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America's leading advocate for oral health

MINUTES OF THE SPECIAL MEETING OF THE COUNCIL ON DENTAL BENEFIT PROGRAMS
Via Zoom Teleconference
September 9, 2020

Call to Order: The special meeting of the Council on Dental Benefit Programs (CDBP) was called to order by Dr. Randall Markarian chair, on Wednesday, September 9, 2020 at 6:00 p.m. virtually, via Zoom teleconference.

Roll Call: Dr. Randall Markarian, Dr. Hope Watson, Dr. Thomas R. a'Becket, Dr. Roderick H. Adams (*not present)*, Dr. Paul Calitri, Dr. Kenneth Chung, Dr. Kevin W. Dens, Dr. William V. Dougherty, Dr. Rodney C. Hill, Dr. James W. Hollingsworth, Dr. Mark H. Johnston (*not present)*, Dr. Yvonne E. Maldonado, Dr. Cynthia H. Olenwine, Dr. Eugene G. Porcelli, Dr. L. King Scott, Dr. Jessica A. Stilley-Mallah, Dr. Walter G. Weber, Dr. Cesar Sabates, trustee liaison, Dr. Sara Stuefen, new dentist member, Mr. Jared Ricks (ASDA) *(not present)*

Practice Institute (PI) Staff in attendance (for all or part of the meeting): Dr. Krishna Aravamudhan, Mr. Frank Pokorny, Ms. Joan Feifar

Association Staff in attendance for all or part of the meeting: Mr. C. Michael Kendall

Noting that a quorum was present, Dr. Markarian called the meeting to order.

PRELIMINARY BUSINESS

Approval of Agenda: The Council adopted the agenda by general consent.

COUNCIL POSITION ON RESOLUTION 71

Dr. Markarian presented a draft policy proposal for discussion as a substitute for Resolution 71 submitted by the Eldercare Workgroup. He reminded the Council that the draft proposal had been developed as a starting point for discussion based on input received electronically prior to the meeting regarding Resolution 71. He noted that the Council had the option to either support Resolution 71 or present a substitute at the Reference Committee.

Members of the Council expressed interest in supporting a substitute but debated the issue of program eligibility in the draft proposal. The main consideration was balancing the need to provide seniors a meaningful benefit with the need to be cognizant of limitations to public program funding. The Council noted that around 9% of the senior population were under 100% FPL; 30% below 200% FPL and 60% below 400% FPL. Based on these data, the Council determined that the best approach would be to support a means-tested program that would cover all seniors under 400% FPL and provide a comprehensive benefit.

With agreement on wording for a substitute policy, the Council discussed the draft rationale statement that provides background information to support the policy proposal. Members of the Council supported adding information to explain "comprehensive services". On vote, the Council adopted the following resolution.

> **Resolved,** that the following substitute policy statement and accompanying rationale be approved as the Council's position when providing testimony for Resolution 71 at the 2020 House of Delegates, and be it further,
>
> **Resolved**, that this substitute policy and accompanying rationale be shared by all CDBP members with their districts as discussion on Resolution 71 begins.
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> [*Policy and Rational included as Appendix*]

1 Dr. Markarian thanked Council members for their work in efficiently determining the Council's position
2 on this complex policy issue. He encouraged Council members to continue to educate their districts.
3 The Council agreed that the most favorable approach to ensure transparency and allow adequate time
4 for districts to evaluate a substitute would be to transmit CDBP's proposed testimony to the districts
5 immediately. The Council also agreed to allow any district wishing to submit a district substitute prior to
6 the September 30th deadline to use the proposal developed by the Council.

7 **ADA REPRESENTATIVE TO THE JOINT COMMISSION**

8 Dr. Markarian provided the Council with an update on Dr. Gehani's decision regarding the appointment
9 of Dr. James Strohschein as ADA representative to The Joint Commission Board of Commissioners.

10 **Adjournment: 6:50 PM**

APPENDIX

POLICY PROPOSAL

1 **Resolved**, that the American Dental Association recognizes that oral health care for adults
2 age 65 and older depends on acceptable and sustainable financing of that care, and be it
3 further,

4 **Resolved**, that **IF** potential legislation is being developed to include dental benefits for adults
5 age 65 and over in public programs, then the ADA shall support a program administered either
6 at the state or federal level that:

7 - Covers individuals under 400% FPL
8 - Covers comprehensive services necessary to achieve and maintain oral health
9 - Is funded by the federal government and not dependent upon state budgets
10 - Is adequately funded to support a reimbursement rate such that at least 50% of
11 dentists within each geographic area receive their full fee to support access to care
12 - Includes minimal and reasonable administrative requirements
13 - Allows freedom of choice for patients to seek care from any dentist while continuing to
14 receive the full program benefit

RATIONALE STATEMENT

15 The Council on Dental Benefit Programs appreciates the work of the Eldercare Workgroup
16 supplementing the work submitted by the Council in 2018.

