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The following information is a compilation of the published legislative issues and public policy positions of each of the major U.S. professional dental associations. This document should act as a quick reference guide for DTA members so they can identify where each professional associations stand on key political and public policy issues.

The information and advocacy positions included in the DTA GUIDE TO LEGISLATIVE ISSUES AND PUBLIC POLICY POSITIONS OF THE MAJOR U.S. PROFESSIONAL DENTAL ASSOCIATIONS were provided directly from the participating professional dental associations and are presented in this guide, as they were received. The opinions included in this guide are not necessarily those of the Dental Trade Alliance or its member organizations. As priorities and policies change, DTA will update this document to reflect the latest stated legislative and public policy positions of the professional dental associations that represent your clients.

The DTA wishes to thank the following professional dental associations and their government relations offices for their help in compiling this guide:

American Dental Association (ADA)
Academy of General Dentistry (AGD)
American Academy of Pediatric Dentistry (AAPD) American Dental Education Association (ADEA) American Association for Dental Research (AADR) National Dental Association (NDA) American Dental Hygienists’ Association (ADHA) American Association of Women Dentist (AAWD)
LEGISLATIVE INITIATIVES DETAILS

- **Protect Medical Innovation Act of 2015**
  
  **Federal - HR 160**
  
  Essentially, the medical device tax is a manufacturer’s excise tax, which would require dental equipment, materials, and supplies purchased by a dentist to be taxed. The dental industry estimates that the excise tax will increase the cost of dental care by $160 million annually.

- **Coordination of Pro Bono Medically Recommended Dental Care Act**
  
  **Federal - HR 963**
  
  This legislation would create a grant program that supports national dental programs that coordinate medically recommended dental care for low income individuals. The dental services will be provided by volunteer dentists at no cost to patients who have medical conditions, such as diabetes, cancer, autoimmune disease, kidney disease, or who need heart or joint replacements or transplants.

- **Dental Insurance Fairness Act of 2013**
  
  **Federal - HR 1798**
  
  Dental coverage helps 173 million Americans get care that is vital to ensuring good oral and overall health. Representative Paul Gosar (R-AZ) introduced the bi-partisan Dental Insurance Fairness Act of 2013, H.R. 1798 that will help consumers receive the full value of their dental coverage by amending the Employee Retirement Income Security Act (ERISA). Under H.R. 1798, all self-funded health plans that offer dental benefits will provide uniform coordination of benefits and will permit patients to assign the payment of benefits directly to their dentists.

- **Competitive Health Insurance Reform Act of 2015**
  
  **Federal - HR 494**
  
  Overturn McCarran-Ferguson law provisions. H.R. 494 is narrowly drawn to apply only to the business of health insurance, including dental insurance, and would not affect the business of life, property, or casualty insurance. The bill effectively authorizes the Federal Trade Commission and the Justice Department to enforce the federal antitrust laws against health insurance companies engaged in anti-competitive conduct.
• **Small Business Investment Act**

**Federal - HR 4019**
H.R. 4019 would restore the maximum accelerated depreciation deduction to $500,000 allowed per Sec. 179 of the Internal Revenue Code. Capital investment incentives such as these allow small businesses, like dental practices, to afford equipment upgrades and continue to expand.

• **Student Loan Interest Deduction Act of 2015**

**Federal - HR 509**
This bill will assist in easing the burden of student loan debt by significantly increasing the deduction allowed for student loan interest and making the deduction available to all regardless of income. H.R. 1527 increases the current $2,500 deduction ceiling to $5,000 for individuals and $10,000 in the case of a joint return.

• **Action for Dental Health Act 2015**

**Federal - HR 539**
This bill seeks to amend part B of title III of the Public Health Service Act to improve essential oral health care for lower income individuals by breaking down barriers to care. The Action for Dental Health Act will allow organizations to qualify for HHS oral health grants to support activities that improve oral health education and dental disease prevention, including developing and expanding outreach programs that will facilitate establishing dental homes for children and adults, including the elderly, blind and disabled.

• **Federal Student Loan Refinancing Act**

**Federal - S 1066**
S. 1066 will help ease the burden of dental student loan debt by enabling dental school graduates to consolidate or refinance their Direct Unsubsidized Stafford Loans (and/or Federal Direct Consolidation Loans) at a fixed rate of 4 percent. It would retroactively apply to all such loans taken out between July 1, 2006, and the date of the bill’s passage.

• **Dynamic Repayment Act**

**Federal - HR 2612**
Similar to the ExCEL Act, the Dynamic Repayment Act makes income-based repayment (IBR) the universal repayment method for federal student loans and streamlines the repayment process by allowing borrowers to repay through the employer-withholding system. This bill would also:

- Enroll all federal borrowers in an income based repayment program capped at 10 percent
- Collect payments directly from the borrowers’ paychecks
- Expect no repayment from those earning less than $10,000 per year
- Entirely forgive debt less than $57,500 after 20 years
- Forgive all debts over $57,500 after 30 years

• **Children’s Health Insurance Program (CHIP) Extension Act of 2015**

**Federal - HR 919**
CHIP Extension and Improvement Act of 2015 - Revises and extends through FY2019 at generally increased levels the program under title XXI (State Children's Health Insurance) (CHIP) of the Social Security Act (SSA), and adjusts CHIP allotment requirements accordingly, including the rebasing and growth factor update rules for computing state allotments. Makes appropriations for certain allotments. Directs the Secretary of Health and Human Services (HHS) to make payments to shortfall states from the Child Enrollment Contingency Fund in each of FY2016-FY2019.
# SUMMARY OF ADVOCACY POSITIONS OF THE MAJOR PROFESSIONAL DENTAL ASSOCIATIONS

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* Specific language regarding the positions on these initiatives may differ by association. For the exact positioning of each association refer to their sections below.
**Action for Dental Health**

The ADA launched Action for Dental Health: Dentists Making a difference, a nationwide, community-based movement aimed at ending the dental health crisis facing America today.

On January 27, 2015, Representative Robin Kelly introduced the Action for Dental Health Act of 2015 (H.R. 539)

**Affordable Care Act**

The ADA is working closely with lawmakers, regulators, and others to ensure the dental plans (and benefits) in the health insurance marketplace are robust, affordable, easy to use, and of the highest quality possible. This includes addressing regulatory proposals that would affect the way dental benefits are defined, offered, and administered under the Affordable Care Act (ACA).

The Association is calling on policy makers to:

- Maximize competition among plans by offering consumers plans with real value and providing consumers with an adequate network of providers.
- Ensure plan transparency so that consumers understand a plan’s benefit package, the list of participating providers, and the total out-of-pocket costs when purchasing dental coverage.
- Make the necessary changes so that stand-alone dental plans and medical plans with embedded dental benefits are able to compete on an equal footing inside and outside the marketplace.
- Properly implement the ACA, including a requirement that pediatric dental coverage be purchased as part of the essential benefit (EHB) package for families with children.
- Make dental benefits more affordable by allowing consumers to claim the health insurance premium tax credit for stand-alone dental plans.

**Children's Health Insurance Program (CHIP)**

The ADA is working closely with lawmakers, regulators, and others to help mend America's tattered dental safety net. This includes sustaining and improving dental benefits in the Children's Health Insurance Program (CHIP), which provides health coverage to nearly eight million children from low-income families. The Association is calling on policy makers to:

- Reauthorize the CHIP program to ensure children do not lose dental coverage.
- Maintain the federal requirement for states to cover dental services in their respective CHIP programs.

**Coverage & Benefits**

There is a direct correlation between dental benefit coverage and the likelihood that someone will seek and receive dental care. That is why the ADA is working with lawmakers, regulators, and others to improve the way dental care is financed and administered, both publicly and privately.
The ADA’s legislative and regulatory priorities for expanding dental benefit coverage (and making it
easier to use) include, among others:

- Maintaining the federal requirement for states to cover dental services for children
  enrolled in Medicaid, and requiring states to cover dental services for Medicaid-eligible
  adults.
- Maintaining the federal requirement for states to cover dental services in their
  respective Children’s Health Insurance programs (CHIP).
- Requiring that dental benefits in the health insurance marketplace be properly defined,
  offered, and administered under the Affordable Care Act (ACA).
- Requiring self-insured, employer-sponsored dental benefit plans to permit assignment of
  benefits, and to coordinate benefits when acting as secondary payers.

