VOLUME 57 NO.1

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VIEWPOINT

A wake-up call from the future for dentists

What dentists can learn from the decline of organized medicine and its impact on physician job satisfaction. Can it happen to us?

BY CHRIS BULNES, D.M.D., AND JAMES G. WILSON, D.M.D.

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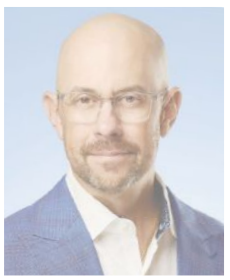

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But what happens if everything we cherish about dentistry gradually disappears? What happens when a profession lives off yesterday's victories but forgets to protect tomorrow's?

WHY ORGANIZED

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A colleague in private practice recently battled a large insurance carrier over unfair reimbursement policies. Only with the backing of organized dentistry, armed with legal resources and lobbying power, were those policies reversed.

Years ago, a member faced legislation that would have sharply limited the procedures general dentists could perform. It was his state association, in partnership with the ADA, that stopped the bill. Without that intervention, his career would have been altered overnight.

These aren't abstract victories; they are tangible protections for our practices, our patients and our livelihoods. These wins weren't free. They were earned through decades of dues, lobbying, grassroots organizing and countless hours of dentists volunteering. And, the fact is, no individual dentist could achieve these outcomes alone.

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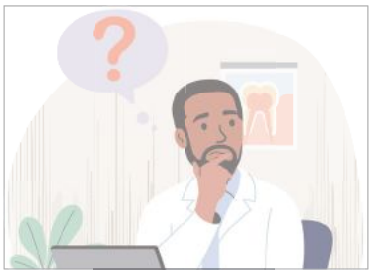

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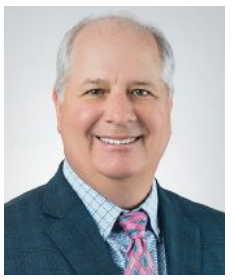

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WHY ORGANIZED DENTISTRY MATTERS

How many times have you heard a colleague say, or maybe even thought to yourself, "Why should I join the ADA? What do they really do for me?"

It's a fair question, but here's the truth: Organized dentistry is the reason we can still ask it.

Without the ADA's federal and state victories on insurance reform, carriers would operate with near-total impunity. Network leasing would let your patients' plans be sold and resold without your knowledge, slashing reimbursement rates without recourse. "Noncovered services" laws, which today prevent insurers from dictating fees on procedures they don't even pay for, wouldn't exist. Dentists would have no shield from balance-billing nightmares or predatory insurer practices. Antitrust exemptions for dental insurers would remain untouched, allowing companies to collude openly and drive our fees into the ground.

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Many see the benefits of organized dentistry's advocacy as background noise, rights that "just exist." They don't realize those rights only exist because organized dentistry fought for them. Without an organized voice representing us, dentists would be voiceless in the halls of power. Legislators would only hear from insurance lobbyists, corporate chains or well-funded activist groups. Dentistry would be regulated, funded and legislated by everyone except dentists.

But here's the problem: Association membership is shrinking, and our profession is silently eroding its own future. Each year, fewer dentists join organized dentistry, leaving the burden of advocacy to a smaller and smaller group. Some become disengaged, focusing only on frustrations while overlooking the victories. Others expect protection without contributing, and when organized dentistry loses a fight or takes a stance they disagree with, they walk away entirely.

When our collective voice grows weaker,

See FUTURE, Page 4

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PRACTICE

Dental care utilization stagnant among Medicaid beneficiaries

ADA Health Policy Institute finds that Medicaid reimbursement continues to lag in most states

BY NOAH LEVINE

Dental care utilization rates among children have remained unchanged for the past few years and are down from pre-pandemic levels. Further, the gap in utilization between children covered by Medicaid or the Children's Health Insurance Program and children covered by private dental benefits is "not shrinking," according to the latest findings from the ADA Health Policy Institute.

The latest data on the Medicaid dental landscape compiled by HPI indicate that the stagnancy in dental care utilization is mirrored in Medicaid participation rates among dentists. The share of U.S. dentists participating in Medicaid or the Children's Health Insurance Program is 41% as of 2024 — around the same as it was in 2015.

Dentist participation, overall, in Medicaid has not changed despite a decade of expansions to dental benefits for adults covered by Medicaid. As of 2025, 38 states and Washington, D.C., offer enhanced dental benefits to adults under the Medicaid program. Eighteen states have expanded their benefit offerings since 2021, and no state has cut back benefits, which the HPI report notes reflects "progress in improving coverage for adult beneficiaries." Still, there is a stark gap in dental care utilization between publicly and privately insured adults and children in most states.

Stagnancy in dentist Medicaid participation and beneficiary utilization may be largely attributable to reimbursement rate stagnation. Medicaid fee-for-service reimbursement in most states falls far below 50% of dentist charges and 60% of private insurance reimbursement. However, the recent HPI report notes that even with appropriate reimbursement for Medicaid services, access to care may still be an issue if "the numerous barriers to dental care that go beyond access to providers" are not addressed.

HPI will continue to monitor these trends and how they impact access to dental care for the U.S. population. View the full data, including state-by-state comparisons and trends over time on HPI's website at ADA.org/resources/research/health-policy-institute/coverage-access-outcomes/dental-care-in-Medicaid-programs.

The ADA offers Medicaid-specific resources for policymakers. See the ADA toolkits for Medicaid programs available to help advocate for dental benefits under Medicaid. The toolkits are available at ADA.org/advocacy/advocacy-issues/medicaid/ada-toolkits. ■

SCIENCE & TECH

January JADA outlines emerging dental therapies for obstructive sleep apnea

BY MARY BETH VERSACI

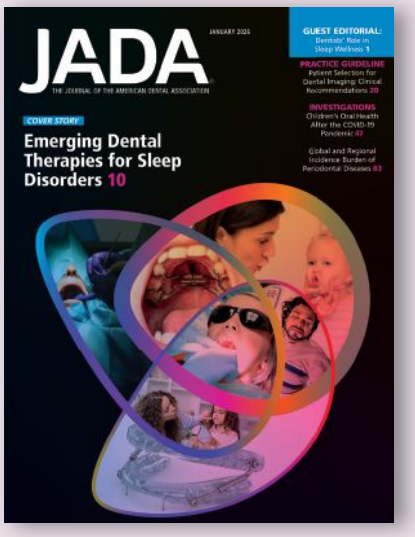
Dentists play an increasingly important role in the management of sleep health and disorders, according to the cover story of the January issue of The Journal of the American Dental Association.

"Emerging Dental Therapies for Sleep Disorders: Evidence Synthesis from the American Academy of Dental Sleep Medicine 2024 Consensus" synthesizes the academy's consensus report on new and emerging dental therapies for obstructive sleep apnea and snoring. The authors' intent was to provide a broader understanding of preventive, curative and management approaches for sleep health and disorders in dentistry, especially for dentists with less exposure to sleep medicine, according to the article.

The authors highlighted the report's strengths and limitations and outlined priorities for future research. They found no emerging dental therapy met the criteria for a first-line monotherapy for obstructive sleep apnea or snoring to substitute for mandibular advancement devices. However, evidence suggests some therapies may serve adjunctive or individualized roles when established treatments are ineffective or declined.

Major limitations in the report included a lack of pediatric subgroup stratification; reliance on apnea-hypopnea index, oxygen desaturation and subjective snoring as primary outcomes of success; and variability found in study design and sample diversity.

"Dentists can contribute to multidisciplinary sleep care through established therapies, selective use of emerging interventions, and early recognition of airway growth issues," the authors said in the article. "Adoption of new therapies should follow expert consensus and robust evidence until stronger data are available."



To read the full JADA article online, visit JADA.ADA.org.

Other articles in the January issue of JADA discuss patients' satisfaction with digital complete dentures, pediatric oral health since the COVID-19 pandemic and the global and regional burden of periodontal diseases.

Every month, JADA articles are published online at JADA.ADA.org. ADA members can access JADA content with their ADA username and password. ■

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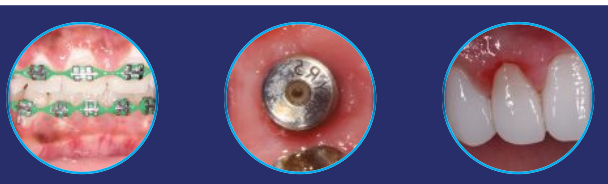

*with twice daily brushing
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† Prevents Harmful Oxidants from causing oxidative stress which contributes to gingival tissue damage, by neutralizing plaque bacteria.
1 Biesbrock A, et al. J Clin Periodontol, Dec 2019

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AROUND THE ADA

ADA, Academy for Sports Dentistry collaborate to advance oral health, athlete safety

Initiatives include educational opportunities, awareness efforts

BY MARY BETH VERSACI

A new collaboration between the American Dental Association and Academy for Sports Dentistry aims to enhance the visibility of sports dentistry within the broader dental community.

"The power of play and physical activity is undeniable for all ages," said ADA President Richard Rosato, D.M.D. "A greater awareness of sports dentistry's opportunities for our profession and its impact on the public's oral and overall health will greatly benefit our dental community and the patients they serve."

Over the coming months, members of both organizations can expect updates on the collaboration, including the development of a sports dentistry continuing education course supported by the Academy for Sports Dentistry for the ADA CE catalog in 2026. The academy also offers certification courses for all dentists through its website.

