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AGD BACKGROUND ON DENTAL BENEFITS FOR THE MEDICARE POPULATION

FINDINGS

Financial Health of the United States of America

Debts/Deficits

On April 11, 2018, Keith Hall, Director of the Congressional Budget Office (CBO), in prepared testimony to the U.S. Senate Committee on the Budget, stated the following:

"…In the Congressional Budget Office's baseline projections...the federal budget deficit grows substantially over the next few years.[1]

…Projected deficits over the 2018–2027 period have increased markedly since June 2017, when CBO issued its previous projections. The increase stems primarily from tax and spending legislation enacted since then…

…CBO estimates that the 2018 deficit will total $804 billion, $139 billion more than the $665 billion short fall recorded in 2017... For the 2018–2027 period, CBO now projects a cumulative deficit that is $1.6 trillion larger than the $10.1 trillion that the agency anticipated in June.

…As deficits accumulate in CBO's projections, debt held by the public rises from 78 percent of GDP (gross domestic product) (or $16 trillion) at the end of 2018 to 96 percent of GDP (or $29 trillion) by 2028…

Such high and rising debt would have serious negative consequences for the budget and the nation:

- Federal spending on interest payments on that debt would increase substantially, especially because interest rates are projected to rise over the next few years.
- Because federal borrowing reduces total saving in the economy over time, the nation's capital stock would ultimately be smaller, and productivity and total wages would be lower.
- Lawmakers would have less flexibility to use tax and spending policies to respond to unexpected challenges.
- The likelihood of a fiscal crisis in the United States would increase. There would be a greater risk that investors would become unwilling to finance the government's borrowing unless they were compensated with very high interest rates; if that happened, interest rates on federal debt would rise suddenly and sharply."

Interest payments on the debt consume more of the budget as interest rates increase. A greater portion of the debt service must be allocated to interest payments rather than paying off principal.

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[1] U.S. Congressional Budget Office, *The Budget and Economic Outlook: 2018 to 2028*, Keith Hall before the U.S. Senate Committee on the Budget, April 11, 2018. https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53721-testimony.pdf (Accessed May 10, 2018)

U.S. Fiscal Gap

On February 25, 2015, in testimony to the U.S. Senate Committee on the Budget, Laurence J. Kotlikoff, Professor of Economics at Boston University, explained the concept of the "infinite-horizon fiscal gap." This gap determines if the government has receipts to cover projected spending and "equals the present value of all projected future expenditures less the present value of all projected future receipts."[2]

The infinite-horizon fiscal gap annotates all debt service, transfer payments, and discretionary spending of present and future obligations. It also displays all government assets. The U.S. government does not currently calculate assets and deficits in this manner. In 2015, Professor Kotlikoff projected the U.S. fiscal gap at $210 trillion. For instance, the U.S. government budget underfinances Social Security benefit payments by 33 percent.

Unfunded Liabilities in the States

Likewise in our states, unfunded liabilities continue to increase. As noted in a Hoover Institution essay, pension obligations are consuming state and local budgets. Even though government accounting standards underwent changes in 2014 and 2015, the basic flaw in government pension accounting is that "the fallacy that liabilities can be measured by choosing an expected return on plan assets."[3] A 2015 analysis of state and local government pension systems projected a deficit of $3.846 trillion.

The Effect of World Debt on the U.S.

The International Monetary Fund (IMF) In April 2018 assessed the debt of the entire world at $164 trillion, this would obviously not include unfunded liabilities.[4] The U.S. debt-to-GDP is 108 percent. Since other nations are experiencing high levels of indebtedness, it is unlikely that the U.S. can continue to borrow from other nations indefinitely.

The Medicare Program is Financially Unstable and Unsustainable

According to the March 2018 Medicare Payment Advisory Commission (MEDPAC) report, the total national health care spending in 2016 was $3.3 trillion, or 17.9 percent of gross domestic product. [5] Medicare spending was $672.1 billion at 3.6 percent of GDP.[6]

Over the next decade, growth rates for health care spending are anticipated to be 5.6 percent. In 2025, total health care spending as a share of GDP is expected to reach 19.9 percent.[7] Costs are projected to total 6.5 percent in private health insurance spending and 4.6 percent in Medicare spending of GDP, with $5.5 trillion spent on health care costs in the U.S.