**Dental Amalgam**

The ADA works with lawmakers, regulators, public health officials, and others to safeguard patient
access to the safest and most affordable and durable dental materials for their specific treatment
needs. This includes the option to use dental amalgam, which the scientific community has
extensively reviewed and affirmed to be a safe and effective restorative material.

Moreover, the ADA encourages dental offices to follow its Best Management Practices for Amalgam
Waste, which will help reduce discharges of used amalgam into dental office wastewater.

The Environmental Protection Agency (EPA) announced proposed amalgam separator standards for
dental offices and said it expects to finalize a rule in September 2015. Consistent with ADA policy, the
Association has consulted with the EPA as it developed the rule and supports a reasonable national
pretreatment standard for amalgam waste so long as it is not unduly burdensome on dental
professionals. The EPA’s proposed rule is consistent with many, but not all, aspects the ADA’s best
management practices. The ADA is continuing to work with the agency seeking additional changes
before the standards are finalized.

**Employee Retirement Income Security Act (ERISA)**

The ADA works closely with lawmakers to ensure patients receive the full value of their dental
benefits. Unfortunately, several provisions of the Employee Retirement Income Security Act (ERISA)
limit and/or deter patients from taking full advantage of their self-insured, employer-sponsored dental
benefit plan(s). The ADA is seeking to reform ERISA by:

- Requiring self-insured, employer-sponsored dental benefit plans—acting as secondary
  payers—to honor the plan benefit for the unpaid balance of a dental claim (i.e.,
  coordination of benefits);
- Requiring self-insured, employer-sponsored dental benefit plans to pay the treating
  dentist directly whenever a patient requests it, even when the treating dentist does not
  participate in the patient’s dental payment plan (i.e., assignment of benefits).

Reforming ERISA will encourage patients to get care that is vital to their oral health and overall well-
being.

**Federal Dentist Services**

The ADA continues to press for funding for Military Dental Research for FY15.

The ADA will also continue to fight to protect the Two-Star Ranking for the Army and Air Force Dental
Chiefs and will continue to watch for Two-Star reduction language in the 2016 National Defense
Authorization Act (NDAA).
• **ADA Advocacy for Fluoride and Fluoridation**

The ADA works closely with state and local dental societies to promote the fluoridation of municipal water supplies at recommended levels. The ADA also supports capacity-building grants to help communities establish, upgrade, and maintain an effective public water fluoridation infrastructure.

• **McCarran-Ferguson**

The ADA works closely with lawmakers, regulators, and others to protect consumers from anticompetitive market practices that can make health insurance less affordable, such as cooperative ratemaking and joint underwriting. This includes repealing parts of the McCarran-Ferguson Act of 1945, which permits state-regulated health insurers to ignore some of the competitive rules (i.e., federal antitrust laws) that apply to every other business in the United States.


• **Medicaid**

The ADA is working closely with lawmakers, regulators, and others to help mend the tattered dental safety net. This includes reforming parts of the Medicaid program, which is the largest source of funding for medical and other health-related services for people with low income in the United States. The Association is calling on policy makers to:

  • Maintain the federal requirement for states to cover dental services under the Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.
  • Require states to cover dental services for Medicaid-eligible adults, and exempt all preventive dental services from cost-sharing requirements.
  • Preserve the federal financing role in the Medicaid program and update the federal matching formula to address economic changes.
  • Enhance the federal Medicaid matching rate to 90/10 for dental care.

• **Medicaid Recovery Audit Contractor Program (RAC Audits)**

The ADA works closely with lawmakers, regulators, and others to help ensure the integrity of public health care programs. This includes working with state Medicaid Recovery Audit Contractor (RAC) auditors, who are contracted to identify overpayments and underpayments to health care providers who treat Medicaid patients. Unfortunately, many well-meaning dentists are receiving significant and sometimes arbitrary fines for unintentional, often minor infractions when there was never any intent to defraud the government.

In an effort to enhance program integrity and help grow provider participation, the ADA is calling on the Centers for Medicare and Medicaid Services (CMS) to improve the Medicaid RAC audit program by:

  • Issuing fair, transparent guidelines to protect dentists from being fined for minor, unintentional infractions, such as those resulting from clerical errors, computer glitches, etc.
  • Examining the impact state Medicaid RAC audits have had on dentists who treat Medicaid patients and patient access to dental care.
  • Compiling a list of state education and outreach efforts to ensure dentists can function well within the Medicaid program, as required by law.
  • Requiring Medicaid RAC auditors to use an in-state dentist to review clinical records, as appropriate.
  • Revisiting the method for determining fines to ensure the process is fair and transparent (i.e., the extrapolation method).
Establishing a fair and transparent process to address Medicaid overpayments and underpayments will encourage dentists to continue treating Medicaid patients.

- **Medicare Part D**
  ADA is continuing to fight implementation of the requirement that providers who write prescriptions covered under Medicare Part D for Medicare eligible patients be enrolled in Medicare or have completed the opt-out process. The section of the regulation requiring providers to enroll or register with Medicare or opt-out does not take effect until June 1, 2015. ADA staff has had a continuing dialogue with CMS to clarify problems that members have experienced with the Medicare Contractors regarding enrollment or opting-out. At the same time, the ADA met with the Office of Advocacy and the Ombudsman for the Small Business Administration who has agreed to advocate on the ADA’s behalf for relief from this requirement with CMS.

- **Prevention & Education**
  The most effective way to ensure optimal oral health is to prevent oral disease before it starts. That is why the ADA is working with lawmakers, public health leaders, and others to strengthen the nation’s dental public health infrastructure.

  The ADA’s legislative and regulatory priorities for promoting oral health and preventing oral disease include, among others:
  - Educating the public about how most oral diseases can be prevented with simple interventions (e.g., brushing and flossing, regular dental visits, healthy diets, not using tobacco, etc.).
  - Investing in community-based prevention programs (e.g., community water fluoridation, school-based sealant programs, etc.).
  - Fostering interprofessional collaborations to promote optimal oral health and integrated care within the larger healthcare system.
  - Placing Community Dental Health Coordinators (CDHCs) in underserved communities—to improve oral health literacy and access to preventive dental care.

  Additionally, the ADA is calling on Congress and the Administration to adequately fund (and maintain the division-level status of) the Centers for Disease Control and Prevention’s (CDC) Division of Oral Health (DOH). The DOH provides knowledge, tools, and networks to help state health departments develop and maintain effective dental public health programs. It is a critical part of the nation’s oral health care system.

- **Student Debt**
  The ADA works closely with lawmakers, regulators, dental schools, and others to ensure the cost of dental education is not a prohibitive factor for those wanting to practice in underserved areas or pursue careers in teaching, research and public health. These efforts include, among others:
  - Minimizing the interest rate(s) and the total amount of interest that can accrue on federal graduate student loans;
  - Enabling federal graduate student loans to be refinanced more than once to take advantage of the current interest rate and economy;
  - Extending the period of deferment for repaying federal graduate student loans to the maximum extent practicable; and
  - Expanding and enhancing the federal income tax deduction for student loan interest.

  Equally important is the need to ensure our dental schools:
• Have an adequate supply of well-trained faculty;
• Can offer most modern teaching facilities and equipment;
• Are plentiful enough to generate a sufficient number of well-trained clinicians, researchers, faculty and public health professionals; and
• Can support an adequate number of postgraduate dental residencies to care for our most vulnerable citizens.
• Ensuring state tobacco settlement funds are used to reduce the morbidity and mortality of tobacco-related diseases, especially oral diseases.
• Reducing exposure to second-hand smoke.
• Enforcing age restrictions for purchasers of tobacco products.
• Imposing strict licensure requirements for tobacco product retailers.
• Requiring insurance coverage for evidence-based cessation counseling (and medications).
• Educating clinicians about evidence-based interventions to help curb tobacco use.
• Continuing research into the oral health effects of tobacco use.

The Association is especially concerned about the scarcity of published research on the oral health effects of the latest generation of smokeless tobacco products. The ADA strongly supports further study about the immediate and long-term effects of these products on oral health.