17 ***Eligibility based on means-testing***. The Council fully agrees with the Workgroup's intent to support a
18 means-tested program. Limited public funding should be used towards supporting our most vulnerable
19 seniors with high quality, affordable and sustainable care. At 400% FPL, around 60% of U.S. seniors
20 over age 65 will be eligible for a benefit (approximately 30 million seniors with incomes of $51,040 for
21 individuals or $68,960 for a 2-person household).[1]

22 ***Leveraging existing public programs***. CDBP believes that the four-program (Medicaid, CHIP,
23 Medicare Advantage and Private model) with four levels of benefits (Level I, II, III, IV) proposed in
24 Resolution 71 is a significantly complex policy proposal. Understanding and implementing such a
25 system of care will in itself be a barrier to implementation and is not a viable solution. A less complex
26 proposal that lays out clear principles that the ADA believes are essential for success is necessary.

27 With regards to Medicaid, the ADA has argued for years that the Medicaid program is underfunded
28 and must be fixed. Medicaid is often dependent on state budgets and has thus far not supported
29 meaningful coverage for low-income working-age adults. These considerations do not support placing
30 our most vulnerable seniors into the existing Medicaid system.

31 The Council supports the intent of the workgroup to consider a *single federal* CHIP-like[2] program as a
32 viable policy option as long as the fee schedules are sufficient to support access to care.

[1] How Many Seniors Live in Poverty? Kaiser Family Foundation Issue Brief. Juliette Cubanski, Wyatt Koma, Anthony Damico, and Tricia Neuman. Published: Nov 19, 2018. Accessed September 10, 2020.

[2] Child Health Insurance Program (CHIP) is a state-based program jointly funded by the state and federal government. Federal funding for CHIP, has pre-set limits (i.e., it is a capped program). Each state is given an allotment every year. Some states use the money to support combined Medicaid/CHIP programs. Others have separate CHIP programs. States with a separate CHIP program may either provide a Secretary-approved package of dental benefits that meets the CHIP dental requirements, or a benchmark dental benefit package. The benchmark dental package must be substantially equal to either (1) the most popular federal employee dental plan for dependents or (2) the most popular plan selected for dependents in the state's employee dental plan or (3) dental coverage offered through the most popular commercial insurer in the state. More at: https://www.medicaid.gov/chip/financing/index.html and https://www.medicaid.gov/chip/benefits/index.html

Medicare Advantage is a program structured to deliver Part A and Part B covered services through private insurers. It is unclear to us how additional benefits such as dental, not covered within one of these parts, can be offered as a standard benefit to all Medicare Advantage enrollees (1/3 of individuals over age 65) with no path to offer a similar benefit to those enrolled in Original Medicare (2/3 of individuals over age 65).

The Council takes this opportunity to reiterate that Medicaid, Medicare or any other public program is not the panacea. In fact, a program like Medicare has enormous market power and is known to influence and shape the rest of the private sector. However, the Council is cognizant of consumer advocacy groups and certain congressional legislators who may be fixated on Medicare as the program of choice under which a dental benefit should be pursued.

Given these considerations, a policy that is less specific but offers guidance on funding and structure may provide a stronger basis for advocacy efforts. Our goal is to achieve common ground in the form of a model that is both sustainable for practices and affordable for our seniors.

Program funding. We must acknowledge the perception that cost is a barrier to oral health care. We must also acknowledge that fair fee schedules that satisfactorily sustain a dental practice are necessary to support access to care. In balance, this Council believes that advocating for an adequately funded program that is not dependent on state budgets is essential to success.

"Levels of care". Dentistry is essential. Achieving and maintaining optimal oral health should be the goal and the patient's dental needs must dictate treatment plans. Therefore, the Council believes that an arbitrary categorization of service types (e.g., excluding surgical periodontal care as a basic covered service) into "levels of care" cannot be justified. Instead, the Council proposes "comprehensive" services to be covered for this population. The benchmark for such coverage may be services currently covered by commercial dental plans or a definition that applies to seniors similar to "EPSDT" for children in Medicaid.

Comprehensive services through an appropriately funded means-tested program is, to us, the best step forward if legislation is introduced to support a dental benefit for seniors.