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[2] U.S. Senate Committee on the Budget, The Coming Crisis: America's Dangerous Debt. Dr. Laurence Kotlikoff, February 25, 2015. https://www.budget.senate.gov/imo/media/doc/PDF.Kotlikoff%20-%20Testimony%20to%20Senate%20Budget%20Committe%202-25-2015.pdf (Accessed May 10, 2018)

[3] Rauh, Joshua, D. Hoover Institution Essay: Hidden Debt, Hidden Deficits: 2017 Edition. https://www.hoover.org/sites/default/files/research/docs/rauh_debtdeficits_36pp_final_digital_v2revised4-11.pdf (Accessed May 10, 2018)

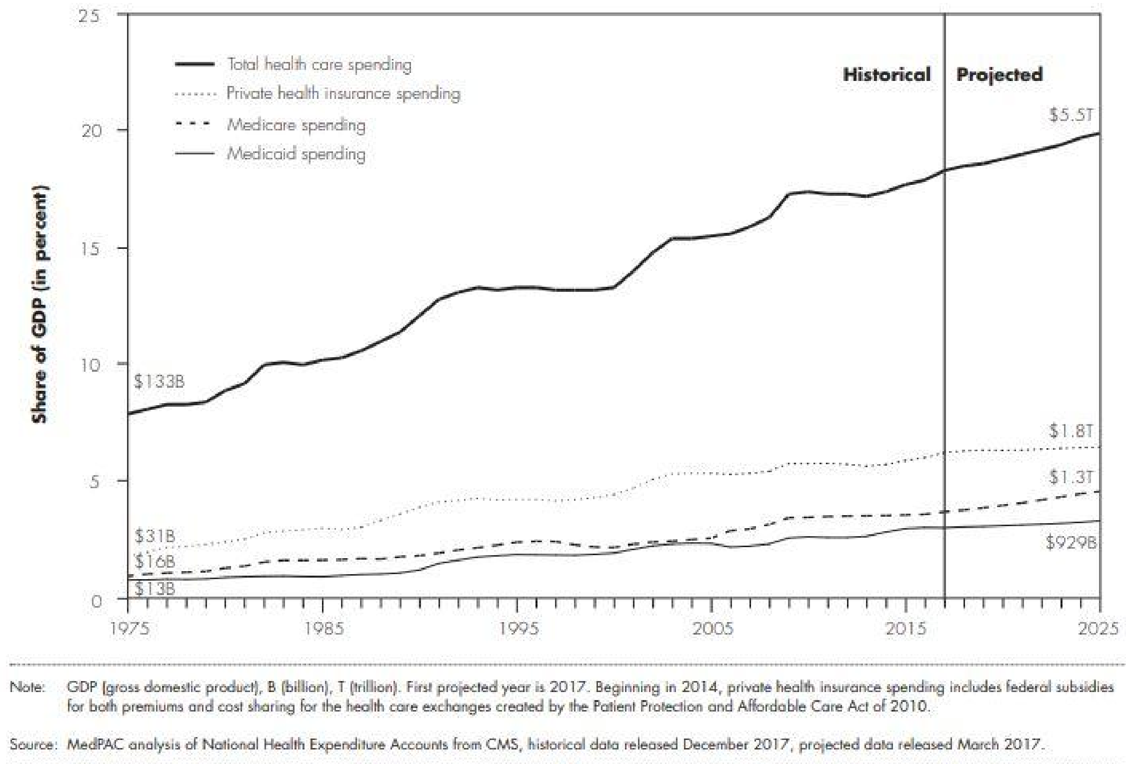
[4] International Monetary Fund, World Economic Outlook, April 2018, Cyclical Upswing, Structural Change. http://www.imf.org/en/Publications/WEO/Issues/2018/03/20/world-economic-outlook-april-2018 (Accessed May 10, 2018)

[5] Medicare Payment Advisory Commission (MEDPAC) Report to the Congress: Medicare Payment Policy, March 2018. http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0 (Accessed May 10, 2018)

[6] Ibid.

