

**UNOFFICIAL REPORT OF MAJOR ACTIONS
SPECIAL MEETING OF THE COUNCIL ON DENTAL BENEFIT PROGRAMS
September 9, 2020**

The Council on Dental Benefit Programs (CDBP) met on September 9, 2020, remotely via Zoom. The following is a summary of major actions taken by the Council.

The Council approved the following policy proposal and accompanying rationale as the Council's position when providing testimony for Resolution 71 at the 2020 House of Delegates. The Council also approved a resolution encouraging Council members to share this information with their districts as discussion on Resolution 71 begins.

POLICY PROPOSAL

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

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

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

RATIONALE STATEMENT

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

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

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

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.

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

The Council supports the intent of the workgroup to consider a *single federal* CHIP-like² program as a viable policy option as long as the fee schedules are sufficient to support access to care.

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.

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>

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