"We are thrilled to announce this affiliation between the Academy for Sports Dentistry and the American Dental Association," said Academy for Sports Dentistry President Michael Salyzyn, D.D.S. "This alliance not only celebrates the artistry and dedication inherent in both fields, but also opens doors for every dentist to utilize the specialized skills of sports dentistry in their practice. This will facilitate prevention of injuries and promote evidence-based treatment in trauma situations. Together, we elevate the standard of care and champion innovation, ensuring our patients benefit from the best of both worlds."

Future initiatives will include developing an ADA sports dentistry ambassador group to reinforce the specialty of sports dentistry among general practice dentists and exploring ways to reach dental students about sports dentistry. ■

FUTURE *continued from Page 1*

policymakers and corporations step in to fill the vacuum.

FORESHADOWING FROM MEDICINE

If this sounds alarmist, just look at medicine. In the 1960s, nearly 75% of U.S. physicians were members of the American Medical Association. Over the past several decades, the AMA saw its membership plummet. As a result, physicians lost much of their influence over health care policy. Today, many doctors work in environments where insurance companies, government agencies and corporate interests dictate how medicine is practiced.

As AMA membership fell below 15%, Medicare physician payments dropped 33% (adjusted for inflation since 2001). Those numbers aren't just statistics; they represent lost opportunities, rising burnout, overregulation and the steady erosion of a once-independent profession. Many physicians were driven out of private practice, taking with them a profound loss of autonomy. This isn't science fiction. It's exactly what happens when a profession stops standing together.

Physicians are still respected, but their ability to shape their own destiny has been gutted. Dentistry is not immune. If we follow the same path, we risk losing control over our profession. Decisions about how we practice, how we are reimbursed and how patients view our role in health care could soon be made for us, not with us.

A WARNING FROM THE FUTURE

Imagine opening your practice in 2040. You're no longer in control of your fees; insurance companies dictate them. Your autonomy in patient care is diminished; government regulations and corporate dental chains set the parameters. Patients see you not as an independent professional, but as a cog in a system that values volume over relationships.

The future of dentistry will not be decided by the loudest lobbyist in Washington or the biggest corporations. It will be decided by whether dentists themselves believe the profession is worth protecting.

A CALL TO ARMS

The future of our profession depends on what we do now. Our prosperity was earned, not granted. Organized dentistry is our shield and our voice. Without strong membership, our ability to influence policy, protect patient relationships and preserve professional autonomy will slip away.

Some of you may already feel disenfranchised, trapped by debt, overwhelmed by corporate pressures or worn down by bureaucracy. But if you think it's difficult now, imagine a future of even higher burnout, financial strain and loss of control.

So, the real question isn't: "What does the ADA do for me?" The real question is: "What happens if I don't join?"

The hard truth is that if too many dentists choose to free ride on yesterday's victories, tomorrow's dentists will not inherit the same profession.

This is our call to arms. Join. Renew. Most importantly, encourage your colleagues. When one of them asks, "What does the ADA do for me?" Speak up! Remind them that organized dentistry doesn't exist just for one of us, but for all of us. The future of your profession depends on you being an advocate for organized dentistry to those who choose to denigrate its importance to all of us.

Our profession that we worked so hard to become a part of is changing rapidly, not always for the better, but it will be exponentially worse if we lose our collective voice. By investing in organized dentistry, we preserve not only our careers but the very identity of our profession.

The strength of dentistry tomorrow depends on the choices we make today. ■

Dr. Bulnes was born and raised in Tampa, attended the University of South Florida to attain his undergraduate degree in chemistry and earned his DMD from Southern Illinois University in 2000. He then obtained his Advanced Education in General Dentistry in 2001 from Southern Illinois University. He is a Trustee to the Florida Dental Association and presently serves Florida as their representative to the American Dental Association Council on Governmental Affairs.

Dr. Wilson received his DMD degree with high honors from the University of Florida College of Dentistry. Following dental school, he completed a one-year fellowship in Oral Maxillofacial Surgery and a one-year Advanced Education in General Dentistry residency. Dr. Wilson obtained his Certificate in Periodontics from the University of Florida College of Dentistry. Following his residency, he opened Tampa Bay Periodontics and Implant Dentistry. Dr. Wilson is a Diplomate of the American Board of Periodontology and a Fellow of the American College of Dentists and the International College of Dentists. Dr. Wilson is a Past President of the American Academy of Periodontology and currently serves as Secretary-Treasurer of the American Academy of Periodontology Foundation, Editor for Florida's West Coast District Dental Association as well as Immediate Past President of the Hillsborough County Dental Association.

This article was reprinted with permission. It was originally published in the Fall 2025 issue of Check Up, a newsletter from the West Coast District Dental Association, a component of the Florida Dental Association.

NCOIL approves 'opt-in' amendment to Transparency in Dental Benefits Contracting Model Act

BY OLIVIA ANDERSON

The National Council of Insurance Legislators, or NCOIL, voted to approve amendments to the 2020 Transparency in Dental Contracting Model Act, marking a key development for state dental societies that have advocated for changes to virtual credit card payment provisions.

ADA Trustee Randall Markarian, D.M.D., attended NCOIL's Health Committee meeting to provide input from the dental community.

At NCOIL's Health Committee meeting, members adopted language that shifts virtual credit card-related payments from an "opt-out" to an "opt-in" system. Under the revised model, dental plans must obtain a dentist's permission before issuing any payment method that carries associated fees, such as a virtual credit card. The amendment also specifies that a dentist's selected payment method remains in place until the dentist proactively elects a different option.

New York Assemblymember Jarett Gandolfo, a sponsor for the amendments, said the sponsors were originally seeking more amendments but after some back and forth with the dental plans and other stakeholders, settled on virtual credit cards, which he called a "great step."

"I don't think it's the end of changing the way things are done between dental plans and providers. But we got to a place that I think was fair, especially for these dental practices that have been stuck with these opt-out approaches that weren't exactly beneficial to them," Mr. Gandolfo said.

The ADA has supported these changes over the past year, stating that an opt-in approach provides greater transparency and allows dentists to avoid unwanted fees tied to certain electronic payment types. Dental plans opposed the amendment, and a last-minute proposal from a legislator sought to preserve the existing opt-out structure. The Health Committee ultimately rejected that proposal and approved the ADA-supported opt-in language.

ADA Trustee Randall Markarian, D.M.D., attended the meeting to provide input from the dental community. He emphasized the permanence element to the new legislation, stating that previously, a clock would reset every time a dentist renewed their provider agreement with an insurer. The insurer would issue a new virtual credit card, and the provider would have to go through the entire opt-out process again. Under the new opt-in approach, the choice is permanent.

"I think it's very important that when the ADA is engaging with any legislators, whether in their state or at a legislative conference like NCOIL, we have the volunteer leaders present to talk about how the laws, or in this case, the model legislation, can directly impact private practice dentists," Dr. Markarian said. "It's really rewarding to be able to give that perspective and have the legislators understand what's actually happening with these laws."

Arkansas Sen. Justin Boyd also sponsored the amendments. He highlighted the fact that several states have already enacted an opt-in approach to virtual credit cards and that there will likely be movement with the opt-in approach in more state legislatures.

"It's encouraging to see this model legislation updated — proof that NCOIL's work isn't carved in stone but can evolve as states' needs change. As more states look to regulate the insurance industry, they'll look to what NCOIL has done here, and this sets an important precedent for continual improvement. With several states already adopting the opt-in approach to virtual credit cards, I hope even more legislatures follow suit," Mr. Boyd said. ■

Tips to avoid claim denials due to common coding mistakes

ADA provides guidance to code correctly

BY MARY BETH VERSACI

The American Dental Association hopes to help dentists avoid common coding mistakes as they begin using CDT 2026 this month.

"Often, denial and delayed payment of claims occur due to common coding errors. Always refer to the code's full nomenclature and descriptor, and code for what you do," said Paula Crum, D.D.S., chair of the ADA Council on Dental Benefit Programs' Coding and Transactions Subcommittee.

Dr. Crum

Below are examples and explanations of some common miscoding issues to help address potential misinterpretation during claims processing.

> **Often, denial and delayed payment of claims occur due to common coding errors. Always refer to the code's full nomenclature and descriptor, and code for what you do.**
>
> -Paula Crum, D.D.S.

EXAMPLE 1

The ADA is often asked if code D7210 extraction (erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated) can be reported for all extractions. In the past, this code was often referred to as the "surgical extraction code" since all extractions are essentially surgeries.

Code D7210 is appropriate when the clinical circumstances involve the removal of bone and/or sectioning of tooth. However, code D7140 extraction, erupted tooth or exposed root (elevation and/or forceps removal), may be the appropriate code to use when such bone removal is not indicated and the erupted tooth is removed using an elevator or forceps. Both codes include the removal of the tooth structure, minor smoothing of the socket bone and closure of the extraction site.

"Always refer to the code's full nomenclature and descriptor regarding the differentiation between D7210 and D7140," Dr. Crum said. "It is imperative that each tooth is coded accurately according to clinical circumstances."

EXAMPLE 2

Coding for the extraction of impacted teeth often raises questions. The CDT Code includes four different codes for the extraction of an impacted tooth — D7220, D7230, D7240 and D7241 — and none of them are based on difficulty. Each captures a different clinical presentation of the tooth and the procedural differences required to remove that tooth.