[7] Keehan, SP et.al. National Health Expenditure Projections, 2016-25: Price Increases, Aging Push Sector to 20 Percent of Economy. *Health Affairs* 36(3), 2017:553-563.

Health Care spending growth rates have begun to gradually increase following recent slowdown[8]



Medicare is the single largest purchaser of health care in the U.S.[9] Health care costs continue to rise at an unsustainable rate and consume more of the federal budget each year. In the 2017 Annual Report from the Boards of Trustees of the Medicare programs, the 2017-2021 expenditures estimated for Part B Medicare average an increase of 7.8 percent.[10] The Trustees also predict asset depletion of Medicare Part A by 2026.[11]

The Government Accountability Office (GAO) has cited Medicare as a high-risk program since 1990 due to its susceptibility to mismanagement, improper payments, complexity, and size of the program.[12] The aging of the U.S. population and continual increase in health care costs add to challenges of the program. The Congressional Budget Office predicts that in 2026, Medicare spending will reach nearly $1.3 trillion.

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[8] MEDPAC, March 2018.

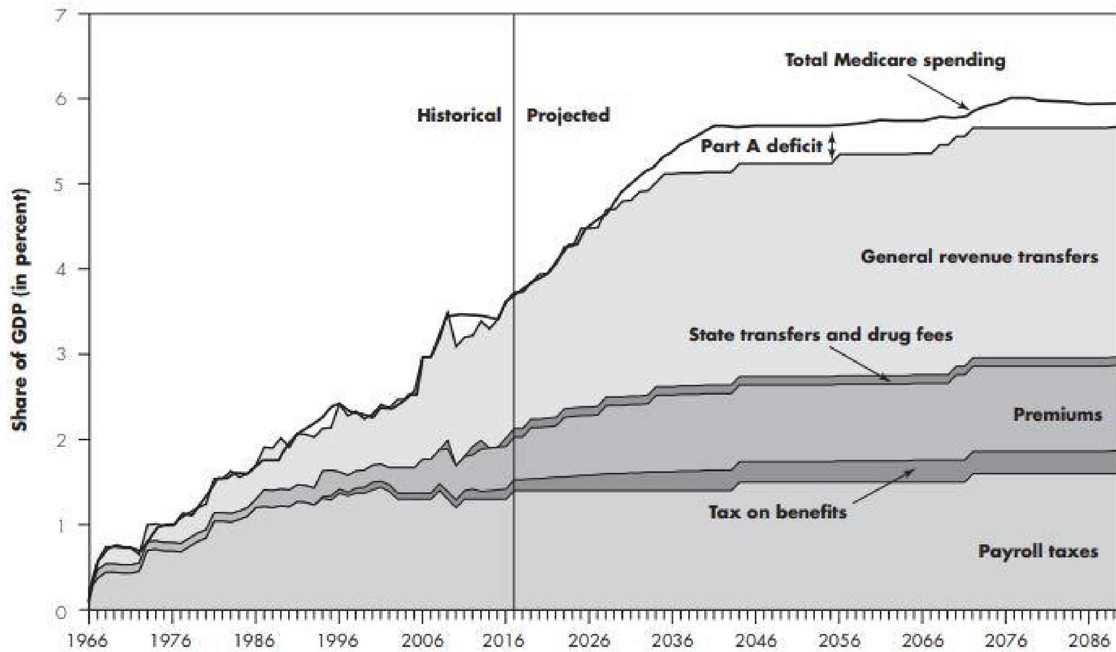
[9] Medicare Payment Advisory Commission (MEDPAC) Report to the Congress: Health Care Spending and the Medicare Program, June 2017. http://medpac.gov/docs/default-source/data-book/jun17_databookentirereport_sec.pdf?sfvrsn=0 (Accessed May 11, 2018)

[10] 2017 Annual Report of The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, July 13, 2017. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf (Accessed May 11, 2018)

[11] 2018 Annual Report of The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, June 5, 2018. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf (Accessed June 8, 2018)

