

# DENTAL COVERAGE FOR SENIORS

March 2026

## Introduction

Access to and uptake of dental care are among the areas where gaps in Arkansas's healthcare system are most evident. The state's dental visit rate was the fourth lowest in the nation 2024.<sup>1</sup> Arkansas's rural communities are disproportionately affected by this gap in dental care. Only 37% of rural Arkansas county residents had a dental visit in 2019,

compared to 40% in urban counties. In the same year, 11 rural Arkansas counties had more than 5,000 residents for each dentist, the threshold set by the Health Resources and Services Administration for a dental health provider shortage area.<sup>2</sup> Two of those 11 counties had no dental providers at all.

### LIMITED ACCESS TO DENTAL PROVIDERS IN ARKANSAS

Arkansas had the third-lowest ratio of dental providers to patients in 2025 with 45.7 providers per 100,000 residents.<sup>1</sup>

This may soon see improvement with the opening of Arkansas's first dental school, the Lyon College School of Dental Medicine, in June 2025.<sup>5</sup>

### ORAL HEALTH IMPACTS OVERALL WELL-BEING

Poor oral health is associated with:

- More frequent emergency department visits<sup>2</sup>
- Higher risk of chronic disease<sup>6,7</sup>
- Poor mental health outcomes<sup>8</sup>

Arkansas also has a dental coverage gap which disproportionately affects people over 65.

Seniors make up a larger share of the population of rural counties than urban counties, and most rely on Medicare, which does not cover routine dental care.<sup>3</sup> The lack of consistent dental coverage among seniors contributes to poor oral health outcomes, particularly in rural communities where provider access is limited.<sup>4</sup>



This explainer explores what dental coverage is available for seniors, the extent to which coverage gaps affect older Arkansans, and what policy options could potentially address these challenges.

## The Dental Coverage Gap

Medicare is the federal government’s public health insurance program for Americans who are 65 or older or have certain qualifying disabilities or diseases. Unlike Medicaid, which is jointly run by states and the federal government to cover Americans with low incomes, Medicare is fully administered by the federal government, and its structure is the same nationwide. Medicare has four parts, as outlined in the following table.

TABLE 1: DENTAL COVERAGE UNDER MEDICARE

<b>Part A: Hospital Insurance</b>	Covers inpatient medical care. Only covers dental procedures necessitated by a covered medical service.
<b>Part B: Medical Insurance (“Traditional Medicare”)</b>	Covers outpatient medical care. Only covers dental procedures necessitated by a covered medical service.
<b>Part C: Medicare Advantage</b>	An alternative to Part B administered by private health insurers. Dental benefits vary by plan. Nearly all plans offer some degree of dental coverage, either integrated into the medical plan or as an optional supplemental plan.
<b>Part D: Prescription Drug Coverage</b>	Coverage for prescription medication administered by private insurers. Some plans cover medications necessitated by uncovered dental services.
<b>Note: Medicare Supplemental Insurance, also called Medigap, only covers Medicare cost-sharing requirements (copays, coinsurance). It does not provide supplemental benefits, such as dental or vision coverage.<sup>9</sup></b>	

**MEDICARE ENROLLMENT IN ARKANSAS, SEPTEMBER 2025<sup>10</sup>**

**22.1%**

(687,101 beneficiaries) of Arkansans were enrolled in Medicare

**53.4%**

(367,114 beneficiaries) of Arkansans enrolled in Medicare were enrolled in Medicare Part B, compared to 48.8% of Medicare enrollees nationwide

**46.6%**

(319,987 beneficiaries) of Arkansans enrolled in Medicare were enrolled in Medicare Advantage, compared to 51.2% of Medicare enrollees nationwide

*Note: Medicare enrollment counts vary month-to-month. Figures given here are averages of monthly enrollment counts reported between September 2024 and September 2025.*

Notably, none of the current Medicare parts necessarily offer a dental benefit, leaving many Medicare beneficiaries without access to routine, non-emergency dental care. This coverage

gap has narrowed in recent years, but it remains substantial: A KFF analysis of public enrollment data found that 47% of Medicare beneficiaries had no dental coverage in 2019.<sup>11</sup> More recently, a 2024 survey by the CareQuest Institute for Oral Health found that 31% of Medicare beneficiaries lacked dental insurance.<sup>12</sup>