• Taxation & Small Business

The ADA works closely with lawmakers, regulators, business leaders, and others to promote tax policies that are favorable to dental practices, most of which are small businesses. These efforts include, among others:

• Maintaining the tax deduction for investments in new dental equipment and property (i.e., section 179 deduction);
• Ensuring small dental practices can leverage the tax benefits associated with the cash method of accounting;
• Eliminating the estate tax, which significantly impacts family owned dental practices; and
• Preventing the double taxation of dentists as both individuals and small business owners (i.e., pass-through status).
• The ADA is working with an extensive coalition of affected organizations in supporting a change to tax law that would allow small service businesses to continue using the cash method of accounting (as opposed to the accrual method). Cash accounting is much simpler for small businesses. While a change to the statute is not likely to occur soon, it is important for the ADA to be in the fight.
• The ADA continues to work with a coalition of manufacturers and other provider organizations to repeal the Medical Device Excise Tax. While repeal has had widespread bipartisan support in both the House and Senate, repeal legislation has not advanced in either body. However, the coalition has high hopes for the coming Congress.

Keeping overhead costs low will help small dental practices succeed and encourage others to enter the profession.

• Tobacco Use

The ADA works closely with lawmakers, regulators, public health leaders, and others to help prevent oral (mouth) and pharyngeal (throat) cancers and other oral diseases associated with tobacco use. These efforts include, among others:

• Educating the public about the dangers associated with tobacco use.
• Classifying nicotine as an addictive substance.
• Levying significant taxes on tobacco products.
• Mandating graphic warning labels on tobacco products.
• Restricting the advertising and promotion of cigarettes, pipes, cigars and smokeless tobacco products (including bans on free sampling).

**Workforce**

Mending America’s tattered dental safety net requires having an adequate (and sufficiently funded) dental workforce—located where it is needed and with the necessary facilities and equipment to carry out its mission. That is why the ADA is working with lawmakers, public health leaders, and others to protect a number of longstanding programs that provide essential dental care and dental-related services to our most vulnerable citizens.

The high-priority programs the ADA is seeking to protect, improve, and (in some cases) expand include, among others:

• Health Centers
• Public Health Service Dental Corps (incl. the Indian Health Service)
• National Health Service Corps dental programs
• Title VII General, Pediatric, and Public Health Dental Residency Programs
• Graduate Medical Education programs
• Ryan White HIV/AIDS Dental Programs
• Dental student loan forgiveness and service payback programs

The ADA is also working with state dental societies, state governments, higher education leaders, charitable organizations, and the private sector to bring Community Dental Health Coordinators (CDHCs) to dentally underserved communities throughout the country.

**Workplace Health & Safety**

Dentists have a vested interest in maintaining safe and healthful office environment for themselves, their employees, and their patients. This includes preventing exposure to infectious agents, waste anesthetic gas, allergens, damaging noise, and x-ray hazards, among others.

The ADA has long advocated for the use of modern applications to prevent workplace injuries and illnesses. The ADA provides scientific evidence, information, and commentary to ensure workplace health and safety regulations are rooted in sound science and practical for small dental practices to administer. The Association also provides resources to help dentists identify workplace hazards and understand how to prevent them.

The Academy of General Dentistry (AGD) has long been a proponent of removing the barriers that limit the underserved from seeking and receiving quality oral health care. In 2013, the AGD’s language on improving oral health literacy was adopted as a model resolution by the American Legislative Exchange Council (ALEC). This year, the AGD is proposing model language to provide scholarships for dental students that commit to practice in underserved areas.

In 2008, the AGD created its first white paper on oral health care issues, “White Paper on Increasing Access to and Utilization of Oral Health Care Services.” This was followed in 2012 by “Barriers and Solutions to Accessing Care.” These two documents outline the challenges to bettering the state of oral health, and provide over 30 proven solutions to increasing care.

The public remains largely unaware of the connection between oral health and overall well-being. Oral disease left untreated can result in pain, disfigurement, loss of school and work days, nutrition problems, expensive emergency department use for preventable dental conditions, and even death. Reducing the incidence of dental disease among America’s children through oral health literacy needs to be embraced, since it will boost students’ academic performance, improve their overall health, and lessen the burden of parents, caregivers, and the dental Medicaid system.

The AGD calls for collaboration from all oral health stakeholders to:

• Develop a comprehensive oral health education component for public schools' health curriculums;
• Provide oral health exams for one-year-olds to help facilitate early screenings; and
• Equip teachers and day care providers with creative educational tools on the importance of oral health.

To this end, the AGD joined Partnership for Healthy Mouths Healthy Lives and the Ad Council to create an ad campaign on teaching children to brush at least two times a day for two minutes each time.

However, a patient’s awareness of the importance of his or her oral health is not the same as actually seeking or receiving care. The AGD understands that we need to turn oral health literacy into healthy behaviors and patient action. Education must be coupled with dealing with the psychological factors that may inhibit some from seeking oral health care. This includes:

• Helping the public understand that, unlike many medical ailments, the most prevalent dental diseases are entirely preventable, and prevention is cheap. This can be described as the difference between a prevention model in oral health care, versus a treatment mentality in traditional medical health care. A prevention model encourages regular check-ups to detect problems before they become bigger, more costly difficulties.
• Ensuring that healthcare delivery considers cultural diversities that might affect patient perceptions.
• Establishing patient navigators within communities to provide hands-on education about oral health and provide social services, including transportation, to convert health literacy into action. However, using navigators to provide clinical services must be prohibited because it is unnecessary, it creates a needless risk to the patient, and it adds to the cost of training the navigator.
What is important to understand is that there is no shortage of dentists. However, uneven geographical distributions of dental practices may give the incorrect impression of a shortage. The fact is, with the influx of new dental schools, new dentists are seeking employment and established dentists are seeking patients. Where a true environmental scan reveals a chasm between the geography of supply and the geography of demand, our calling must be to bridge that gap.

There are a variety of programs to bring dentists to areas that do not have practicing full-time dentists. Dental Loan Repayment Programs for dental students to practice in areas where there is no dentist upon graduation is one such example.

However, the AGD also understands that other factors must be considered when talking about underserved areas of the state. The issue is not just about a lack of dentists in a particular county, but also about practice capacity. Sparsely-populated counties, such as those with fewer than 1,000 residents, would be better-served by mobile dental units, provision of transportation services, community health clinics and use of patient navigators.

Some have argued that the solution to bridging the divide is to have non-dentists provide dental care for the poor. Setting aside for a moment the moral indignation in creating two tiers of care with non-dentists for the poor and dentists for everyone else, relegating these alternative providers to underserved areas is also financially unsustainable. In a December, 2013 webinar by the National Conference of State Legislatures and Pew, Minnesota state representative Kim Norton commented that the new dental therapists are not moving to the rural areas of the state, as had been predicted when the legislation was enacted in 2009. Additionally, a 2005 ADA study[^1] revealed that, when provided the opportunity to practice in underserved areas without the physical presence of dentists, alternative non-dentist providers nonetheless flee to wealthier neighborhoods, driven by the inability to cover overhead costs.

On the other hand, the AGD supports proven solutions of establishing oral health care delivery service programs, including arranging for transportation to and from care centers, mobile dentistry units and soliciting volunteer participation from the private sector, through programs such as Missions of Mercy (MoM).

As state legislatures seek out solutions to the issue of improving oral health care, the AGD stands ready to work with them. The matter is complex, but there are a variety of ways to combat the current barriers to better oral health care, including oral health literacy, dental loan repayment options, and breaking down the psychological factors that keep people from seeing a dentist.

The AGD is working to bring some of those options to the states, and nationally, through our White Papers, model legislation and Ad Council participation.

The bottom line is that we must remain focused on the best interest of the patients. Dentistry works best as a prevention system, with a dental team providing care from start to finish.

- **Midlevel Providers**

AGD members need to communicate with their state legislators about the proven solutions presented in the AGD’s White Paper, and the wisdom in funding solutions that work rather than experiments that do not.

Independent midlevel providers are dental auxiliaries who work outside the dental team and without dentist supervision, accepting responsibility for patient diagnosis, treatment, and coordination of

dental services. Midlevel providers are not required to reach the same level of education as a practicing dentist, so the care they provide may fall short of standards for quality and safety. Utilizing such providers for the care of underserved patients is not economically feasible or in line with the prevention model.

Independent midlevel providers would not be immune to economic forces, so they likely would find it difficult to maintain an independent practice in underserved areas. The absence of full-service, dentist-led practices in these areas would compound midlevel providers’ economic problems, leaving them to bear the financial burden of maintaining fully equipped, modern dental facilities.