"Yes, removal of a tooth impacted in soft tissue is typically easier than a completely bony impacted tooth, but that difference in effort is implicit, not explicit," Dr. Crum said.

EXAMPLE 3

The ADA often receives questions about the appropriate way to document a "difficult" prophylaxis, meaning a cleaning that takes longer than expected. Can code D4341 periodontal scaling and root planing — four or more teeth per quadrant, or code D4342 periodontal scaling and root planing — one to three teeth per quadrant, be used for a difficult cleaning, considering the amount of calculus present on the coronal surfaces of the teeth and the intensity required to remove it?

The descriptors for codes D4341 and D4342 say they are indicated for patients with periodontal disease, so without that, the codes are not appropriate. Scaling and root planing is indicated for patients with periodontal disease and is therapeutic, not prophylactic. The ADA Council on Dental Benefit Programs has developed a detailed guide on coding for scaling and root planing available at ADA.org/dentalinsurance.

Code D4346 scaling in presence of generalized moderate or severe gingival inflammation — full mouth, after oral evaluation, may be applicable if there is generalized moderate to severe gingival inflammation. This code is often an appropriate choice because a patient with heavy buildup of plaque and calculus might also have generalized moderate or severe inflammation. A complete guide for using code D4346 is available at ADA.org/publications/cdt/coding-education.

Code D4355 full mouth debridement is another option if debridement of buildup is needed to enable a comprehensive periodontal evaluation and diagnosis. However, this code is not intended to be used to describe a difficult prophy. It should only be used if the debridement is needed to enable the periodontal evaluation. A complete guide for using code D4355 is also available at ADA.org/publications/cdt/coding-education.

"This issue as outlined illustrates what is most important in coding," Dr. Crum said. "That is, the only way to code is by the literal definition of the procedure as seen in the full CDT Code entry."

EXAMPLE 4

Can dentists report code D3331 treatment of root canal obstruction; non-surgical access, with every root canal procedure? The answer is no. This code is appropriate only when it is necessary to create a pathway for an apical seal without surgical intervention because of a nonnegotiable canal obstructed by foreign bodies such as separated instruments, fractured posts or significant calcifications.

"Clinical documentation and radiographic evidence must substantiate use of this code," Dr. Crum said.

EXAMPLE 5

If a provider wants to use an expensive adjunct irrigant or irrigating device instead of or in addition to the traditional sodium hypochlorite that is commonly used in root canals, there is no code that can be used to reflect the additional expertise and expense. Irrigation and other aspects of endodontic therapy are considered part of the root canal procedure itself and included in the code set for the type of tooth being treated.

Similarly, alveoloplasty is a distinct procedure from extractions that is usually performed in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery. Any minor smoothing of the socket bone or bone removal to enable or facilitate an extraction is included within the extraction procedure code.

Some "golden rules" of procedure coding include:

- Code for what you do. This is the fundamental rule to apply in all coding situations.
- After reading the full nomenclature and descriptor, select the code that matches the procedure delivered to the patient.
- If there is no applicable code, document the service using an "unspecified ... procedure, by report" code (ends in "999") and include a clear and appropriate narrative.
- Understand that the existence of a procedure code does not mean the procedure is a covered or reimbursed benefit in a dental benefit plan.
- Plan treatment based on clinical need, not covered services.
- Discuss common coding situations with office team members so that everyone understands how to use the CDT Code, and review coding for complex treatment plans before claims are submitted to payers.

If dentists have difficulty finding an appropriate CDT code, they should consider whether there may be another way to describe the procedure. The CDT manual's alphabetic index and the glossary of clinical terms available online at ADA.org/CDT may be helpful in these situations. Dentists can also contact the ADA for help at dentalcode@ada.org. ■

GOVERNMENT

ADA backs PREVENT HPV Cancers Act, citing dentists' role in prevention

BY OLIVIA ANDERSON

ADA leaders are supporting the bipartisan Promoting Resources to Expand Vaccination, Education, and New Treatments for HPV Cancers Act, also known as the PREVENT HPV Cancers Act.

In a Dec. 11, 2025 letter sent to Reps. Kathy Castor, D-Fla., Kim Schrier, D-Wash., and Don Bacon, R-Neb., the ADA highlighted the importance of expanding public awareness about human papillomavirus, strengthening vaccination education and improving access to evidence-based prevention strategies.

In the letter, ADA President Richard Rosato, D.M.D., and Interim Executive Director Elizabeth Shapiro, D.D.S., J.D., underscored the significant impact of HPV on oral and oropharyngeal health. According to the letter, HPV is estimated to cause approximately 70%, or more than 15,000 cases, of head and neck cancers annually in the United States, surpassing tobacco use as the leading cause of these cancers. The Association reiterated the effectiveness of current vaccine options in reducing risks associated with the roughly 40 HPV types linked to oropharyngeal cancer.

If passed, the PREVENT HPV Cancers Act would create a national public awareness initiative focused on evidence-based vaccination.

"The campaign would disseminate vaccination information and communication resources to health care providers, including dentists," Drs. Rosato and Shapiro wrote, noting that with these resources, dental professionals would be better equipped to educate patients, encourage vaccine completion and counter misinformation.

Drs. Rosato and Shapiro also recognized updates in the legislation that address rising HPV-associated oropharyngeal cancer rates among veterans and service members, as well as progress in screening technologies such as HPV self-collection.

"The ADA supports these updates and the bill's focus on appropriate outreach to communities at higher risk," they said. "The ADA appreciates your leadership on this issue and welcomes the opportunity to partner with your offices and the CDC on public education regarding HPV vaccination." ■

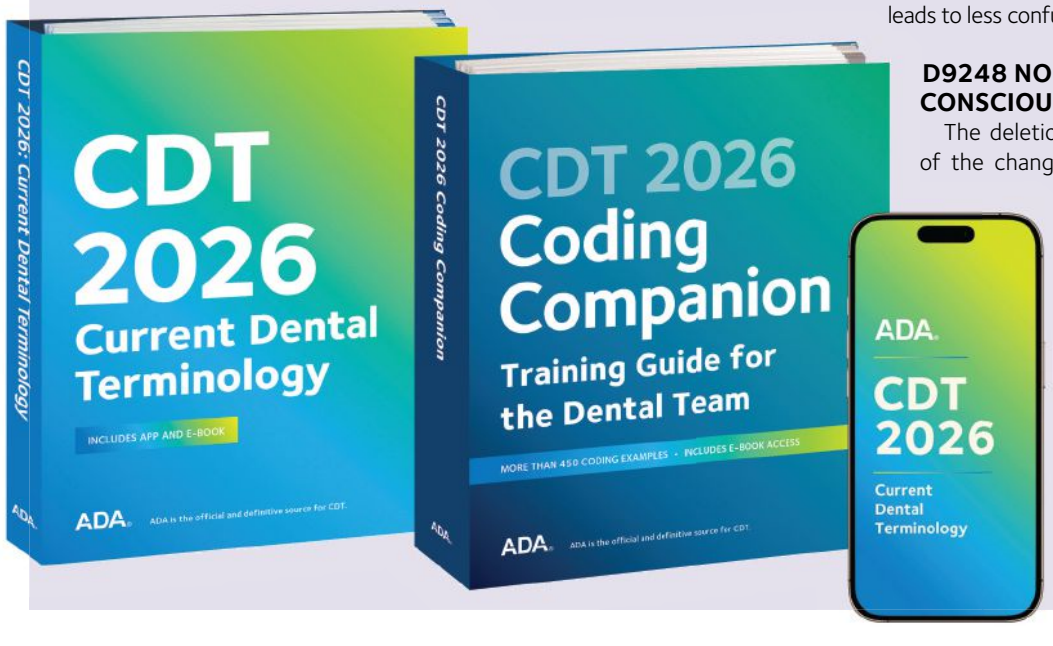
Deleted CDT codes you should know for 2026

CDT 2026 features 60 changes, including 6 deletions

BY MARY BETH VERSACI

CDT 2026 boasts 60 code changes, including six deletions.

Here is information about the six deleted codes to help dentists stay up to date as they begin using the new CDT Code this month.



D1352 PREVENTIVE RESIN RESTORATION IN A MODERATE TO HIGH CARIES RISK PATIENT — PERMANENT TOOTH

The deletion of code D1352 is related to the deletion of the descriptor for code D2391 resin-based composite — one surface, posterior. The descriptor had limited code D2391's application to restorations penetrating into dentin. Because the procedure is done the same way for both codes, having only one code leads to less confusion when documenting.

D9248 NON-INTRAVENOUS CONSCIOUS SEDATION

The deletion of code D9248 is one of the changes made to the suite of anesthesia codes in CDT 2026. The deletion does not create a gap in the CDT Code, as several new codes replace this deleted one to establish current terminology and more accurate detail for documentation and reporting. "CDT Coding Guide: Nitrous Oxide, Sedation and General Anesthesia," a new guidance document available at ADA.org/publications/cdt/coding-education, outlines the sweeping changes to anesthesia codes and serves as an aid to help dentists select the appropriate new and revised codes.

The CDT 2026 and Coding Companion Kit and Consumer-Friendly CDT 2026: Plain Language Terms for Patient Communication are available for purchase at ADAStore.org.