## DENTAL COVERAGE BY TRADITIONAL MEDICARE

Traditional Medicare only covers dental services when they are considered “medically necessary” for the success of a covered medical treatment, such as dental exams typically administered before initiating dialysis or performing organ transplants.<sup>13</sup> Some beneficiaries may acquire coverage through private, supplemental dental plans or employer- or union-sponsored plans. Between 2017 and 2021, about 34% of traditional Medicare beneficiaries nationwide had some form of private, supplemental dental coverage.<sup>14</sup>

## DENTAL COVERAGE BY MEDICARE ADVANTAGE

Medicare Advantage plans may offer dental coverage, either integrated in their medical plans or offered as independent supplemental plans. In 2024, 98% of Medicare Advantage enrollees nationwide were enrolled in plans that either had an integrated dental benefit or offered optional supplemental dental plans.<sup>15</sup>

Among Medicare Advantage enrollees whose plans do not have an integrated dental benefit, nearly all are offered supplemental dental coverage options. Some choose not to enroll in those options because they have another source of coverage, such as a group dental plan through an employer, or because the supplemental coverage often comes with additional premiums. Of the 353,365 Arkansas residents who were enrolled in a Medicare Advantage plan at some point in 2024, 48.7% (172,052 enrollees) enrolled in a plan that included an integrated dental benefit, 14.1% (49,948 enrollees) enrolled in a supplemental dental plan designed to be paired with a

### SOURCES OF DENTAL COVERAGE AMONG MEDICARE ADVANTAGE ENROLLEES IN ARKANSAS, 2024<sup>a</sup>

**48.7%**

Medicare Advantage medical plan with an integrated dental benefit

**14.1%**

Medicare Advantage supplemental dental plan

**27.8%**

Non-Medicare Advantage supplemental dental plan

**23.5%**

No evidence of dental coverage

<sup>a</sup> Based on an ACHI analysis of Arkansas Healthcare Transparency Initiative data. Percentages do not add up to 100% because the enrollment counts in this section include all enrollees who fit into each category at any point in 2024, and enrollees can be counted in multiple categories if their coverage status changed mid-year.



Medicare Advantage plan, 27.8% (98,321 enrollees) enrolled in a dental plan not associated with their Medicare Advantage plan, and 23.5% (82,961 enrollees) did not have a dental benefit at any point in 2024.<sup>b</sup>

## DENTAL COVERAGE FOR DUALY ELIGIBLE MEDICARE BENEFICIARIES

Individuals eligible for Medicare can concurrently enroll in Medicaid if they meet certain state-specific income requirements. This is known as dual eligibility.<sup>16</sup> Arkansas Medicaid currently covers up to \$500 of dental services annually for adult enrollees, with no deductible.<sup>17</sup> Arkansas Act 1025 of 2025 calls for this cap to be raised to \$1,000 in late 2026 for beneficiaries with special needs, subject to federal approval.<sup>18</sup> Because Arkansas includes a routine, non-emergency dental benefit in its Medicaid fee-for-service program, dual eligibility offers another pathway to dental coverage for some Medicare beneficiaries.

Not all dually eligible individuals have access to this benefit, however. Dually eligible Medicare beneficiaries are determined to have either full-benefit or partial-benefit eligibility, depending on their income, assets, and certain health factors.<sup>19</sup> Full-benefit dually eligible individuals receive

### DUAL ELIGIBILITY IN ARKANSAS, JUNE 2025<sup>22</sup>

**128,796**

dually eligible individuals

**74,885**

D-SNP enrollees

**12,341**

dually eligible individuals with no Medicare or Medicaid dental benefit

all Medicaid benefits, just as regular Medicaid beneficiaries do, including Arkansas’s dental benefit. Partial-benefit dually eligible individuals receive assistance with Medicare premiums and cost-sharing requirements, but they do not receive Medicaid-covered dental benefits or any other coverage for services not covered by Medicare. In Arkansas, most dually eligible beneficiaries, regardless of full- or partial-benefit eligibility status, are eligible to enroll in a dual special needs plan (D-SNP), a type of Medicare Advantage plan specifically for dually eligible beneficiaries that coordinates an enrollee’s Medicare and Medicaid benefits. Ninety-five percent of D-SNPs offer a dental benefit.<sup>20</sup> D-SNP options are available in all Arkansas counties.<sup>21</sup>

