without subsidies.

In the monthly premium, we assume some adverse selection: those with need for dental, vision, and hearing services would be more likely to purchase the plan than others. We increased expected participation for those with higher unmet needs and raised their use and cost levels to the same levels of access as those with incomes at or above 200 percent of poverty. Using other programs as guidance, we assumed 70 percent of those with incomes above 150 percent of poverty without employer-sponsored insurance, Medicare Advantage, or Medicaid would purchase the voluntary plan. This represents 6.44 million Medicare beneficiaries, not including those with low-income subsidies. If low-income subsidies were available, we assume that 70 percent of those with incomes below 150 percent of poverty without Medicaid would participate. This increased total participation to 8.83 million beneficiaries. We used higher cost estimates per person for such beneficiaries, reflecting their lower cost-sharing with subsidies.

The design of the low-income subsidies mirrors the Part D low-income subsidy. The intention of the low-income subsidy is to increase participation to the level of the high-income population, by removing cost barriers. This is likely to overestimate the subsidy costs, as take-up of the Part D low-income subsidy has been lower than expected, despite eligibility levels.

NOTES

1 C. Pope, "Supplemental Benefits Under Medicare Advantage," *Health Affairs Blog,* Jan. 21, 2016.

2 A. Willink, C. Schoen, and K. Davis, "Dental Care and Medicare Beneficiaries: Access Gaps, Cost Burdens, and Policy Options," *Health Affairs,* Dec. 2016 35(12):2241–48.

3 J. Huang, L. Saulsberry, A. Damico et al., *Oral Health and Medicare Beneficiaries: Coverage, Out-of-Pocket Spending, and Unmet Need* (Henry J. Kaiser Family Foundation, June 2012).

4 American Dental Association Health Policy Institute, *Oral Health and Well-Being in the United States* (ADA, 2016); and M. H. McNeal, "Say What? The Affordable Care Act, Medicare, and Hearing Aids," *Harvard Journal on Legislation,* Summer 2016 53(2):621–70.

5 B. C. Sun, D. L. Chi, E. Schwarz et al., "Emergency Department Visits for Nontraumatic Dental Problems: A Mixed-Methods Study," *American Journal of Public Health,* May 2015 105(5):947–55; M. H. McNeal, "Say What? The Affordable Care Act, Medicare, and Hearing Aids," *Harvard Journal on Legislation,* Summer 2016 53(2):621–70; J. C. Javitt, Z. Zhou, and R. J. Willke, "Association Between Vision Loss and Higher Medical Care Costs in Medicare Beneficiaries Costs Are Greater for Those with Progressive Vision Loss," *Ophthamology,* Feb. 2007 114(2):238–45; J. Huang, L. Saulsberry, A. Damico et al., *Oral Health and Medicare Beneficiaries: Coverage, Out-of-Pocket Spending, and Unmet Need* (Henry J. Kaiser Family Foundation, June 2012); D. J. Genther, K. D. Frick, D. Chen et al., "Association of Hearing Loss with Hospitalization and Burden of Disease in Older Adults," *Journal of the American Medical Association,* June 12, 2013 309(22):2322–24; B. Chee, B. Bark, and P. M. Bartold, "Periodontitis and Type II Diabetes: A Two-Way Relationship," *International Journal of Evidence-Based Healthcare,* Dec. 2013 11(4):317–29; and K. Nasseh, M. Vujicic, and M. Glick, "The Relationship Between Periodontal Interventions and Healthcare Costs and Utilization: Evidence from an Integrated Dental, Medical, and Pharmacy Commercial Claims Database," *Health Economics,* April 2017, 26(4):519–27.

6 C. Schoen, A. Willink, and K. Davis, *Medicare Beneficiaries' High Out-of-Pocket Costs: Cost Burdens by Income and Health Status* (Commonwealth Fund, May 2017).

7 B. Sanders, *S.570 — Comprehensive Dental Reform Act of 2015*, 114th Congress, U.S. Senate; and J. McDermott, *H.R. 5396 — Medicare Dental, Vision, and Hearing Benefit Act of 2016,* 114th Congress, U.S. House of Representatives.

8 A. Willink, C. Schoen, and K. Davis, "Consideration of Dental, Vision, and Hearing Services to Be Covered Under Medicare," *Journal of the American Medical Association,* Aug. 15, 2017 318(7):605–6.

9 M. H. McNeal, "Say What? The Affordable Care Act, Medicare, and Hearing Aids," *Harvard Journal on Legislation,* Summer 2016 53(2):621–70.

10 Ibid.

11 Humana Gold Plus: Summary of Benefits, Optional Supplemental Benefits, 2017; Blue Cross Blue Shield Blue Care Network of Michigan; Medicare Plus Blue PPO Summary of Benefits, 2016; and Geisinger, Your Guide to Geisinger Gold, 2017.