For the first time, the ADA is also offering a continuing education series to explain some of the changes in CDT 2026. The 2026 CDT Codes: Clinical Practice Series includes eight on-demand courses that give a comprehensive look into the structure, maintenance and ongoing updates of CDT codes. The eight courses can be purchased individually or as a bundle at ADAStore.org.

D1705 ASTRAZENECA COVID-19 VACCINE ADMINISTRATION — FIRST DOSE, D1706 ASTRAZENECA COVID-19 VACCINE ADMINISTRATION — SECOND DOSE, D1707 JANSSEN COVID-19 VACCINE ADMINISTRATION, D1712 JANSSEN COVID-19 VACCINE ADMINISTRATION — BOOSTER DOSE

These four codes related to COVID-19 vaccination were deleted because the AstraZeneca and Janssen vaccines are no longer manufactured or supplied.

Visit ADA.org/CDT for more information on the CDT Code. ■

You Ask, We Answer: Is it safe to use fluoridated water to reconstitute infant formula?

BY OLIVIA ANDERSON

With the release of the ADA's new edition of "Fluoridation Facts," readers can learn the answers to hundreds of frequently asked questions about community water fluoridation and the latest scientific research. "Fluoridation Facts" — the Association's free resource on fluoridation that examines the mineral's effectiveness, safety, practice and cost-effectiveness — works to assist policymakers and the general public in making informed decisions about fluoridation. The new edition contains more than 400 references and 10 new Q&A's for a total of 69 questions answered over 114 pages.

In an ongoing series, the ADA News is delving into many questions explored in the book through conversations with experts about fluoridation information and misinformation — from overall effectiveness to whether ingesting fluoride impacts IQ, health and reproduction.

Steven Levy, D.D.S., University of Iowa dental professor and international expert on fluoride intake, discussed the safety of using fluoridated water to reconstitute infant formula — question No. 28 in "Fluoridation Facts."

Dr. Levy said evidence continues to support the safety of using community-fluoridated water to reconstitute infant formula, while acknowledging a small associated risk of mild dental fluorosis, which is a change in the appearance of tooth enamel that occurs only while teeth are developing. Mild forms present as faint white spots or streaks and do not affect tooth function. Moderate and severe fluorosis — which can involve staining or pitting — occur only with fluoride levels far above those used in community water fluoridation, he said.

> **If it's just an occasional bottle for 4 ounces once or twice a day or something, then that's where you probably wouldn't bother with it. But if it's a frequent, regular thing, and they're getting larger quantities, then it's really good to consider doing that.**
>
> **-Steven Levy, D.D.S.**

Dr. Levy emphasized that research has long shown the benefits of water at about 1 part per million of fluoride, noting that high-fluoride water, or 2 to 3 ppm or more, is linked with more severe forms of fluorosis, while optimally fluoridated water provides substantial cavity prevention with minimal cosmetic risk.

"We generally recommend that it is OK for most parents to use fluoridated water with their infants, including when they reconstitute infant formula," Dr. Levy said.

Infants who consume large volumes of powdered formula reconstituted with fluoridated water may ingest more fluoride than is ideal for their age, which can slightly increase the likelihood of mild fluorosis. However, Dr. Levy noted that online discussions often misrepresent and exaggerate the issue when opponents display images of advanced fluorosis as if they were typical.

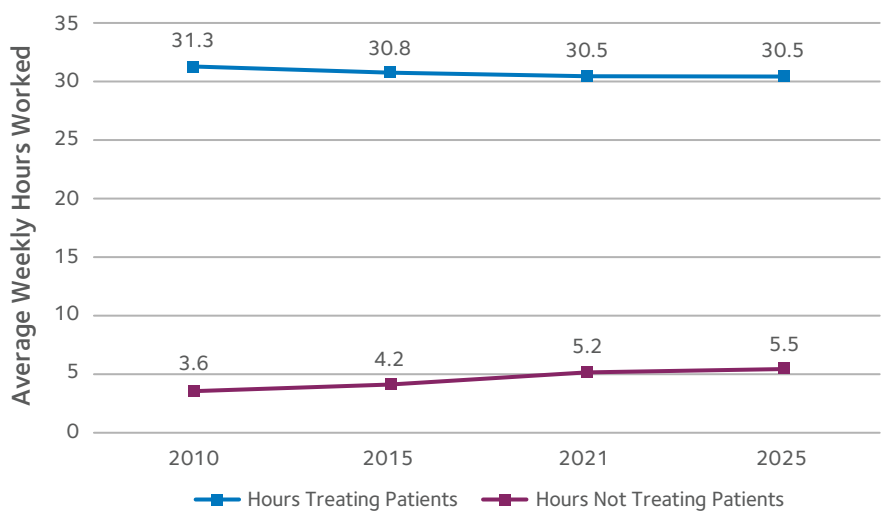
Dr. Levy reiterated that fluoridated water remains appropriate for most families. For parents who are particularly concerned about even mild fluorosis, he said clinicians may recommend the optional use of lower-fluoride or fluoride-free water for formula preparation.

"We generally recommend that dentists and physicians feel comfortable recommending their patients use fluoridated water, but if there is concern expressed, then that's where you would recommend lower-fluoride water," he said. "If it's just an occasional bottle for 4 ounces once or twice a day or something, then that's where you probably wouldn't bother with it. But if it's a frequent, regular thing, and they're getting larger quantities, then it's really good to consider doing that." ■

HPI CORNER

DENTISTS SPENDING MORE TIME ON NONCLINICAL TASKS

Dentists are reporting over time that they are spending more time on nonclinical tasks in the dental office. In 2024, dentists spent an average of 5.5 hours a week in the office not treating patients compared with 3.6 hours in 2010.



Source: ADA Health Policy Institute, "Trends in dentists' income, revenue and hours worked," November 2025. Available from: https://www.ada.org/resources/research/health-policy-institute/dental-practice-research/trends-in-dentist-income.

Dear ADA: Annual maximums

Outdated dental plan maximums limit patient care

BY MARY BETH VERSACI

Dental insurance issues are often rated as one of dentists' chief challenges.

In response to an ADA Health Policy Institute poll in late 2024, more than half of dentists reported that one of their top concerns looking ahead to 2025 was related to insurance, including low insurance reimbursement rates, denied or delayed payments, and issues related to Medicaid and Medicare.

Dr. Hughes

This ADA News series aims to address some of those challenges. Dear ADA will feature answers to common insurance-related questions the American Dental Association receives from members to help provide clarity and direct members to additional resources.

The answer to this month's question is provided by Bert Hughes, D.M.D., vice chair of the ADA Council on Dental Benefit Programs.

Dear ADA: My patients often reach their annual dental plan maximums quickly and then struggle to afford the care they need. Many dental plans' annual maximums have not increased in 50 years. How is the ADA advocating on behalf of dentists?

Dr. Hughes: As dentists, we see firsthand how dental insurance design can support or hinder our ability to provide necessary care. The biggest barriers patients face continue to be plan design elements such as coinsurance and annual maximums, which are imposed by many dental benefit plans. These caps, often unchanged for decades, restrict how much the plan will pay per year, regardless of the patient's true clinical needs.

In 2024, the ADA adopted a strong and clear policy regarding annual maximums. The Association stated that it does not support annual or lifetime maximums in any dental benefit program and emphasized that out-of-pocket costs remain a major barrier to care.

The ADA also urged dental benefit plan issuers to account for inflation when setting premiums and discouraged multi-year contracts with employers that ignore rising costs of delivering dental treatment. This is an important step toward aligning dental benefits with the real cost of care we provide every day.

While some plans now feature higher annual maximums of $2,000 or more, many still are promoting the long-standing $1,000 level that was established some 40 years ago. These limits have not kept pace with inflation or the rising costs of materials, technology and overall dental care.

The ADA has repeatedly brought this issue to the attention of carriers during multiple meetings, urging them to modernize benefit structures. Insurers, however, often place the responsibility on employers, claiming that employers are not requesting higher maximums.

From the employer perspective, the concern typically centers on premium increases and the belief that only a small percentage of employees ever reach their annual maximums.

WHAT THE DATA SHOWS

The industry is slowly changing. According to the National Association of Dental Plans:

- 32.8% of in-network annual maximums are between $1,000 and $1,500.
- 48.2% fall between $1,500 and $2,500.
- 17.2% are between $2,500 and no annual maximum at all.

Yes, some plans now offer no annual maximum, demonstrating that alternatives are possible.

But a 2024 analysis by the ADA Health Policy Institute shows that only 3.4% of dental patients actually reach the typical annual maximum and another 3.3% come within $100 of common maximums like $1,000 or $1,500. At the same time, Americans' median emergency savings sit at just $500, according to Empower, leaving many patients financially unprepared for even modest treatment needs.

As patients approach their annual limit, HPI found they incur higher out-of-pocket costs, too. This is not only due to more money being spent but also because they are required to cover a larger share of that spending themselves through coinsurance. In other words, the closer patients get to using their benefits, the more the financial burden shifts to them. Raising annual maximums alone does not eliminate this imbalance.

This problem is amplified by the benefit structure. While the familiar design is 100% coverage for preventive, 80% for basic and 50% for major services, plans have the discretion of placing procedures normally covered at a higher percentage into a lower tier for reimbursement purposes. This shifts more of the cost burden onto the patient. Some plans are even moving major coverage to 20% and including services not typically considered as major into this category.