[12] U.S. Government Accountability Office (GAO) High-Risk Series: Progress on Many High-Risk Areas, While Substantial Effort Needed on Others. February 2017. https://www.gao.gov/assets/690/682765.pdf (Accessed May 11, 2018)

General Revenue is paying for a growing share of Medicare spending[13]



Note: GDP (gross domestic product). "Tax on benefits" refers to the portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. "State transfers" (often called the Part D "clawback") refers to payments from the states to Medicare, required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, for assuming primary responsibility for prescription drug spending. "Drug fees" refers to the fee imposed by the Patient Protection and Affordable Care Act of 2010 on manufacturers and importers of brand-name prescription drugs. These fees are deposited in the Part B account of the Supplementary Medical Insurance Trust Fund.

Source: 2017 annual report of the Boards of Trustees of the Medicare trust funds.

U.S. Fertility Rate Down

The U.S. fertility rate is at its lowest rate since the Centers for Disease Control and Prevention (CDC) began keeping records in 1909.[14] The reason this is significant is that entitlement programs are partially funded by the number of people paying into the Medicare and Social Security trust funds. To maintain a stable population, the number of births needs to exceed 2.1 births per woman. The U.S. has been below that number since 1972.[15] In 2015, 2.8 workers paid for one retiree's benefits. In twenty years, the ratio is expected to be 2.2. Furthermore, the age 65-plus population is growing almost seven times faster than the overall population placing enormous demands on federal entitlement programs.

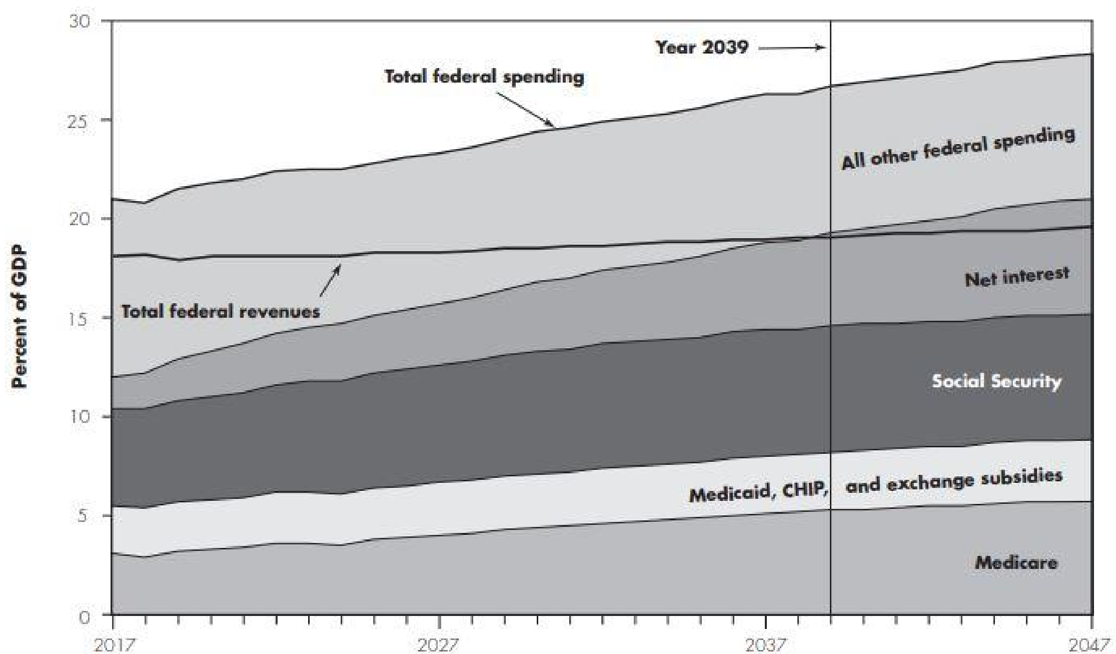
[13] MEDPAC, June 2017.