12 President's Council of Advisors on Science and Technology, *Aging America & Hearing Loss: Imperative of Improved Hearing Technologies* (White House, Oct. 2015); and C. Cassel, E. Penhoet, and R. Saunders, "Policy Solutions for Better Hearing," *Journal of the American Medical Association,* Feb. 9, 2016 315(6):553–54.

13 Office of the Inspector General, U.S. Department of Veteran Affairs, *Audit of VA's Hearing Aid Services* (VA, Feb. 20, 2014); and C. Cassel, E. Penhoet, and R. Saunders, "Policy Solutions for Better Hearing," *Journal of the American Medical Association,* Feb. 9, 2016 315(6):553–54.

14 F. R Lin, W. R. Hazzard, and D. G. Blazer, "Priorities for Improving Hearing Health Care for Adults: A Report from the National Academies of Sciences, Engineering, and Medicine," *Journal of the American Medical Association,* Aug. 23/30, 2016 316(8):819–20.

15 M. H. McNeal, "Say What? The Affordable Care Act, Medicare, and Hearing Aids," *Harvard Journal on Legislation,* Summer 2016 53(2):621–70.

16 C. Cassel, E. Penhoet, and R. Saunders, "Policy Solutions for Better Hearing," *Journal of the American Medical Association,* Feb. 9, 2016 315(6):553–54.

17 B. Sommers, R. Kronick, K. Finegold et al., *Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act* (Office of the Assistant Secretary for Planning and Evaluation, March 16, 2012).

18 Kaiser Family Foundation, State Health Facts, *Medicaid and CHIP Indicators: Medicaid Benefits* (Henry J. Kaiser Family Foundation, n.d.).

19 Ibid.

20 J. Huang, L. Saulsberry, A. Damico et al., *Oral Health and Medicare Beneficiaries: Coverage, Out-of-Pocket Spending, and Unmet Need* (Henry J. Kaiser Family Foundation, June 2012).

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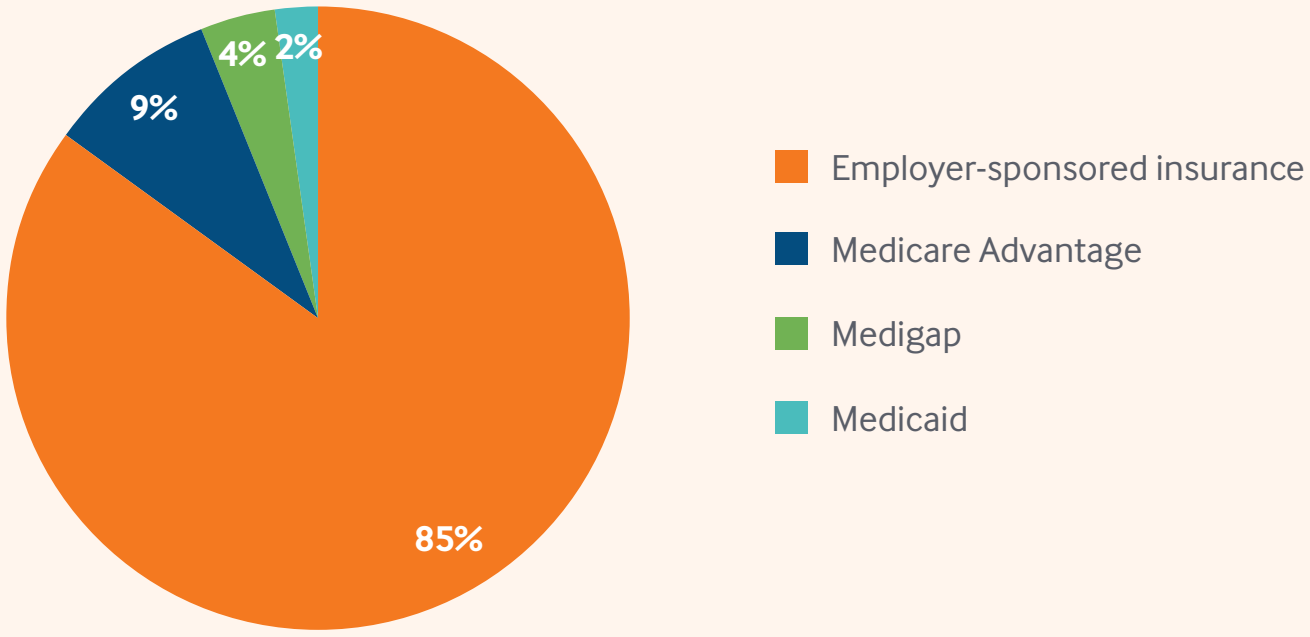
Appendix. Distribution of Dental Insurance Coverage, by Health Insurance Source, 2016



Data: Authors' analysis of the Medicare Current Beneficiary Survey, Cost and Use File, 2012, projected to 2016.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