When a crown is paid at only 50% or less of the insurer's allowable fee, the patient is responsible for the remaining portion. This is another cost burden for the patient. Many dentists report that patients are declining needed treatment or delaying it until the next plan year when their maximum resets. However, due to the coinsurance design, this is not a real solution for affording care.

The combination of low annual maximums and major procedures covered at only 50% or less creates a perfect storm: Patients face a steep financial burden long before their clinical needs have been met.

WHAT DENTAL PRACTICES CAN DO

One effective strategy is encouraging patients to voice their concerns directly to their employer's human resources department. Employers can increase annual maximums and adjust plan designs, but they often don't realize the financial burden their employees experience. If they never hear complaints, they assume the status quo is sufficient.

By advising patients to communicate with their human resources teams, especially when the plan design results in treatment delays or high out-of-pocket costs, dentists can help drive meaningful change. Personally, I feel this is the type of discussion I have with my patients on a weekly, if not daily, basis. This especially occurs during the open enrollment period. I have seen some movement by employers after encouraging patients to speak to their human resources departments and some meaningful change after I personally met with the benefits manager for a city in Florida, my home state.

The ADA continues to advocate to the employer community to emphasize the value of oral health and its importance for overall employee health and productivity. It has created a toolkit to help employers understand and evaluate their current or proposed dental benefit plans, available at ADA.org/dentalinsurance.

The ADA has also advocated for implementing medical loss ratio reforms in dental insurance — often referred to as dental loss ratio legislation — ensuring that a higher percentage of premium dollars goes toward patient care rather than profits, marketing or administrative overhead. The Association is working to guarantee that insurance plan designs include transparent reporting requirements as well as prompt refunds to insured individuals when carriers fail to meet minimum payout thresholds. ■

ADA to conduct governance and organizational health study in 2026

Final report to be submitted to House of Delegates next fall

BY MARY BETH VERSACI

The American Dental Association's governance structure will be evaluated by an outside firm this year.

In October 2025, the ADA House of Delegates adopted Resolution 521H, which calls for a comprehensive governance and organizational health study to be administered in 2026, with an interim progress report ready in April and a final report submitted to the 2026 House of Delegates next October.

"The governance and organizational health study signals a pivotal opportunity for the ADA, allowing us to thoughtfully assess what our Association does well, identify areas for improvement and understand how we can better design our processes to deliver continued value to our members and profession," said ADA President Richard Rosato, D.M.D. "The study is just one key way that the ADA is positioning itself for long-term success."

The ADA has issued a request for proposals to select a consultant to conduct the evaluation, which will include both a review of the Association's governance structure, internal controls, accountability expectations and leadership and management culture as well as an analysis of the causes behind the ADA's recent financial and operational challenges. The evaluation will provide recommendations for a path forward for the ADA and the tripartite, designed to ensure governance and operational health are in alignment with long-term financial sustainability. The recommendations will ultimately go to the ADA Board of Trustees and House of Delegates for their consideration.

To ensure a balanced blend of perspectives, the resolution calls for the Board and its governance committee to ensure the consulting firm collects input from the following stakeholder groups: early-career dentists, past ADA leaders and/or presidents, state executive directors, House members and state dental leaders.

Following the House's adoption of the resolution, the Board authorized Dr. Rosato to form a task force with members representing these stakeholder groups. The task force will advise the governance committee as the process moves forward and be chaired by Karin Irani, D.D.S., J.D., ADA trustee and chair of the governance committee.

"By bringing together voices from various stakeholder groups, I'm confident the task force will provide insights that help the ADA refine its structure and culture to advance our mission with excellence," Dr. Rosato said. ■

Experts at ADA summit agree that dentists can be key in providing care for patients with sleep and airway disorders

ADA Sleep and Airway-Focused Dentistry Summit connected dentists, physicians and industry partners to discuss the challenges of providing optimal care for sleep apnea patients

BY NOAH LEVINE

More than 40 dental and medical professionals from across the country discussed how to strengthen the dental profession's role in sleep and airway health at the American Dental Association's Sleep and Airway-Focused Dentistry Summit on Dec. 3, 2025 in Chicago.

Attendees included dentists who have made sleep and airway care a key part of their practices, neurologists and other sleep medicine physicians, researchers, consultants and representatives from companies developing sleep diagnostic and treatment technologies.

Through a series of remarks, open discussions, panel sessions and breakout groups, attendees noted the potential to improve outcomes for patients with sleep apnea and related conditions by enhancing education for both patients and providers, as well as improving collaboration between dentists and physicians. ADA President Richard Rosato, D.M.D., addressed the summit, noting, "Airway management is exactly the kind of area that invites the best of our abilities."

Participants agreed that the scale of untreated sleep disorders requires a more comprehensive, team-based, patient-centered approach to overcome barriers that include limited public awareness and fragmented insurance systems. Interrupted breathing during sleep affects an estimated 30 million people in the U.S., but only 6 million have been diagnosed with sleep apnea, according to the American Medical Association. Patients are often unaware of treatment options beyond CPAP therapy or surgery. Public awareness of the role dental professionals can play in treating sleep disorders is another barrier, as is collaboration between dental and medical providers which remains a challenge to professionals in both health care settings.

"If we don't all work together we're never going to solve this problem," noted attendee and former president of the American Academy of Dental Sleep Medicine David Schwartz, D.D.S.

Throughout the panel discussions and question and answer sessions, education — both for providers and the public — was commonly cited as a foundational need. Discussion centered on the need to increase knowledge among patients and among physicians that oral appliance therapy can be a viable treatment option for many sleep patients.

"Better sleep health has and will always be a priority for all clinicians, specifically dentists, because one of the key treatments of sleep disorders can be the use of oral appliances. Bringing this systemic health and education to the forefront is of utmost importance for all our patients," noted ADA member dentist Payam Attai, D.M.D., who worked with fellow ADA member dentist Eric Pulver, D.D.S., to organize the summit, which was hosted by the ADA.

Medical-dental collaboration emerged as another major theme. Many attendees described a system in which physicians and dentists operate on parallel tracks, complicating referrals, limiting treatment coordination, and frustrating patients who must navigate two health care systems.

Insurance concerns dominated the discussion during a payer-focused panel. Panelists highlighted challenges related to insurance credentialing, coverage inconsistencies, and financial disincentives that limit the use of combination therapy. Stakeholders noted that underdiagnosed populations that include lower-income patients, women, and diverse populations are disproportionately affected by gaps in coverage and care.

> **Better sleep health has and will always be a priority for all clinicians, specifically dentists, because one of the key treatments of sleep disorders can be the use of oral appliances.**
>
> -Payam Attai, D.M.D.

"As a sleep neurologist, who has recognized for over 30 years the important role of dentistry as part of the collaborative health care team addressing patients with sleep apnea, it is exciting to see that the needle is moving with more attention being directed towards dental sleep medicine," noted summit attendee Jerald Simmons, M.D., who practices at Comprehensive Sleep Medicine Associates in The Woodlands, Texas. "I am honored to be part of this process, which falls in line with my 22 years of conducting an annual conference on collaborative care between dentists and physicians in the sleep space."

Near the close of the summit, attendees broke into working groups to develop recommendations for next steps. Across the four groups, several themes emerged:

LAYING THE FOUNDATION

Participants emphasized the need to clarify the dentist's role in airway health, build public awareness, and educate physicians and patients about dentistry's contributions. When the attendees broke into working groups, their suggestions for the future included efforts to improve communication between dentists and physicians, expand interoperability between dental and medical software systems, and promote joint advocacy initiatives.

Participants emphasized the need for more standardized payment models and medical-driven coverage for sleep-related therapies. Across all discussions, attendees agreed that advancing sleep and airway-focused dentistry will require expanded training, strong partnerships with the medical community, and advocacy that reflects the profession's commitment to comprehensive patient care.

For resources from the ADA related to sleep apnea, visit ADA.org/resources/ada-library/oral-health-topics/sleep-apnea-obstructive.■

ADA Member Advantage launches new ADA Rewards World Elite Mastercard

Cardholders earn bonus points, have access to World Elite Mastercard benefits

BY MARY BETH VERSACI

ADA Member Advantage, the endorsement program for members of the American Dental Association, has launched a new credit card for ADA members as well as their staff and families.

The ADA Rewards World Elite Mastercard is designed for consumers and small businesses. All cardholders will earn 1.5 bonus points per $1 spent on all purchases and five points on ADA, state dental society and select ADA Member Advantage-endorsed product purchases. Consumer cardholders will receive two points on gas and groceries and three points on all travel purchases, including airlines, hotels, rental cars and more. Business cardholders will also continue to earn two points on all dental supplies.

In addition to earning points, cardholders will have access to World Elite Mastercard benefits, including access to exclusive offers with select merchants, World Elite Concierge services and Mastercard's Priceless Experiences. The card will also be enabled with advanced security features, including Mastercard ID Theft Protection, Zero Liability Protection and Global Services for emergency assistance.

"The new ADA Member Advantage credit card program is designed to enhance member value through improvements to the bonus points program as well as the extensive list of cardholder benefits our members have access to as Mastercard World Elite cardholders," said Tony Frankos, chief portfolio officer for ADA Member Advantage. "We conducted a thorough search for a new provider that would offer quality customer service and financial services, in addition to exciting rewards and benefits to our members."

The new credit card program replaced the existing U.S. Bank Visa program. Existing ADA business and consumer cardholders were provided with new credit cards starting at the beginning of November 2025. All account information and existing bonus points will be available on the ADA Rewards World Elite Mastercard platform upon account conversion.

