Remarks by Alicia Georges
National Volunteer President, AARP
Santa Fe Group Salon on Oral Health
Arlington, Virginia
May 10, 2019

Thank you.

Happy Nurses Week, everyone! If you haven't given a special thank you yet to a nurse, don't worry—Nurses Week runs through Sunday!

I welcome this opportunity to speak to all of you about AARP's support for your vital work.

Reaching the crucial goal of a dental benefit in Medicare will require a highly informed, energized, and growing coalition and AARP is proud to be part of this collaboration.

As a nurse, as the dean of a nursing school, as the National Volunteer President of AARP, as someone who has devoted her life to prevention and healing, I want you to know how impressed I am by your advocacy and how committed AARP is to making a dental benefit a basic part of Medicare.

The fact that almost two-thirds of the all the people in Medicare have no dental coverage does not make sense medically. Our job, together, is to insure that it does not make sense politically.

The lack of a benefit comes as a very disturbing surprise to many of our AARP members. Faced with the need for extensive dental work and high costs, they find they have no insurance to pay the bill.

The current policy—or perhaps, more accurately, absence of a policy—is illogical, counterproductive, and a contradiction of good science.

I think about all the vital precepts and components of sound health care policy turned upside down by excluding a basic dental benefit in Medicare.

A partial list of principles and priorities the current policy violates or ignores would include:

- Evidence-based approaches
- Holistic health care
- A focus on prevention
- Lowering the risk for heart disease and cancer
- Brain health
- Good nutrition
- Reducing social isolation, and
- Closing the gap between different groups in health care and health outcomes

The lack of a dental benefit is a costly and unfair anomaly.

The absence of a dental benefit ignores a host of studies showing a direct link between oral health and overall health. If my nursing school students showed such flawed reasoning in their papers or exams, I would be hard-pressed to give them a passing grade.

There are so many cases where science has yet to find answers to serious medical problems. Here we have proven health care interventions right in front of us but they are financially out of reach for millions of Medicare beneficiaries.

The lack of a dental benefit stands in stark contrast to a positive development in health care—thinking and acting holistically to keep the person healthy—not just treat the symptom or disease.

For instance, the lack of a dental benefit worsens the problem of social isolation.

Helping older adults build strong social connections is a top priority for AARP, which works with vulnerable people over 50. One respected study has found that the impact of prolonged social isolation is equivalent to smoking 15 cigarettes a day.

So we have to ask, why continue a policy that ignores oral health, that leaves so many older adults with tooth loss, that makes them embarrassed about their smile, and makes it harder for them to communicate? We can help prevent the social isolation that comes with losing your self-confidence and ability to connect with friends and loved ones.

In a similar vein, we have to ask, why continue a policy that has a negative effect on nutrition?

We are all aware of how loss of teeth and oral pain can prevent people from eating well, from getting the nutrition they need to maintain good health. But the problem is even more widespread than many imagine.

A report by the Kaiser Family Foundation, a report that AARP helped to fund, put it this way, in discussing dry mouth and nutrition:

Dry mouth “is a side effect for hundreds of medications. Dry mouth significantly increases the risk of dental caries, loosening dentures that can lead to painful ulcerations, difficulty chewing or swallowing and altered taste, which can negatively impact nutrition, as well as a series of other health issues such as recurrent oral thrush and lesions on the oral mucosa.”

“Incidence of dry mouth increases with the number of medication used, and is a particular concern for seniors,” the report said, pointing out that “54 percent of adults age 65 and older take at least four prescription drugs.”

Even as we at AARP provide information and encouragement to pursue a healthy diet—high in fruits and vegetables—dry mouth and tooth loss are pulling in the opposite direction.

We have to ask, why continue a policy that widens the troubling disparities we see in health care?

Disparities in health care are an issue I have seen up close over many years, as a nurse and as a nurse educator. This problem is something I feel passionately about and speak about in forums across the country.

We have to face and address this truth: Health disparities exist across ethnic, racial, socioeconomic and geographical lines in the US, often in defiance of more promising trends that affect the population as a whole.

Minorities have fared worse in health and health care throughout their lives. They continue to be worse off as older adults.

Minorities face lower life expectancy; poorer dental health; higher rates of asthma, hypertension, stroke, HIV/AIDS, cancer, cardiovascular conditions, diabetes and cirrhosis of the liver.

African-Americans experience cognitive decline at greater rates and earlier ages than whites. They experience dementia at twice the rate of whites. For Hispanics, the rate of dementia is one-third higher than whites.

Minorities are less likely to have health insurance and they rate their own health status lower.

One study found that black Medicare beneficiaries are 35 percent more likely to be admitted to hospitals that have high mortality rates.

The lack of a dental benefit in Medicare puts us in a deeper hole when it comes to addressing health care disparities. Next time an elected official tells you that he or she is committed to dealing with these disparities, ask the official's position on putting a dental benefit in traditional Medicare.

The Kaiser Family Foundation report, which was released in March, gave us a window into disparities in dental care for Medicare beneficiaries.

The Kaiser Family Foundation showed that in 2016, while 49 percent of Medicare beneficiaries did not visit a dentist, the figures for blacks—at 71 percent—and Hispanics—at 65 percent—were much higher.

The breakdown by income was even more pronounced, with 70 percent of those with incomes below $10,000 having no dental visits over the entire year, compared to 27 percent of those with incomes above $40,000.