[14] U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. General Fertility Rate: 12-Month Ending 2015-Quarter 2, 2017. https://www.cdc.gov/nchs/nvss/vsrr/natality-dashboard.htm (Accessed May 11, 2018)

[15] America's biggest and most predictable train wreck. Unfunded Liabilities. *13D Research*. https://latest.13d.com/americas-biggest-and-most-predictable-train-wreck-unfunded-liabilities-5c6520b469be (Accessed May 10, 2018)

Americans will pay $3.3 trillion in federal taxes in 2018 and another $1.8 trillion in state and local taxes.[16] The 2016 GDP of the U.S. was $18.57 trillion making the $5.2 trillion paid in taxes almost 30% of the GDP. Spending in FY 2018 is anticipated at $4.1 trillion leaving a deficit of $800 billion. Discretionary spending accounts for 16 percent of the total budget. Altogether, three entitlement programs expend 50 percent of the U.S. federal budget. Social Security consumes 24 percent, Medicaid is at 9 percent, while Medicare encompasses 17 percent of the budget. An increase in spending is predicted for all of these programs, in years to come. The U.S. government may not be able to adequately deal with budgetary deficits without significant entitlement reform, including cuts to the Medicare program. In order to save the Medicare program for future generations, it is imperative that the Medicare program not be expanded at this time.

Spending on Medicare, other major health programs, Social Security, and net interest is projected to exceed total federal revenues in 22 years (by 2039)[17]



Note: GDP (gross domestic product), CHIP (Children's Health Insurance Program).

Source: *The 2017 Long-Term Budget Outlook* (published March 2017) and *Update to the Budget and Economic Outlook: 2017 to 2027* (published June 2017) from the Congressional Budget Office.

[16] Tanner, Michael. Taxes Don't Cover America's Expenses. *National Review*. April 18, 2018. https://www.nationalreview.com/2018/04/federal-debt-problem-entitlement-reform-only-solution/ (Accessed May 11, 2018)

[17] MEDPAC, June 2017.

Options for Coverage for the Medicare Population

Create new benefits products

New insurance products are created in the market constantly. However, dental benefits are not insurance, in the traditional sense, as discussed in the next section. Insurance provides subscribers with policies that protect the insured for coverage of catastrophic events, while dental benefits merely reduce the out-of-pocket costs for non-catastrophic costs. Medicare enrollees may find that there is a need for industry to create new dental benefits products that would provide coverage for some of the more expensive dental services at a reasonable cost.

A health savings account (HSA) paired with an HSA-qualified health plan allows for tax-free contributions to a savings account. Funds from these accounts can be used to pay for qualified expenses, including most dental expenses. In 2017, the Internal Revenue Service (IRS) allowed premiums paid for Medicare Part B and D to be included as permissible medical expenses.[18] The use of HSAs continues to grow in popularity as consumers may shop for cost effective services.[19]

New dental benefits products should be created in the private sector to provide coverage similar to the dental coverage received by the seniors when they were employed. Given that even the most expensive dental services pale in contrast to medical expenses, the premiums for new dental benefits products will be much lower than medical insurance premiums. Moreover, products may provide variable premiums based upon what the seniors can afford, in order to enable seniors across the economic spectrum to participate.

Medicare vs. Medicare Advantage

Funding

The Medicare program was established in 1965 and is funded by two separate trust funds: the Hospital Insurance Trust Fund (HI) and the Supplementary Medical Insurance Trust Fund (SMI).[20] The HI funds Part A Medicare expenses such as hospital, hospice, and skilled nursing facilities. SMI funds Medicare Part B and Part D, otherwise known as physician payments and subsidized drug insurance coverage, respectively. Medicare and Medicare Advantage have the same funding sources. Each program is funded by these two government trust funds, in addition to the Medicare enrollee's payment of Medicare Part B premiums.

Medicare Advantage plans differ from Medicare Parts A, B, or D in that they provide measures to reduce the financial burden on the taxpayer and the Medicare system. Medicare Advantage plans may charge their enrollees a monthly premium. Also, Medicare Advantage plans define maximum annual out-of-pocket costs whereas traditional Medicare has no limit. One substantial difference between the Medicare Advantage plans and traditional Medicare is that the Centers for Medicare & Medicaid Services (CMS) pays private insurance companies a fixed amount per enrollee in Medicare Advantage plans, in contrast to a fee-for-service amount for every Medicare charge in traditional Medicare.