"At Mastercard, we're committed to supporting consumers and health care professionals with solutions that make their everyday financial lives easier," said Stefany Bello, senior vice president of digital partnerships, fintech and enablers for North America at Mastercard. "The ADA Rewards World Elite Mastercard empowers dentists and their teams to earn more on the purchases that matter most to their practice and their patients, whether it's dental supplies, health care essentials or everyday needs, while enjoying the security, convenience and exclusive benefits that come with being a World Elite cardholder."

Tallied Technologies and FinWise Bancorp will serve as the official program manager, network issuer processor, servicer and issuer for the program.

"We're so excited to work with ADA Member Advantage to provide this member benefit," said Sunil Singh, founder and CEO of Tallied Technologies. "Dentists can earn even more bonus points where they spend the most and can redeem those points on travel, gift cards, cash back and even more. ADA Rewards World Elite Mastercard cardholders will not only have access to a rich and comprehensive rewards platform, but an exceptional cardholder experience enabled through Tallied's modern credit platform."

ADA members and their staff and families who do not have an existing ADA credit card can apply at adamastercard.com to receive special introductory bonus point offers. Learn more about the ADA Rewards World Elite Mastercard program at adamemberadvantage.com. ■

ADA begins discussions with other groups to advance dental licensure exams

BY MARY BETH VERSACI

The American Dental Association, Joint Commission on National Dental Examinations and American Board of Dental Examiners have begun a series of collaborative discussions focused on enhancing the standards and delivery of clinical licensure competency examinations for dental professionals.

The discussions reflect a shared commitment by these organizations to ensure dental licensure assessments continue to evolve alongside advancements in clinical education, technology and patient care, according to a joint statement from the ADA and American Board of Dental Examiners.

"By working together, we are advancing our mutual goal of ensuring every licensed dentist enters the profession with proven competence and the highest standards of patient safety," ADA President Richard J. Rosato, D.M.D., said.

Through this collaboration, the ADA and American Board of Dental Examiners aim to identify opportunities for alignment in exam content, evaluation methods and candidate experience — ultimately strengthening the process by which new dentists demonstrate their readiness for practice, the groups said in the statement.

"Our dialogue with the ADA highlights our commitment to a modern, equitable licensure standard — grounded in rigorous clinical hand skills assessment and reflective of today's dental practice," said Mark Armstrong, D.D.S., chair of the American Board of Dental Examiners.

Both organizations anticipate continued engagement over the coming months as they explore best practices and potential innovations to further the dental licensure exam standards nationwide, according to the statement. ■

GOVERNMENT

ADA calls for adoption of higher funding levels in Labor-HHS bill

BY OLIVIA ANDERSON

The ADA, American Academy of Pediatric Dentistry, American Dental Education Association, and American Association for Dental, Oral and Craniofacial Research submitted a joint letter urging congressional appropriators to finalize the fiscal year 2026 Labor, Health and Human Services, Education and Related Agencies appropriations bill with strong support for federal oral health programs.

In the letter, addressed to the chairs and ranking members of the House and Senate Appropriations committees, the groups asked lawmakers to adopt the higher of the House or Senate committee-approved funding levels for multiple programs affecting oral health research, workforce development and oral disease prevention.

"We respectfully request your bipartisan support in finalizing the fiscal year 2026 Labor, Health and Human Services, Education and Related Agencies bill with strong investments in programs essential to dentistry and oral health," the letter said. "Specifically, we urge you to adopt the higher amount of the House and Senate Committee-approved funding levels for each of the individual programs."

It highlighted concerns about the Centers for Disease Control and Prevention Division of Oral Health, noting its role in supporting state and territorial programs and its contributions to community water fluoridation and other disease prevention initiatives. The organizations warned that staffing reductions could hinder the division's ability to maintain these efforts.

Workforce issues also featured prominently in the request. The groups cited recent Health Resources and Services Administration data showing that Title VII oral health training programs reached 1.5 million patients in medically underserved communities in academic year 2022–23. They emphasized that nearly 69% of program graduates practice in underserved areas.

The groups also voiced support for the Health Careers Opportunity Program, pointing to persistent recruitment challenges. More than one-third of dentists are actively recruiting dental hygienists and dental assistants, according to the letter, adding to the need for federal investments in strengthening the pipeline of future oral health professionals.

"Dental practice difficulties limit the number of patients dentists can see, and this problem is especially acute in underserved communities, which underscores the need for pathway programs to ensure the future strength and diversity of our nation's oral health workforce," the letter said.

In addition, the letter called for continued and increased funding for the Ryan White HIV/AIDS Program's dental components, citing stagnant reimbursement levels and rising care needs for people living with HIV. The organizations also thanked lawmakers for maintaining the National Institutes of Health's current structure allowing the National Institute of Dental and Craniofacial Research to remain as an independent institute.

"We also urge Congress to adopt language included in the Senate Appropriations bill that prohibits the administration from imposing an arbitrary cap on [National Institutes of Health] indirect research costs," the letter said.

A detailed table of fiscal year 2026 House and Senate proposed funding levels accompanied the letter, comparing each program with fiscal year 2025 enacted amounts. ■

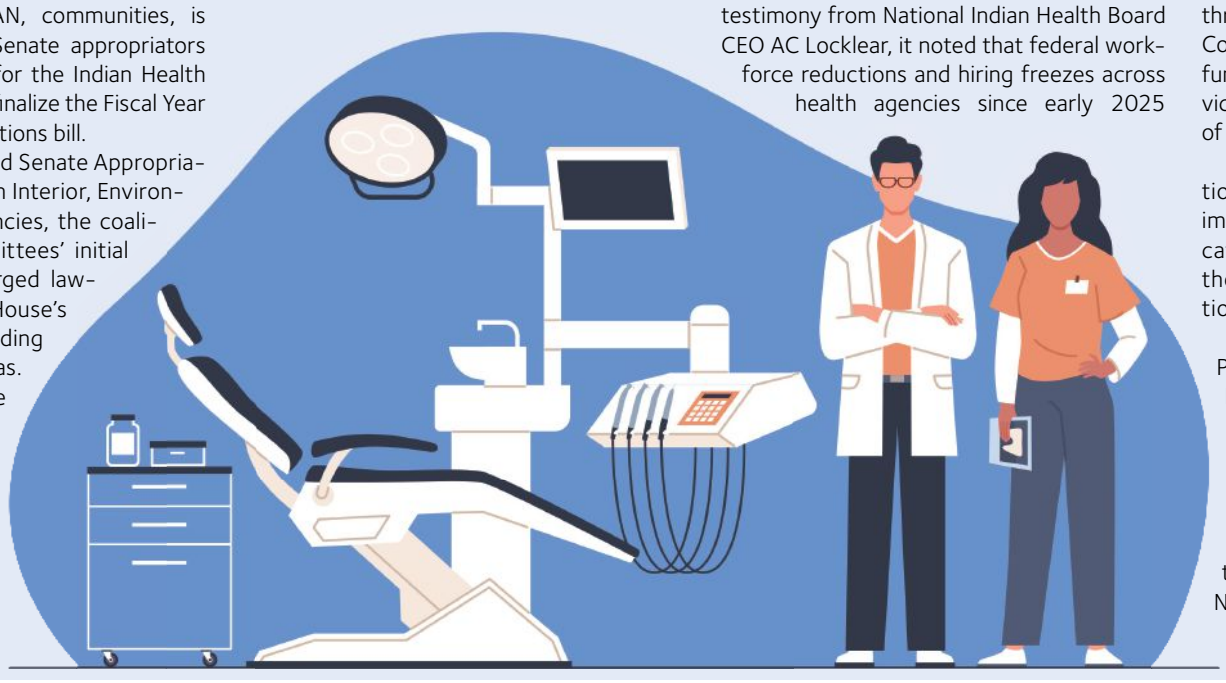
Boost Indian Health Service funding, AI/AN Health Partners urge

BY OLIVIA ANDERSON

The AI/AN Health Partners, a coalition that includes the ADA and is committed to improving health outcomes for American Indian and Alaska Native, or AI/AN, communities, is calling on House and Senate appropriators to strengthen funding for the Indian Health Service, or IHS, as they finalize the Fiscal Year 2026 Interior Appropriations bill.

In letters to House and Senate Appropriations Subcommittees on Interior, Environment and Related Agencies, the coalition praised the committees' initial support for IHS but urged lawmakers to adopt the House's higher proposed funding levels in three key areas. Their requests include $95.3 million for Indian health professions to address the service's 30% provider vacancy rate, $188.7 million for health care facilities to replace aging staff housing and $41.9 million for equipment to help modernize outdated diagnostic tools still in use across tribal, urban and federal facilities.

"The Indian Health Service is critical to how they access health care. However, the IHS must have sufficient resources to meet its mission to raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level," the coalition said.



The coalition underscored the growing urgency of IHS workforce challenges. Citing testimony from National Indian Health Board CEO AC Locklear, it noted that federal workforce reductions and hiring freezes across health agencies since early 2025 have disrupted tribal programs and worsened staff morale.

As the IHS marks its 70th anniversary, AI/AN Health Partners emphasized that the agency has never been fully funded and warned that recent program cuts further threaten access to care. The group urged Congress to provide the highest possible funding levels for FY 2026 to help the service meet its mission of elevating the health of AI/AN communities.