In June 2025, there were 128,796 Medicare beneficiaries in Arkansas who were dually eligible, of whom 66,198 (51.4%) were full-benefit eligible and 62,598 (48.6%) were partial-benefit

<sup>b</sup> Based on an ACHI analysis of Arkansas Healthcare Transparency Initiative data. Percentages do not add up to 100% because the enrollment counts in this section include all enrollees who fit into each category at any point in 2024, and enrollees can be counted in multiple categories if their coverage status changed mid-year.



eligible.<sup>22</sup> There were 74,885 (58.1%) dually eligible individuals enrolled in D-SNPs, of whom 34,996 (46.7% of D-SNP enrollees) were full-benefit eligible and 39,889 (53.3% of D-SNP enrollees) were partial-benefit eligible. There were 12,341 partial-benefit eligible individuals (9.6% of all dually eligible individuals) who had no Medicare or Medicaid dental benefit.

## OTHER SOURCES OF MEDICARE DENTAL COVERAGE

In addition to D-SNPs, Medicare offers other special needs plans (SNPs), with different benefits and eligibility criteria. Most SNPs, regardless of type, offer a dental benefit.

Institutional Special Needs Plans (I-SNP) are available to Medicare beneficiaries in long-term care facilities, such as nursing homes and intermediate care facilities, and to beneficiaries in inpatient institutions, such as psychiatric facilities and rehabilitation centers.<sup>23</sup> While all I-SNPs offered by major nationwide insurance companies offer a dental benefit, some plans from smaller regional companies do not.<sup>24</sup> The only I-SNP available in Arkansas in 2025 was offered by a regional insurance company.<sup>25</sup> This plan covered dental procedures at no cost to Medicaid-eligible enrollees, but it limited benefits for others to Medicare-covered services (i.e., services covered by parts A and B) with 20% coinsurance. In June 2025, the 123,950 I-SNP enrollees nationwide included 2,228 Arkansans.<sup>26</sup> The overwhelming majority of I-SNP enrollees nationwide and in Arkansas are dually eligible, suggesting that most Arkansas I-SNP enrollees had a dental benefit in 2025.<sup>22,27</sup>

Chronic Condition Special Needs Plans (C-SNP) are available to Medicare beneficiaries with certain qualifying conditions, such as cancer, dementia, or diabetes mellitus.<sup>23</sup> Ninety-six percent of C-SNPs nationwide offered a comprehensive dental benefit in 2024.<sup>28</sup> In June 2025, five C-SNPs were available in Arkansas, with 41,560<sup>c</sup> people enrolled in them.<sup>27</sup> There were 917,709 C-SNP enrollees nationwide.

## Policy Options

The largest gap in Medicare dental coverage is in traditional Medicare, which does not cover routine dental services. While some enrollees obtain limited benefits through Medicaid, many must buy separate coverage or pay out of pocket. Some advocates have called for adding a

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<sup>c</sup> Two of the plans available in Arkansas were regional Arkansas-Missouri preferred provider organizations, so this figure likely includes some Missouri enrollees. These plans together only had 2,976 enrollees, so the overcount is likely minimal.

standard dental benefit to Medicare, either wrapped into Part B outpatient services or as an entirely new Medicare part. Legislation to add comprehensive dental benefits to Part B has been introduced in Congress multiple times in the past decade but has not advanced.<sup>29</sup>

The positions of professional organizations on these attempts have been mixed. The American Dental Association (ADA) has consistently opposed a Part B dental benefit, arguing that it would inadequately reimburse dental providers and would apply inappropriate regulatory requirements to dental practices.<sup>30</sup> Instead, the ADA suggests creating a separate Medicare part that would be tailored to meet the needs of dentists and Medicare patients and would be limited to beneficiaries with incomes below 300% of the federal poverty level. In contrast, the National Dental Association — whose members include the National Dental Hygienists Association, National Dental Assistants Association, and other professional organizations — has supported adding a Part B dental benefit, arguing that it would reduce financial barriers to care.<sup>31</sup>

The addition of a Part B dental benefit would increase Medicare spending, but there is some evidence to suggest it could lead to lower out-of-pocket costs for beneficiaries and could substantially reduce per-beneficiary costs for emergency dental care. It should also be noted that current evidence does not clearly suggest that expanded coverage alone improves provider access and uptake of dental care. Literature on these potential impacts is explored below.