According to a 2005 American Dental Association (ADA) study, “The Economic Aspects of Private Unsupervised Hygiene Practice and Its Impact on Access to Care,” the overhead of maintaining a practice drives independent midlevel providers away from underserved areas. This indicates that these providers would not help to care for the needy.

Additionally, data has not demonstrated that midlevel providers help reduce untreated dental decay. A March 2013 report from the Pew Children’s Dental Campaign, “Dental Therapists in New Zealand: What the Evidence Shows,” made a faulty comparison between New Zealand and the United States, so the AGD cautions against taking this report as evidence of the midlevel provider model’s success. New Zealand has had a dental therapist program since the 1920s, but its percentage of children suffering from untreated dental decay is almost identical to that of the U.S., which indicates that a dental therapist model would not help to decrease untreated dental decay in children. Authors of the report write that only 3 percent of children ages 5 to 11 in New Zealand have untreated dental decay in their permanent teeth, as compared to 20 percent of the same age group of children in the U.S. However, the 20 percent refers to decay in primary and permanent teeth in U.S. children. In reality, while 2.7 percent of children in the age group in New Zealand suffer from untreated dental decay in their permanent teeth, another 17.3 percent of these children suffer from untreated dental decay in their primary teeth. The amount of decay is almost the same in both nations, thereby invalidating the argument that a dental therapist model may reduce the prevalence of children’s dental decay.

The authors of the Pew report also claim that more than 1,000 studies exist to show that dental therapists offer quality care across the globe. The ADA refuted that claim, explaining that those studies failed to demonstrate that dental therapists have a positive impact on a population’s overall health status.2

In July 2008, the AGD published its “White Paper on Increasing Access To And Utilization of Oral Health Care Services,” and in 2012 published “Barriers and Solutions to Accessing Care” which both question the need for independent midlevel providers and suggest that funding and effort be directed toward other solutions to the access to care problem.

The AGD wants all patients to receive the best possible oral health care. Some state Legislatures may see midlevel providers as a “quick fix” to access to care problems, but the AGD maintains that direct supervision by a licensed dentist is necessary to ensure patient safety. Although the access to care issue is complex, the AGD has focused on oral health literacy and fluoridation as two viable strategies for eliminating oral health disparities. AGD members are encouraged communicate with their state legislators and encourage them to support the solutions presented in the AGD’s white papers (below), rather than midlevel provider models:

• Barriers and Solutions to Accessing Care
• White Paper on Increasing Access To and Utilization of Oral Health Care Services

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• Oral Health Literacy

The public remains largely unaware of the connection between oral health and overall health and well-being. Oral disease left untreated can result in pain, disfigurement, loss of school and work days, nutrition problems, expensive emergency department use for preventable dental conditions, and even death. Reducing the incidence of dental disease among America’s children through oral health literacy needs to be embraced, since it will boost students’ academic performance, improve their overall health, and lessen the burden of parents, caregivers, and the dental Medicaid system. In 2013, the AGD’s language on improving oral health literacy was adopted as a model resolution by the American Legislative Exchange Council (ALEC).

The AGD offers the following model for implementing an oral health literacy program in schools:

• The purpose is to adopt and implement into the mandatory curricula of public schools a grade-specific educational program that informs, trains, and educates students about the importance of achieving and maintaining good oral health. The overall goal of the program is to reduce the burden of dental disease. It is intended to not only teach students about oral health, but also empower them to implement the information they have learned, producing measurable behavioral changes.
• The program curricula will be:
  ▪ Based on state department education standards.
  ▪ Incorporated into existing health and science curricula when possible.
  ▪ Implemented in a graduated manner, beginning with early elementary curricula and reaching full implementation with high school curricula within a six-year period.
• The state department of education department will have one year to develop appropriate curricula and/or select curricula from existing sources.
• Initial integration into early elementary curricula shall begin no later than the fall 20XX semester, and integration into high school curricula shall begin no later than the fall 20XX+6 semester.
• Those involved in making educational, curriculum or healthcare changes as well as appropriate dental experts and organizations may be invited to assist in the process.

The AGD urges Congress to make oral health literacy a priority public health concern, leading to increased funding and other practical support for oral health literacy related education, research and interventions. In addition, the AGD joined Partnership for Healthy Mouths Healthy Lives and the Ad Council to create an ad campaign on teaching children to brush at least two times a day for two minutes each time.

• Student Debt

The level of a health professional’s student loan debt affects his or her future practice options, and the growing amount of debt in dentistry affects access to oral health care in underserved areas.

According to the Council of Graduate Schools, the student debt issue has become more challenging over the past decade, with tuitions increasing at an alarming rate. In February 2012, the Federal Reserve Bank of New York released data indicating that student loan debt reached $867 billion in the fourth quarter of 2011, exceeding the $704 billion Americans owed in credit card debt”.

The majority of the student loans taken out by graduate and professional students in 2010–11 ($34 billion) came from the federal government, most commonly in the form of unsubsidized and subsidized Stafford loans, according to a 2011 statement by the College Board.

The AGD advocates Congress to:

• Ensure reauthorization of the Higher Education Act addresses the cost of both graduate and undergraduate education.
• Increase funding for the National Health Service Corps to allow more dental graduates to participate and take advantage of loan forgiveness opportunities in exchange for service and allow dentists practicing in medically underserved areas or populations as designated by HRSA to participate in the Public Service Loan Forgiveness (PSLF) program.
• Reinstate subsidized Stafford loans for graduate students to prevent interest on qualifying loans from accruing while student is still in school.

• Statistics:

  • New graduates: According to a 2011 American Dental Education Association (ADEA), U.S. dental schools produced 4,796 graduates in 2010. This number has fluctuated over the years, from approximately 3,000 graduates per year in the early 1960s, to more than 5,000 in the late 1970s and early 1980s, and back down to 3,000 in the 1990s. Over the last decade, the number has gradually ascended into the mid-4,000 range. Expectedly, the volume of dental school enrollment has mirrored these trends.

  • Average debt: The 2011 ADEA survey also indicated that the average dental school graduate in 1998 had incurred a dental school debt of nearly $100,000, or $125,000 for those graduating from private dental schools. Just 10 years later, the average dental school graduate’s debt had increased to more than $175,000 for those attending public schools (a 75 percent increase), with private school students’ debt approaching $225,000 (an 80 percent increase).

  • Career choices: According to a 2012 American Dental Association survey, 69 percent of new dentists who entered private practice indicated that their debt was “very much” a factor in their employment decision. These are both factors to consider when considering strategies to get more dentists to practice in underserved areas. Debt also acts as an obstacle to new dentists’ ability to accept Medicaid patients, as the program has low fees and high rates of no-shows.

• Insurance

About 173 million Americans utilize dental insurance to get the oral health care they need. Unfortunately, unfair practices have crept into the administration of dental benefit plans. The AGD is working with legislators to eliminate insurance issues such as fee capping, unfair pricing, and regulations that limit consumers’ ability to utilize their benefits:

  • Fee Capping: Several major dental benefits carriers set fees for dental services that are not covered under their plans. However, some states have introduced legislation to prohibit this practice, also known as fee capping.

Carriers maintain that holding dentists to a maximum charge for non-covered services allows patients to receive procedures that they otherwise might not seek. However, fee capping disrupts long-standing patient-dentist relationships and forces private-pay patients to absorb the additional costs incurred by the dentist. This practice also relieves carriers’ obligation to provide coverage for a wider range of services, which ultimately would improve access to care.

Dentists and patients should be allowed to agree on payment terms that fit the patient’s needs while allowing the dentist to operate a successful practice and provide the best possible care. The AGD has been collaborating with the American Dental Association and other organizations to support legislation preventing fee capping. While these efforts have proven successful in some states, these states do not have jurisdiction over all
dental benefits carriers, so organized dentistry must pursue solutions at the national level, as well.

- **Dental Insurance Fairness Act**: Some dental insurance guidelines prohibit secondary plans from covering the cost of care. As a result, families with two dental insurance plans end up paying for coverage they can’t use when they need it.

- **H.R. 1798, the Dental Insurance Fairness Act of 2013**, aims to ensure that patients receive the full value of their dental benefits. Introduced by U.S. Rep. Paul Gosar (R-Ariz.) on April 26, 2013, the legislation would amend the Employee Retirement Income Security Act of 1974; ensuring patients may use both primary and secondary policies to cover dental care costs. The bill, which is currently with the House Education and the Workforce Committee, also would allow consumers to avoid long reimbursement periods by assigning dental plan payments to out-of-network providers. After the 2014 Hill Day, at least one new legislator has signed on to be a co-sponsor to H.R. 1798.