"With the Service experiencing additional program cuts this year, it is more important than ever that Congress allocate the highest funding level possible for the IHS in the Fiscal Year 2026 appropriations," the coalition said.

Along with the ADA, the AI/AN Health Partners include the American Academy of Pediatrics, American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, Association of Diabetes Care & Education Specialists, Commissioned Officers Association of the USPHS, International Certification & Reciprocity Consortium and National Kidney Foundation. ■

ADA calls for stronger dental benefits, transparency measures in Senate cost review

BY OLIVIA ANDERSON

The ADA is urging lawmakers to prioritize oral health as they examine strategies to address rising health care costs.

In a Dec. 3, 2025 letter to the Senate Committee on Health, Education, Labor and Pensions, the Association stressed that rising costs place a strain on patients, families, employers and taxpayers. Oral health, the ADA said, is inseparable from overall health, and the design and financing of dental benefits have a direct impact on whether individuals can obtain appropriate care when it is needed or must wait to be treated until their oral health problems grow even more serious, often leading to increased pain and higher overall costs. This problem is especially felt by low-income and medically vulnerable populations.

"Oral health is inseparable from overall health, and the design and financing of dental benefits have a direct impact on whether individuals can obtain timely, appropriate care or instead delay treatment until problems become more serious, painful, and costly, especially among low-income and medically vulnerable populations," the letter stated. It was signed by ADA President Richard Rosato, D.M.D., and Interim Executive Director Elizabeth Shapiro, D.D.S., J.D.

Drs. Rosato and Shapiro told the committee that sustainable cost containment must begin with prevention and early intervention. Because dental disease is largely preventable, they said that avoiding financial barriers to routine care and supporting public health measures such as community water fluoridation and school-based prevention programs can significantly reduce the need for expensive emergency treatment and restorative procedures.

> **Better transparency around where premium dollars go is an essential tool for tackling health care costs without reducing needed care.**
>
> –Richard Rosato, D.M.D., and Elizabeth Shapiro, D.D.S., J.D.

Addressing the growing burden of out-of-pocket expenses, Drs. Rosato and Shapiro reiterated that insurance should not be used in a way that creates cost barriers, noting that low annual maximums, high deductibles and excessive coinsurance often leave patients with chronic conditions exposed to the highest costs. They encouraged Congress to support clearer, more comparable summaries of dental benefits and stronger standards for supplemental dental coverage in Medicare Advantage so consumers can better understand what their plans actually provide.

The Association also highlighted the importance of improving value and transparency through dental loss ratios. In the letter, the ADA explained that requiring dental plans to report how premium dollars are spent, including the portion going to patient care versus administration or profit, would give families, employers and policymakers a clearer sense of value. The letter urged lawmakers to extend such transparency to employer-sponsored plans governed by the Employee Retirement Income Security Act, which often lack state-level consumer protections.

"Better transparency around where premium dollars go is an essential tool for tackling health care costs without reducing needed care," Drs. Rosato and Shapiro wrote.

To expand affordable care options, the letter encouraged Congress to support in-office dental membership plans and Direct Reimbursement arrangements, both of which emphasize prevention, patient choice and administrative simplicity. It also pressed for strengthened adult dental benefits in Medicaid, along with payment rates that support sustained dentist participation and reduce avoidable emergency department visits.

Finally, the ADA asked Congress to preserve and enhance health savings accounts and flexible spending arrangements while avoiding new taxes on dental services or essential oral health products. The letter emphasized that well-designed tax policy can help families manage out-of-pocket costs and avoid financial shocks associated with needed dental care.

"We encourage the Committee to ensure that any proposals to address rising health care costs recognize that ignoring oral health ultimately raises, rather than lowers, overall spending. When patients can access affordable, preventive-focused dental care, they are less likely to require expensive emergency treatment, hospitalizations, or complex interventions that strain families and public programs alike," the letter concluded. ■

Senate passes National Defense Authorization Act

Bill includes ADA-supported dental accreditation provision

BY OLIVIA ANDERSON

The U.S. Senate passed the National Defense Authorization Act on Dec. 17, 2025, clearing the annual defense policy bill for the president's signature after the House approved the measure last week. The bill includes an ADA-supported provision that aims to promote consistent accreditation standards for dental treatment facilities serving service members.

The legislation authorizes defense spending levels and establishes policy for the Department of Defense and related agencies. It is one of Congress' few "must-pass" legislative vehicles and has been enacted for 64 consecutive years.

The fiscal year 2026 National Defense Authorization Act authorizes $901 billion in defense spending. The measure also includes several provisions affecting military health care, including a section addressing accreditation of military dental treatment facilities that the ADA strongly supported throughout the entire legislative process.

Section 735 of the bill, sponsored by Rep. Brian Babin, D.D.S., R-Texas, directs the Department of Defense inspector general to examine potential accreditation gaps within military dental treatment facilities. Under the fiscal year 2021 National Defense Authorization Act, all military medical treatment facilities — including dental units — are required to be accredited.

The inspector general review would assess the extent of any remaining gaps, identify obstacles to accreditation and evaluate the resources needed to achieve full compliance with the 2021 mandate. The provision is intended to support consistent standards of care across dental facilities. The House previously passed a version of this legislation Sept. 10, 2025, and the ADA engaged in bicameral advocacy efforts to ensure the accreditation provision remained in the final version of the bill.

The latest legislation also includes Section 717, which requires the secretary of defense to submit plans to the House and Senate Armed Services Committees outlining how each military department will prioritize assignment of active-duty medical and dental personnel to military medical treatment facilities. The provision is aimed at addressing staffing shortages, meeting patient needs and maintaining standards of care. The ADA has not taken a formal position on that section.

The National Defense Authorization Act was signed by President Donald Trump on Dec. 18, 2025. ■

ADA urges HHS to withdraw proposed HIPAA cybersecurity rule

BY OLIVIA ANDERSON

A broad coalition of national health care organizations, including the ADA, sent a joint letter to Health and Human Services Secretary Robert F. Kennedy Jr., calling on the department to withdraw a proposed update to the HIPAA Security Rule and restart the process with greater collaboration from provider groups.

The Dec. 8, 2025 coalition letter was in response to the Notice of Proposed Rulemaking issued by the Health and Human Services' Office for Civil Rights, titled "HIPAA Security Rule To Strengthen the Cybersecurity of Electronic Protected Health Information." Originally advanced during the previous administration, the proposal would establish new cybersecurity requirements for regulated health care entities. The coalition said the rule should be immediately withdrawn "without further consideration."

"We instead encourage HHS to conduct a collaborative outreach initiative with our organizations and other regulated entities that are impacted to develop practical and actionable cybersecurity standards for more robust protections of individuals' health information, without the extreme and unnecessary regulatory burden that health care providers and other stakeholders would face under the crushing and unprecedented provisions of this Proposed Rule," the letter said.

The coalition emphasized that it supports strong cybersecurity standards and recognizes the importance of the existing HIPAA framework. However, it said the proposal would create significant new financial burdens for providers and require implementation timelines that do not align with the complexity of today's health care technology systems.

While urging withdrawal of the proposal, the coalition called for Health and Human Services to partner more closely with providers and other stakeholders to craft cybersecurity standards that improve patient protections while remaining feasible for organizations of varying sizes.

"We urge you to withdraw the Proposed Rule; our organizations stand ready to work with the Trump Administration to ensure that we develop a more innovative approach and address cybersecurity concerns without imposing excessive burdens on the health care sector. We remain deeply committed to enhancing cybersecurity policies collaboratively and thoughtfully," the coalition concluded. ■

Appeals court declines immediate review of Delta Dental class certification

BY NOAH LEVINE

A federal appeals court has denied a request for immediate review of the decision rejecting class certification in the ongoing antitrust litigation against Delta Dental. As a result, individual dental providers who wish to pursue claims may need to act promptly to protect their rights.

The litigation, filed in 2019, alleges that Delta Dental Plans and the Delta Dental Plans Association violated federal antitrust laws by agreeing to reduce reimbursements through territorial restrictions, fix prices for dental goods and services, and limit competition. Plaintiffs estimate that nearly 240,000 dental providers were harmed by the alleged conduct.

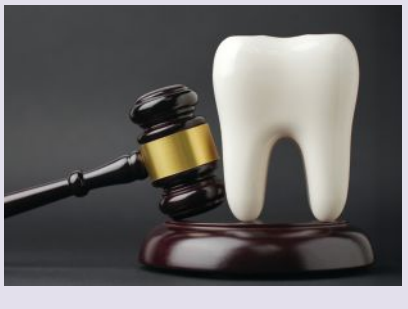
Plaintiffs sought to proceed on behalf of a nationwide class of in-network Delta Dental providers, but in September 2025, the U.S. District Court for the Northern District of Illinois denied the motion for class certification. The plaintiffs then asked the Seventh Circuit Court of Appeals for permission to immediately appeal that ruling, but the appellate court denied the request.

These decisions do not address the merits of any individual provider's claims, which plaintiffs continue to believe are strong. However, without a certified class, providers must file separate lawsuits to seek recovery. While the class certification issue was pending, the statute of limitations was paused, but it has now begun to run again. Providers who do not act promptly may lose their right to recover.