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[18] U.S. Department of the Treasury, Internal Revenue Service. Publication 502. Medical and Dental Expenses 2017 Returns. https://www.irs.gov/pub/irs-pdf/p502.pdf (Accessed August 20, 2018)
[19] Grow, Kristine. Health Savings Accounts Continue to Grow in Popularity. *America's Health Insurance Plans.* February, 16, 2017. https://www.ahip.org/health-savings-accounts-continue-to-grow-in-popularity/ (Accessed August 20, 2018)
[20] MEDPAC, March 2018.

Medicare Advantage

The Medicare Advantage program was established to provide Medicare beneficiaries with greater flexibility and more options. The Medicare Advantage plans allow beneficiaries to receive benefits from private health insurance plans rather than the established Medicare fee-for-service plans.

If a senior contracts with a private company for a Medicare Advantage plan, all of the enrollee's expenses are paid for by the private company and not the government.[21] This is significant.

From a national fiscal perspective, Medicare Advantage imposes greater financial restraint on the Medicare program than paying for each and every service in the regular fee-for-service plan. If a beneficiary chooses a Medicare Advantage plan, the CMS pays the private plan a risk-adjusted predetermined amount, or capitated amount, rather than a per service fee. The CMS pays the Medicare Advantage plans different amounts depending on each enrollee's specific risk score and the plan's payment rate. Medicare Advantage plans may use innovative care management practices to deliver more efficient care and varied services including dental and vision services.

Medicare Advantage plans had 18.9 million enrollees in 2017, comprising 32 percent of all Medicare beneficiaries.[22] Medicare Advantage plan types include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and special needs plans (SNP).

Cost Containment under Medicare Advantage Plans

In 2018, almost 70 percent of Medicare Advantage plans covering 77 percent of anticipated Medicare Advantage enrollees have bids below fee-for-service Medicare spending.[23] A study found that Medicare Advantage plans paid 5.6 percent less for hospital services than fee-for-service Medicare. Furthermore, in consolidating networks of providers, the Medicare Advantage program paid 8.0 percent less than fee-for-service Medicare.[24] Two studies found that elderly dental care utilization increased significantly from 2000 through 2011, predominantly from those with private dental benefits.[25,26] Some argue that cost containment measures employed in Medicare Advantage plans may extend the life of Medicare.

Potential for Greater Savings

The impact of oral health on systemic conditions has long been recognized.[27]

Several insurance providers and the American Dental Association (ADA) Health Policy Institute conducted retrospective analyses on insurance claims to determine the effect of providing dental care on the costs

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[21] The only exception is hospice care. If a senior is in need of hospice care, payment is rendered from traditional Medicare. Centers for Medicare & Medicaid Services. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/hospice_pay_sys_fs.pdf (Accessed May 11, 2018)

[22] MEDPAC, March 2018.

[23] MEDPAC, March 2018.

[24] Baker, LC, et al. Medicare Advantage Plans Pay Hospitals Less Than Traditional Medicare Pays. *Health Affairs*. Vol. 35, No. 8. August 2016.

[25] Nasseh, Kamyar, Vujicic, Marko. Dental Care Utilization Continues to Decline among Working-Age Adults, Increases among the Elderly, Stable among Children. Research Brief. *American Dental Association Health Policy Institute*. October 2013. http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1013_2.ashx (Accessed May 11, 2018)

[26] Nasseh, Kamyar, Vujicic, Marko, Glick, Michael. The Relationship between Periodontal Interventions and Healthcare Costs and Utilization. Evidence from an Integrated Dental, Medical, and Pharmacy Commercial Claims Database. *Health Economics*. 26: 519-527 (2017). Published online Jan. 22, 2016 in Wiley Online Library.

[27] Gaddey, HL. Oral manifestations of systemic disease. *Gen Dent*. 2017. Nov-Dec;65(6):23-29.

of treating beneficiaries with histories of stroke, cardiovascular heart disease, and diabetes. Four analyses determined significant medical cost savings when dental treatment was provided.[28, 29, 30] although it should be noted that some have refuted the findings of the Jeffcoat study.