- **Repeal McCarran-Ferguson Act**: Gosar also sponsored House Bill 911, the Competitive Health Insurance Reform Act of 2013. This legislation, introduced on Feb. 28, 2013, would repeal the portions of the McCarran-Ferguson Act that exempt health and dental insurance plans from federal antitrust laws. This would allow federal agencies to investigate and challenge collective action by insurance companies, and enable those impacted by illegal practices to take corrective action. By curtailing anti-competitive practices in the health insurance industry, H.R. 911 would promote a greater range of options for patients and more appropriate reimbursement rates for health care providers.

In the absence of federal oversight, regulation of the insurance industry will remain the states, which often lack the time and resources to effectively investigate antitrust claims, leaving anti-competitive activities largely unchecked. This must change, because competition is necessary for innovation and fosters variety in the marketplace.

The AGD urges lawmakers to support efforts to repeal the McCarran-Ferguson Act. This is an important step toward bringing competition to the health insurance market, where there is no place for anti-competitive abuses.

*Learn more about the specific AGD public policy/advocacy positions at: http://cqrcengage.com/agd/issues*
• **Federal Appropriations for FY 2016**

**Workforce Goal:**

1. Seek appropriations for sec. 748 Title VII dental primary care cluster of $33.928 million, with directed funding of not less than $10 million going to pediatric dentistry in recognition of the demand for training grants and the increased need for pediatric dentists to treat newly insured children under the ACA.

2. Support efforts of Children’s Hospital Association to obtain full funding of $300 million for Children’s Hospitals GME, and oppose any HRSA efforts to restructure the program and eliminate dental positions from residency count in funding formula.

3. Seek HRSA support to implement AAPD proposal for restructured MCHB program for Leadership in Pediatric Dentistry Education.

• **Federal Health Care Reform**

**Access to Care Goal:**

1. **Support corrections to Affordable Care Act (ACA) to:**
   
   a) Make pediatric oral health coverage mandatory.
   
   b) Include dental premium cost under calculation of tax subsidy for low income families.
   
   c) Exempt preventive dental services from deductibles in embedded plans and SADPs.
   
   d) Extend CHIP funding for at least two years.

**Access to Care and Medicaid Dental Reform Goal:**

2. Explore possibility of targeted pediatric oral health bill to address Medicaid dental reform by increasing Medicaid matching payments for states that pursue specific Medicaid dental reforms including reimbursement at competitive market-based rates (per previous proposals such as S. 1522/H.R. 3120). Protect Medicaid EPSDT guarantee in Medicaid block grant and other cost-savings proposals.

**Access to Care Goal:**

3. Assist ADA in promotion of ERISA reform bill from Congressman Gosar (H.R. 1798 in previous Congress), that would require all health plans offering dental benefits to provide uniform coordination of benefits and permit consumers to designate payment of dental benefits to providers who do not participate in the network.

4. Work with ADA and other dental and medical organizations to support a simplified process across appropriate governmental agencies to designate individuals with intellectual disabilities as a medically underserved population.

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3 Congressional appropriators have included the Feingold-Collins State Oral Health grants under this total amount. The AAPD, ADA, and ADEA supported $10 million each for pediatric dentistry and general dentistry in FY 2015, and obtained $10 million for pediatric dentistry and $9 million for general dentistry, and $33.928 million overall.

4 If Congress considers tax reform legislation explore possible inclusion of tax exemption of faculty loan repayment amount, or via Title VII reauthorization explore authority for school or residency program to provide additional amounts to cover tax liability as done in NIH loan repayment programs.
- **Federal Regulations**

  Access to Care Goal:

  1. As the Affordable Care Act (ACA) provision defines **pediatric oral health as an essential health benefit (EHB)**, ensure that implementing regulations require robust coverage consistent with the AAPD Policy on a Model Dental Benefits for Infants, Children, Adolescents, and Individuals with Special Health Care Needs. Coordinate joint response/comments on proposed regulations with ADA and keep key members of Congress informed.

     Support mandatory purchase (vs. offer) of an appropriately structured embedded or stand-alone dental plan for children inside exchanges, and encourage states to adopt such a requirement as several have already done (Kentucky, Nevada, Washington state).

     Sustain regulatory inclusion of general anesthesia coverage state mandates as EHB beyond 2014 and 2015. Monitor types of pediatric oral health insurance offered in state health insurance exchanges as compared with AAPD model benefits.

     Evaluate and respond to key ACA insurance plan issues such as network adequacy, provider fees, family out-of-pocket costs, and the impact of pediatric dental coverage embedded in medical plans. Communicate recommendations to Center for Consumer Information and Insurance Oversight.

  2. Work closely with ADA, state dental associations, and state pediatric dentistry chapters to ensure that **state health insurance exchanges** appropriately adhere to federal guidelines and regulations concerning insurance plans offering pediatric oral health coverage. Fully engage state Public Policy Advocates in this effort.

Medicaid Dental Reform Goal:

  3. Ensure that **Medicaid EPSDT regulations** continue to promote the dental home and a required examination by a dentist.

Medicaid Dental Reform and Access to Care Goal:

  4. Ensure that **Head Start program regulations** implementing the 2007 reauthorization reflect appropriate oral health care requirements, including the dental home/age one visit. Also monitor Head Start’s adherence to these requirements.

Access to Care Goal:

  5. Secure HRSA review and **update of dental health professions shortage area (HPSA) criteria**, building from unimplemented 2005 UNC/Sheps Center report along with other recommendations. An improved dental HPSA will provide a more accurate federal assessment of oral health workforce needs.

Medicaid Dental Reform Goal:

  6. Encourage CMS to include **pediatric oral health quality measures developed by the Dental Quality Alliance** as part of the Medicaid dental program.
• State Legislation and Regulations

Workforce and Access to Care Goal:

1. Promote states’ adoption of expanded duties for dental assistants as recommended in the AAPD’s Policy on Workforce Issues and Delivery of Oral Health Care Services in a Dental Home, and assist state chapters dealing with dental therapist and other mid-level proposals.

Medicaid Dental Reform Goal:

2. Provide continued technical assistance to state pediatric dentistry chapters for Medicaid dental reform for their efforts with both state legislatures and state dental associations.

Continue to promote states’ adoption of appropriate dental periodicity schedules consistent with AAPD guidelines, and update research and policy center dental periodicity schedule adoption map on website as appropriate.

Promote state Medicaid programs’ adoption of pediatric oral health quality measures developed by the Dental Quality Alliance (DQA). Continue to inform and educate key constituencies about reforms that work, including MSDA (Medicaid/CHIP State Dental Association), NCSL, NGA etc.

Work with research and policy center and CDBP to respond to Medicaid medical movement to managed care by:

   a) promoting dental managed care hybrid payment models that leave the risk with the plan contractor (or at least share it between the plan and the provider); and
   b) maintaining accountable dental fee-for-service plans.

3. Ensure that state Medicaid programs conducting provider audits do so in an appropriate and fair manner, adhering to AAPD clinical guidelines and utilizing peer review by pediatric dentists. Secure appropriate guidance to states from CMS Center for Medicaid and State Operations.

Access to Care Goal:

4. Continue to provide technical assistance to states for General Anesthesia legislation, highlighting ongoing cost analysis and using TRICARE coverage and recent success in Arizona, Vermont, Pennsylvania, and West Virginia to spur momentum. Evaluate likelihood of states considering future insurance mandates in light of ACA EHB provision.

Utilizing research and policy center technical brief and working closely with CDBP, educate insurers and insurance regulators on necessity of this benefit and role of pediatric dentists in treating high risk children.

5. Provide technical assistance to states seeking legislation for mandatory oral health examinations prior to school matriculation. Seek support of state dental associations and other interested organizations via efforts of state Public Policy Advocates.

6. Work with ADA, state dental associations, and state pediatric dental units to promote community water fluoridation, and prevent efforts to remove fluoride from currently fluoridated communities.