Because the ADA cannot provide legal advice to member dentists or represent them in the current proceeding, a dentist considering legal action should consult with an attorney to determine whether to file an individual claim or contact one of the law firms representing the plaintiffs in the ongoing litigation:

- Quinn Emanuel Urquhart & Sullivan, LLP 191 N. Wacker Drive, Suite 2700, Chicago, IL 60606, email: deltadentallitigation@quinnemanuel.com, phone: (312) 705-7424
- Wollmuth Maher & Deutsch LLP 500 Fifth Avenue, New York, NY 10110, email: dentists@wmd-law.com, phone: (212) 556-0391

The ADA is not promoting or endorsing any law firm. The ADA News will continue to update members as developments occur in this litigation. ■



ADA seeks representative for American Medical Association advisory committee

Nominations open Jan. 15

BY MARY BETH VERSACI

The American Dental Association is seeking a representative to serve on an American Medical Association advisory committee that provides input on the value of medical procedures to help inform Medicare payment calculations.

The Medicare Resource-Based Relative Value Scale describes the resources required to provide a medical service. The Centers for Medicare & Medicaid Services applies it to Current Procedural Terminology (CPT) codes used to document and report medical procedures to calculate Medicare payments.

The Relative Value Scale Update Committee makes relative value recommendations to CMS for new, revised and potentially misvalued CPT codes. While the ADA does not sit on the Relative Value Scale Update Committee, it does sit on the committee that advises it.

The RUC Advisory Committee assists in the development of relative value units and presents its specialties' recommendations to the Relative Value Scale Update Committee. The advisory committee consists of representatives from specialty societies seated in the American Medical Association House of Delegates as well as other invited specialty societies, including the ADA. The ADA appoints a primary and alternate adviser to the committee.

Nominations for the primary adviser position will be open from Jan. 15 to Feb. 15. Nominations should include a curriculum vitae that is no more than three pages and a formal letter to the ADA outlining familiarity, experience and interest related to the RUC Advisory Committee and CPT process. Nominations should be sent to dentalcode@ada.org for review by the ADA Council on Dental Benefit Programs.

The primary adviser will be required to attend three in-person Relative Value Scale Update Committee meetings per year and assist in developing surveys, when needed, to determine the amount of work and practice expense health care providers put into delivering procedures associated with certain oral health-related CPT codes. The three year term begins in late April.

To learn more about these processes, visit the American Medical Association website at ama-assn.org. ■

Nominate new dentists for ADA 10 Under 10 Award

2026 submissions open Jan. 7

BY MARY BETH VERSACI

The American Dental Association is seeking nominations for new dentists who are demonstrating excellence in their work and inspiring others.

Developed by the ADA New Dentist Committee in 2017, the ADA 10 Under 10 Award honors 10 dentists who graduated from dental school less than 10 years ago and are making

a difference in science, research and education; practice excellence; philanthropy; leadership; and advocacy. Each awardee will receive a commemorative plaque and be featured at an ADA event and across ADA channels.

"I would encourage everyone to nominate anybody that inspires you that is doing great things in dentistry," said Allison C. Scully, D.D.S., a 2025 recipient of the 10 Under 10 Award. "I know that there are so many people around the country who are doing amazing work that maybe isn't getting the publicity that it deserves. ... Just think of the impact that nominating somebody who's already doing amazing work can have, not only on them, but future generations as well."

Nominations will be open from Jan. 7 to March 16. Nominees must be active ADA members who graduated from a U.S. accredited dental school between 2016 and 2025 or international ADA members who graduated from dental school between those same years. The New Dentist Committee will select the award recipients.

To learn more or download the nomination guide, visit ADA.org/10under10. ■

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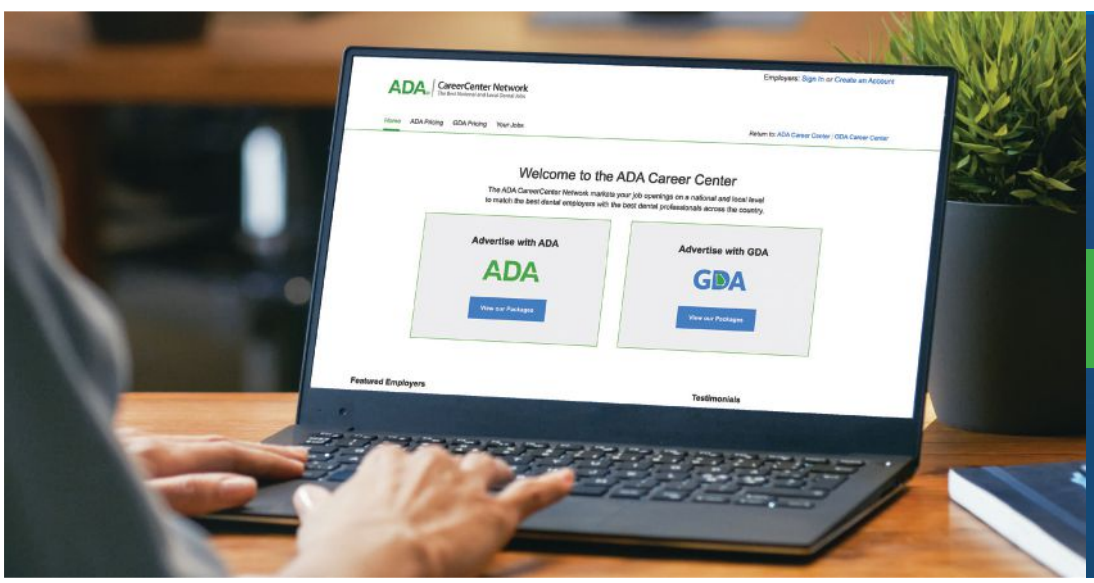

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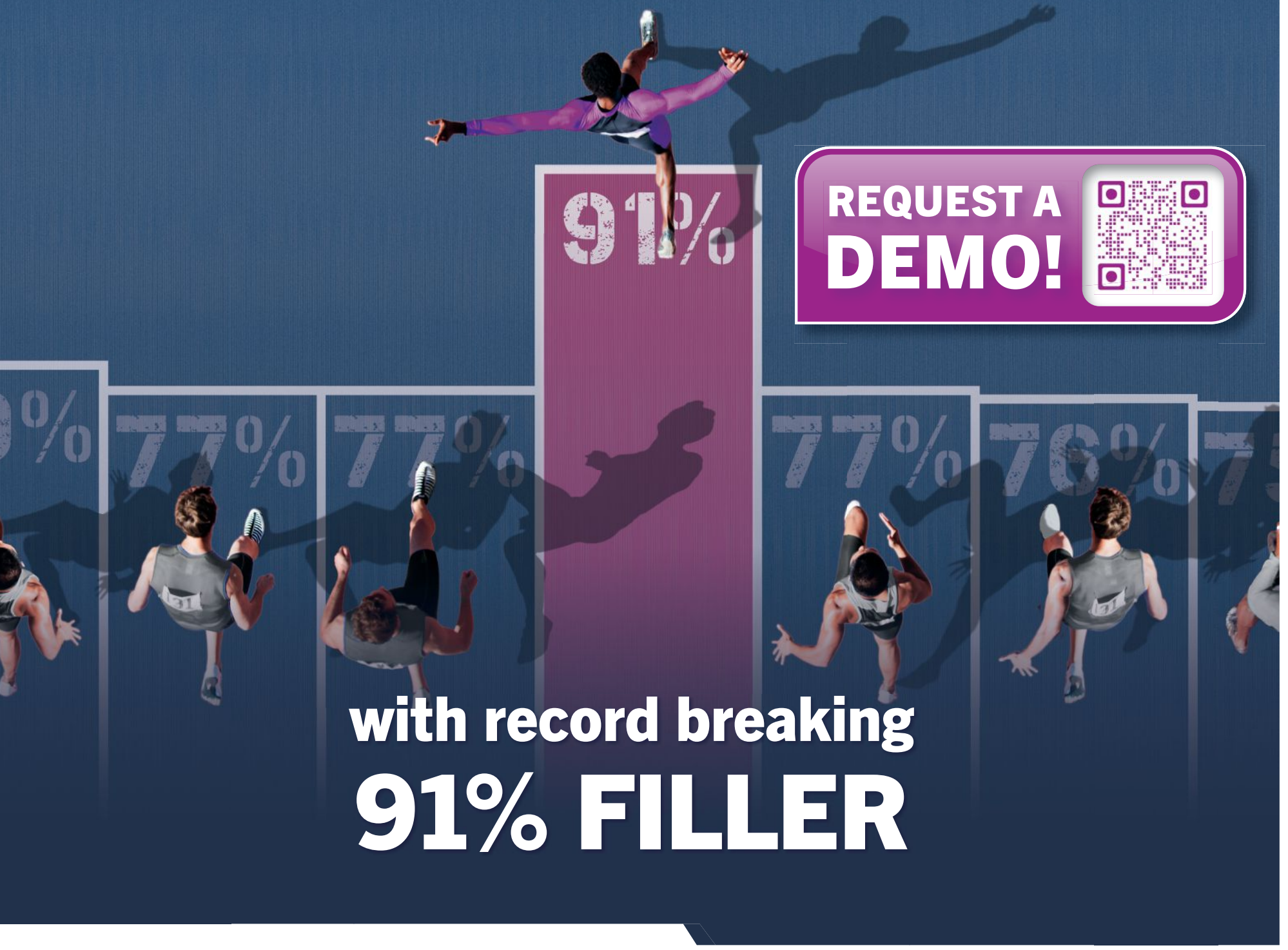

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