The issue brief also pointed to a disproportionately high rate of no dental visits in a year among Medicare beneficiaries younger than 65 with disabilities—at 62 percent—and beneficiaries in rural areas—at 59 percent.

AARP's financial support for this Kaiser Family Foundation paper is one element of our involvement on the issue of oral health.

Another component is a special section last fall in AARP Bulletin on the health benefits of oral hygiene and practical tips on what to do.

AARP Bulletin goes to more than 20 million households across the country. An article called Healthy Teeth, Healthy Body, pointed to connections between good oral care and avoiding or lessening the impact of a number of diseases.

While people have a general belief that oral health is key to overall health, many of the specific connections are not widely known—so informing our members about them is an especially important service.

A prime example is brain health. Keeping our brains sharp is the leading health concern for older adults.

In our special report on oral health in AARP Bulletin, we pointed out that “people with severe periodontal disease were three times more likely to have Alzheimer’s disease, according to a statistical review” and that another study showed a connection between oral hygiene and the risk of stroke, with stroke patients having higher levels of certain bacteria in their saliva.

We also told our Bulletin readers that for postmenopausal women, taking care of their teeth and gums could reduce cancer risk. We noted that a 2017 study showed these women who have experienced periodontal disease are at higher risk for breast, esophageal, gallbladder, skin, and lung cancers.

We cited an NIH warning that “poor dental hygiene and unhealthy teeth and gums” increase the risk for endocarditis.

We told our readers that for those with diabetes, periodontal disease may make it more difficult to control glucose levels.

We noted that a recent large-scale review had shown that men suffering from ED “were three times more likely to have been diagnosed with chronic periodontal disease.”

We also provided advice from the American Dental Association, the American Dental Hygienists Association, and other sources of expertise. This guidance on caring for teeth and gums was clear and specific, with recommendations on brushing, flossing, toothbrushes, toothpaste, and more.

Our work on oral health proceeds with two mutually reinforcing elements: What individuals should do and what government policy should be. In fact, the heightened attention to oral health that would result from the creation of a new Medicare benefit could go hand-in-hand with new, coordinated efforts to help people become educated about why our dental habits have such profound consequences, and what they should be doing to help themselves.

The more information about the impact of oral health that we can all convey in many different ways, the more momentum we can build for a new Medicare benefit and for the exercise of personal responsibility to take care of our teeth and gums.

I mentioned the extraordinary reach of AARP Bulletin. Each of us in the coalition can drive home these messages not only in print, but also in social media, on our organization's websites, in video, and in many other ways. In various formats across a wide range of platforms, we can bring the issue alive through study results and, especially, through personal stories.

One productive means of getting the word out is public opinion surveys designed to better understand the gaps in coverage and the needs of older Americans.

Last October, AARP conducted a survey to examine the oral health care needs of older adults, the obstacles they face in getting oral health care, and how highly they value having access to that care.

Almost 40 percent of survey respondents 65 and older told us they had not been to a dentist or dental hygienist for more than a year. For one in six respondents 65 and over, the figure was more startling—they had not gone to a dentist in over five years.

Ninety percent of the survey respondents 65 and older said that oral health is extremely important or very important to a person's overall health.

Eighty percent said that regular dental visits are just as important as regular visits to the doctor or other health care professional—a much higher percentage hold this belief than actually make such visits.

Over half of the respondents said they had no dental coverage—and more than a third were somewhat or extremely concerned about being able to pay their dental bills over the next six months.

How do they feel about adding a dental benefit to Medicare? As AARP's Public Policy Institute put it, people are "willing to put their money where their mouths are."

Sixty-two percent of the people over 65 in our poll said they would support adding a dental benefit to Medicare even if their costs would increase.

We want to build on the very useful findings from this poll with further survey research, looking at questions such as what oral health services older adults want and how much they are willing to pay to get them.

So these are some of the ways in which we are deepening our engagement on this issue—articles on oral health in our AARP Bulletin and, I should add, on our website; helping to fund the Kaiser Family Foundation's work on oral health; conducting survey research.

We've also joined with you to make the case directly to HHS and CMS, urging them to use their existing authority to cover medically necessary dental care.

We've all seen how CMS is not shy about approving changes designed to restrict coverage through work requirements for Medicaid.

We'd like to see them use their time and energy to expand coverage for dental care as a benefit under Medicare.

We believe HHS can provide medically necessary coverage through administrative action. But we are certainly not stopping there.

Creating a dental benefit in traditional Medicare is a legislative priority for AARP and we are eager to keep working with you to achieve it.

As I think about how we can deepen and accelerate our joint efforts, I take heart from how the paradigm in our country has shifted over the past decade on health insurance coverage for preexisting conditions.

As a strong supporter of the Affordable Care Act, both in urging its passage and safeguarding its protections, we at AARP have seen how attempts to weaken coverage for preexisting conditions have become politically perilous.

That hard-won battle on preexisting conditions, which sometimes still has to be refought, turned on the power of a broad coalition, the impact on the health and finances of millions of Americans who were denied coverage, and the power of personal stories in every part of the country.

I am not suggesting the effort to provide a dental benefit will rise to a similar level of visibility, but on the positive side neither will it generate the level of political hostility that has surrounded the ACA.

I think what the fight over preexisting conditions shows is that it is possible, through a painstaking and broad-based coalition that provides compelling facts and tells heart-wrenching personal stories, to change the paradigms in health care policy at the national level.

AARP looks forward to working with all of you, sharing ideas, information, and strategies, to make that happen.

Thank you for listening.