Learn more about the specific AAPD public policy/advocacy positions at:
http://www.aapd.org/advocacy/
### Federal Appropriations

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<th>Description</th>
<th>Lead</th>
<th>Monitor</th>
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<tr>
<td>National Institutes of Health (with key focus on NIDCR)</td>
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<tr>
<td>General funding for NIH</td>
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<tr>
<td>Dental Health Improvement Act</td>
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<tr>
<td>Title VII (focus on dental, advanced dental education and allied dental</td>
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<td>HIV/AIDS Ryan White Program Dental Reimbursement programs</td>
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<td>Agency for Health Research and Quality (dental/oral health research)</td>
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<td>Centers for Disease Control and Prevention (oral health research, state</td>
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<tr>
<td>oral health infrastructure, fluoridation, sealants, etc.)</td>
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<td>Military/Veteran’s Administration (dental/oral health research)</td>
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<td>Federally Qualified Health Centers</td>
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### Federal Reauthorizations

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<td>High Education Act</td>
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<td>National Institutes of Health (with focus on NIDCR)</td>
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### Federal Regulatory & Policy Implementation

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<td>Implementation of the ACA (with focus on dental education, oral health</td>
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<td>provisions, Essential Health Benefits, IPE)</td>
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<td>Food and Drug Administration (Dental Products Panel, amalgam, medical devices)</td>
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<td>People Oral Health goals, Oral Health division, prescription drugs)</td>
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<td>Higher Education Act regulations (including Gainful Employment)</td>
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<td>Medicaid (FMAP, state waivers, etc.)</td>
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<td>Children’s Health Insurance Program (SCHIP)</td>
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<td>Financial Aid and Loan Repayment (students, faculty, URM, interest rates,</td>
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<td>income-based repayment)</td>
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### Training and Research

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<td>• NIH Roadmap Programs, including Clinical and Translational Science, (primary focus program development, review, etc.)</td>
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<td>• Federally Qualified Health Centers (dental school capacity, service learning, access, enhanced reimbursement rate)</td>
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<td>• NIH pipeline of researchers and practice-based research networks</td>
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### Access, Infrastructure and Workforce

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### State Issues

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<td>Medicaid, funding for dental services on the state level</td>
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<tr>
<td>Amalgam, regulatory concerns, state and federal</td>
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<tr>
<td>Alternative and expanded workforce model issues on the state level</td>
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<tr>
<td>Corporate dentistry issues on the state level</td>
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<tr>
<td>Implementation of ACA on state level (exchanges)</td>
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Learn more about the specific ADEA public policy/advocacy positions at: http://www.adea.org/policy_advocacy/Pages/default.aspx
The American Association for Dental Research (AADR) calls on Congress to prioritize funding for the National Institutes of Health and the National Institute of Dental and Craniofacial Research (NIDCR) for FY2016. Rolling back sequestration cuts and providing increased funding will go a long way to improve the health of all Americans.

NIDCR is the largest institution in the world dedicated exclusively to research to improve dental, oral and craniofacial health. The health of the mouth and surrounding craniofacial (skull and face) structures is central to a person’s overall health and well-being. Left untreated, oral diseases and poor oral conditions make it difficult to eat, drink, swallow, communicate and maintain proper nutrition. Scientists also have discovered important linkages between gum (periodontal) disease and heart disease, stroke, diabetes, and pancreatic cancer.

Treating oral health conditions is costly: the nation spent $111 billion on dental services in 2013. While tooth decay and gum disease are the most prevalent threats to oral health, complete tooth loss, oral cancer, and craniofacial congenital anomalies, like cleft lip and palate, impose heavy health and economic burdens on Americans. Below are examples of the important research supported by NIDCR:

- **Point of Care Diagnostics**
  Salivary diagnostics are measures that draw and analyze saliva to test for conditions such as HIV, human papillomavirus (HPV), substance abuse, caries, periodontitis and oral cancer. As a result of research supported by NIDCR over the last decade, diagnostics also are showing great promise in screening for diabetes, heart disease, lung cancer, ovarian cancer and pancreatic cancer.

- **Enhanced Tissue Regeneration**
  NIDCR-funded scientists have developed effective techniques to prevent inflammation from interfering with the use of stem cells to form bone and cartilage for oral, dental, and craniofacial purposes. The isolation and enrichment of stem cells is also being explored, which would enhance the cells’ ability to regrow bone and cartilage, with potential impacts throughout the health sciences sector.

- **HPV-Related Oral Cancer**
  Scientists predict that this will be the most common HPV-related cancer by 2020. HPV-induced oral cancers among men are likely to exceed HPV-induced cervical cancers within the next eight years. In fact, HPV is now causing more oral cancers than smoking. But simply identifying the presence of HPV in a mouth swab or a blood draw does not definitively indicate the presence of cancer. More research is needed for the early detection of HPV-related oral cancer, and for the development of therapies that would lead to the prevention of cancer progression.

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**NIH/NIDCR FY16 Funding Recommendations**

<table>
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<tr>
<th>Agency</th>
<th>FY12</th>
<th>FY13</th>
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*In Millions of Dollars*
• **Cleft Lip and/or Cleft Palate**
  Craniofacial anomalies such as cleft lip and/or cleft palate are among the most common birth defects. Both genetic and environmental factors contribute to oral clefts. Studies supported NIDCR are providing important new leads about the role genetic factors and gene-environment interactions play in the development of these conditions.

• **Evidenced-Based Practice**
  NIDCR awarded a seven-year grant that consolidates its dental practice-based research network initiative into a unified nationally coordinated effort. The consolidated initiative, the National Dental Practice Based Research Network (NDPBRN) is headquartered at the University of Alabama at Birmingham School of Dentistry. A dental practice-based research network is an investigative union of practicing dentists and academic scientists. The network provides practitioners with an opportunity to propose or participate in research studies that address daily issues in oral health care. These studies help to expand the profession’s evidence base and further refine care.

When adjusted for inflation, the NIDCR budget is 25 percent, or $94 million, less than it was in 2004. This creates an atmosphere that discourages new scientific investigators and seriously jeopardizes the chances for promising breakthroughs in prevention and treatment.

NDA priorities reflect its members and their patients’ needs, and include but not limited to NDA efforts and recommendations of Institute of Medicine, National Academy of Science, Department of Health and Human Services and more. NDA capitalizes on these and action opportunities at the national and state level in policies, strategies, programs and initiatives. While oral is fundamental to overall health, it must be elevated in the health conversations. Oral health complications are associated with adverse pregnancy outcomes, respiratory disease, cardiovascular disease, cancer, diabetes and other health conditions. NDA priorities identified below will help to elevate oral health on all fronts. The Affordable Care Act law helps to pave the way for considerable opportunities in this regard.

Since its inception in 1913, the National Dental Association, Inc. (NDA) has worked tirelessly to ensure access to oral health care. NDA views access as a matter of social justice. In advancing the principle of health equity for all, the NDA has become the voice of moral authority for all of the underserved populations and has been. The NDA ascribes to the philosophy that health care is a right for all, not a privilege for a few. Despite advances in health care and technology, glaring disparities exist among underserved and vulnerable, diverse populations. Clearly, access is a matter of social justice. In fact, the widely quoted U.S. Surgeon General’s Report (2000) stated, “Although major improvements have been seen nationally for most Americans, disparities exist in some population groups as classified by age, sex, income, race/ethnicity.”

The NDA’s community practitioners are essential safety net providers who have made a commitment to community “first”, and who have for decades sacrificed personal and financial gains in order to bridge the gap in health disparities. NDA members are trusted and respected providers who have been at the forefront of treating those who have the least and need the most, creating dental homes needed to meet their needs. The NDA, by far, is shouldering an unequal burden of providing access to care for the underserved; and, as a result, is best qualified to speak on best options to achieve health equity and access. The NDA promotes access for all to oral health care by serving the underserved and vulnerable populations. As both caregivers and citizens of the communities that we serve, the NDA’s members seek to improve the health of the underserved, eliminate disparities and promote health equity.

There are considerable needs, challenges and opportunities in oral health including but not limited to access to care, workforce, awareness, training, and education. In regard to enrollment, IOM/NSA points out that only modest gains have been made in national enrollment of underrepresented minority students. While underserved and vulnerable population students have distinct and heterogeneous needs, NDA believes that they also have direct knowledge and understanding of how to better serve their communities. Yet, that resource of knowledge, life experience, information, knowhow and related resources far too often go untapped. These situations contribute to the ongoing void of success in building a more responsive overall health care system. Missed opportunity in diversity impact the classroom, boardroom, research bench, and bedside – the void of underrepresented racial and ethnic minorities is serious.