Medicare Advantage Satisfaction

Seniors on Medicare Advantage plans report greater satisfaction with their plans than traditional Medicare.[31,32] Additionally, enrollees in Medicare Advantage plans are more satisfied with their benefits than seniors with traditional Medicare.

Medicare Advantage plans are widely available in each county in the U.S. Enrollees had an average of 10 Medicare Advantage plans to choose from in 2018.[33] Some Medicare Advantage plans have coverage for select enrollee dental expenses while others do not allow for them.

Medicare Advantage Dissatisfaction

Notwithstanding that some patients express satisfaction with their Medicare Advantage plans, other patients experience dissatisfaction with their plans usually for reasons relating to a narrow network of providers.[34] Medicare Advantage organizations employ a range of tactics to control costs, principally, by offering a limited selection of physicians and hospitals considered to be in-network.[35] If a patient visits an out-of-network provider, the costs to the patient may be considerably higher than the negotiated in-network fees. Several studies found that sicker patients may be more likely to disenroll with Medicare Advantage plans and enroll in traditional Medicare primarily due to access to care issues.[36]

Physicians report excessive and burdensome administrative tasks relating to participation in Medicare Advantage plans.[37] Many Medicare Advantage plans employ different quality metrics to measure patient quality.[38] As a result, physicians and hospitals have conflicting reporting requirements depending on the

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[28] Ibid.

[29] Jeffcoat, MK, Jeffcoat, RL, Gladowski, PA, et. al. Impact of Periodontal Therapy on General Health: Evidence from Insurance Data for Five Systemic Conditions. *Am J Prev Med*. 2014; 47(2):166-74.

[30] United Healthcare. Medical Dental Integration Study 2013. https://www.uhc.com/content/dam/uhcdotcom/en/Private%20Label%20Administrators/100-12683%20Bridge2Health_Study_Dental_Final.pdf (Accessed May 11, 2018)

[31] Sullivan, Peter. Poll: Seniors more satisfied with Medicare Advantage. *The Hill*. March 31, 2015. http://thehill.com/policy/healthcare/237492-poll-seniors-more-satisfied-with-medicare-advantage (Accessed May 11, 2018)

[32] Morning Consult Poll Results. March 23, 2016. http://medicarechoices.org/wp-content/uploads/2016/03/National-poll-results-.pdf

[33] MEDPAC, March 2018.

[34] Jacobson, G, Rae, M, Neuman, T, Orgera, K, Boccuti, C. Medicare Advantage: How Robust are Plans' Physician Networks? Oct. 5, 2017. https://www.kff.org/report-section/medicare-advantage-how-robust-are-plans-physician-networks-report/ (Accessed August 20, 2018)

[35] Ibid.

[36] U.S. Governmental Accountability Office. Medicare Advantage- CMS Should use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight. GAO-17-393. May 30, 2017. (Accessed August 20, 2018) https://www.gao.gov/assets/690/684386.pdf (Accessed August 20, 2018)

[37] American College of Physicians A Position Paper. Promoting Transparency and Alignment in Medicare Advantage. 2017.
https://www.acponline.org/acp_policy/policies/promoting_transparency_and_alignment_in_medicare_advantage_2017.pdf (Accessed August 20, 2018)

[38] U.S. Centers for Medicare & Medicaid Services. 2018 National Impact Assessment Quality Measures Report. February 28, 2018. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/2018-Impact-Assessment-Report.pdf (Accessed August 20, 2018)

Medicare Advantage plan.[39] Furthermore, not all Medicare Advantage plans use alternative payment models as incentives are defined in contracts between the Centers for Medicare & Medicaid Services and Medicare Advantage organizations.[40] Consequently, physicians and or hospitals may not be eligible for value-based incentive payments.[41]

Dental Benefits vs. Medical Insurance

As stated above, dental benefits are not insurance, because, while insurance provides beneficiaries with policies that protect the insured for coverage of catastrophic events, dental benefits reduce the out-of-pocket costs for non-catastrophic costs. The Medicare program already covers those few catastrophic events that can affect the oral cavity in the Medicare population.[42]

A 2006 JADA article differentiates between dental and medical care.[43] "Medical diseases have all of the characteristics of an insurable risk. They are "unpostponable, unpredictable and unbudgetable."[44] "Oral diseases have none of these characteristics. They are nearly universal, though their prevalence, particularly dental disease, have decreased significantly in the general population."[45]

Dental benefit plans should be differentiated from insurance plans, as they are prepayment plans. As such, they are designed to be used by the beneficiary to the maximum extent each year to pay for routine dental care. Dental benefit plans are not designed to cover major medical expenses in oral health, as those are covered under medical insurance plans.