Beyond federal policy on dental coverage, additional action by state and local governments and healthcare system stakeholders targeting access and uptake could be taken to improve dental health outcomes. Many such policy options are under discussion. Some of these approaches align with the Rural Health Transformation Program, a new federal initiative providing states with funding for projects to improve rural health systems.<sup>32</sup> Arkansas will begin implementing projects funded by the program this year.<sup>33</sup> Options include:<sup>32, 34</sup>

- Offering recruitment incentives, such as grant and/or loan forgiveness programs for dental professionals practicing in rural communities, paired with a service commitment.
- Expanding scope of practice for dental hygienists to increase their ability to provide preventive services. Arkansas's Rural Health Transformation Program application indicates the intention to pursue legislation to this effect in 2027.<sup>33</sup>
- Investing in non-traditional care delivery methods, such as tele-dentistry, mobile dental care, and pop-up care provided in community settings.

- Expanding patient transportation programs, such as the Medicaid Non-Emergency Medical Transportation program.
- Integrating dental care into medical care (e.g., including oral health screenings in annual wellness visits).
- Improving care coordination through shared electronic health records systems across dental, medical, behavioral, and other segments of health care.

### **POTENTIAL IMPACTS OF ADDING DENTAL COVERAGE TO TRADITIONAL MEDICARE**

#### **1. Increased Annual Medicare Spending**

Cost presents a substantial political barrier to expansion of Medicare benefits. The Urban Institute estimates that a dental benefit would increase annual Medicare spending by about \$60 billion.<sup>35</sup>

#### **2. Long-Term Savings**

Improved access to dental care may prevent severe dental conditions and other chronic diseases, leading to long-term savings for Medicare. Several studies have found associations between preventive dental care and lower annual medical expenditures among those with certain diseases.<sup>36,37</sup> Several studies have associated Medicaid dental benefits with reduced per-beneficiary spending on emergency dental care.<sup>38,39,40</sup> While literature specific to Medicare is sparse, preliminary analyses show potential for long-term cost-effectiveness.<sup>41,42</sup>

#### **3. Shift in Financing From Beneficiaries and Other Payers to Medicare**

The Urban Institute estimates that a dental benefit would reduce beneficiaries' annual out-of-pocket spending by \$35.6 billion, reduce annual Medicaid spending by \$100 million, and reduce annual spending by private insurers by \$4.9 billion.<sup>35</sup>

#### **4. Effect on Dental Care Utilization Unclear**

A 2025 study found no difference in utilization of dental care between traditional Medicare and Medicare Advantage beneficiaries, even though Medicare Advantage offers dental coverage to most enrollees and Medicare does not cover routine dental care.<sup>14</sup> The study suggests that this may be partly due to low awareness of benefits among Medicare Advantage beneficiaries. However, similar studies in Medicaid found that those reporting Medicaid dental coverage had greater utilization of both basic and major dental care compared to those without coverage.<sup>43</sup> Based on these conflicting findings, it is unclear to what extent a dental benefit in traditional Medicare would affect utilization of care, if at all.

## **Conclusion**

While the Medicare dental coverage gap has narrowed over time, a substantial share of seniors still do not have dental coverage. This gap contributes to limited access to dental care, which is



already a serious problem in Arkansas. Because the largest gap in Medicare dental coverage is found in traditional Medicare, there has been significant political pressure in recent years to add a dental benefit to Medicare Part B, or alternatively, to create a new Medicare part for dental coverage that operates under a similar model to Part D prescription drug plans. Concerns about cost and disagreement on the specifics of implementation have derailed previous attempts to implement additional dental benefits in Medicare. Even if an expansion of federal benefits is achieved, state policy promoting access to and uptake of dental care will be important to improve oral health outcomes among America's seniors.

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