**NDA Action Priorities**

**Affordable Care Act Implementation including oral health access, awareness and literacy**

- Support full implementation of the Affordable Care Act including efforts to maximize enrollment, address oral health, health literacy, prevention, workforce, OMH, NIMHD and more.
- Urge expansion of essential health benefits package to include oral health benefits across the life span.
- Identify oral health components that need to be included in an essential oral health benefits package across the life span.
- Support demonstration project that responds to inclusion of oral health benefits package.
- ACA essential benefits include oral health for children and that stimulates the need for workforce expansion of racial/ethnic underrepresented oral health providers.
- Promote public education initiative outreach and awareness that also includes emphasis on prevention and oral health disease promotion and control.
- Support the conduct of the Oral Healthcare Prevention Education Campaign authorized by Patient Protection and Affordable Care Act (Public Law 111-148).
Workforce Diversity and Emerging Workforce Models

The goal is to craft and adopt a multi-faceted approach to a decades old problem that has not and will not be remediated by traditional methods. Consistent with recommendations of the Institute of Medicine and the National Research Council of the National Academies:

- Oral health is an integral component of overall health and must, therefore, be a core component of comprehensive health care.
- Improving access to oral health care will help to: prevent disease and improve overall health.

Although some gains have been made in access to oral healthcare for all, they are not nearly enough and remain deficient with regard to communities of color. Overall, the data reveals:

- Only 34% of uninsured Americans had a dental visit in the past year.
- More than 100 million American adults and children do not have dental insurance.
- In 2011, 14.5 million Medicaid enrolled children didn’t get dental care.
- In 22 states, Pew reports that fewer than half of Medicaid enrolled children received dental care.
- In 2010, 2.1 million dental related ER visits had cost estimates up to $2.1 Billion.
- Every state reports a decrease in adult dental benefits with increases in ER visits in the 21-35 age groups.
- There are currently 4,800 Dental Health Professional Shortage Areas based on a dentist to population ration of 1:5,000.
- 7,100 additional dentists would be required in order to meet the needs of the underserved in the dental shortage areas.

- In fact, the Institute of Medicine’s in the Nation’s Compelling Interest report reaffirmed the importance of diversity across the health care professions fields. The report pointed to the benefits of diversity including but not limited to improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, better patient-provider communication and better educational experiences for all students while in training. To help achieve these benefits:

- Support provisions, programs and initiatives that increase ranks of underrepresented racial and ethnic persons in the workforce. Voids in diversity adversely impact the patient client population, service delivery outcomes, providers, and the direct and indirect public and private industry sectors.

- Identify, support and develop innovative strategies that will help increase workforce diversity and grow the diversity pipeline of underrepresented racial and ethnic minorities. To this end, the ranks of such must also be increased in the faculty populations.

NDA Report Findings: Research has proven that better health outcomes are achieved when ethnic minority populations are served by ethnic minority providers. That is why the NDA members are committed to increasing the number of African American dentists and other oral health care professionals in the workforce. IOM views are shared by the NDA, specifically stating that, “ensuring that non-dental health care professionals are properly trained to take a role in delivering quality oral health care will be crucial.

The core set of oral health and cultural competencies developed for non-dental professionals need to be developed with input from a variety of stakeholders to ensure that the competencies are appropriately broad and therefore, applicable to many health professionals. The competencies also need to reflect the collective expertise and experience of dental professionals and their non-dental counterparts to ensure that the competencies prepare professionals to provide care that meets appropriate standards of quality (i.e. care that is safe, timely, effective, efficient, equitable, and patient-centered.)

Education and Training

- Support programs, projects, strategies and initiatives developed to help increase the number of underrepresented racial and ethnic minorities in the oral health professions. Identify and help develop bridges and pipelines to address this void.

- Help ensure across the oral health professions training expanded exposure to and training in a variety of clinical practice settings and community base entities to broaden training experience to reflect the diversity of the nation’s populations. Thereby, they would gain a better understanding and broaden experience working with vulnerable populations.

- Increase the ranks of underrepresented racial ethnic minorities in the faculty populations. To this end also build bridge and pipeline early on in the education process that includes recruitment and expose to the field of pre-dental college education.
• Increase recruitment, retention and graduation of underrepresented racial and ethnic minorities in oral health.

• Urge support for the increase of scholarship loan repayments and related efforts to expand the numbers of underrepresented minorities in oral health.

• Support expansion of opportunities for consistent with recommendations of IOM/NSA to have residency take place in settings where services are most needed. This provides added value for all.

**Access to Oral Health Care**

• Urge improved, expanded and sustained access to oral healthcare services.

• Support a comprehensive health model that incorporates oral health.

• Eliminate barriers to oral health and urge facilitated access to oral health services.

• Support access to ready to work oral health needs (first impressions impact employment).

• Identify and support provisions of oral health services in a variety of settings including but not limited to school-based, faith-based, mobile, institutions serving the elderly and the disabled, and more.

• Ensure appropriate training in curriculum of non-oral health focus health professions training and in telehealth services to help ensure quality care.

• Address regulatory and policy provisions that negatively impact patients and providers, and are barriers to expansion of access to oral health care.

• Identify voids in best practices that contribute to gaps in access to comprehensive quality affordable care and treatment of vulnerable populations.

• Address reimbursement’s impact on patients and providers as relates to access to needed care services in public and private coverage systems.

• Ensure use of case management across the health professions.

• Strengthen access to oral health services in community health centers, FQHC, Head Start, school-based settings, and others.

• Support loan repayment programs for oral health tied to those willing to serve in a designated amount of time in medically underserved area.

• Ensure coverage of oral health services in health plans

**Appropriations**

• Urge increased funding for oral health and minority health focus entities including but not limited to Office of Minority Health, National Institute on Minority Health and Health Disparities, Diversity in Health Professions Training, The National Institute of Dental and Craniofacial Research (NIDCR), and more.

• Support funding for CDC oral health program, demonstration oral health essential benefits projects, and for efforts to build bridges and pipelines to oral health education and training of underrepresented minorities.

• Encourage strengthened loan repayment programs in oral health that help to ensure improved access. Such efforts tend to include provisions for assignment to serve in underserved areas for designated period of time.
• Support appropriations funding for the Oral Healthcare Prevention Education Campaign authorized by Patient Protection and Affordable Care Act Public Law 111-148. It authorizes a national public education campaign focused on oral health and disease prevention targeted towards vulnerable and underserved populations.


• Support funding for safety net programs.

NDA Targeted Issue Positions

Patient Access Issues

Recommendation 1: Increase underrepresented minorities in the oral health careers.

Recommendation 2: Consider workforce development as a determinant of access.
• The NDA supports the development and continuation of demonstration projects that can demonstrate the impact and effectiveness of Emerging Workforce Models on access to care, and total health outcomes. Support the full utilization of existing oral health providers. Safety net dental providers should play leadership roles in community-based training, oversight, and advisory capacities.

• The NDA supports quality education and training; curriculum; scope of service; appropriate supervision; cultural competency; and safety net providers in vulnerable communities serving as adjunct faculty and community-based clinical preceptors.

• Dental Boards, as regulatory and credentialing bodies, should reflect the cultural, ethnic and gender composition of the population in the states being served.

Recommendation 3: Prioritize prevention and total health.
• Develop and deliver targeted messages for Community Health Education.

• Mandate workforce cultural and linguistic competency.

• Promote inter-active, inter-professional collaboration for patient-centered care.

• The NDA recommends adopting a core set of national standards for consistent, high quality education for all Emerging Workforce Models, including the Dental Therapist; and that these standards should be consistent with the Advisory Panel Report and Recommendations of Community Catalyst, as well as those outlined by the American Association of Public Health Dentistry. The scope of practice, supervision, and workforce regulations should be based on competence, education, training and safety of the services.

Recommendation 5: Promote research and data collection.
• The Centers for Medicare and Medicaid Services (CMS) should fund and evaluate state-based, Community-Based Participatory Research (CBPR) demonstration projects that cover essential oral health benefits for Medicaid beneficiaries, children and adults.

• HRSA should support projects established in FQHCs.

• Office of Minority Health, NIDCR and Minority Health Institute should support demonstration projects and should be extended to include private practitioners who practice in underserved, diverse population areas.