The Imprudent Attempt to Include Dentistry in Medicare

Advocacy/Public Relations Efforts

Advocacy organizations, coalitions, and not-for-profit associations may draft op-eds in various publications, produce a public relations campaign, or hire a contractor with a specific intent in order to advance their advocacy agendas. Such appears to be the case when considering the possibility of including dental benefits into the Medicare program.

Some of the content of the advocacy campaigns is based on the use of biased or agenda driven surveys, focus groups, and consultancy products with a predetermined outcome. Consumers should do their due diligence to determine if the content of questions are neutral or are biased to effectuate a desired outcome. Survey instruments, methodology, demographics, and data should be publically available and presented in an unbiased manner so that the results can be replicated in a scientific manner.

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[39] Ibid.

[40] O'Shea, J. Salvaging MACRA Implementation through Medicare Advantage. Health Affairs. October 17, 2017. https://www.healthaffairs.org/do/10.1377/hblog20171017.462746/full/ (Accessed August 8, 2018)

[41] Ibid.

[42] The National Academies of Sciences, Engineering, Medicine. Extending Medicare Coverage for Preventive and Other Services. *National Academies Press*. 2000. Page 63. https://www.nap.edu/read/9740/chapter/6 (Accessed May 11, 2018)

[43] Guay, Albert H. The differences between dental and medical care. Implications for dental benefit plan design. *JADA*, Vol. 137, June 2006: 801-806.

[44] Avnet HH, Nibrios MK. Insured dental care: A research project report. New York: Group Health Dental Insurance; 1967:3-7.

[45] Guay, Albert H. 802.

Finding a balance between financial reality and entitlement needs and wants

In some segments of the population, there is support for the U.S. government to create a "Medicare for all" or universal health care program that is being championed by some advocacy organizations and politicians.[46, 47] Dental benefits are sometimes included in these types of proposals.[48]

Public policy advocates frame arguments to include dental benefits into Medicare Part B as coming from a place of compassion. [49,50] However, it is the opposite of compassion to relegate future generations to a precipitous and unstable financial future.[51]

Importance of Self-Care

Medical and dental patients can affect their disease states and general health by exercising habits and practices that support the best outcomes for their teeth. From a dental perspective, self-care and the utilization of early preventive care is essential in the vitality of oral health and will reduce needs for extensive treatment. Oral health literacy is an integral component of every individual's health and well-being, and resources should be directed to advance this concept.

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[46] Center for American Progress: Medicare Extra for All: https://www.americanprogress.org/issues/healthcare/reports/2018/02/22/447095/medicare-extra-for-all/ (Accessed June 13, 2018)
[47] Medicare for All: Senator Bernie Sanders. https://berniesanders.com/medicareforall/
[48] Center for American Progress: https://www.americanprogress.org/issues/healthcare/reports/2018/02/22/447095/medicare-extra-for-all/
[49] Cheryl-Fish Parcham, "Medicare Should Pay for Oral Health Care That is Necessary to Manage Serious Illness," *FamiliesUSA, August* 29, 2017:http://familiesusa.org/blog/2017/08/medicare-should-pay-oral-health-care-necessary-manage-serious-illnesses.
[50] Julie Carter, "The Time Has Come for Medicare Dental Benefits," *Medicare Rights* blog, February 22, 2018: https://blog.medicarerights.org/time-come-medicare-dental-benefits/
[51] Alan J. Auerbach and William G. Gale, "Fix Health Care. But Fix the Deficits Too," *Brookings*, September 8, 2009: https://www.brookings.edu/articles/fix-health-care-but-fix-the-deficits-too/