Recommendation 6: HRSA should dedicate Title VII funding to NDA practitioners serving as community-based preceptors for expanded and inter-professional teams.
Provider Issues in Underserved Communities

**Recommendation 1:** Provide incentives, guidelines and protection for Medicaid providers, public and private.
- Reduce financial and administrative barriers.
- Medicaid providers are safety-net providers and should be considered "Essential Providers”.
- States should promote and reward maximizing access to care and optimal utilization of Medicaid programs.

**Recommendation 2:** HRSA should increase Title VII funding for recruitment to support the advanced dental education of URM and lower-income applicants and those from rural areas.

**Recommendation 3:** Provide community/state based incentives for providers to establish businesses in Dental Health Shortage Areas. (Loan repayment, low interest loans, tax credits for accepting reduced Medicaid fees, business and finance programs, etc.).
- Provide training for dentists as leaders of expanded oral health teams and inter-professional teams.
- Create programs for dentists and students to learn about alternative practice delivery systems in preparation for future business trends, technological advances and consumer demands.

**Recommendation 4:** Standardize protocols and processes for Medicaid auditing, re-credentialing, and providers’ appeal mechanisms. Ensure that providers are fully aware of and knowledgeable of the process.

**Recommendation 5:** Cultivate collaborations with community health centers, FQHC’s, and non-dental safety net health providers to increase referrals and encourage enrollment, optimize access and increase utilization of public assistance programs.

**Recommendation 6:** State laws should allow allied dental personnel to work in a variety of settings under evidence-supported supervision levels; and practice to the full extent of their education and training to allow dentists to more productively use their training and skills to treat patients with complex needs.

**Recommendation 7:** Scope of practice, supervision, and workforce regulations should be based on competence, education, training and safety of the services to ensure that there are no double standards of care in our most vulnerable, underserved and diverse populations.

**Position on Amalgam**

Dental amalgam has been used as a restorative material in dentistry for over 150 years. The Food and Drug Administration (FDA) stated that there is “more significant human experience with dental amalgam than any other restorative material.” The National Dental Association (NDA) supports the findings of the FDA, The National Institute of Dental and Craniofacial Research (NIDCR), the National Institutes of Health Technology Assessment Conference, The U.S. Public Health Service (USPHS) and the World Health Organization (WHO) that dental amalgam is a safe and effective restorative material.

Dental amalgam is an alloy formed by combining various metals including silver, copper, tin and mercury. Mercury chemically binds these components into a hard, stable and safe substance. Under the Code of Federal Regulation Title 21-Sec. 872-3050 amalgam alloy is identified as a medical device that is used to form a filling material for the treatment of dental caries. Under standards set by the Occupational Safety and Health Administration (OSHA), the maximum “safe” occupational dose of mercury-vapor concentration that the most sensitive of workers can be chronically exposed without suffering adverse effects is approximately three hundred (300) to five hundred (500) micrograms (ug) per day. A microgram is one millionth of a gram. Estimates predict that people with moderate to large number of amalgam fillings are only exposed to one (1) to three (3) micrograms of mercury vapor daily.

In addition, USPHS scientists analyzed approximately 175 peer-reviewed studies submitted in support of amalgam in response to three (3) citizens petitions received by the FDA after the 1993 scientific report about the safety and use of dental amalgam. There is no scientifically valid evidence correlating systemic disease with dental amalgam. Consequently, the relative risk of mercury anaphylaxis is negligible.
Position on Water Fluoridation

Fluoride occurs naturally in the earth’s crust in combination with other minerals in rocks and soil. Small amounts of fluoride appear naturally in our water and much of the food we consume. The concentration of fluoride in the water found to be most effective in combating dental decay is between 0.7 parts per million to 1.2 ppm.

Water Fluoridation has been recognized by the center for Disease Control and Prevention and other organizations as a critical variable in preventing dental decay in adults and children. David Satcher, Surgeon General, wrote in his report, Oral Health in America, “Community water fluoridation is safe and effective in preventing dental disease in both children and adults”. In addition, over one hundred national and International organizations recognize today the public health benefits of community water fluoridation.

As a result of water fluoridation half of all children ages 5 to 17 have never had a cavity in their permanent teeth. Despite the overwhelming evidence of the value of water fluoridation 34% of the population still does not have access to fluoridated water. Water fluoridation would save over 1.5 billion dollars per year.

It is therefore, the position of the National Dental Association that Community Water Fluoridation is safe, beneficial and cost effective and should be encouraged and supported under the following conditions:

• Community water supplies should contain the optimal fluoride levels as recommended by the U.S. Public Health Service (a range from 0.7 – 1.2 parts per million)

• Local communities and dental societies should be in agreement with and support the fluoridation project in their communities.

• Appropriate resources monitoring capabilities should be available to ensure that the appropriate water fluoride monitoring infrastructures are in place at all times in the impacted communities.

The National Dental Association is committed to working with other dental organizations, government agencies, dental societies and individual dentists to encourage and facilitate the use of water fluoridation in local municipal water supplies, especially underserved areas, in an effort to impact as large a number of individuals as is possible.

Learn more about the specific NDA public policy/advocacy positions at:
http://ndaonline.org/about-nda/
• ADHA 2015 Public Policy Priorities Include:

Workforce Innovation
• Implement the Alternative Dental Health Care Provider Demonstration Grants Program (Section 340G-1 of the Public Health Service Act).
• Encourage HRSA to analyze workforce innovations that increase access to dental care, including providing data on innovative models to guide states.

CHIP Extension Act of 2014
• Ensure that eligible children continue to receive a guaranteed dental benefit.
• Funding expires Sept. 30, 2015. Extension is for funding through 2019.

2015 White House Conference on Aging
• Ensure appropriate consideration of the inclusion of oral health.

Community Water Fluoridation (CWF)
• ADHA supports CWF as a safe and effective public health measure.

Dental, Oral, and Craniofacial Research
• ADHA supports evidence-based research and the link between oral health and systemic disease.

Fully Utilize Dental Hygienists
• ADHA advocates that dental hygiene and/or dental practice acts be amended so that the services of dental hygienists can be fully utilized in all settings.

The ADHA affirms its support for optimal oral health for all people and is committed to collaborative partnerships and coalitions that improve access to oral health services.

Why Dental Hygiene-Based?
The ADHA is committed to advocating in support of new dental hygiene-based models for oral health care delivery. Dental hygienists are educated, prepared and an available asset to the workforce. The educational infrastructure is in place, with 335 dental hygiene programs presently educating students across the country. Dental hygienists are currently working in a variety of settings, and the public will benefit from a practitioner who can provide both preventive and restorative services.

The ADHA supports workforce models that culminate in:
* Graduation from an accredited institution
* Professional licensure
* Direct access to patient care
Direct access allows a dental hygienist the right to initiate treatment based on his or her assessment of a patient's needs without the specific authorization of a dentist; to treat the patient without the presence of a dentist; and to maintain a provider-patient relationship.

Creating a New Provider
The ADHA has defined a Mid-level Oral Health Practitioner as follows:
A licensed dental hygienist who has graduated from an accredited dental hygiene program and who provides primary oral health care directly to patients to promote and restore oral health through assessment, diagnosis, treatment, evaluation, and referral services. The Mid-level Oral Health Practitioner has met the educational requirements to provide services within an expanded scope of care and practices under regulations set forth by the appropriate licensing agency.

Learn more about the specific ADHA public policy/advocacy positions at:
http://www.adha.org/advocacy
AMERICAN ASSOCIATION OF WOMEN DENTISTS (AAWD)

Advocacy Initiatives

- Raising awareness about the state of Women’s Oral Health.
- Fighting to keep alive a guaranteed dental benefit for children under the children’s Health insurance Program (CHIP).
- Backing funding for HRSA programs that provide Oral Health Training and Diversity Training that aims to recruit, train and retain underrepresented minority students and faculty in health professions.
- Protecting federal programs at HRSA that fund pediatric and general dental residencies.
- Working to make sure federal regulations are in place that safeguards children by alleviating affordability barriers for families who choose or are forced to purchase their children’s dental coverage through a stand-alone dental plan in the ACA.
- Urging the FDA to be attuned to minority health as it arrives at a policy for naming biosimilars.
- Fighting for oral health screenings to be included in the Older Americans Act.
- Ensuring oral health is included in disparities legislation and in funding requests of coalition health groups.
- Working to grow the congressional Oral Health Caucus.

Learn more about the specific AAWD public policy/advocacy at:
www.aawd.org